



# CIVIL SOCIETY FUND

Strengthening civil society for improved  
HIV&AIDS and OVC service delivery in Uganda



## Effectiveness of OVC Interventions towards Improvement in Food and Nutrition Security and Economic Strengthening among OVC Households in Uganda

### FINAL REPORT



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### **Cover Photos:**

**Photo 1:** A caregiver's backyard garden with green vegetables in Ibanda District, where Ankole Diocese trained and supported caregivers to establish vegetable gardens to improve household nutrition.

**Photo 2:** Sarah, a caregiver at age 15 (4<sup>th</sup> right) in Mayuge District with her siblings whom takes care of look at their goat that had recently delivered a kid. The goat was provided by FLEP Diocese.

# CONTENTS

|  |           |
|--|-----------|
| CONTENTS .....   | iii       |
| LIST OF TABLES.....  | v         |
| LIST OF FIGURES.....   | vii       |
| ACKNOWLEDGEMENTS .....   | viii      |
| ACRONYMS/ABBREVIATIONS.....  | ix        |
| OPERATIONAL DEFINITIONS.....   | x         |
| EXECUTIVE SUMMARY .....  | xii       |
| <b>I INTRODUCTION AND BACKGROUND.....</b>  | <b>1</b>  |
| 1.1 Introduction .....   | 1         |
| 1.2 The Civil Society Fund.....  | 1         |
| 1.3 Background to the Study.....   | 1         |
| 1.4 Problem Statement.....   | 3         |
| 1.5 Objectives of the Study .....  | 3         |
| 1.5.1 General Objective .....  | 3         |
| 1.5.2 Specific Objectives.....   | 3         |
| 1.5.3 Research Questions .....   | 4         |
| 1.6 Justification of the Study.....  | 4         |
| 1.7 Methodology .....  | 4         |
| 1.7.1 Study Design .....   | 4         |
| 1.8 Study population.....  | 5         |
| 1.9 Study Sites.....   | 5         |
| 1.9.1 Sampling of Sub-counties and Villages.....   | 6         |
| 1.9.2 Sample Size and Sampling Procedures for OVC Households, Caregivers and Child Respondents ..... | 6         |
| 1.9.3 The Sample of Out-of-School OVC trained in Skills through Apprenticeships.....                 | 7         |
| 1.9.4 The Qualitative Sample .....   | 7         |
| 1.9.5 Training of Field Data Collectors and Pre-test of Tools .....                                  | 8         |
| 1.10 Data Collection Methods and Tools .....   | 8         |
| 1.11 Ethical Considerations and Approval .....   | 9         |
| 1.12 Data Processing and Analysis .....  | 9         |
| 1.12.1 Processing and Analysis of Quantitative Data.....   | 9         |
| 1.12.2 Processing and Analysis of Qualitative Data.....  | 10        |
| 1.13 Conceptual Framework.....   | 10        |
| 1.14 Limitations and Challenges of the Study.....  | 12        |
| 1.15 Profiles of the Study Organizations in the Sample .....   | 13        |
| <b>2 SOCIO-DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS.....</b>                                       | <b>14</b> |
| 2.1 Introduction .....   | 14        |
| 2.1.1 Characteristics of Caregivers.....   | 14        |
| 2.1.2 Characteristics of Child Respondents.....  | 15        |
| 2.1.3 Characteristics of Out-of-School OVC Skills Apprentices .....                                  | 17        |
| <b>3 SUPPORT TOWARDS ECONOMIC STRENGTHENING OF OVC HOUSEHOLDS.....</b>                               | <b>18</b> |
| 3.1 Introduction .....   | 18        |
| 3.2 Interventions implemented for Economic Strengthening of OVC Households and Approaches Used.....  | 18        |

|       |   |    |
|-------|---|----|
| 3.3   | Effectiveness of Economic Strengthening Interventions in increasing Income Growth                       | 29 |
| 3.3.1 | Income Growth.....  | 29 |
| 3.3.2 | Savings .....   | 36 |
| 3.4   | Effectiveness of Economic Strengthening Interventions in relation to Assets Growth and Protection ..... | 38 |
| 3.4.1 | Types of Assets Acquired .....  | 41 |
| 3.4.2 | Protection of Household Assets .....  | 44 |
| 4     | SUPPORT TOWARDS FOOD AND NUTRITION SECURITY .....   | 47 |
| 4.1   | Introduction .....  | 47 |
| 4.2   | Food and Nutrition Interventions Supported.....   | 47 |
| 4.3   | Effectiveness of Food and Nutrition Security Support.....   | 49 |
| 4.3.1 | Food Availability amongst Supported OVC Households.....   | 49 |
| 4.3.2 | Use of better farming practices ever since support was received .....                                   | 57 |
| 4.3.3 | Food Accessibility amongst Supported OVC Households.....  | 60 |
| 4.3.4 | Food Utilization amongst OVC Households.....  | 68 |
| 5     | CONTRIBUTION OF OVC SUPPORT TO THE WELFARE OF OVC AND THEIR HOUSEHOLDS.....                             | 72 |
| 5.1   | Introduction .....  | 72 |
| 5.2   | Impact of Support on the Education of OVC.....  | 72 |
| 5.3   | Impact of Support on the Health of OVC and their other Household Members .....                          | 75 |
| 5.4   | Factors influencing Improvement in Children’s Welfare .....   | 77 |
| 6     | DISCUSSION.....   | 80 |
| 6.1   | Introduction .....  | 80 |
| 6.2   | The Contribution of Economic Strengthening Interventions.....   | 80 |
| 6.3   | Contribution of Food and Nutrition Security Interventions.....  | 83 |
| 6.4   | Contribution to Children’s Wellbeing .....  | 85 |
| 7     | CONCLUSIONS, LESSONS AND RECOMMENDATIONS.....   | 86 |
| 7.1   | Conclusions .....   | 86 |
| 7.2   | Lessons .....   | 88 |
| 7.3   | Recommendations .....   | 88 |
|       | ANNEX 1: REFERENCES .....   | 91 |
|       | ANNEX 2: LIST OF SUB-COUNTIES STUDIED .....   | 92 |
|       | ANNEX 3: LIST OF KEY INFORMANTS INTERVIEWED .....   | 93 |
|       | ANNEX 4: PROFILES OF SAMPLE ORGANIZATIONS STUDIED.....  | 95 |

## LIST OF TABLES

|   |    |
|---|----|
| Table 1: Districts, CSF Sub-Grantees and other IPs in the Sample.....   | 5  |
| Table 2: Sample Size of Caregivers and OVC covered by the Study.....  | 6  |
| Table 3: Sample of Out-of-School OVC by Gender and by District.....   | 7  |
| Table 4: Socio-Demographic Characteristics of Caregivers in the Sample .....  | 14 |
| Table 5: Socio-Demographic Characteristics of OVC in the Sample .....   | 16 |
| Table 6: Socio-Demographic Characteristics of Out-of-School OVC in the Sample .....   | 17 |
| Table 7: Support to OVC Households to run IGAs.....   | 19 |
| Table 8: Proportion of OVC Households that received IGA Support by District.....  | 19 |
| Table 9: Distribution of Types of IGAs operated by Caregivers by District.....  | 21 |
| Table 10: Training of Caregivers in Business Skills and IGA Management by District.....   | 23 |
| Table 11: Benefits from Training of OVC HH Members in Economic Strengthening/IGA Management.....                                  | 24 |
| Table 12: Percentage Distribution of Trainees by type of Trades .....   | 26 |
| Table 13: Percentage Distribution of trainees by their current Main Occupation.....   | 27 |
| Table 14: Caregiver Reported Changes in Income over the Past 3 Years by District .....  | 30 |
| Table 15: Income from IGAs.....   | 31 |
| Table 16: Modality of IGA Support and Change in Household Income.....   | 31 |
| Table 17: Descriptive Statistics for Monthly Income of Out-of-School OVC Trained in Skills...                                     | 32 |
| Table 18: Results of the Multinomial Logistic Regression Model for Income.....  | 35 |
| Table 19: Modality of IGA Support and Savings by Caregiver.....   | 37 |
| Table 20: Caregivers' Savings Level by District .....   | 38 |
| Table 21: Relationship between training in economic strengthening (IGAs/business skills) and asset acquisition .....              | 39 |
| Table 22: Detailed Results of logistic Regression Model for Asset Acquisition.....  | 40 |
| Table 23: Type of Assets acquired by OVC Households.....  | 42 |
| Table 24: Legal Protection and Potential to access Legal Services for OVC Households.....   | 45 |
| Table 25: Perception of Legal Status on Land/Home by Male and Female Caregivers.....  | 45 |
| Table 26: Perception of Access to Legal Support by Male and Female Caregivers.....  | 45 |
| Table 27: Type of Food and Nutrition support received by District .....   | 48 |
| Table 28: Membership into Farming Group/Association.....  | 48 |
| Table 29: Ways in which Support received for Food and Nutrition was Useful .....  | 49 |
| Table 30: Food Harvests from the Last Season amongst OVC Households [ <i>number of Kilograms harvested</i> ] .....                | 50 |
| Table 31: Caregiver Reported Changes in Food Production in Past 3 Years by District.....  | 51 |
| Table 32: Caregiver Reported Reasons for Increased Household Food Production .....  | 52 |
| Table 33: Application of the Knowledge Acquired through Training amongst OVC Households .....                                     | 53 |
| Table 34: Results of the Logistic Regression Model for Food Increase .....  | 55 |
| Table 35: Change in use of better farming practices since three years ago.....  | 58 |
| Table 36: Percentage of Caregivers reporting an increase in use of better Farming Practices in the past 3 years by District ..... | 58 |
| Table 37: Descriptive Statistics for Number of Meals Eaten in OVC Households by District....                                      | 61 |

|  |    |
|--|----|
| Table 38: Caregivers' Responses regarding whether their Households are to meet all their Food Needs .....                  | 64 |
| Table 39: Caregiver Responses to Questions on Food Accessibility during the Past 6 Months.                                 | 64 |
| Table 40: OVC Responses to questions on Food Accessibility in the Past 3 Months .....                                      | 65 |
| Table 41: Ways in which received support for Food and Nutrition has not been Useful.....                                   | 66 |
| Table 42: Caregiver Reported Reasons for Inadequate Food in their Households .....   | 67 |
| Table 43: Consumption of a Fruit, Meat, Fish and Greens by Children in the last one Week amongst OVC Households.....       | 69 |
| Table 44: Consumption of a Fruit, Meat, Fish and Greens by Children in the last one Week by District .....                 | 69 |
| Table 45: Presence and Usefulness of a Backyard Garden in OVC Households .....   | 70 |
| Table 46: Reasons for not being able to eat the kind of food wanted by household members..                                 | 71 |
| Table 47: Caregivers' Views about Changes in their Capacity to meet the Education Needs of Children under their Care.....  | 72 |
| Table 48: Caregiver's views about whether Children under their care would continue in school without External support..... | 72 |
| Table 49: Reasons for Non-School Attendance among OVC .....  | 75 |
| Table 50: Distribution of Household's Capacity to pay for Children's Education or Medical Bills by District.....           | 77 |
| Table 51: Factors Contributing to Household's capacity to Pay for Children's Education or Medical Bills.....               | 78 |

## LIST OF FIGURES

|  |    |
|--|----|
| Figure 1: Conceptual Framework .....   | 11 |
| Figure 2: Type of IGA Support received by Caregivers.....  | 20 |
| Figure 3: Type of IGA being run by OVC Caregivers/Households .....   | 21 |
| Figure 4: Perceptions of the Skills Trainees about the Usefulness of Training.....                                       | 28 |
| Figure 5: Reported Changes in OVC Household Income over the Past 3 Years (Caregiver Reported) .....                      | 29 |
| Figure 6: Reported Monthly Earnings by OVC Trained in Skills.....  | 32 |
| Figure 7: Caregiver has Savings (Caregiver Reported).....  | 36 |
| Figure 8: Level of Savings reported by Caregivers .....  | 37 |
| Figure 9: Reported Acquisition of Assets by OVC Households in Past 3 Years by District (Caregiver Reported) .....        | 39 |
| Figure 10: Measures taken to Protect OVC Household Assets .....  | 44 |
| Figure 11: Type of Food and Nutrition Support received by OVC Households .....   | 47 |
| Figure 12: Caregiver Reported Changes in Food production by Provider of Support.....                                     | 51 |
| Figure 13: Percentage of Caregivers or their Household members who received Training in Improved Farming Practices ..... | 52 |
| Figure 14: Presence of a granary/food store .....  | 59 |
| Figure 15: Presence of Food in the Store/Granary .....   | 59 |
| Figure 16: Number of Meals eaten in OVC Households 1 day Preceding the Study .....                                       | 61 |
| Figure 17: Type of Food consumed during the Past Week.....   | 62 |
| Figure 18: Reasons for Missing School Days amongst OVC Respondents.....  | 74 |
| Figure 19: OVC who sought treatment the last time they were ill .....  | 76 |

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Principal Investigator



## ACRONYMS/ABBREVIATIONS

|        |   |   |
|--------|---|---|
| CSF    | - | Civil Society Fund  |
| CSOs   | - | Civil Society Organizations                               |
| DFID   | - | Department for International Development                  |
| EMESCO | - | EMESCO Development Foundation <sup>3</sup>                |
| IEC    | - | Information, Education and Communication                  |
| IRCU   | - | Inter-Religious Council of Uganda                         |
| KCSON  | - | Kibaale Civil Society Organizations Network               |
| MEA    | - | Monitoring and Evaluation Agent                           |
| OVC    | - | Orphans and Vulnerable Children                           |
| PPS    | - | Probability proportional to Size                          |
| RFP    | - | Request for Proposals                                     |
| SDS    | - | Strengthening Decentralization for Sustainability Project |
| SEDC   | - | Socio-Economic Data Centre Ltd                            |
| TASO   | - | The AIDS Support Organization                             |
| TMA    | - | Technical and Management Agent                            |
| ToR    | - | Terms of Reference  |
| VHTs   | - | Village Health Teams                                      |
| VSLAs  | - | Village Savings and Loans Associations                    |

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<sup>3</sup> The acronym EMESCO is derived from the organization's philosophy and approach: '**E**' for Empowering communities; '**M**' for Meeting needs in a sustainable way; '**E**' for Enabling rural communities to live in harmony and in a healthy environment; '**S**' for Supporting better livelihoods; '**C**' for Cooperating with local, national and international development organizations and other stakeholders and '**O**' for Offering opportunities for development.

## OPERATIONAL DEFINITIONS

**Asset:** Any physical or tangible item of economic value owned by an individual, a household or a group, especially that which could be converted into cash.

**Primary Caregiver:** The individual who takes primary responsibility for the physical, mental and emotional needs and well being of a child

**Child:** A person who is below the age of 18 years

**Economic Strengthening:** Includes a range of strategies and interventions that provide or enhance people's income, build their knowledge, skills and increase their social and economic assets.

**Food Access:** The household's ability to get food in the marketplace or from other sources (barter, transfers, gifts, etc.) to obtain levels of appropriate foods needed to maintain consumption of an adequate diet/nutrition level. Food access depends largely on household purchasing power.

**Food Availability:** The consistent availability to individuals or households of sufficient quantities of appropriate, necessary types of food from domestic production, commercial imports or donations or existence of such food within reasonable proximity to them or within their reach.

**Food insecurity:** Food insecurity is distinguished in two ways; chronic (a long-term or persistent inability to meet minimum food consumption requirements) and transitory (a short-term or temporary food deficit).

**Food Security:** Food security is a situation when all people in a household at all times have both physical and economic access to sufficient food to meet their dietary needs for a productive and healthy life.

**Food Utilization:** Refers to the proper use of food; proper food processing and storage; adequate knowledge and use of nutrition and child care techniques; and adequate health and sanitation practices.

**Household:** A group of people who normally live and eat together in one spatial unit and share domestic functions and activities.

**Income:** The amount of money or its equivalent received during a period of time in exchange for labor or services, or from the sale of goods or property, or as profit from financial investments.

**Income-generating activity:** Any legal activity that can boost household income and living standards, including agricultural/livestock production, horticulture, micro-enterprises, handicrafts, etc.

**Livelihood:** Capabilities, assets and strategies that individuals and households use to sustainably meet their basic needs including adequate food, goods and services

**Orphans:** A child who has lost one or both parents or the survival status of the biological parents is unknown

**Orphans and Vulnerable Children interventions:** All activities / services provided to an OVC, their household or their community, aimed at improving the well-being of the child or their household.

**Vulnerable child:** A child who is suffering and/ or is likely to suffer any form of or deprivation and is therefore in need of care and protection

**Vulnerability:** A state of being in a risky situation, where a person is likely to suffer significant physical, emotional or mental harm that may result in their human rights not being fulfilled.

**Wellbeing:** In the context of children's rights, well being refers to the realization of children's rights and the fulfillment of the opportunity for a child to be what she or he can be.

## EXECUTIVE SUMMARY

Up to 43% of all children (7.3 million) in Uganda live in moderately and 8% (1.3 million) in critically vulnerable situations. Although several efforts by government and civil society organizations (CSOs) have been made in the recent past, services provided over the years remain inadequate. In response to this gap, the Civil Society Fund (CSF) through 42 sub grantees provided interventions to 98,795 OVC (49.7% females, 50.3% males) and their households between 2009 and 2011. Up to 72% of these received services in social economic security, while 61% received services in food and nutrition security. However, there is no evidence about the effectiveness of food and nutrition security and economic strengthening interventions in the national OVC response, and what models or approaches work best in delivering these interventions.

The overall objective of this study was to assess the effectiveness of OVC interventions towards improvement in food and nutrition security and economic strengthening among targeted OVC households in five selected districts of Uganda. The study was conducted in a sample of five districts of Mityana in Central Region, Mayuge in Eastern Region, Gulu in Northern Region, Kibaale in Western Region, and Ibanda in South Western Region.

The study was undertaken using a cross-sectional study design, combining both the qualitative and quantitative research methods. The primary study population consisted of OVC aged 10-17 and their primary caregivers. The secondary study population included a wide-range of key informants. A total sample of 850 OVC and 866 caregivers were interviewed during this study. Data was also collected through Focus Group Discussions (FGDs) with OVC and caregivers, in-depth interviews with key informants, observation and document reviews.

### ***Contribution of OVC Interventions to Income Growth in OVC Households***

About one third (33.4%) of the caregivers reported that they had received support in the past 3 years to run an IGA. Of those who received support for an IGA, 71.3% were still running the IGAs for which they received support at the time of this study. A few of the original IGAs had evolved into other activities, while others had collapsed due to bad weather, crop or animal diseases, caregiver illness, among others. Slightly more than half (51.9%) of the caregivers that received IGA support reported that they realized income from the IGA. Many caregivers (68.4%) at the same time reported challenges with their IGAs, which included being expensive to run (59.6%), lack of quick benefits (36.9%), being labor demanding (29.1%), being time consuming (19.1%), and poor markets and prices for the products (11.3%).

Findings indicate that the VSLA support promoted a culture of savings and enabled caregivers to accumulate savings. Almost half (49.3%, n=427) of the caregivers reported that they had some savings. However, majority of those who reported savings (61.1%) had savings of not more than 50,000, indicating a very low level of savings. Thus whereas the culture of savings is slowly taking root, the level of savings is still meager.

Up to 42.1% of the caregivers reported an increase in their income in the past 3 years, the most cited sources of the increase in income being training in IGAs (31.6%), use of improved seeds/breeds (23.2%), and joining saving groups (14.6%). About 60.8% of the households who

received both agriculture/farming and IGA support in the last 3 years reported increase in household income compared to 39.2% who received only agriculture/farming support ( $p = 0.000$ ). On the other hand, it is striking that there were almost as many caregivers reporting a decrease in income as those reporting an increase. Among those who reported a decrease in income, the most cited reason was ill-health of the caregiver (27.9%), followed by bad weather that affected crops (27.2%), and crop pests and diseases (17.9%).

Amongst the out-of-school OVC trained in skills through apprenticeships, 75% rated the training received as very useful, and 62.7% reported that they were utilizing the skills acquired from the training at the time of this study; and 58.2% stated that the skills had enabled them get some income. Those who ranked the training as moderately useful or not useful at all cited lack of start-up capital/tools, lack of materials, lack of premises, failure to complete training, and lack of employment. However, more than half (51%) of the OVC reported that they earned 50,000 or less in a month. The low earnings were attributed to lack of their own independent workplaces, inadequate materials and tools, and the fact that they were still new in the market.

The determinants of increase in income were found to include: education level of the caregiver, Size of land owned/accessed by OVC households, type of IGA run by OVC household, and training household members economic strengthening (managing IGAs, running business, etc).

### ***The Contribution of OVC Interventions to Assets Growth and Protection***

Slightly more than half of the caregivers (53.9%,  $n=467$ ) reported that their households had acquired new assets during the past 3 years. The findings indicate that there was a positive relationship between receiving training in business skills and IGA management, and acquisition of assets ( $p=0.000$ ). Further analysis also shows that 63.8% of the caregivers who received both agricultural/food and IGA support also reported that they had acquired assets as compared to 43.3% who did not get IGA support ( $p=0.000$ ). Acquisition of assets or property over the last 3 years was also associated with access to micro-credit, and training agro-business management.

Only slightly more than one third (36.4%,  $n=315$ ) of those who reported having acquired new assets reported that some measures were taken to safeguard or protect the assets. The measures reported mainly consisted of acquisition of titles (44.1%), writing the assets in Wills (24.1%), and registering them with the authorities (26%). More than a half (56.9%) of the caregivers believed that they have sufficient legal status to remain in their home/land, while less than half (49.4%) believed s/he would be able to access legal support if needed. These beliefs and confidence were significantly higher among male compared to female caregivers.

### ***The Contribution of Food and Nutrition Security Interventions to Improving Food Availability, Access and Utilization in OVC Households***

**Food Availability:** All (100%) of the caregivers reported that they received support to improve food production and nutrition in their households. The support was mainly in form of crop seeds, animal breeds, farm tools and training in improved agricultural practices. Up to 58% of the caregivers assessed the support received in food and nutrition security was useful, having led to increased food security (51.1%), adoption of new food crops and animal breeds (10.2%), and contributed to increased income through the sale of surplus food (31.6%). Almost half

(47.9%) of the caregivers reported an increase in their food production in the past 3 years. Increases in food production were mainly attributed to training in improved farming methods (73.7%), and use of improved seeds/planting materials (61.2%). The determinants of increase in food production were found to include: household size, education level of the caregiver, age category of caregiver, land ownership and size, application of better farming practices (such as manure/fertilizers, improved seeds/varieties and pesticides), and training caregivers in improved farming and livestock rearing practices.

**Food Access:** Results indicate that overall, less than half of the OVC households (47.1%) had 3 meals the day before the interview; 40.3% had two meals; while 11% had one meal. Types of food eaten the previous day by OVC households were found to be almost balanced between carbohydrates, proteins and vitamins. Awareness levels regarding good nutritional practices were found to be relatively high, attributed to trainings received on nutrition. About half (49.3%) of the OVC caregivers believed their households were able to meet all their food requirements through the food they grow, while on the contrary, majority of the caregivers (79.4%) reported that their households always had enough to eat during the past 6 months. Overall these findings indicate that for some households, food accessibility is still a challenge. Availability of food was negatively affected by such factors as ill health of the caregiver, bad weather, and small pieces of land.

**Food Utilization:** Majority (76.7%) of caregivers as well majority of OVC (76.5%) acknowledged that children had eaten a fruit in the last one week and there were not significant differences ( $P=0.870$ ) in the consumption of a fruit by children between OVC households supported by CSF sub-grantees and other IPs. Overall consumption of other essential foods in the past one week was meat (35.0%); fish (27.1%); and greens (94.1%). The high figure for greens was attributed to the promotion of backyard/kitchen gardens by the implementers.

### **Contribution of OVC Support to the Welfare of OVC and their Households**

Majority of the OVC respondents (95%,  $n=810$ ) were in school, and 46.7% of the caregivers acknowledged that their ability to pay for either their children's scholastic requirements or medical bills has improved over the last 3 years. Some caregivers who participated in the FGDs also reported that the support received was helping them with the education of their children, paying medical bills, and meeting other domestic needs. Some key informants also observed that due to the increase in school retention of OVC some other problems such as teenage pregnancies and child marriages that had previously been rampant within particular communities had reduced, as children are kept busy in school. The main factor influencing improvement in children's welfare was found to be increase in household income accruing from IGAs.

### **Conclusions**

Interventions for OVC in economic strengthening contribute to an increase in income for OVC households. Most caregivers who received, IGA support, training, or participated in VSLAs all report an increase in their income over the past 3 years. Households which receive both IGA support and support for food and nutrition security are more likely to realize increase in incomes, and to acquire new assets than those who receive only one form of support.

Economic strengthening interventions for OVC households also contribute positively to assets growth. Asset acquisition was found to be significantly related to IGA support and economic strengthening training. However, there remains little being done to protect the assets and rights to assets of OVC and their households. The need for this protection is greater among female caregivers, and female-headed households.

OVC interventions contribute positively to food availability, accessibility and utilization. However, this study notes that some households are still food insecure.

OVC targeted interventions in economic strengthening and food and nutrition security positively contribute to the improvement in the wellbeing of OVC and their households by making income available that is used to meet children's needs for education, medical care, clothing and other basic needs. Beyond these, the interventions have longer term positive impacts e.g., by keeping children in school.

### **Lessons**

- Group-based approaches are critical for raising household incomes, growing savings and generating other benefits to caregivers.
- IGA projects that have a quick multiplication potential and short gestation period such as pigs can be very productive and increase household incomes in a short period. At the same time, the 'revolving animal' or 'animal multiplication' approach is best suited working with such animals, compared to goats or cows.
- Transition to employment for trained youths is a complex process with many challenges, and requires much more support going beyond start-up kits.
- Interventions in the two CPAs, of economic strengthening, and food and nutrition security complement each other in raising OVC household incomes, assets growth and improving welfare.

### **Recommendations**

#### *Recommendations for Economic Strengthening Support*

- There is need for more closer and regular extension support services to the beneficiaries of animal-based IGAs. Besides working with sub-county and district based extension staff, implementers of OVC programs should explore other options of making extension services available to supported farmers.
- The gestation period of IGAs should be an important consideration in choice of the IGA approach/model, as well as the specific projects to be implemented. The gestation period of projects can also be reduced by supplying mature breeds rather than young ones.
- Given the relative strengths and limitations of individual/household and group IGAs, it is recommended that OVC programs continue to apply both approaches, combining them and where possible, supporting most if not all caregivers to access both.

- OVC programmes should compute the other costs (non-tuition) that go into apprenticeship training (transport, food, materials, etc) and determine the extent to which they are affordable to the trainees. This should then provide a basis for further decisions regarding whether these costs should be met by the child/caregiver, or the programme.
- To support better earnings by OVC that have completed skills training and joined employment, there is need for a system of support that continues with them for some time after the completion of training. This might include provision of start-up grants, rather than just kits, giving working OVC contracts (as a form of affirmative action) to make uniforms (in the case of tailors), or chairs and desks (in case of carpenters) and so on. Challenges of machine breakdowns, lack of spares parts for machines, and others which were raised by several working OVC should also be addressed through arrangements that provide warranty or after sales service, or contracts with private mechanics for a certain period after completion of training.
- There is need for more legal support to secure rights of all caregivers and OVC, but more especially those of female caregivers and female OVC. There is also need to provide information about where and how they can access legal support services if needed.

#### *Recommendations for Food and Nutrition Security Support*

- OVC programmes should support landless or land-constrained OVC households to rent land, where they can grow food both for the home consumption and for sale.
- The recommendation of extension services made above – also applies for food and nutrition security interventions.
- It is also important that OVC caregivers should continue to be supported to form and work in groups. Here they can continue to benefit from each other and share inputs and experiences for improving food and nutrition security amongst their households.
- OVC programs should provide other farming tools and equipment such as pesticides, watering cans, and spraying machines.
- There is need for programs to identify the food insecure households, such as those that report having one meal a day, and specifically target them with more tailored support to improve their food production and nutrition.

#### *General*

- Given the complementarities identified between the two CPAs, OVC programs should extend multiple forms of support to OVC households, rather than a single type of support, in order to enable households enjoy the complementarities of these various forms of support.



# I INTRODUCTION AND BACKGROUND

## I.1 Introduction

This report presents the results of a study undertaken by the Civil Society Fund (CSF) through a contract with Socio-Economic Data Centre Ltd (SEDC) to assess the effectiveness of OVC supported interventions towards improvement in food and nutrition security, and economic strengthening among OVC Households in Uganda. The study was carried out in five districts namely Gulu, Ibanda, Kibaale, Mayuge and Mityana. Data for the study was collected during the month of September 2012.

## I.2 The Civil Society Fund

The Civil Society Fund (CSF) was established in May 2007 to provide a coordinated system of capacity building and support to civil society organizations to scale up effective and comprehensive HIV/AIDS prevention and care services, as well as multisectoral services to orphans and other vulnerable children (OVC). The goal of the CSF is to ensure that civil society provision of prevention, care, treatment, and support services in HIV/AIDS and OVC is harmonized, streamlined, effective, and in support of the National Strategic Plan (NSP), National Strategic Program Plan of Interventions for OVC (NSPPI), National Priority Action Plan (NPAP), and other national plans and policies. Its purpose is to bring together multiple donor funds and disburse grants to civil society organizations; align grants with national plans and decision-making processes; and enable an effective, scaled up, and comprehensive response to HIV/AIDS and OVC. This initiative is a partnership involving the Government of Uganda through the Uganda AIDS Commission, AIDS Development Partners and civil society.

The Civil Society Fund (CSF) provides grants and capacity building services to civil society organizations. Operations of CSF are executed by the Technical Management Agent, Financial Management Agent, and Monitoring and Evaluation Management Agent.

## I.3 Background to the Study

Since the advent of the HIV epidemic, the vulnerability of children in Sub-Saharan Africa has increased several folds. It is currently estimated that over 12 percent of children in sub-Saharan Africa are orphans (PEPFAR, 2008). In Uganda where children under the age of 18 constitute about 57.4% of the country's total population of 30.7 million people (UNHS, 2009/2010), 14% (2,430,000) of the 17.1 million children are orphans (Uganda OVC Situation Analysis Report 2010). Up to 43% of all children (7.3 million) live in moderately and 8% (1.3 million) in critically vulnerable situations. It is estimated that nearly half (48%) of all Ugandan orphans are a result of HIV&AIDS. Other reasons for this magnitude of orphanhood and child vulnerability include conflict, poverty, high population growth rates, inadequacy of support services, weak implementation of existing laws and programs, and disease.

The potential impact of vulnerability on children includes loss of family and identity, loss of assets and their inheritance, depression, homelessness, migration, decline in health status and health care, declining nutritional status, increase demands on them for labor and caregiving, and loss of educational opportunities (Richter *et al*, 2004; Belsey, 2005). As such, the need to address the vulnerability of children is of critical urgency.

Uganda continues to face a challenge in providing comprehensive and quality services for children who have lost their parents, and those who face various forms of vulnerability. Currently, in Uganda and elsewhere in Africa, families and communities provide the majority of the care and support to children affected by HIV&AIDS (Foster, 2006). This trend is also supported by an emerging consensus in the literature which shows that the most promising approaches to addressing child vulnerability are those that support children within their families and communities. Family and community support for OVC has traditionally been embedded in a network of structures of extended families and kinship that formed strong safety nets to support vulnerable members of the community, including orphaned children. However, the past decade has witnessed the weakening of the traditional support system especially due to HIV&AIDS, resulting in overburdened family and kinship networks.

As a result, a lot of attention has been put on family-focused approaches to OVC support. Civil society organizations have played a key role in supporting vulnerable children and their families. Despite this, the vast majority of families and communities caring for affected children do not receive adequate external assistance (UNICEF, USAID & UNAIDS, 2004). Various literature show that despite the enormous strain that HIV&AIDS has placed on families, they continue to absorb orphans, but are in urgent need of greater external support (Richter *et al*, 2004; Wiegers *et al*, 2006; Monasch & Boerma, 2004).

In 2004, the Government of Uganda responded to the high level of child vulnerability by formulating the National OVC Policy (2004) and the National Strategic Programme Plan of Interventions (NSSPI-1 (2005-2010) and NSPPI-2 (2010-2016) to guide the provision of sustainable quality services for OVC. These frameworks have provided a momentum that has since 2005 resulted into extensive services, both direct and indirect being targeted at OVC and their households. The NSPPI-2 calls for provision of services to OVC organized under six strategic intervention areas or core programme areas (CPAs), namely:

- economic strengthening
- food and nutrition security
- health, water, sanitation and shelter
- education
- psychosocial support and basic care
- child protection and legal support

The seventh CPA, namely, *Legal, Policy and Institutional Mechanisms* does not directly target OVC and their households).

Although the response to the needs of OVC has involved a huge number of actors, especially civil society organizations, services provided over the years remain inadequate (OVC Situation Analysis Report, 2010). The Uganda OVC situation analysis report 2010 revealed that only 36.9 % of the 2.43 million OVC received external support services. Of these OVC, the majority received education support (70%) and health services (57%). Despite prevailing need, economic strengthening and food and nutrition security interventions were among the least provided services.

As a result of this, CSF established an OVC support initiative that feeds into the national OVC response aimed at sustainable interventions that respond to basic needs of the most vulnerable children and their households. The CSF contributed to the OVC response by supporting the provision of integrated and equitably distributed protection, care and support services for OVC and their households in selected districts between the period 2008- 2012. The services provided and principles followed during implementation were in line with the National OVC Policy (NOP). The sub -grantees were expected to implement at least 4 core program areas (CPAs) outlined above. Each of sub-grantees was required to support at least 2,000 OVC and their households. The most vulnerable households with OVC were selected in collaboration with existing community structures. In addition, strategic partnerships were developed in an effort to ensure that beneficiaries received comprehensive and quality services.

#### **1.4 Problem Statement**

In response to the limited external support going to OVC households as established by the Situation Analysis (MoGSLD 2010), the CSF through 42 sub grantees provided interventions to 98,795 OVC (49.7% females, 50.3% males) and their households between 2009 and 2011. The interventions were in the areas of social economic security (72%), food and nutrition security (61%), care and support (22%), education (40%), psychosocial support (90%), basic health (34%), child protection (66%) and legal support (2%) services.

Although different implementing partners, CSF inclusive made progress in providing the critical economic and food/nutrition interventions as noted, there was inadequate evidence to demonstrate the effectiveness of food and nutrition security and economic strengthening interventions in the national OVC response. Current studies as reported in NSSPI-2, Uganda Demographic Health Survey 2011, the 2012 CSF Lot Quality Assurance Survey and the Uganda OVC situation analysis report 2010 give the numbers of OVC served with the different OVC interventions but little exists regarding the effectiveness of the interventions towards improving OVC livelihoods.

This study therefore sought to establish the most effective interventions for improving food and nutrition security and economic strengthening among OVC households. The study not only focused on CSF interventions but also on interventions of other implementing partners in the selected districts of Uganda.

#### **1.5 Objectives of the Study**

##### **1.5.1 General Objective**

The overall objective of this study was to assess the effectiveness of OVC interventions towards improvement in food and nutrition security and economic strengthening among targeted OVC households in five selected districts of Uganda.

##### **1.5.2 Specific Objectives**

The specific objectives were:

1. To establish the efficacy of OVC interventions in improving food availability, access, and utilization in the targeted OVC households

2. To determine the extent to which OVC interventions contribute to strengthening assets growth and protection in OVC households.
3. To find out the extent to which OVC interventions contribute to income growth in the targeted OVC households.
4. To assess the contribution of food & nutrition security and economic strengthening interventions towards improving the wellbeing of OVC and their households

### **1.5.3 Research Questions**

In order to achieve the above objectives, the study was guided by the following research questions:

1. What is the efficacy of OVC interventions in improving food availability, access, and utilization in the targeted OVC households?
2. To what extent have the OVC interventions contributed to strengthening growth and protection of assets in the targeted OVC households.
3. To what extent have OVC interventions contributed to increased savings and income in the targeted OVC households?
4. To what extent have the food and nutrition security and economic strengthening outcomes translated into better welfare of the targeted OVC?

### **1.6 Justification of the Study**

The findings of this study are expected to contribute to better understanding of the effectiveness of various OVC interventions. This is a concern that has been re-echoed at various national OVC meetings, in particular, at the quarterly national OVC coordination meetings hosted by MGLSD. The findings therefore are expected to be useful towards strengthening the effectiveness of the national OVC response. The results should be useful to various stakeholders for OVC programming and policy purposes. The potential users of the results include the Uganda AIDS Commission, the Civil Society Fund, the Ministry of Gender Labour and Social Development, and a number of other actors implementing or supporting OVC interventions.

### **1.7 Methodology**

#### **1.7.1 Study Design**

This was a cross-sectional study design combining qualitative and quantitative research methods. The study design entailed the use of the 'before and after' approach to determine the effectiveness of the OVC supported interventions. The information pertaining to the 'before' situation was obtained from baseline data where it was available, or from the respondents accounts of how they were before the interventions. The information regarding the 'after' was collected during this study. 'Stories of change' from respondents were also collected and are analyzed in this report to contribute to determining what positive changes have taken place as a result of the interventions. Quantitative and qualitative methods of data collection and analysis were employed in a complimentary manner and both primary and secondary data sources were utilized.

## 1.8 Study population

The study population consisted of both primary and secondary study populations. The primary study population included OVC (aged 10-17) and their primary caregivers. The secondary study population included community leaders (LCs and religious leaders), local government staff at different levels (sub county and district), specifically those in the departments of Community Development, Health, Probation and Welfare, and Agriculture), Child Protection Committees and other volunteers, CSF sub grantee staff, and CSF staff. Whereas only children aged 10 and above were eligible for direct inclusion in the study, data about those aged less than 10 was collected from the caregivers.

## 1.9 Study Sites

The study was conducted in five districts of Mityana in Central Region, Mayuge in Eastern Region, Gulu in Northern Region, Kibaale in Western Region, and Ibanda in South Western Region. These districts were selected purposively using the following criteria:

- Existence of CSF supported sub-grantees implementing interventions in the two CPAs of economic strengthening and food and nutrition security,
- Existence of other Implementing Partners supporting OVC households in the 2 CPAs of interest. This was necessary in order to compare results from CSF sub-grantees with findings from other Implementing Partners, in line with the objectives of the study.
- Representation of different regions in the country
- Findings of the CSF 2011 LQASs results

The sample districts, CSF-Sub-grantees and other IPs that participated in the study are as shown in the table 1 below:

**Table 1: Districts, CSF Sub-Grantees and other IPs in the Sample**

| Region            | Sample District | SCF Sub-Grantee in District | Other Implementing Partners in District                            |
|-------------------|-----------------|-----------------------------|--|
| Central           | Mityana         | Caritas Mityana             | Kireku Health Program (IRCU Sub-grantee)                           |
| East              | Mayuge          | FLEP Busoga Diocese         | Child Fund, Mayuge   |
| North & West Nile | Gulu            | TASO Gulu                   | Health Alert Uganda  |
| S/Western         | Ibanda          | Ankole Diocese              | Compassion International – Uganda, Ibanda Child Development Centre |
| Western           | Kibaale         | KCSON                       | EMESCO <sup>4</sup> Development Foundation                         |

<sup>4</sup> The acronym EMESCO is derived from the organization's philosophy and approach: 'E' for Empowering communities; 'M' for Meeting needs in a sustainable way; 'E' for Enabling rural communities to live in harmony and in a healthy environment; 'S' for Supporting better livelihoods; 'C' for Cooperating with local, national and international development organizations and other stakeholders and 'O' for Offering opportunities for development.

### 1.9.1 Sampling of Sub-counties and Villages

In cases where the OVC interventions of a particular implementing organization were in three (3) or less sub-counties, all the project sub-counties were covered by the study. On the other hand, where the project interventions covered several sub-counties, a multi-stage sampling strategy was used to select sub-counties and villages, which formed the geographical units for selection of sample OVC households. The list of sub-counties covered by the study is included in Annex 2.

### 1.9.2 Sample Size and Sampling Procedures for OVC Households, Caregivers and Child Respondents

A representative sample size of 850 OVC households was calculated using the Cochran (1963) formula. The sample of OVC households was disproportionately distributed between CSF Sub-grantees and other IPs, with about 80% coming from CSF sub-grantees and 20% selected from those supported by other Implementing Partners. In each of the households sampled, the target was to interview a caregiver and an OVC aged 10-17. The target for caregivers was exceeded thus interviewing, 866 caregivers and 850 OVC. The table below shows the sample size of caregivers and OVC drawn for each district and implementing agency.

**Table 2: Sample Size of Caregivers and OVC covered by the Study**

| Region & District           | CSF Sub-grantee and Other IPs | Number of Caregivers Interviewed |                             |                              |              | Number of Child Respondents Interviewed |                             |                              |              |
|-----------------------------|-------------------------------|----------------------------------|-----------------------------|------------------------------|--------------|---|-----------------------------|------------------------------|--------------|
|                             |                               | M                                | F                           | Total                        | %ge          | M                                       | F                           | Total                        | %ge          |
| Central (Mityana)           | Caritas Kiyinda Mityana       | 20                               | 89                          | 109                          | 12.6         | 52                                      | 50                          | 102                          | 12.0         |
|                             | Kireku Health Program         | 5                                | 20                          | 25                           | 2.9          | 12                                      | 13                          | 25                           | 2.9          |
| Eastern (Mayuge)            | FLEPP Busoga Diocese          | 36                               | 132                         | 168                          | 19.4         | 77                                      | 89                          | 166                          | 19.5         |
|                             | Child Fund                    | 11                               | 30                          | 41                           | 4.7          | 15                                      | 26                          | 41                           | 4.8          |
| Northern & West Nile (Gulu) | TASO Gulu                     | 32                               | 101                         | 133                          | 15.4         | 66                                      | 68                          | 134                          | 15.8         |
|                             | Health Alert Uganda           | 9                                | 24                          | 33                           | 3.8          | 20                                      | 13                          | 33                           | 3.9          |
| Western (Kibaale)           | KCSON                         | 35                               | 109                         | 144                          | 16.6         | 77                                      | 67                          | 144                          | 16.9         |
|                             | EMESCO Foundation             | 18                               | 24                          | 42                           | 4.8          | 18                                      | 16                          | 34                           | 4.0          |
| South Western (Ibanda)      | Ankole Diocese                | 22                               | 115                         | 137                          | 15.8         | 69                                      | 82                          | 151                          | 17.8         |
|                             | Compassion Uganda             | 3                                | 31                          | 34                           | 3.9          | 11                                      | 9                           | 20                           | 2.4          |
| <b>Total</b>                |                               | <b>191</b><br><b>(22.1)</b>      | <b>675</b><br><b>(77.9)</b> | <b>866</b><br><b>(100.0)</b> | <b>100.0</b> | <b>417</b><br><b>(49.1)</b>             | <b>433</b><br><b>(50.9)</b> | <b>850</b><br><b>(100.0)</b> | <b>100.0</b> |

For sampling purposes, lists of supported OVC households and OVC were obtained from the implementing organizations and used as the sampling frames. A systematic random sampling strategy was used to select sample OVC households and OVC from the registers. Sampled households were located with the guidance of volunteers that worked with the implementing organizations.

### 1.9.3 The Sample of Out-of-School OVC trained in Skills through Apprenticeships

A sample of 67 out-of-school OVC that were trained in practical skills through apprenticeship and vocational training were also interviewed. These were selected purposively based on their availability and proximity, as well as through snowballing. This selection procedure was used because most of the OVC had completed training and dispersed in search of employment.

**Table 3: Sample of Out-of-School OVC by Gender and by District**

| District | Male<br>(N=25)<br>(n) | Female<br>(N=42)<br>(n) | Total<br>(N=67)<br>(n) | Total<br>Percentage<br>(%) |
|----------|-----------------------|-------------------------|------------------------|----------------------------|
| Gulu     | 2                     | 3                       | 5                      | 7.5                        |
| Mityana  | 3                     | 6                       | 9                      | 13.4                       |
| Mayuge   | 6                     | 13                      | 19                     | 28.4                       |
| Ibanda   | 10                    | 9                       | 19                     | 28.4                       |
| Kibaale  | 4                     | 11                      | 15                     | 22.4                       |

As shown in the table above, more female out-of-school OVC were interviewed compared to males. Comparison by district shows that the biggest numbers came from Mayuge and Ibanda, while the least were from Gulu. These disparities arose because different implementers had trained different numbers and interviewees in this category were recruited into the sample based on the availability within the sample communities at the time of the study.

### 1.9.4 The Qualitative Sample

In each of the 5 districts, FGDs disaggregated by age and gender were conducted as follows: (i) male OVC aged 10-13; (ii) male OVC aged 14-17; (iii) female OVC aged 10-13; (iv) female OVC aged 14-18; and (v) mixed sex caregivers, (vii) mixed sex program volunteers. Between 4 and 6 FGDs were conducted in each district, the number varying depending on the availability of the targeted participants. In some programs, for instance under Compassion International, some of the supported OVC were in boarding schools and FGDs for certain age-groups could not be conducted in communities.

Key informants were selected purposively depending on their relevance and availability. The key informants included political leaders at district level, religious leaders (especially included where FBOs were involved in supporting OVC), District technical/extension staff (for Community Development, Probation & Welfare, and/or Agriculture), political leaders at sub-county level, Sub-county technical/extension staff (for Community Development, Health, and/or Agriculture/NAADS), community leaders at village level, members of Child Protection Committees and other volunteers, CSF Sub-grantee Staff, staff of other IPs, and relevant CSF staff.

### **1.9.5 Training of Field Data Collectors and Pre-test of Tools**

A gender-balanced team of interviewers was recruited and trained for 3 days to assist in data collection. Interviewers had to be fluent in the local languages spoken in the districts where they were deployed to work, and respondents were interviewed by interviewers of the same sex. The pre-test of tools was conducted in Mukono District after the training. The aim of the pre-test was to test the validity and flow of questions, and the interviewers' ability to administer them properly. A feedback session was held after the pre-test to share observations and experiences, and feed into the finalization of the tools.

### **1.10 Data Collection Methods and Tools**

Data collection for this study was undertaken using a combination of qualitative and quantitative methods which included the following;

#### **(i) Review of project documents**

Relevant project documents both from CSF and implementing organizations were reviewed to enable the understanding of the project interventions in the food and nutrition security and economic strengthening core program areas. Other documents such as the NSPPI-1, NSPPI-2 and the NOP produced by the MGLSD, those from other government departments/agencies, as well as relevant literature were also reviewed. The review of documents commenced before data collection and continued throughout the period of data collection, analysis and report writing.

#### **(ii) Structured Interviews**

Structured interviews were conducted among the sample of OVC (aged 10-17) and their caregivers using interviewer-administered questionnaires. The interviews among other things investigated the type of support received, the level of food and nutrition security including feeding practices, household incomes, access to health and education, and ownership of basic assets. For every OVC interviewed, an attempt was made to interview a caregiver. Where this was not possible, an OVC from a different household was interviewed to compensate for the household where none was found. Interviews with caregivers collected data about all the children in the household, including those who were not eligible for interviews due to age. A separate short questionnaire was also used to collect data from out-of-school youths trained in skills through apprenticeship. All interviews were conducted in the local languages spoken by the respondents.

#### **(iii) Focus Group Discussions (FGDs)**

FGDs were conducted with groups of 8-12 persons of relatively similar characteristics. Separate FGDs were conducted for male and female OVC, and mixed sex caregivers as outlined in section 1.9.3. The FGDs explored the nature of support received, how it was delivered and what positive changes the intended beneficiaries have realised as a result of interventions in food and nutrition security and economic strengthening among OVC households. In addition, experiences with the OVC interventions as well as their impact on the welfare of OVC and their caregivers were investigated. A focus group discussion guide was used to moderate the discussions. The FGDs were moderated by 2 members of the study team, whereby one moderated the discussion and another took notes and managed the recording of the FGD proceedings. FGD question guides



were prepared and used to facilitate the moderation of the discussions.

**(iv) Observation and Photography**

Observation was conducted at household level to observe and verify the existence and status of income generating projects and farming activities being undertaken by caregivers and OVC as part of their economic strengthening and food and nutrition security activities. Where possible, photographs of such projects/activities were taken with the consent of the caregivers and are included in this report.

**(v) In-depth Interviews/Case Profiling**

The team held detailed interviews and took case profiles of selected beneficiaries such as out-of-school youth that have been trained through apprenticeships. Detailed stories were also collected from beneficiary OVC and caregivers as case studies to demonstrate how the project interventions have changed their lives.

**(vi) Key Informant Interviews (KIIs)**

KIIs were held with local government and community leaders, local government staff the at sub county and district levels, members of Child Protection Committees, CSF sub grantee staff, staff of other IPs and CSF staff. The interviews focused on their experiences with the various OVC interventions, achievements, partnerships developed, capacities built, and their suggestions regarding feasible strategies that would have greater positive impact the OVC in as far as food and nutrition security and economic strengthening are concerned. Key informant interview question guides were prepared and used for this purpose.

## **1.11 Ethical Considerations and Approval**

Ethical clearance was received from the MildMay Uganda Research Ethics Committee (MUREC) and the Uganda National Council for Science and Technology (UNCST). The study team undertook all relevant measures to fulfil ethical requirements including seeking informed consent, ensuring voluntary participation, confidentiality and anonymity, and respecting the privacy of participants.

## **1.12 Data Processing and Analysis**

### **1.12.1 Processing and Analysis of Quantitative Data**

Field editing was done for each completed questionnaire immediately after the interview to ensure that it is properly filled-in and complete. Further editing was done by the Field Supervisors after each day's work. Following the completion of fieldwork, the open-ended questions were coded. Data was then entered in pre-designed *Epidata* data entry screens. After cleaning, data was exported to the Statistical Package for Social Scientists (SPSS) for analysis. Data analysis was conducted at univariate, bivariate and multivariate levels.

Descriptive statistics focusing on measures of central tendency and dispersion (i.e. mean, median, mode totals, minimum, maximum and etc.) were generated for the continuous variables namely: age of the respondents, household size, crop/farm output, size of land, household monthly expenditure levels and household annual savings. The frequency distributions were

generated for the categorized variables. Bivariate analysis was used to determine relationships between variables of interest. Variables of focus included the type of support provided/received, beneficiary socio-demographic characteristics, changes in household income levels over the last 3 years, food availability in the last 6 months, and availability of income savings. Chi-square test statistic was used to test the strength of the relationship between the dependent variable and independent categorical variables. A logistic regression is used to predict the odds ratios for factors that influence food availability and increase in household income.

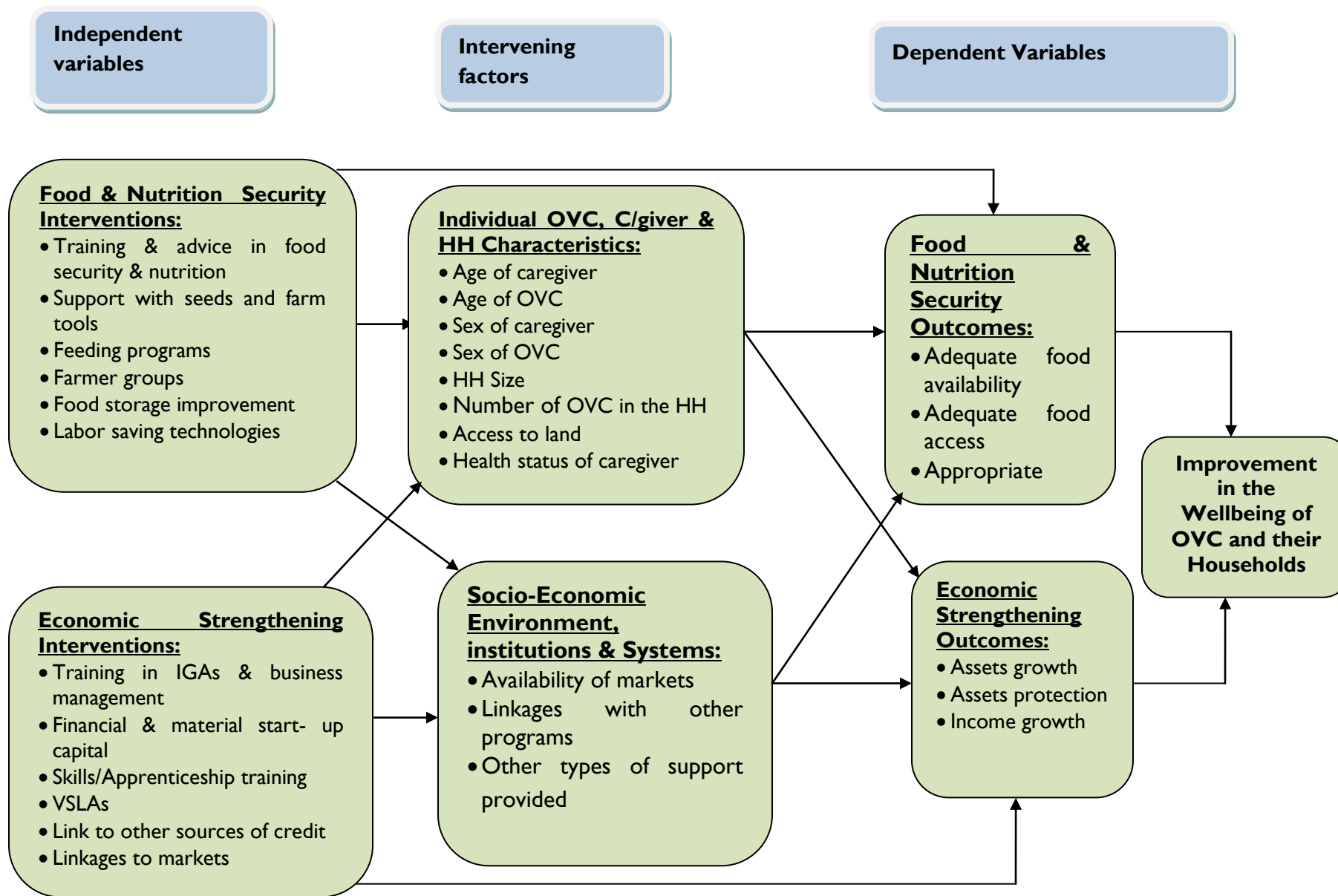
### **1.12.2 Processing and Analysis of Qualitative Data**

Qualitative notes from key informant interviews and focus group discussions were transcribed and typed into a *Microsoft Word 2007*. The notes were transcribed verbatim to ensure they capture the complete responses of the study participants. Thematic analysis was used to categorize the data and to establish emerging patterns that respond to the research questions. In addition, whole texts for use as direct quotations were identified and extracted. Later both qualitative and quantitative data were triangulated to generate a complete picture from the findings.

### **1.13 Conceptual Framework**

This study was conceived in a framework of the relationship between various factors that include program models and interventions, caregiver background characteristics, outcomes and impacts as illustrated in the diagram below:

**Figure I: Conceptual Framework**



In the above conceptual framework, the key independent variables are the interventions implemented by CSF and other implementing agencies towards improving the food and nutrition security and economic strengthening of OVC and their households. These variables for instance include training, farm tools, seeds, start-up capital and other forms of support given to OVC and caregivers. These inputs are expected to cause a change in the dependent variables.

The dependent variables are the outcomes, broadly categorized above into food and nutrition security outcomes, and economic strengthening outcomes. At a higher level, another dependent variable is the level of improvement in the welfare of OVC and their households. These are conditions that are expected to change as a result of the interventions implemented.

From the conceptual framework, it is also shown that the effect of the independent variables (the interventions) on the outcome variables is mediated by the intervening factors, mainly entailed in the socio-demographic characteristics of the OVC, the caregivers and their households and the broader socio-economic environment and systems. The socio-demographic characteristics include the age and sex of the OVC, the age and sex of the caregivers, the levels of education of the caregivers, whether the caregivers are also the household heads, the sex of the household head, the number of OVC in the household and the overall household size. It can be expected that when the food and nutrition security, and economic strengthening interventions are introduced into an OVC household, the extent to which the OVC, the caregiver and the household as a whole will respond to this support, utilize it, and benefit from it will partly be influenced by their socio-demographic characteristics. The intervening variables also include the operating environment, institutions and systems. Such factors include the availability of markets for the output/products generated from the caregivers' income generating projects, the extent to which the project interventions link with or are embedded within other existing programs, such as government development programs. Others include the functionality of child protection systems (relevant for assets protection), and other forms of support provided to a household to enable access to a comprehensive package of services.

In this study therefore, the efficacy or effectiveness of OVC interventions was assessed in terms of changes in the outcome variables, namely, income growth, assets growth, food availability, food accessibility, and food utilization.

#### **1.14 Limitations and Challenges of the Study**

The following limitations are acknowledged as having impacted or had the potential to impact of the study results:

- Recall bias - Whereas the study team took all necessary measures to collect accurate data, some of the information sought from participants required them to draw from their memory and to compare with the situation in the past. This could have had some minimal effect on the quality of the responses. To the extent possible, questions were based on a short reference period to minimize this effect.
- Some of the study variables under investigation such as income are subject to mis-reporting due to lack of records, poor memory and deliberate under-reporting. In

order to address this challenge, expenditure data was also collected to corroborate income data.

- Whereas CSF support to OVC targets all OVC from the age of 0, this study was only able to directly collect data from OVC that have attained a minimum age of 10. The study team interviewed caregivers about all children in their households including infants, though this does not guarantee a complete representation of the young children's voices and experiences.
- Data was collected at a time when the CSF funded projects had already closed. In some cases therefore, it was difficult to access all records or to find all the staff that were knowledgeable about the projects to provide needed information. Project documents, including sub-grantee reports were reviewed to fill any gaps in the primary data.
- The study participants were scattered over wide geographical areas due to the fact that the implementers had selected for support only about 2 to 4 OVC households per village. This meant that the study team had to cover a very wide geographical area in order to raise the needed sample. As a result fieldwork took longer than earlier planned.
- Enrolling other implementing partners to participate in the study took some time and caused loss of time from the study schedule. Nevertheless, this effort was eventually successful, and in each district, a non-CSF implementer of OVC interventions in the two CPAs of interest participated in the study.

### **I.15 Profiles of the Study Organizations in the Sample**

In this study, two categories of organizations were studied. The first category comprised organizations that were recipients of support from the Civil Society Fund to implement OVC support interventions in the two core program areas of food and nutrition security and economic strengthening. These are referred to in this report as CSF Sub-grantees. The second category comprised organizations that were not funded by the Civil Society Fund, but got their funding from other sources, and were nonetheless implementing similar interventions to support OVC. These are referred to in this report as other implementing partners (IPs). The profiles of these sample organizations that were visited from both categories are provided in Annex 3.

## 2 SOCIO-DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

### 2.1 Introduction

In this study, three types of quantitative samples were interviewed. These included caregivers of OVC, younger OVC under the care of their caregivers (also referred to here as child respondents), and out-of-school OVC trained in practical skills. In this section, we present the socio-demographic characteristics of each of these sub-sample groups.

#### 2.1.1 Characteristics of Caregivers

A total of 866 caregivers were interviewed in this study. Table 4 below presents the socio-demographics of the caregivers in the sample.

**Table 4: Socio-Demographic Characteristics of Caregivers in the Sample**

|                                | Male<br>% | Female<br>% | Total<br>% | Number<br>(N=866) |
|--------------------------------|-----------|-------------|------------|-------------------|
| <b>Sex of Caregiver</b>        | 22.1      | 77.9        | 100.0      | 866               |
| <b>Age of Caregiver</b>        |           |             |            |                   |
| <21 Years                      | 1.0       | 1.2         | 1.2        | 10                |
| 21 - 30 Years                  | 9.4       | 12.9        | 12.1       | 105               |
| 31 - 40 Years                  | 22.0      | 29.9        | 28.2       | 244               |
| 41 - 50 Years                  | 29.8      | 31.1        | 30.8       | 267               |
| 51 - 60 Years                  | 20.4      | 14.5        | 15.8       | 137               |
| >60                            | 17.3      | 10.4        | 11.9       | 103               |
| <b>Level of Education</b>      |           |             |            |                   |
| None                           | 15.2      | 32.1        | 28.4       | 246               |
| Primary                        | 63.9      | 59.6        | 60.5       | 524               |
| Secondary                      | 16.2      | 7.4         | 9.4        | 81                |
| Tertiary                       | 3.1       | 0.7         | 1.3        | 11                |
| Other                          | 1.6       | 0.1         | 0.5        | 4                 |
| <b>Marital Status</b>          |           |             |            |                   |
| Never married                  | 2.6       | 3.0         | 2.9        | 25                |
| Married                        | 78.5      | 37.9        | 46.9       | 406               |
| Divorced                       | 5.8       | 9.8         | 8.9        | 77                |
| Widowed                        | 13.1      | 49.3        | 41.3       | 358               |
| <b>Main Occupation</b>         |           |             |            |                   |
| Student                        | 0.5       | 0.6         | 0.6        | 5                 |
| Trade/business                 | 2.6       | 6.7         | 5.8        | 50                |
| Farming                        | 88.0      | 88.9        | 88.7       | 768               |
| Fishing                        | 1.0       | 0.7         | 0.8        | 7                 |
| Salaried employment            | 3.7       | 0.7         | 1.4        | 12                |
| Informally employed            | 0.5       | 1.2         | 1.0        | 9                 |
| Artisan/builder/carpenter, etc | 2.1       | 0.3         | 0.7        | 6                 |
| Other                          | 1.6       | 0.9         | 1.0        | 9                 |

|  | Male % | Female % | Total % | Number (N=866) |
|--|--------|----------|---------|----------------|
| <b>Respondent is Head of HH</b>        |        |          |         |                |
| Yes                                    | 95.8   | 72.9     | 77.9    | 675            |
| No                                     | 4.2    | 27.1     | 22.1    | 191            |
| <b>Number of People in HH</b>          |        |          |         |                |
| <6 People                              | 24.6   | 31.7     | 30.1    | 261            |
| 6 - 10 People                          | 55.5   | 56.0     | 55.9    | 484            |
| 11 - 15 People                         | 12.6   | 9.8      | 10.4    | 90             |
| 16 - 20 People                         | 5.8    | 2.2      | 3.0     | 26             |
| >20 People                             | 1.6    | 0.3      | 0.6     | 5              |
| <b>Number of Children &lt;18 in HH</b> |        |          |         |                |
| <4 Children                            | 25.8   | 32.1     | 30.8    | 266            |
| 4 - 6 Children                         | 47.9   | 50.8     | 50.2    | 434            |
| 7 - 9 Children                         | 16.8   | 12.9     | 13.8    | 119            |
| 10 + Children                          | 9.5    | 4.1      | 5.3     | 46             |
| <b>Number of Orphans in HH</b>         |        |          |         |                |
| <4 Children                            | 87.6   | 88.5     | 88.0    | 1083           |
| 4 - 6 Children                         | 11.2   | 10.7     | 11.0    | 135            |
| 7 - 9 Children                         | 1.1    | 0.7      | 0.9     | 11             |
| 10 + Children                          | 0.0    | 0.2      | 0.1     | 1              |

As shown in the table, majority (77.9%) of the caregivers in the sample were females compared to males (22.1%). Although most caregivers were in the ages between 31 and 50, it is important to highlight that a total of about 27% of the caregivers were aged above 50 – pointing to the role of elderly caregivers. These findings also agree with previous studies which have shown that most OVC are under the care of female-headed families, and caregivers are usually grandmothers or surviving mothers<sup>5</sup>. Majority of the caregivers (60.5%) had only attained primary level of education. It is worth noting that the proportion of female caregivers who had never attended school was more than twice as much as that of males (32.1% and 15.2% respectively). Correspondingly more male caregivers than females had attained secondary and tertiary education. Almost half of the caregivers were married; however more than three quarters (78.5%) of the male caregivers were married compared to the female caregivers, who were mostly (49.3%) widowed. This highlights the prevalence of single-female caregivers in the care of OVC. The majority of caregivers (88.7%), both male and female were peasant farmers; they were also the heads of households. More than half of the OVC households (55.9%) reported a household size of 6 to 10 people, with a mean of 7.4, which is much higher than the national mean household size of 4.7<sup>6</sup>. Half of the households (50%) had 4 to 6 children, but with less than 4 orphans.

### 2.1.2 Characteristics of Child Respondents

Table 5 below shows the characteristics of the 850 OVC (child respondents) that were interviewed in this study.

<sup>5</sup> Hunter S.S.(1990): Orphans as a window on the AIDS epidemic in Sub-Saharan Africa: initial results and implications of a study in Uganda. Soc Sci Med.;31(6):681-90.

<sup>6</sup> UBOS (2002): Population and Housing Census 2002. Final Report

**Table 5: Socio-Demographic Characteristics of OVC in the Sample**

|                              | Male<br>% | Female<br>% | Total<br>% | Number<br>(N=850) |
|------------------------------|-----------|-------------|------------|-------------------|
| <b>Gender</b>                | 49.1      | 50.9        | 100.0      | 850               |
| <b>Age</b>                   |           |             |            |                   |
| 10-11                        | 24.3      | 24.1        | 24.1       | 205               |
| 12-13                        | 33.5      | 36.2        | 34.9       | 297               |
| 14-15                        | 26.6      | 27.1        | 26.8       | 228               |
| 16-17                        | 15.6      | 12.7        | 14.1       | 120               |
| <b>Enrolled in School</b>    |           |             |            |                   |
| Yes                          | 94.5      | 96.1        | 95.3       | 810               |
| No                           | 5.5       | 3.9         | 4.7        | 40                |
| <b>Class Attended</b>        |           |             |            |                   |
| P1-P4                        | 48.5      | 42.5        | 45.4       | 368               |
| P5-P7                        | 46.4      | 47.1        | 46.8       | 379               |
| S1-S4                        | 5.1       | 10.1        | 7.7        | 62                |
| S5-S6                        | 0.0       | 0.2         | 0.1        | 1                 |
| <b>R/Ship to HH Head</b>     |           |             |            |                   |
| Father/Mother                | 68.1      | 64.4        | 66.2       | 563               |
| Brother/Sister               | 1.9       | 3.0         | 2.5        | 21                |
| Grandmother/Grandfather      | 23.0      | 22.2        | 22.6       | 192               |
| Brother/Sister/Sister in law | 0.5       | 0.5         | 0.5        | 4                 |
| Uncle/Aunt                   | 5.0       | 7.4         | 6.2        | 53                |
| Stepfather/Stepmother        | 0.7       | 1.2         | 0.9        | 8                 |
| Other relative               | 0.2       | 0.0         | 0.1        | 1                 |
| Other                        | 0.2       | 1.2         | 0.7        | 6                 |
| Don't know                   | 0.2       | 0.2         | 0.2        | 2                 |

As shown in Table 5 above, female OVC respondents were slightly more (51%) than male OVC respondents (49%). The biggest proportion of the child respondents were in the age group 12-13, with a mean age of 13 for both males and females. The majority of child respondents (95%) were enrolled in school, compared to 5% that were not in school. Those in school were mostly in the upper primary classes (P.5-P.7), followed by those in lower primary. Very few children in secondary schools were sampled, partly because most of the children in secondary schools attend boarding schools and were therefore not found at home during fieldwork.

Up to two thirds (66%) of the child respondents lived in households where their biological parent (father or mother) was the household head. The second biggest proportion (23%) of OVC respondents reported that they lived with their grandparent as the household head. Once again this reflects the national and Africa-wide situation, characterized by the enormous burden that falls on grandparents as caregivers for OVC<sup>7,8</sup>.

<sup>7</sup> Hunter SS. Orphans as a window on the AIDS epidemic in Sub-Saharan Africa: initial results and implications of a study in Uganda. Soc Sci Med. 1990;31(6):681-90.



### 2.1.3 Characteristics of Out-of-School OVC Skills Apprentices

A total of 67 OVC trained in skills through apprenticeship and vocational training were approached and interviewed. Table 6 below shows their socio-demographic characteristics:

**Table 6: Socio-Demographic Characteristics of Out-of-School OVC in the Sample**

|                                     | Number | Percentage |
|-------------------------------------|--------|------------|
| Sex of Respondent                   |        |            |
| Male                                | 25     | 37.3       |
| Female                              | 42     | 62.7       |
| Age of Respondent                   |        |            |
| Under 17                            | 14     | 20.9       |
| 17-18                               | 30     | 44.8       |
| 19+                                 | 23     | 34.3       |
| Highest Level of Education Attained |        |            |
| None                                | 1      | 1.5        |
| Some Primary                        | 32     | 47.8       |
| Completed Primary                   | 11     | 16.4       |
| Some Secondary                      | 6      | 9.0        |
| Completed O level                   | 9      | 13.4       |
| A level                             | 1      | 1.5        |
| Vocational                          | 7      | 10.4       |
| Provider of Support                 |        |            |
| CSF Sub grantee                     | 57     | 85.1       |
| Other IP                            | 10     | 14.9       |

The above findings show that more female than male out-of-school OVC were interviewed. The biggest proportion (44.8%) was aged 17-18, and the overall mean age of the apprentices was 18 years. This mean age reflects the strategy and practice amongst implementers of targeting older OVC rather than younger ones for skills training. Those aged 19 and above indicate the youths that were recruited into the training at the age of around 17-18, but who have since out-grown the standard definition of an OVC. The majority of the interviewees in this category (85.1%) had obtained support for training from CSF Sub-grantees and the rest (14.9%) obtained support from other implementing partners.

Almost a half of the apprentices (49.3%) had attained either only primary level of education or no school at all, while 16.4% had completed primary, and 13.4% had completed secondary. Some of the trainees (10.4%) had attended vocational schools, and only one (1.5%) had attained advanced level of education.

<sup>8</sup> Bicego G, Rutstein S, Johnson K. (2003): Dimensions of the emerging orphan crisis in sub-Saharan Africa. Soc Sci Med. Mar;56(6):1235-47.

## **3 SUPPORT TOWARDS ECONOMIC STRENGTHENING OF OVC HOUSEHOLDS**

### **3.1 Introduction**

The importance of economic strengthening of OVC households is emphasized in the NSPPI-2. Economic strengthening empowers OVC households with the required resources that can facilitate meaningful production, income growth and asset accumulation which in turn enable OVC households to provide for other basic needs such as food, education and health care.

This study sought to assess the contribution of interventions that aimed at economic strengthening of OVC households. In this respect, two of the specific objectives of this study were (a) to find out the extent to which OVC interventions contribute to income growth in the targeted OVC households, and (b) to determine the extent to which OVC interventions contribute to strengthening assets growth and protection in OVC households. In this subsection therefore we first identify and describe the interventions that were implemented to support the economic strengthening of OVC households, and thereafter assess their contribution to income growth, assets growth and assets protection amongst OVC households.

### **3.2 Interventions implemented for Economic Strengthening of OVC Households and Approaches Used**

Both the CSF sub grantees and the other Implementing Partners that participated in this study supported a range of economic strengthening interventions targeted at OVC households. There were various similarities as well as differences in the interventions implemented and the strategies used. Common interventions included support to start or expand income generating projects or activities (IGAs), training in business skills and IGA management, practical/vocational skills trainings, and promotion of micro-finance or credit support services through the establishment of Village Savings and Loan Associations (VSLAs). Each of these will be briefly discussed below.

#### **(i) Support for Income Generating Activities (IGAs)**

All the 10 organizations studied were supporting income generating activities designed to increase the incomes of OVC households. Some (4) of the organizations mainly supported IGAs for individual caregivers or households, while others (6) mainly supported IGAs for groups of caregivers. Some supported both types. Among CSF Sub grantees, those who supported group IGAs included Ankole Diocese and to a small extent TASO Gulu. Among the other IPs, they included Kireku Health Program, Health Alert, and on a small scale, Compassion Uganda – Ibanda CDC. Organizations such as Health Alert, Ankole Diocese and KCSON also used the group IGA model of the ‘revolving animal’ or ‘animal multiplication’, which usually entailed providing a goat or a pig to a few group members who would rear these animals until they reproduce, and then the off-spring is passed on to another group member. In the particular case of KCSON (through one its sub-grantees named INCODE), the approach used was such that a caregiver would receive an item say a pig, then he or she would give back a half ( $\frac{1}{2}$ ) of the proceeds from that item after it was sold and this half was then given to another person.

Tables 7 and 8 below show the proportion of caregivers who reported that they received support to run an IGA.

**Table 7: Support to OVC Households to run IGAs**

|   | Percentage | Number |
|---|------------|--------|
| <b>Received support over the past 3 years to run an IGA (N=866)</b>             |            |        |
| Yes   | 33.4       | 289    |
| No  | 66.6       | 577    |
| <b>IGA support received as an individual/household or Group (N=289)*</b>        |            |        |
| Individual/household  | 81.3       | 235    |
| Group   | 31.8       | 92     |
| <b>Currently running the IGA for which support was received (N=289)</b>         |            |        |
| Yes   | 71.3       | 206    |
| No  | 28.7       | 83     |
| <b>Do you run any other IGA or business that gives you some income? (N=866)</b> |            |        |
| Yes   | 52.1       | 451    |
| No  | 47.9       | 415    |

\*The total number of respondents reporting individual/household and group IGAs (N=327) is bigger than those who received support to run an IGA in past 3 years (N=289) because some caregivers received both individual/household and group IGAs.

**Table 8: Proportion of OVC Households that received IGA Support by District**

| Received support to run an IGA in past 3 year | District          |                      |                     |                     |                      | Total      |                               |
|---|-------------------|----------------------|---------------------|---------------------|----------------------|------------|-------------------------------|
|   | Gulu (N=166)<br>% | Mityana (N=134)<br>% | Mayuge (N=209)<br>% | Ibanda (N=171)<br>% | Kibaale (N=186)<br>% | Percentage | Number of Respondents (N=866) |
| Yes   | 24.1              | 6.7                  | 12.9                | 75.4                | 45.2                 | 33.4       | 289                           |
| No  | 75.9              | 93.3                 | 87.1                | 24.6                | 54.8                 | 66.6       | 577                           |

The results in Tables 7 and 8 above indicate that almost one third (32.4%) of the caregivers reported that they had received support to run an IGA. Table 8 shows that the biggest proportions of caregivers who reported to have received IGA support were from Ibanda (75.4%), followed by those from Kibaale (45.2%). The least were from Mityana (6.7%), followed by Mayuge (12.9%). The majority (81.3%) of the caregivers who received IGA support received it as individual/households rather than as groups, as shown in Table 7. It is however important to note that 11.4% of those who received household IGAs also at the same time were part of groups that received group IGAs. Further analysis also shows that Gulu district had the highest proportion of caregivers (82.5%) reporting that they received IGAs as groups, rather than as

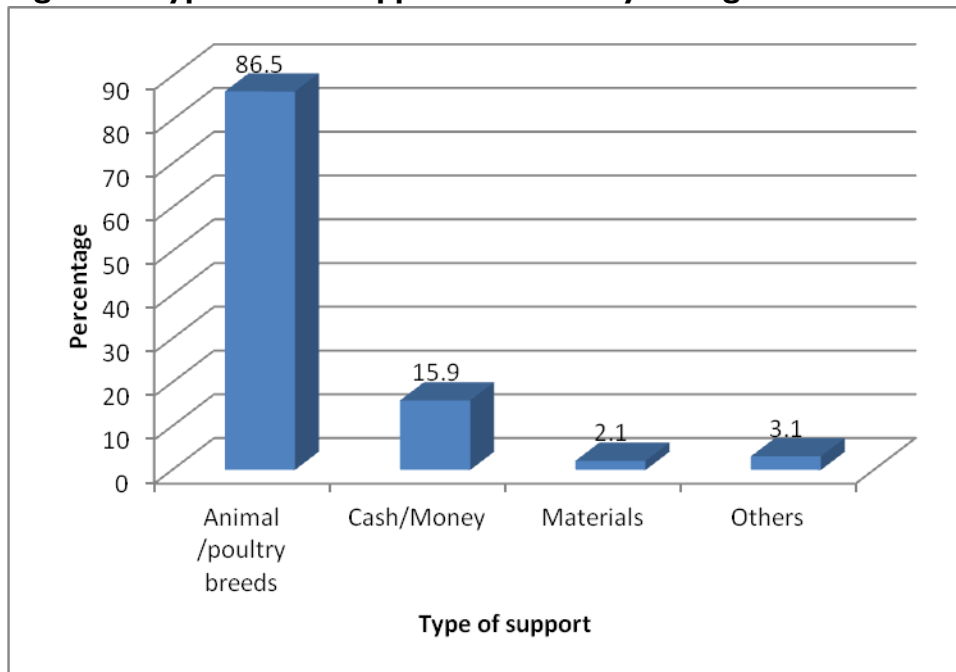
individuals/households, compared to other districts (Mityana, 55.6%; Mayuge, 37.0%; Kibaale, 28.6%; and Ibanda, 15.5%).

The majority (71.3%) of those who received IGA support were still running the IGAs, compared to 28.7% whose supported IGAs were no longer operational. The reasons for the dysfunctionality of some IGAs were mainly related to the death of the poultry and in some cases other animals given as IGAs. This challenge will be discussed further ahead in this report.

More than half (52.1%) of the caregivers reported that they were engaged in another business or economic activity that gave them some income.

Support to run IGAs was mainly provided in kind rather than in cash. Figure 2 below indicates the type of support received by caregivers to run IGAs.

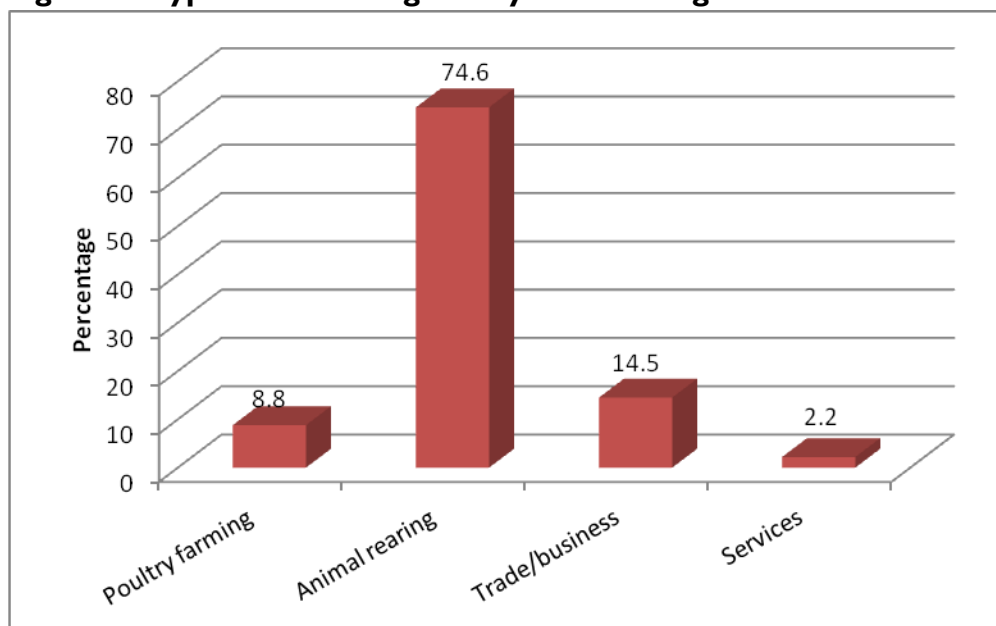
**Figure 2: Type of IGA Support received by Caregivers**



The above data show that animal breeds (including poultry) were the most widely received form of IGA support (86.5%), followed by cash or money (15.9%).

Types of IGAs supported included among others; poultry, piggery, goat rearing, and small-scale businesses, such as retailing of general merchandise or foodstuffs. Figure 3 shows the types of IGAs run by caregivers at the time of the study.

**Figure 3: Type of IGA being run by OVC Caregivers/Households**



As shown in the figure above, animal rearing was the most popular type of project run by caregivers. Almost three quarters (74.6%) of all caregivers who were operating IGAs at the time of this study reported that they had animal projects (pigs, goats, cows), followed by those who reported trade or business (14.5%). Table 9 below shows the type of IGA that was being operated by caregivers at the time of this study across the study districts.

**Table 9: Distribution of Types of IGAs operated by Caregivers by District**

| District | Types of IGAs currently being run by caregivers |                         |                       |                | Total (N=228) |        |
|----------|---|-------------------------|-----------------------|----------------|---------------|--------|
|          | Poultry farming (N=20)                          | Animal rearing* (N=170) | Trade/business (N=33) | Services (N=5) | Percentage    | Number |
| Gulu     | 7.1   | 42.9                    | 42.9                  | 7.1            | 12.3          | 28     |
| Mityana  | 5.9   | 52.9                    | 35.3                  | 5.9            | 7.5           | 17     |
| Mayuge   | 15.0  | 80.0                    | 5.0                   | 0.0            | 8.8           | 20     |
| Ibanda   | 1.0   | 95.0                    | 4.0                   | 0.0            | 44.3          | 101    |
| Kibaale  | 21.0  | 59.7                    | 16.1                  | 3.2            | 27.2          | 62     |

\*Animals included pigs, goats and cows

From the above findings, animal rearing projects were more popular in Ibanda (95%) which is a traditionally cattle keeping area compared to other districts. Poultry was more popular in Kibaale (21%), while trade/business was more popular in Gulu and Mityana districts.

Slightly more than a half (51.9%) of the caregivers that received IGA support reported that they realized income from the IGA. For those who had not realized income from their IGAs, this was partly explained by the fact that some of the IGAs had not yet matured to generate income, while others had collapsed as already mentioned. In addition, many caregivers (68.4%) also at the same time reported challenges with their IGAs. The challenges reported by

caregivers in running IGAs included being expensive to run (59.6%), lack of quick benefits (36.9%), being labor-demanding (29.1%), being time consuming (19.1), and poor markets and prices for the products (11.3%).

One of the limitations of group IGAs was that not all caregivers were able to join groups due to different reasons, hence systematically excluding those who because of their peculiar situation were incapable of participating in certain group activities such as the elderly caregivers and the children from child-headed households whose school schedule conflicted with that of group activities. In the particular case of revolving or multiplication approach, a key limitation was that the support provided took long to benefit the recipients. Even the first recipient took long to enjoy any benefits as the would-be benefits are passed on to another waiting member. The waiting members, after receiving the off-spring, have to nurture the young animal until it matures which they in turn pass on to another member in the line. This process was reported to keep group members in uncertainty. How long will the animal take to reproduce? What if it does not reproduce? Supposing the animal dies before giving birth? How long will it take one to nourish a young animal to maturity so that s/he can also begin to enjoy its benefits? These and other questions were found to be at the minds of members in such groups. These challenges are reflected in the voices below:

*We were first given goats and the problem is that they supplied very young goats. It would take long for these to mature and by the time the next person would receive a goat from that of the neighbor that has produced, it would be too long” (Caregiver Bisheshe Sub county – Ibanda district – Under Ankole Diocese)*

In other instances, some members would refuse to pass on the animal to their waiting counterparts. The end consequence was that the possibility of raising income from such projects remained quite limited. As a result, some caregivers reported that they would have preferred to receive mature breeds.

On the other hand, those who received pigs did not face similar challenges, largely because pigs produce several piglets, unlike goats. Beneficiaries that received pigs reported that the pigs received had helped to increase their incomes.

Whereas most of the support for IGAs was given in form of in-kind inputs and materials, e.g. by directly procuring animals and distributing them to the beneficiary caregivers, non CSF implementing partners also provided support in form of direct cash aid. The findings from the study showed that in some cases, donations or funds from sponsors abroad came directly to the individual OVC or caregiver, and they would use this to start up an IGA. This approach was found to be used by Child Fund in Mayuge and Compassion CDC in Ibanda. Child Fund in Mayuge district reported that they provided money to the caregivers with the discretion to utilize it to as they chose. Some of the caregivers interviewed reported that they had used the money from Child Fund to purchase animals including goats, cows and chicken. Some of this information is captured in the following quotations.

*I got money from Child Fund and I bought goats for one of the children which I reared and I got a cow in return. Recently they added him more money and I bought for him more goats (Caregiver in an FGD; Buwaaya Village – Mayuge District).*

Similar to Child Fund in Mayuge, some caregivers of children being supported by Compassion International reported that their children often receive gifts from their sponsors in form of money which is often used to purchase animal breeds like goats and pigs for the children under their care. Such animals often act as buffers in times of shock or contingencies or in the face of any unforeseen crisis.

*There is a lady we gave 200,000 Shs to purchase second hand clothes. Now she is telling me that she is doing well. There is another lady whom we gave 200,000 Shs and she started with three goats, but now she is prospering because this morning she was telling me that she has 11 goats (Child Development Officer; Compassion Ibanda CDC).*

*Sometimes our children get money as gift from their donors from abroad. That is the money we use to buy like goats so that we also have something at home... (Caregiver in an FGD – Kyaruhanga parish; Ibanda district – Under Compassion).*

#### **(ii) Training of Caregivers in Business Skills and IGA Management**

Training is important in knowledge and skills development. Provision of training was therefore another form of economic strengthening intervention provided to the OVC care givers. The training focused on the initiation, planning and management of IGAs and business enterprises, including specific aspects such as enterprise selection, record keeping, savings, and loans management. CSF staff reported that all caregivers who received support received training in one way or another. Those who received support for IGAs in form of animals or poultry or any other support also received some accompanying training to enable the recipients to make good use of the support and be able to sustain it.

The table below shows the proportion of caregivers who reported that they or another member from their household had attended economic strengthening training in the past 3 years.

**Table 10: Training of Caregivers in Business Skills and IGA Management by District**

| Caregiver or another member of the HH attended training on business skills & managing IGAs in the last 3 years? | District          |                      |                     |                     |                      | Total           |                |
|---|-------------------|----------------------|---------------------|---------------------|----------------------|-----------------|----------------|
|   | Gulu (N=166)<br>% | Mityana (N=134)<br>% | Mayuge (N=209)<br>% | Ibanda (N=171)<br>% | Kibaale (N=186)<br>% | Percent (N=866) | Number (N=866) |
| Yes   | 15.1              | 35.1                 | 30.6                | 39.8                | 65.1                 | 37.5            | 325            |
| No  | 84.9              | 64.9                 | 69.4                | 60.2                | 34.9                 | 62.5            | 541            |

The results in table 10 above show that 37.5% of the caregivers reported that they or another member of their household had attended some training related to economic strengthening in the 3 years preceding the study. This proportion almost matches the 33.4% of the caregivers who received support to run an IGA. The results further show that Kibaale had the highest

proportion of caregivers or household members (65.1%) that had attended training in business skills and IGAs management. Others had 39.8% (Ibanda), 35.1% (Mityana), 30.6 (Mayuge), and 15.1% (Gulu).

Among those who attended the economic strengthening training, majority (89.5%) reported that they acquired new knowledge or skills from the training; majority (82.2%) reported that they were able to use the knowledge and skills acquired; and a corresponding majority (85.8%) reported that the skills acquired enabled the trainee to earn some income. The details are shown in Table II below.

**Table II: Benefits from Training of OVC HH Members in Economic Strengthening/IGA Management**

|   | Percentage | Number |
|---|------------|--------|
| <b>Acquired new knowledge or skills from this training (N=325)</b>                  |            |        |
| Yes   | 89.5       | 291    |
| No  | 10.5       | 34     |
| <b>Used the skills acquired through economic strengthening/IGA training (N=325)</b> |            |        |
| Yes   | 82.2       | 267    |
| No  | 17.8       | 58     |
| <b>Skills learnt enabled trainee to earn some income (N=267)</b>                    |            |        |
| Yes   | 85.8       | 229    |
| No  | 14.2       | 38     |

In addition, some organizations such as TASO Gulu and Kireku Health Program reported that they provided such training to caregivers to equip them with knowledge and skills of running IGAs, although they never provided any start-up capital. The rationale was that training alone would re-awaken the caregivers interest and ability to initiate and run economic enterprises, or enable others to look for start-up capital from elsewhere. It was reported that in such cases, the implementers also made efforts to organize the caregivers into groups and to link them to other sources of capital support, such as NAADS, Micro-Finance Institutions (MFIs) or other NGOs/CBOs. In addition, such trained caregivers were encouraged or supported to form themselves into groups.

The benefits of training caregivers was also reflected in their increased capacity to act as viable social and economic groups. In Mityana for instance where Kireku Health Program had mobilized caregivers of OVC into groups and trained them in record keeping, saving, loan management and financial management, some of these groups have now turned into robust structures that is not only able to negotiate for soft loans from financial institutions like FINCA but is also in position to benefit from government programs such as NAADs and Community Driven Development (CDD). Through these programs, they are able to access capital and further increase their earning opportunities to generate income. One group of women supported by Kireku Health Program decided to build a stall after the training where they were taught to join groups and also taught how to start up IGAs. One of them stays by the road side in a strategic place, after the training in marketing they formed a group of eight people and built



a stall. Before they used to eat all their food or give out some to the neighbors because they did not have market. Now whoever harvests anything among the eight brings to the stall to sell. The owner of that home helps to sell in their absence and they share the proceeds.

**(iii) Micro-Finance and Credit Support Services through VSLAs**

Using the VSLA approach, caregivers were mobilized to make savings in their groups, and once the savings had accumulated, group members would borrow from the pooled funds and pay back with a small interest. Organizations which promoted VSLAs include KCSON, Ankole Diocese and TASO, all sub-grantees of CSF, and Health Alert Uganda, which is a non CSF-supported organization. KCSON mobilized and promoted 13 VSLAs in the sub-counties of Kagadi, Mabale and Ruteete sub counties, and distributed VSLA kits.

Findings indicate that VSLAs have enabled group members to accumulate savings. This is was mainly because these groups had overtime translated into viable associations, through which members could obtain loans, increase their incomes, and mobilize savings.

*When we were starting, we received 420,000=. We used part of this money to buy nine pigs. The other money which remained was put on the account and it is this money that we have been using to lend to members. ...we have about 494,000= currently lent out to people but in total when you add all the money we have, it reaches 971,500=" – (Chairperson Gambanokora Group, Bisheshe Sub County, Ibanda District).*

**(iv) Skills Training for Out-of-School OVC through Apprenticeships and Vocational Training**

Under this component, organizations supported training of selected OVC in practical skills including: tailoring, carpentry and joinery, welding and metal fabrication, motorcycle/vehicle mechanics, hair dressing, brick laying and catering among others (see table 12 below). The main target group for such skills training was school dropouts particularly OVC who lacked the means to enable them stay in school. Among the sample of 67 OVC apprenticeship trainees interviewed in this study, the biggest proportion (49.3%) had either not completed primary level or had no schooling at all.

**Table 12: Percentage Distribution of Trainees by type of Trades**

| Type of Trade                         | Provider of Support |              | Total %(n) |
|---------------------------------------|---------------------|--------------|------------|
|                                       | CSF Sub grantee (%) | Other IP (%) |            |
| Motor-vehicle mechanic                | 6.7                 | 0.0          | 5.7 (4)    |
| Motor cycle mechanic                  | 5.0                 | 0.0          | 4.3 (3)    |
| Hair dressing/Salon                   | 6.7                 | 10.0         | 7.1 (5)    |
| Silk weaving                          | 3.3                 | 0.0          | 2.9 (2)    |
| Tailoring                             | 58.3                | 70.0         | 60.0 (42)  |
| Carpentry                             | 11.7                | 20.0         | 12.9 (9)   |
| Metal fabrication and welder          | 1.7                 | 0.0          | 1.4 (1)    |
| Brick laying                          | 1.7                 | 0.0          | 1.4 (1)    |
| Agriculture and Veterinary management | 5.0                 | 0.0          | 4.3 (3)    |
| Total                                 | 60                  | 10           | 70*        |

*\*Three of the OVC had trained in more than one trade*

As shown in the table above, interviews with the sample of apprenticeship trainees revealed that tailoring (60.0%) was the most common trade in which they were trained, followed by carpentry (12.9%), hair dressing/salon (7.1%) and motor-vehicle mechanics (5.7%). Other skills offered during training included motor-cycle mechanics (4.3%), agricultural and veterinary management (4.3%) and silk weaving (2.9%).

Most of the skills training (80.6%) took place in form of placements with local artisans, while only 19.4% took place in formal vocational institutes or schools. The majority of the organizations that supported apprenticeship training only provided tuition fees, while OVC were expected to cater for their feeding. It was thought that since master artisans with whom OVC were attached resided within the community, OVC would not incur costs relating to transport and accommodation.

Upon successful completion of the training, organizations would as part of the package of support provide graduands with a start up kit comprising the required materials for the particular skill learned. This was intended to facilitate a smooth transition of OVC trained into the labor market. Organizations which provided kits included Ankole Diocese, to a small extent, FLEP. KCSO solicited kits from a different source of funding and the trained OVC were required to pay the cost of transporting the kits from Entebbe to Kibaale. TASO Gulu quarterly reports indicate that they provided start up grants to trained OVC. Such grants included some funds to enable the trainees to start their own work or businesses. Less than half of the trainees (43.3%) reported that they received start-up tools kit after training. About half of these (51.7%) were from Ibanda district. The results show that there was no significant difference ( $p>0.05$ ) between the proportions by implementing partner of the OVC who received start-up tool kits after training.

Up to 61.4% and 70.0% of the apprentices supported by CSF sub grantees and the other implementing partners respectively reported that they were utilizing the skills acquired from the training. Furthermore, reporting of utilization of the skills acquired by district was in the

following order; Gulu (100%), Mityana (77.8%), Ibanda (68.4%), Mayuge (57.9%) and Kibaale (40.0%) respectively. OVC reported to be utilizing the skills mainly through starting their own business or workshop (59.5%) and getting relevant employment (35.7%) respectively. The table below shows the distribution of OVC skills trainees by their occupations, which reflect the extent to which they were utilizing the skills acquired.

**Table 13: Percentage Distribution of trainees by their current Main Occupation**

| Occupation                          | Provider of Support |              | Total      |                              |
|-------------------------------------|---------------------|--------------|------------|------------------------------|
|                                     | CSF Sub grantee (%) | Other IP (%) | Percentage | Number of Respondents (N=67) |
| Trainee (Vocational/apprenticeship) | 5.3                 | 20           | 7.5        | 5                            |
| Trade/business                      | 1.8                 | 0            | 1.5        | 1                            |
| Builder                             | 1.8                 | 0            | 1.5        | 1                            |
| Carpenter                           | 10.5                | 20           | 11.9       | 8                            |
| Tailor                              | 29.8                | 50           | 32.8       | 22                           |
| Salon/hair stylist                  | 8.8                 | 10           | 9.0        | 6                            |
| Motor-vehicle mechanic              | 1.8                 | 0            | 1.5        | 1                            |
| Motor cycle mechanic                | 3.5                 | 0            | 3.0        | 2                            |
| Farmer                              | 26.3                | 0            | 22.4       | 15                           |
| Casual labor                        | 5.3                 | 0            | 4.5        | 3                            |
| Others                              | 5.3                 | 0            | 4.5        | 3                            |
| Total                               | 100                 | 100          | 100        | 70*                          |

\*Multiple response allowed

The majority of the apprentices interviewed (61.2%) reported that they were employed in the work related to the courses they trained in. More males (64.0%) than females (59.5%) reported to be engaged in the professional employment they trained in. The biggest percentage (32.8%) of these trainees was engaged in tailoring as their main occupation, carpentry (11.9%), salon/hair styling (9.0%), motor cycle mechanics (3.0%), motor-vehicle mechanics (1.5%), and building (1.5%).

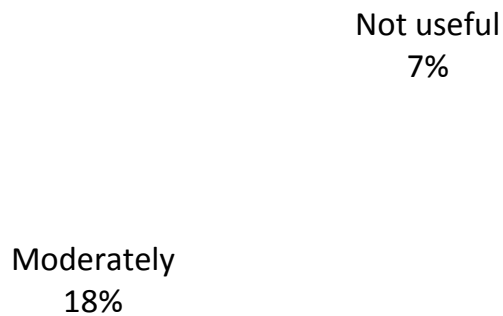
Furthermore, only 69.0% of those who received the start-up tool kits were actually using them. Problems in using start up kits included among others lack of space/premises, lack of spare parts, and lack of materials. In one of the districts, it was reported that trainees only received the head of the sewing machine and were supposed to get the rest of the machine set by themselves. In other cases, a single sewing machine was given to four trainees to be shared amongst them. And yet in others, trainees were asked to contribute funds to transport sewing machines from Entebbe airport to their localities. In all such cases, OVC found challenges in getting complete sets of kits that they could use comfortably and effectively to earn a descent living.

*The machine is Olvite, weak and needs to be repaired most of the time. The spare parts are also expensive and they are sold very far thus the transport costs are high...When I get some money, I am planning to buy a stronger machine....they should at least get for us a nearby spare parts shop where*

*we can easily go in case the machine gets a problem. Am also requesting that they should give us start-up materials like pieces of clothes which we can use as we begin in our work (Male OVC, recipient of a sewing machine, Mityana District).*

Nonetheless, almost three quarters of the beneficiaries of skills training rated the training as very useful. Below is a pie chart showing reported levels usefulness of training as perceived by the trainees.

**Figure 4: Perceptions of the Skills Trainees about the Usefulness of Training**



Majority (74.0%) of the trainees said the training was very useful because the skills which they acquired could enable them to startup an IGA, while others (26.0%) said that the training had enabled them to get money to meet their needs and those of their siblings.

The trainees who ranked the training as moderate did so because they lacked start-up capital/tools (66.7%). On the other hand, those who ranked the training as not useful did so because they were yet to complete the training, did not complete or because there were no training materials during the training.

Majority (67.2%) of the graduated trainees reported that they were facing challenges in their work. Main challenges mentioned included lack of capital to start/improve their IGA (39.1%), lack of tools (37.0%) and inaccessible spare parts (13.0%) respectively for the different machines which they are using.

In Mayuge district, FLEP staff reported that some OVC who had commenced skills training in various disciplines dropped out mid way due to varying reasons. Some of the boys were taken up by the fishing industry while some girls either conceived or run away with boyfriends hence

abandoning the training. There were also cases where trainees successfully completed the training, received start up kits but were not using them, some having deserted the trade. In Ibanda district, a case was found of a child who had trained in tailoring and given a sewing machine but was not using the machine because the family lacked income to purchase materials to make clothes. The boy therefore postponed practicing his trade and took up another job with a road construction company, so that he can earn some money with which he would then purchase the needed materials to start his own tailoring enterprise. There is a danger that he might forget what he learnt as time goes by.

Other OVC who had been trained in mechanics reported that they lacked the resources to purchase spare parts so that they could put to use the skills that they had learnt. Some expressed concern that they were not earning a good income since they could only earn from doing minor repairs on bicycles and motorcycles, leaving the 'bigger' work that brings in much profit to the already established mechanics who owned workshops that were at the same time selling spare parts.

*For me the problem I am facing is the lack of spare parts. Even if you have the skill to repair motorcycles but if you do not have the spares, you cannot earn much income since you will simply be doing repairs* (Male OVC trained in Mechanics, Bugarama parish, Ibanda district – Under Ankole Diocese).

Despite the above challenges and limitations, it can be noted that these youths have been given a starting point, and it can be expected that as they get employment, start their own enterprises, and gain experience, they will be able to do a lot using the acquired skills. It might be important however, that CSOs consider giving a start up package that not only includes tools and materials, but also some cash grant, with which trained OVC can rent premises or buy other needed items to start self employment.

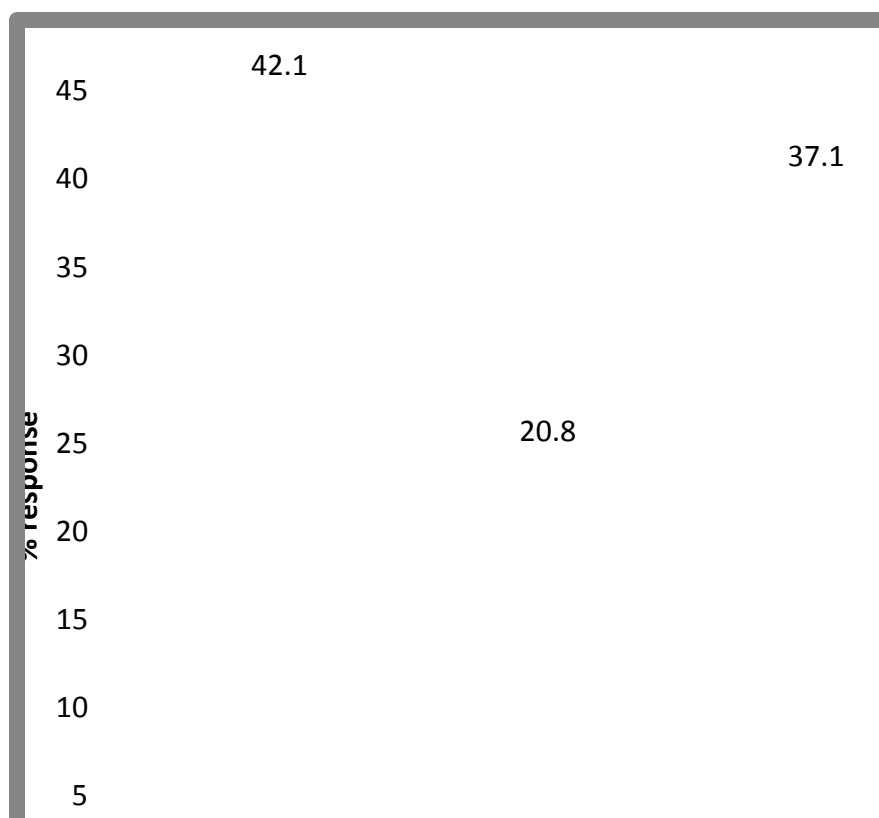
### **3.3 Effectiveness of Economic Strengthening Interventions in increasing Income Growth**

One of the objectives of this study was to assess the extent to which economic strengthening interventions for OVC have contributed to income growth in the targeted OVC households. In this sub-section, we look at the changes in household incomes and savings reported by supported caregivers.

#### **3.3.1 Income Growth**

Caregivers who participated in this study were asked how their household incomes had changed over the past 3 years. Figure 5 below shows the details.

#### **Figure 5: Reported Changes in OVC Household Income over the Past 3 Years (Caregiver Reported)**



As can be seen from the figure above, more caregivers (42.1%) reported an increase in their income in the past 3 years compared to those who reported that the income was the same as three years ago (20.8%) or reduced (37.1%). Further analysis shows that a greater proportion of respondents from Kibaale reported an increase in income compared to other districts.

**Table 14: Caregiver Reported Changes in Income over the Past 3 Years by District**

| Reported changes during the last 3 years | District       |                   |                  |                  |                   | Total              |                |
|--|----------------|-------------------|------------------|------------------|-------------------|--------------------|----------------|
|  | Gulu (N=166) % | Mityana (N=134) % | Mayuge (N=209) % | Ibanda (N=171) % | Kibaale (N=186) % | Percentage (N=866) | Number (N=866) |
| Increased                                | 45.8           | 53.7              | 20.6             | 39.2             | 57.5              | 42.1               | 365            |
| Same                                     | 26.5           | 32.1              | 16.7             | 26.3             | 7.0               | 20.8               | 180            |
| Decreased                                | 27.7           | 14.2              | 62.7             | 34.5             | 35.5              | 37.1               | 321            |

Amongst those who reported an increase in household incomes, the most cited sources of the increase in income were training in IGAs (31.6%), and use of improved seeds/breeds (23.2%). Other mentioned sources included joining saving groups (14.6%), better agricultural support services (11.5%), and improved access to markets/prices (11.1%).

Among those who reported a decrease in income, the most cited reason was ill-health of the caregiver (27.9%), followed by bad weather that affected crops (27.2%), and crop pests and

diseases (17.9%). Others were lack of markets for produce, poor prices, and lack of improved seeds and extension services. Overall, it can be observed that the major factors for reductions in income were not project related.

As already reported, slightly more than a half (51.9%) of the caregivers that received IGA support reported that they realized income from the IGA. Analysis by district shows that reporting of earnings from IGAs was highest

**Table 15: Income from IGAs**

| Amount of money realized from the IGA per month |         |         |        |           |           |
|---|---------|---------|--------|-----------|-----------|
|   | Gulu    | Mityana | Mayuge | Ibanda    | Kibaale   |
| Number of respondents                           | 22      | 7       | 10     | 37        | 60        |
| Mean  | 34,182  | 149,050 | 23,867 | 72,387    | 173,550   |
| Median  | 10,000  | 60,000  | 11,666 | 50,000    | 69,334    |
| Mode  | 10,000  | 3,330   | 10,000 | 60,000    | 20,000    |
| Minimum   | 1,667   | 3,333   | 1,667  | 1,333     | 6,000     |
| Maximum   | 400,000 | 700,000 | 75,000 | 1,000,000 | 2,000,000 |

Further analysis was done to find out if the modality of IGA support had an effect on the changes in OVC household income. The results are shown in the table below.

**Table 16: Modality of IGA Support and Change in Household Income**

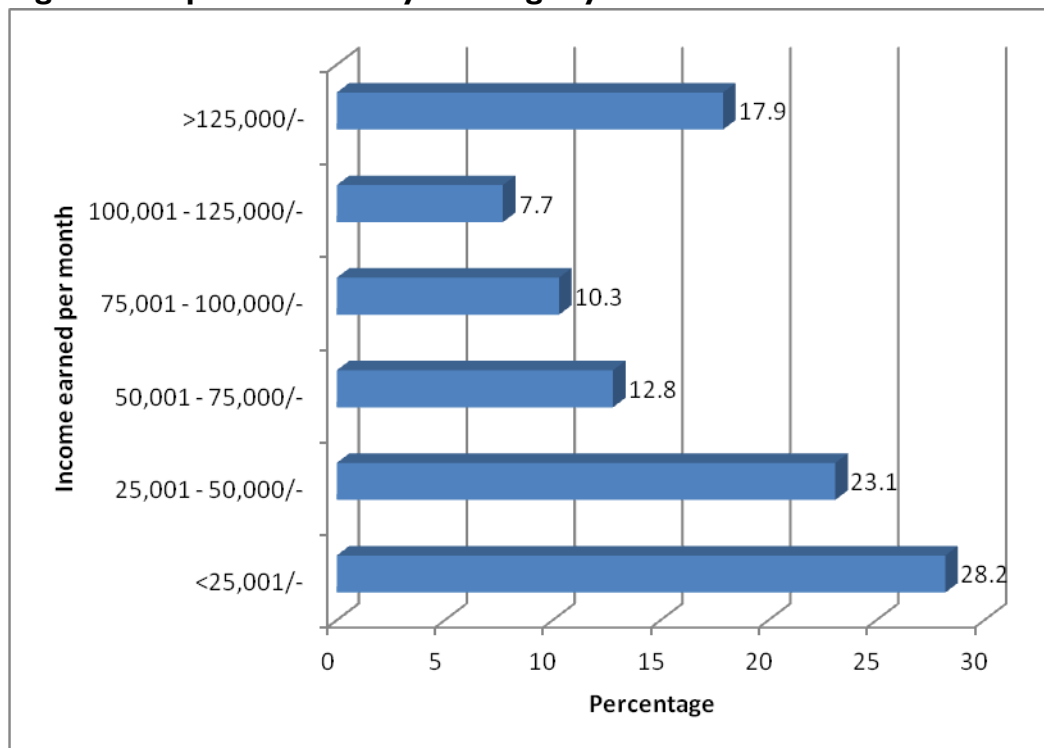
| Reported change in household income during the last 3 years | Modality of IGA Support Received |                    |   | Total             |                               |
|---|----------------------------------|--------------------|---|-------------------|-------------------------------|
|   | Individual/HH IGA (N=197) %      | Group IGA (N=59) % | Both Individual/HH & Group IGA (N=33) % | Percent (N=289) % | Number of Respondents (N=289) |
| Increased   | 46.2                             | 59.3               | 60.6                                    | 50.5              | 146                           |
| Same  | 17.8                             | 25.4               | 3.0                                     | 17.6              | 51                            |
| Decreased   | 36.0                             | 15.3               | 36.4                                    | 31.8              | 92                            |

*P=0.005*

The above data show that a higher proportion of caregivers who received group IGAs (59.3%) and those who received both group and individual/household IGAs (60.6%) reported that their incomes had increased over the past 3 years compared to those who received IGAs as individuals/households (46.2%). The differences between these proportions were statistically significant ( $p=0.005$ ).

Among the trainees from apprenticeships, 58.2% (n=39) of those interviewed stated that the skills given to them during training have enabled them get some income. The figure below shows the level of income from skills obtained by trained out-of-school OVC.

**Figure 6: Reported Monthly Earnings by OVC Trained in Skills**



The findings above show that a total of up to 51.3% of the OVC reported to be earning 50,000 or below. The low earnings were attributed to lack of their own independent workplaces, inadequate materials and tools, and the fact that they were still new in the market. Table 17 below further shows the descriptive statistics for the reported incomes amongst working OVC.

**Table 17: Descriptive Statistics for Monthly Income of Out-of-School OVC Trained in Skills**

| Measurements                    | Result  |
|---------------------------------|---------|
| Number of respondents reporting | 39      |
| Mean                            | 89,400  |
| Median                          | 50,000  |
| Mode                            | 20,000  |
| Minimum                         | 4,000   |
| Maximum                         | 600,000 |

Although the biggest proportion of the working OVC reported earning about 20,000/- the data in the above table indicate an average of 89,400/- per month. The findings from qualitative data indicate an improvement in OVC incomes as a result of the support provided. In Ibanda for instance, beneficiaries of Ankole diocese boasted of increased incomes resulting from the support provided.



*I was taught motorcycle repairing and now I am able to earn some small income from the repairs I make – (OVC trained in motorcycle mechanics, Bugarama parish, Bisheshe sub county, Ibanda District – supported by Ankole Diocese).*

**Case Study I: Earning from Skills Training:** My name is Alex, I live in Bisheshe Sub County, Ibanda District. I am from a family of seven children and we are being taken care of by our mother and I also offer a hand as a first born. Before the skills training, I was always at home digging with my mother and my siblings. Though I was in school, I used to cultivate and provide casual labor in order to meet my basic needs. We were very poor and meeting school requirements was usually a struggle until I dropped out of school. The Community Worker from Ankole Diocese advised me to apply to enroll in the skills training. The skills I was trained in were exactly what I wanted. My mother was of great influence since she had always seen motor mechanics as successful people for they are able to earn in a day hence opted for the same. It only took me one year to finish my training and I was trained by a local artisan, Mr. Hannington Shazi an expert in motor mechanic in our village. I did not pay any money since Ankole Diocese was sponsoring my training.



**Picture 1: Alex with his box of tools**

I now repair motorcycles and cars and from that I can earn some money, not sure but can estimate 10,000UG shillings a day, save about 25,000UG shillings per week and around 60,000UG shillings per month. Before the support, I was so needy, I am independent now, am able to sustain myself and meet my basic needs and those for my siblings sometimes. The challenge is, I don't have my own spares and enough tools. The savings are not yet enough to have enough

tools for myself, so I have to share with others which is sometimes an inconvenience. The customers are also still few. I am planning to work so hard and save some money so that I buy more spares and own a garage so that I can expand and sustain myself. I really do not know how I can express my gratitude. I do so much appreciate the help that they offered to me, which has enabled me to take care of myself and my family as well. I would ask them to offer a hand in expanding my business. Otherwise may God bless the works of their hands.

Further analysis of the occupations of the highest and lowest income earners amongst working OVC that were trained in skills indicates a mixed picture with OVC in most occupations tailoring distributed almost evenly across both lowest and highest income earners. This seems to indicate that levels of earning were not related to the occupation that one was practicing, but probably other factors such as location of the business/work.

Qualitative findings from the study indicated that some OVC households who received ox-ploughs and oxen from Health Alert are earning some income by ploughing people's gardens and banking that money into their group account. They are also participating in business called "awaru", whereby they use group money given by the programme to buy produce (food crops) from village and bring it to towns for sale, thereby earning some income.

### ***Determinants of Increase in the Income of OVC Households: Results of a Multinomial Logistic Regression Model***

As already shown, when caregivers were asked whether the income of their households had changed during the last 3 years, 42.1% of them reported that their income had increased. In order to understand the factors that underlie this reported increase in income, a multinomial logistic regression model was used. The results show that the following factors are statistically significant in explaining the increase in household income:

- Education level of the caregiver,
- Size of land owned by OVC households,
- Type of IGA run by OVC household,
- Training household members in business skills and managing IGAs.

**Table 18: Results of the Multinomial Logistic Regression Model for Income**

| <b>Change in OVC household income over the support period (Reference = OVC Household Income reduced)</b> | <b>Risk Ratio<sup>9</sup></b> | <b>p-value</b> | <b>95% confidence Interval</b> |
|--|-------------------------------|----------------|--------------------------------|
| <b>OVC Household Income Increased</b>  |                               |                |                                |
| <b>Education Level (Reference=None)</b>  |                               |                |                                |
| Primary  | 1.68                          | 0.007          | 1.15 – 2.45                    |
| Secondary+   | 4.29                          | 0.000          | 2.29 – 8.03                    |
| <b>Size of land owned (Reference = &lt;6 Acres)</b>  |                               |                |                                |
| 6– 10 Acres  | 1.46                          | 0.191          | 0.83 – 2.58                    |
| 10+ Acres  | 3.07                          | 0.006          | 1.37 – 6.87                    |
| <b>Type of IGA Received (Reference = No support received)</b>  |                               |                |                                |
| Cash/money   | 0.96                          | 0.917          | 0.41 – 2.21                    |
| Materials  | 2.16                          | 0.510          | 0.22 – 21.24                   |
| Animal breeds  | 1.12                          | 0.736          | 0.58 – 2.15                    |
| <b>IGA being run by OVC HH (Reference = No IGA)</b>  |                               |                |                                |
| Poultry farming  | 1.43                          | 0.584          | 1.00 – 5.12                    |
| Animal rearing   | 1.89                          | 0.028          | 1.07 – 3.34                    |
| Crop farming   | 0.85                          | 0.617          | 0.46 – 1.59                    |
| Trade/business   | 3.87                          | 0.030          | 1.14 – 13.18                   |
| • Training household members in business skills and managing IGAs  | 2.16                          | 0.000          | 1.50 – 3.12                    |
| <b>OVC Household Income remain the same</b>  |                               |                |                                |
| <b>Education Level (Reference=None)</b>  |                               |                |                                |
| Primary  | 1.17                          | 0.460          | 0.77 – 1.76                    |
| Secondary+   | 1.62                          | 0.212          | 0.76 – 3.48                    |
| <b>Size of land owned (Reference = &lt;6 Acres)</b>  |                               |                |                                |
| 6– 10 Acres  | 1.67                          | 0.121          | 0.87 – 3.21                    |
| 10+ Acres  | 0.63                          | 0.489          | 0.17 – 2.36                    |
| <b>Type of IGA Received (Reference = No support received)</b>  |                               |                |                                |
| Cash/money   | 1.13                          | 0.809          | 0.42 – 3.05                    |
| Materials  | 2.42                          | 0.547          | 0.14 – 42.85                   |
| Animal breeds  | 0.94                          | 0.870          | 0.42 – 2.08                    |
| <b>IGA being run by OVC HH (Reference = No IGA)</b>  |                               |                |                                |
| Poultry farming  | 1.73                          | 0.497          | 0.36 – 8.45                    |
| Animal rearing   | 1.09                          | 0.801          | 0.55 – 2.18                    |
| Crop farming   | 0.36                          | 0.031          | 0.14 – 0.91                    |
| Trade/business   | 1.47                          | 0.620          | 0.33 – 6.63                    |
| • Training household members economic strengthening (managing IGAs, running business, etc)               | 0.74                          | 0.261          | 0.48 – 1.22                    |

Education level of caregivers had significant influence on reported household income increase. When none educated caregivers were compared with educated counterparts, it was found that

<sup>9</sup> Risk Ratio (or Relative Risk) is the ratio of probability of households/caregivers who were exposed to the independent variables (treatment) and probability of counterparts who were not exposed to the same treatment will say their household income increased or remained the same relative to the probability of those whose household income reduced.

in relation to those who reported reduction incomes, caregivers who had reached primary or secondary and above level of education had higher relative risk (1.68 or 4.29 respectively) of reporting that their household incomes have increased compared to those who had no education at all. When the same comparison was applied to the group of caregivers who reported that their income had remained the same, the results revealed higher relative risk ratios (1.17 and 1.62 respectively) though not statistically significant ( $p=0.460$  and  $p=0.212$ ).

Size of land is also an important factor as seen found above that relative to those whose incomes reduced, caregivers who had 10 or more acres of land were 3.07 times more likely to say their incomes have increased compared to caregivers who had less than 6 acres of land.

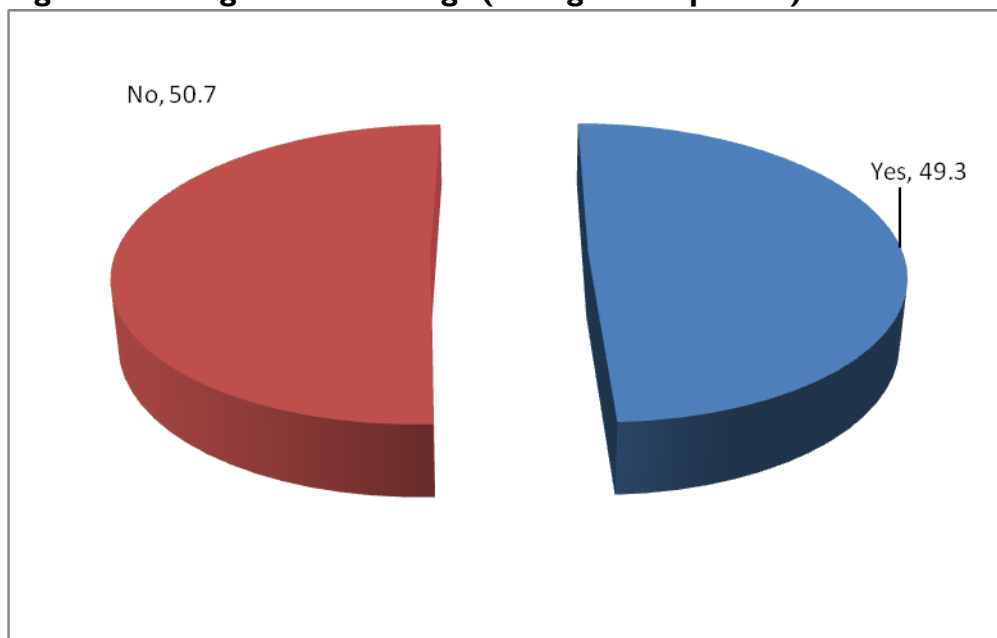
Type of income generating projects being run by OVC households have influence in income increase as seen that caregivers who are rearing animals or running trading business have significantly high relative risk of reporting income increase. Relative to those who reported reduction in income, caregivers who were either rearing animals or trading had relative risk of 1.89 or 3.87 respectively reported income increase compared to caregivers who were not running any income generating project.

Relative to those who reported reduction in incomes, caregivers who were trained in economic strengthening (managing IGAs, running business, etc) skills had high relative risk of reporting income increase compared to caregivers who were not trained (see table 18 above).

### 3.3.2 Savings

Accumulation of savings is a good indicator of one's ability to earn more than they spend, and their potential to re-invest their income or to purchase assets. Caregivers were asked if they have any savings, and the results are shown in the figure below:

**Figure 7: Caregiver has Savings (Caregiver Reported)**



The results in the figure above show that almost half (49.3%, n=427) of the caregivers reported that they had some savings, while another slightly more than half (50.7%) reported no savings. This study also examined whether the modality of IGA support (individual/household support versus group support) had anything to do with caregiver’s ability to have savings. The results are shown in table 19 below.

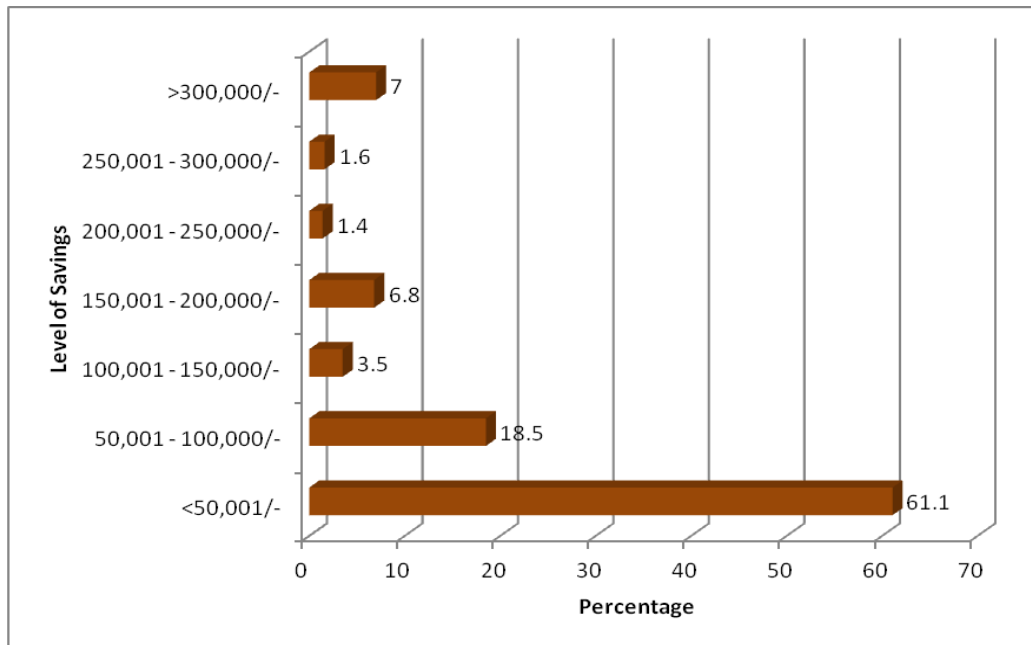
**Table 19: Modality of IGA Support and Savings by Caregiver**

| Caregiver has savings | Modality of IGA Support to OVC caregiver/household |                    |   | Total             |                |
|-----------------------|--|--------------------|---|-------------------|----------------|
|                       | Individual/HH IGA (N=197) %                        | Group IGA (N=59) % | Both Individual/HH and Group IGA (N=33) % | Percent (N=256) % | Number (N=256) |
| Yes                   | 47.2   | 66.1               | 57.6                                      | 51.6              | 132            |
| No                    | 52.8   | 33.9               | 42.4                                      | 48.4              | 124            |

The results in the table above indicate that a higher proportion of caregivers who received group IGAs (66.1%) and those who received both group and individual/household IGAs (57.6%), reported having savings compared to those who received individual/household savings only.

The figure below further presents the level of savings reported by caregivers.

**Figure 8: Level of Savings reported by Caregivers**



Majority of those who reported savings (61.1%) had savings of not more than 50,000, indicating a very low level of savings.

Overall, the average amount of savings reported amongst about 427 households was 101,274, accumulated in a period of an average of 5.7 months. The mode was 20,000 accumulated in 1 month. This indicates that for most caregivers that had any savings, their savings amounted to 20,000 per month. Thus whereas the culture of savings is slowly taking root, the level of savings is still meager. Table 20 below further shows the reported levels of savings by district.

**Table 20: Caregivers' Savings Level by District**

| Reported Level of savings | District      |                 |               |               |                 | Total             |                |
|---------------------------|---------------|-----------------|---------------|---------------|-----------------|-------------------|----------------|
|                           | Gulu (N=85) % | Mityana N=59) % | Mayuge (N=94) | Ibanda (N=72) | Kibaale (N=115) | Percentage N=425) | Number (N=425) |
| <50,001/-                 | 68.2          | 71.2            | 77.7          | 56.9          | 40.9            | 61.1              | 261            |
| 50,001 - 100,000/-        | 17.6          | 18.6            | 12.8          | 19.4          | 23.5            | 18.5              | 79             |
| 100,001 - 150,000/-       | 2.4           | 3.4             | 1.1           | 2.8           | 7.0             | 3.5               | 15             |
| 150,001 - 200,000/-       | 4.7           | 5.1             | 4.3           | 9.7           | 9.6             | 6.8               | 29             |
| 200,001 - 250,000/-       | 1.2           | 0.0             | 1.1           | 1.4           | 2.6             | 1.4               | 6              |
| 250,001 - 300,000/-       | 0.0           | 0.0             | 0.0           | 1.4           | 5.2             | 1.6               | 7              |
| >300,000/-                | 5.9           | 1.7             | 3.2           | 8.3           | 11.3            | 7.0               | 30             |

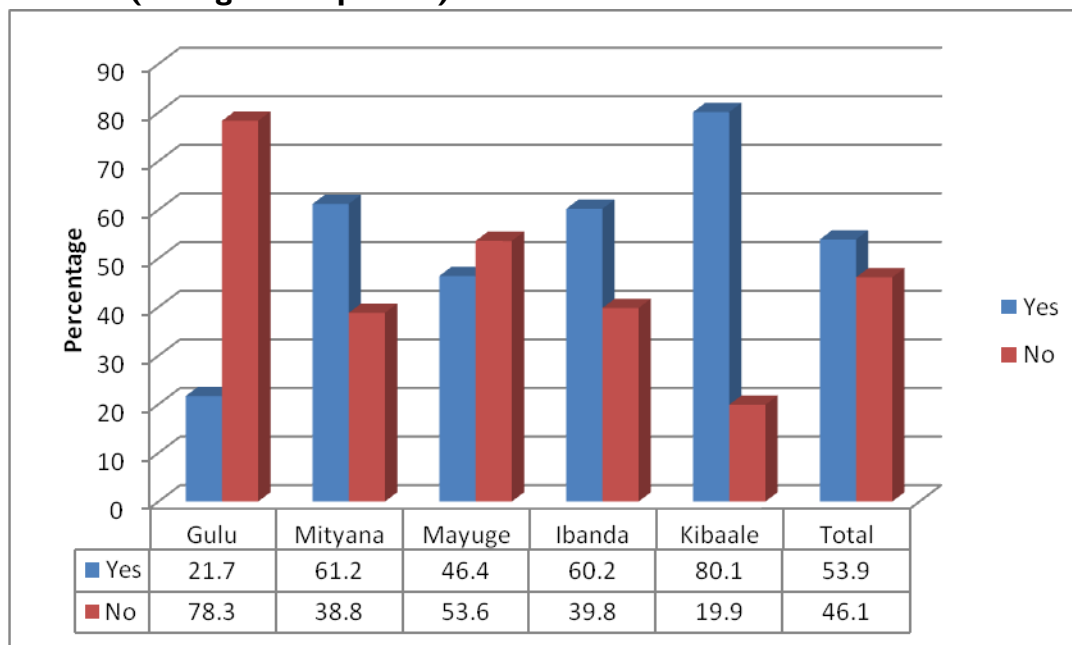
The data in the above table show that a bigger proportion of those who reported higher savings were from Kibaale district, followed by Ibanda. The districts with lowest levels of savings reported were Mityana and Mayuge.

### **3.4 Effectiveness of Economic Strengthening Interventions in relation to Assets Growth and Protection**

One of the objectives of this study was to determine the extent to which OVC interventions contribute to strengthening assets growth and protection in OVC households. This section therefore presents the findings regarding assets growth and protection within OVC households during the period of support.

First, this study investigated whether OVC households had acquired any new assets during the 3 years preceding the study. Overall, slightly more than half of the caregivers (53.9%, n=467) reported that their households had acquired new assets during the past 3 years as shown in Figure 9 below. The results are shown by district.

**Figure 9: Reported Acquisition of Assets by OVC Households in Past 3 Years by District (Caregiver Reported)**



The above results by district show that the biggest proportion of caregivers who reported acquiring assets in the previous 3 years were from Kibaale. The difference between Kibaale and other districts was also remarkable, with the Mityana and Ibanda following with a margin of almost 20 percentage points. It is also striking that Gulu had only 21.7% that reported having acquired assets.

In addition, the relationship between training and asset acquisition was investigated. The results are shown in the table below.

**Table 21: Relationship between training in economic strengthening (IGAs/business skills) and asset acquisition**

| Household acquired new assets over past 3 years | Caregiver or another member of the household attended training in economic strengthening in past 3 years |              | Total             |                |
|---|--|--------------|-------------------|----------------|
|   | Yes (N=214) %  | No (N=211) % | Percent (N=425) % | Number (N=425) |
| Yes   | 58.9   | 41.1         | 100               | 287            |
| No  | 32.6   | 67.4         | 100               | 138            |

*P=0.000*

The data in the table show that the majority of the caregivers who reported asset acquisition (58.9%) had received training in economic strengthening (managing IGAs, running business, etc)

in the last 3 years, compared to 41.1% who acquired new assets despite having not received training. This showed a statistically significant difference ( $p=0.000$ ) between trained and non-trained caregivers as far as asset acquisition is concerned.

To further ascertain the factors that might have been associated with acquisition of assets, a logistic regression model for asset acquisition was performed.

### **Logistic Regression Model for Asset Acquisition**

The results revealed that about 54% of the caregivers interviewed had acquired new assets or property over the last 3 years. This necessitated an investigation using a logistic regression model to study other factors that influenced these results. The resultant model results show that reported acquisition of assets over the last 3 years was associated with factors such as district where the survey was carried out, education level of the caregiver, source of support access to credit financing, and training agro-business management over the last 3 years. Respondents from the district of Kibaale and Mityana had the highest odds of reporting that they have acquired assets or property compared to the district of Gulu.

**Table 22: Detailed Results of logistic Regression Model for Asset Acquisition**

| <b>Variable</b>   | <b>Odds Ratio<sup>10</sup></b> | <b>p-value</b> | <b>95% confidence Interval</b> |
|---|--------------------------------|----------------|--------------------------------|
| <b>District (Reference=Gulu)</b>  |                                |                |                                |
| Mityana   | 7.20                           | 0.000          | 3.13 – 16.56                   |
| Mayuge  | 4.54                           | 0.000          | 2.18 – 9.47                    |
| Ibanda  | 5.21                           | 0.000          | 2.57 – 10.56                   |
| Kibaale   | 14.09                          | 0.000          | 6.74 – 29.42                   |
| <b>Age of caregiver (Reference =&lt;31 years)</b>   |                                |                |                                |
| 31 - 40 years   | 0.85                           | 0.648          | 0.41 – 1.74                    |
| 41 - 50 years   | 0.86                           | 0.691          | 0.41 – 1.80                    |
| >50 Years   | 0.57                           | 0.140          | 0.27 – 1.20                    |
| <b>Education Level of caregiver (Reference=None)</b>  |                                |                |                                |
| Primary   | 1.55                           | 0.070          | 0.97 – 2.47                    |
| Secondary   | 2.68                           | 0.021          | 1.15 – 6.23                    |
| Tertiary+   | 1.51                           | 0.599          | 0.32 – 7.12                    |
| <b>Implementing partner (Reference =Other IP)</b>   |                                |                |                                |
| CSF sub grantees  | 0.53                           | 0.021          | 0.31 – 0.91                    |
| <b>Access to credit (loan) financing for productive activities over the last 3 years (Reference=No)</b> |                                |                |                                |
| Yes   | 1.56                           | 0.052          | 1.00 – 2.44                    |
| <b>OVC household currently running the IGA for which the support was received</b>                       |                                |                |                                |

<sup>10</sup> Odds ratio is a measure of effect size, describing the strength of association or non-independence between two binary data values



| <b>Variable</b>  | <b>Odds Ratio<sup>10</sup></b> | <b>p-value</b> | <b>95% confidence Interval</b> |
|--|--------------------------------|----------------|--------------------------------|
| <b>(Reference=No)</b><br>Yes   | 0.56                           | 0.012          | 0.35 – 0.88                    |
| <b>Any out-of-school OVC in the household trained in apprenticeship skills (Reference=No)</b><br>Yes | 0.53                           | 0.067          | 0.27 – 1.05                    |

More educated caregivers had higher odds to saying they have acquired assets as compared to those who had never gone to school. Caregivers with secondary level of education were 2.68 times more likely to say that they have acquired assets over the preceding 3 years as compared to caregivers who had never gone to school.

Older caregivers had reduced odds of saying they had acquired assets as compared to youthful (less than 30 years old) caregivers. This means that youthful caregivers were more likely to say they had acquired assets or property as compared to older caregivers.

Furthermore, OVC households who were running the IGA for which the support was received or had out-of-school OVC trained in apprenticeship skills had reduced odds of saying that they have acquired assets or property. Also running the IGA for which the support was received or training out-of-school OVC in apprenticeship skills did not necessarily translate into asset or property acquisition. However caregivers who had accessed credit (loan) financing for productive activities had higher odds of saying they have acquired assets or property in the last 3 years.

Based on the results of the model therefore, further assets growth in OVC households can be enhanced through training caregivers in agro-business management and facilitating them to access credit.

### **3.4.1 Types of Assets Acquired**

This study also asked caregivers who said they had acquired assets about the type of assets they had bought. The results are shown in the table below.

**Table 23: Type of Assets acquired by OVC Households**

| Type of Assets/<br>property acquired in<br>past 3 years | Percent<br>(N=866)<br>% | Number<br>Responses<br>of |
|---|-------------------------|---------------------------|
| Domestic utensils                                       | 22.9                    | 203                       |
| Animals   | 19.3                    | 171                       |
| Farm tools  | 10.9                    | 97                        |
| Domestic furnishings                                    | 10.2                    | 91                        |
| Poultry   | 8.2                     | 73                        |
| Land  | 7.0                     | 62                        |
| House/building  | 6.3                     | 56                        |
| Mobile phone  | 6.1                     | 54                        |
| Bicycle   | 4.4                     | 39                        |
| Motor cycle   | 2.5                     | 22                        |
| Other   | 2.3                     | 20                        |
| Total   | 100.0                   | 888*                      |

\*Multiple responses allowed

Domestic utensils were the most common type of asset acquired, followed by animals, farm tools and domestic furnishings. These types of assets acquired probably highlight the types that OVC households value most, but also what they can afford, using their income. It was further established that caregiver groups that had been formed were instrumental in contributing to asset growth for their members.

*In my group when the members gave me money, good enough I had already paid the school fees of my children and so I used this money to buy cups and plates at home for the family to use – (Caregiver, Bisheshe central, Bisheshe sub county, Ibanda District).*

*I borrowed some money from the group and I was able to purchase some plastic chairs for people to sit at home (Chairperson Bamunanika Group; Bisheshe Sub county – Ibanda district).*

A few reported to have purchased assets such as land or built houses with proceeds from project support.

*I have bought a piece of land – (Caregiver with Kireku Health programme, Mityana District).*

*I have been able to build a house and roof it with iron sheets; at least I also sleep like a king now – (Caregiver with Kireku Health programme, Mityana District).*

*I have bought a mattress, chairs and utensils – (Caregiver with TASO, Unyama Sub county; Gulu district).*

Of all the caregivers who reported having acquired new assets, majority (53.5%) reported that these newly acquired assets were being used for domestic consumptive purposes, while 45.7% reported that the assets were being put to some productive use. The story of Agatha below exemplifies how some of the caregivers have used project support to acquire animals that they use as a productive resource to produce more wealth and meet OVC needs.

**Building a herd of goats through project Support: The Story of Agatha**

My name is Agatha. I live in Ibanda District. My family is made up of nine members myself inclusive. Of these nine, 7 are my children and the other one belongs to my brother. The boys are 6 and the girls are 2. All my children are orphans because I lost my husband. Though the other child has parents, his parents cannot provide anything to meet his needs. We live on a small piece of land of about three plots. All the children are in school part from the girl who was given a sewing machine after completing her apprenticeship training. She is now working in Kyengando. She operates from some other person's workshop since she has not yet made enough money to start her own workshop. I also have a boy who had been trained in mechanics but did not complete the training after he broke his hand. He has since returned to school and is now attending S.2. Let me tell you how I started my goat project. Our group had received some money from Ankole Diocese to start savings. However, as others were saving their money in the bank, something inside me told me that if I used my money to buy goats, I might be able to do better compared to someone who saved their money in the bank. I therefore bought two goats and reared them until they multiplied and became ten (10). I later sold some of them and built a house. Later on, I sold some other goats and also my daughter who operates a sewing machine contributed and I purchased a plot of land. Currently, I have 7 mature goats, 10 that have just been weaned and some 5 young ones. From this project, I have also been able to educate my children, provide for their medical care and provide other necessities needed at our home. The biggest challenge I face is lack of land for grazing these animals and lack of good shelter to house them. The other problem is that the goats usually become sick and it is expensive to take bring a veterinary doctor to look at them.



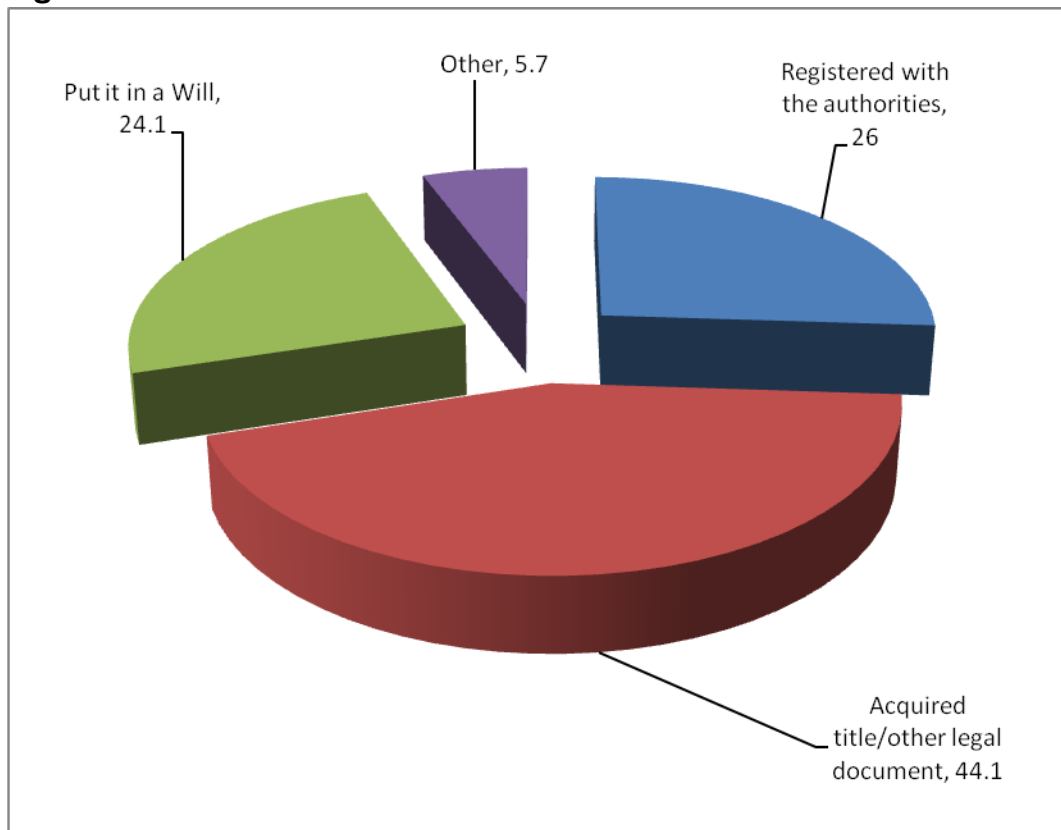
I require support to assist me purchase drugs for the goats whenever they are sick. I also need to be supported to construct a shelter for the goats so that they are protected from bad weather and thieves. I am planning to continue to look after the goats so that they can reproduce after which I will sell some of them to pay tuition for my child to complete S.4. I also hope to sell some of the goats so that I can obtain money to invest in buying and selling coffee which is becoming a lucrative business round here.

**Picture 2: Agatha with her goats**

### 3.4.2 Protection of Household Assets

Overall, only slightly more than one third (36.4%, n=315) of those who reported having acquired new assets reported that some measures had been taken to safeguard or protect the assets, compared to 63.6% (n=551) who reported no measures at all. The measures reported mainly consisted of acquisition of titles, writing the assets in wills and registering them with the authorities as shown in the chart below.

**Figure 10: Measures taken to Protect OVC Household Assets**



It was found that most of the Sub-grantees had not implemented interventions aimed at assets protection. A few such as FLEP in Mayuge reported that they had taught OVC caregivers in succession planning. Caregivers were also asked about their views on their status on the land they occupied and their potential to access legal support to protect their assets. The findings are shown in the table below.

**Table 24: Legal Protection and Potential to access Legal Services for OVC Households**

|  | CSF Supported | Other IP Supported | Total | Number (N=866) |
|--|---------------|--------------------|-------|----------------|
| Caregiver thinks s/he has sufficient legal status to remain in their home/land |               |                    |       |                |
| Yes  | 57.6          | 54.3               | 56.9  | 493            |
| No   | 28.7          | 31.4               | 29.2  | 253            |
| Don't know   | 13.7          | 14.3               | 13.9  | 120            |
| Caregiver believes s/he would be able to access legal support if needed        |               |                    |       |                |
| Yes  | 49.1          | 50.9               | 49.4  | 428            |
| No   | 32.4          | 26.9               | 31.3  | 271            |
| Don't know   | 18.5          | 22.3               | 19.3  | 167            |

As can be seen in the above table, 56.9% of the caregivers believed that they had sufficient legal status to remain in their home/land, while less than half (49.4%) believed that they would be able to access legal support if needed. This calls for more education and information about sources of legal support for OVC and their caregivers.

**Table 25: Perception of Legal Status on Land/Home by Male and Female Caregivers**

| Caregiver thinks h/she has sufficient legal status to remain in your home/land | Sex of respondent /caregiver |                     | Total           |                       |
|--|------------------------------|---------------------|-----------------|-----------------------|
|  | Male (N=191)<br>%            | Female (N=675)<br>% | Percent (N=866) | Number of respondents |
| Yes  | 64.4                         | 54.8                | 56.9            | 493                   |
| No   | 25.7                         | 30.2                | 29.2            | 253                   |
| Don't know   | 9.9                          | 15.0                | 13.9            | 120                   |

*P=0.046*

The above findings indicate that male caregivers were more confident of their legal right to remain on the land or home they occupied compared to female caregivers, and the difference was statistically significant ( $p=0.046$ ).

**Table 26: Perception of Access to Legal Support by Male and Female Caregivers**

| Caregiver believes s/he would be able to access legal support if needed | Sex of respondent /caregiver |                     | Total           |                               |
|---|------------------------------|---------------------|-----------------|-------------------------------|
|   | Male (N=191)<br>%            | Female (N=675)<br>% | Percent (N=866) | Number of respondents (N=866) |
| Yes   | 56.5                         | 47.4                | 49.4            | 428                           |
| No  | 30.9                         | 31.4                | 31.3            | 271                           |
| Don't know  | 12.6                         | 21.2                | 19.3            | 167                           |

*P=0.016*

Similarly, a bigger proportion of male caregivers believed that they would access legal support if they needed it compared to female caregivers, and once again, the difference between the two groups was statistically significant.

## 4 SUPPORT TOWARDS FOOD AND NUTRITION SECURITY

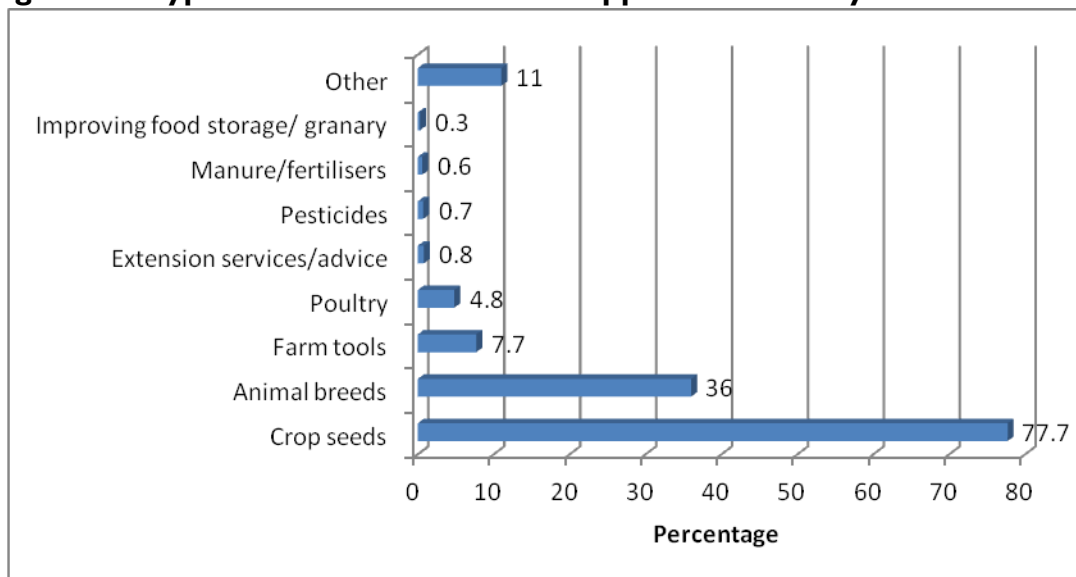
### 4.1 Introduction

Adequate food and nutrition is essential to the health and survival of all human beings, and more so, to the growth and development of children. One of the objectives of this study was to assess the efficacy of CSF and other OVC implementing partners' interventions in improving food availability, access, and utilization in the targeted OVC households. This section therefore presents the results of this study with respect to the support provided towards food and nutrition security.

### 4.2 Food and Nutrition Interventions Supported

The results of this study indicate that all OVC caregiver households (100%) covered in this study whether supported by CSF - sub-grantees or other IPs reported that they received some form of support to improve food production as well as nutrition in their households. This support was in form of any of one or a package of food and nutrition security interventions and prominent among these interventions were; provision of crop seeds, animal breeds, farm tools and training in improved agricultural practices (see Figure 11).

**Figure 11: Type of Food and Nutrition Support received by OVC Households**



The results above indicate that improved crop seeds were the most widely received form of support, followed by animal breeds. While CSF sub-grantees provided more crop seeds support to OVC households, the other IPs offered more animal breeds, training and farm tools.

**Table 27: Type of Food and Nutrition support received by District**

| Type of Food and Nutrition support received | District       |                   |                  |                  |                   | Total             |                      |
|---|----------------|-------------------|------------------|------------------|-------------------|-------------------|----------------------|
|   | Gulu (N=166) % | Mityana (N=134) % | Mayuge (N=209) % | Ibanda (N=171) % | Kibaale (N=186) % | Percent (N=866) % | Number of responses* |
| Crop seeds                                  | 94.0           | 73.9              | 66.0             | 70.8             | 85.5              | 77.7              | 673                  |
| Animal breeds                               | 16.9           | 49.3              | 34.4             | 50.3             | 32.3              | 36.0              | 312                  |
| Poultry                                     | 1.8            | 0.0               | 2.4              | 0.0              | 18.3              | 4.8               | 42                   |
| Pesticides                                  | 0.0            | 0.0               | 1.9              | 0.6              | 0.5               | 0.7               | 6                    |
| Manure/fertilizers                          | 0.0            | 1.5               | 0.0              | 0.0              | 1.6               | 0.6               | 5                    |
| Farm tools                                  | 25.9           | 1.5               | 7.7              | 1.8              | 1.6               | 7.7               | 67                   |
| Improving food storage/granary              | 0.6            | 0.0               | 0.0              | 0.0              | 1.1               | 0.3               | 3                    |
| Extension services/advice                   | 0.6            | 0.7               | 1.4              | 0.0              | 1.1               | 0.8               | 7                    |
| Other                                       | 24.7           | 3.7               | 3.8              | 9.9              | 12.9              | 11.0              | 95                   |

\*Multiple responses allowed

Crop seeds were distributed to more than 65% of the households across all the five districts. On the other hand, animal breeds were mostly distributed Ibanda (50.3%) and Mityana (49.3%) respectively, compared to other districts. A few organizations such as FLEP also provided nutritional support to the very vulnerable that are under two years but under weight with baby soya, sugar and cooking oil. Other innovative practices (categorized under others), include for instance supporting land-constrained OVC households to rent land for cultivation.

The sub-grantee and other IP reports and qualitative data collected indicate that some support was distributed to farmers who had formed groups/associations. Table 28 shows the membership of caregivers to farming groups or associations.

**Table 28: Membership into Farming Group/Association**

| Are you a member of any farming group / association? | District       |                   |                  |                  |                   | Total             |                |
|--|----------------|-------------------|------------------|------------------|-------------------|-------------------|----------------|
|  | Gulu (N=166) % | Mityana (N=134) % | Mayuge (N=209) % | Ibanda (N=171) % | Kibaale (N=186) % | Percent (N=866) % | Number (N=866) |
| Yes  | 44.6%          | 29.1%             | 24.4%            | 57.3%            | 54.3%             | 41.9%             | 363            |
| No   | 55.4%          | 70.9%             | 75.6%            | 42.7%            | 45.7%             | 58.1%             | 503            |

The findings indicate that 41.9% of the beneficiary households belonged to farming group/association. More than half of the OVC households interviewed from Ibanda and Kibaale belonged to farming group/association. The main activities of these groups were reported to include labor sharing and joint gardening, savings and credit, training and learning on improved farming, joint marketing, and sharing or providing of farming inputs.



### 4.3 Effectiveness of Food and Nutrition Security Support

Effectiveness of food and nutrition security support was assessed in this study through three aspects viz; (i) food availability, (ii) food access and, (iii) food utilization.

#### 4.3.1 Food Availability amongst Supported OVC Households

Most (59.5%) and (57.1%) of OVC caregivers interviewed from CSF sub-grantees and other IPs respectively, assessed the support received in food and nutrition security as having been useful. They indicated that the support led to the adoption of new food crops and animal breeds, made more food available for home consumption, and contributed to increase in income through the sale of surplus food. The results are presented in Table 29 below.

**Table 29: Ways in which Support received for Food and Nutrition was Useful**

| Ways in which the received support has been useful to OVC households | CSF Sub-grantees (N=411)<br>% | Other IPs (N=100)<br>% | Total (N=511)<br>% | Number of Responses (N=756)* |
|--|-------------------------------|------------------------|--------------------|------------------------------|
| Increased household food security                                    | 81.5                          | 81.0                   | 81.4               | 416                          |
| Increased household income   | 48.7                          | 39.0                   | 46.8               | 239                          |
| Adopted new crops / animal breeds                                    | 15.1                          | 15.0                   | 15.1               | 77                           |
| Increased acreage farmed   | 7.3                           | 3.0                    | 6.5                | 33                           |
| Other  | 4.1                           | 4.0                    | 4.1                | 21                           |

\*Multiple responses allowed

As shown in the table above, 81.4% of the caregivers reported that the food security situation in their households had improved as a result of the support received, while 46.8% reported an increase in income from crop sales. It was in some cases found that the farming support provided had not yet yielded benefits as the crops were not mature yet. Beneficiaries under Caritas Kiyinda Mityana for instance reported that they had received banana suckers and coffee seedlings from the program, they had planted these but they had not yet harvested. Caregivers were however optimistic that once these crops mature, they will be able to realize a good harvest.

An analysis of food production (harvests) for the last season indicates that most OVC households realized a good harvest. Table 30 below summarizes harvests by crop from the last season.

**Table 30: Food Harvests from the Last Season amongst OVC Households [number of Kilograms harvested]**

|                | Number | Mean  | Median | Mode | Minimum | Maximum |
|----------------|--------|-------|--------|------|---------|---------|
| Cassava        | 413    | 634   | 200    | 200  | 1       | 80,000  |
| Sweet potatoes | 339    | 356   | 200    | 200  | 1       | 20,000  |
| Irish potatoes | 96     | 540   | 200    | 200  | 2       | 25,000  |
| Rice           | 40     | 535   | 200    | 200  | 20      | 9,000   |
| Bananas        | 150    | 1,121 | 500    | 600  | 5       | 20,000  |
| Millet         | 119    | 524   | 100    | 100  | 1       | 12,000  |
| Maize          | 512    | 393   | 200    | 200  | 1       | 30,000  |
| Beans          | 597    | 492   | 200    | 200  | 1       | 20,000  |
| G-nuts         | 397    | 1,046 | 120    | 200  | 1       | 100,000 |
| Sim sim        | 35     | 148   | 100    | 100  | 3       | 1,100   |
| Yams           | 30     | 253   | 60     | 200  | 2       | 5,000   |
| Cow peas       | 2      | 75    | 75     | 50   | 50      | 100     |
| Sorghum        | 61     | 156   | 100    | 100  | 1       | 1,000   |
| Sugarcane      | 7      | 2,817 | 500    | 100  | 20      | 7,000   |
| Coffee         | 131    | 160   | 100    | 200  | 1       | 2,000   |
| Cotton         | 4      | 81    | 60     | 2    | 2       | 200     |
| Tobacco        | 5      | 240   | 200    | 200  | 2       | 500     |
| Other          | 17     | 959   | 100    | 200  | 2       | 8,000   |

The results in the above table show that harvests were on the whole good for most of the staple foods including cassava, sweet potatoes, Irish potatoes, bananas, maize, beans, ground nuts, yams, rice, sorghum, cow peas, as well as cash crops such as coffee, and tobacco.

Caregivers were also asked how their food production had changed over the last 3 years. Almost half (47.9%) reported an increase, compared to 37.9% who reported a decrease in food

production, and 14.2% who said it had remained the same. The table below shows the reported changes in food production by district.

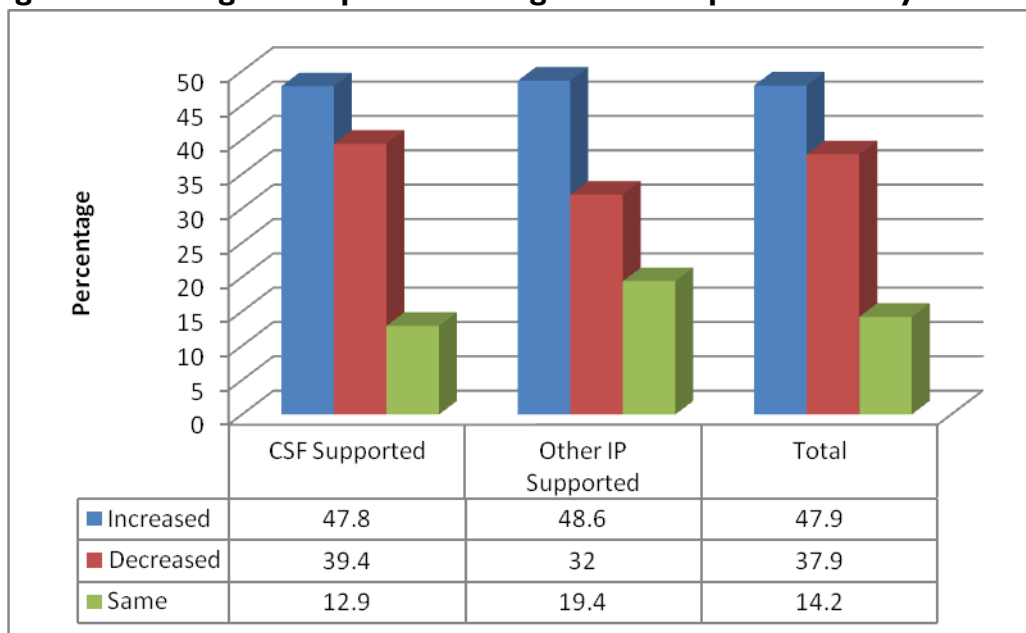
**Table 31: Caregiver Reported Changes in Food Production in Past 3 Years by District**

| Changes in Food production the last 3 years | District       |                   |                  |                  |                   | Total             |                |
|---|----------------|-------------------|------------------|------------------|-------------------|-------------------|----------------|
|   | Gulu (N=166) % | Mityana (N=134) % | Mayuge (N=209) % | Ibanda (N=171) % | Kibaale (N=186) % | Percent (N=866) % | Number (N=866) |
| Increased                                   | 63.9           | 64.9              | 21.5             | 39.2             | 59.1              | 47.9              | 415            |
| Decreased                                   | 25.3           | 10.4              | 65.6             | 42.7             | 33.3              | 37.9              | 328            |
| Same  | 10.8           | 24.6              | 12.9             | 18.1             | 7.5               | 14.2              | 123            |

The results in the above table show that food production was most reported to have increased in the districts of Mityana, followed by Gulu. On the other hand, the least reporting of increase in food production (which corresponds to highest reporting of decrease) was in the districts of Mayuge and Ibanda.

Analysis by type of provider of support does not show much difference as shown in the chart below.

**Figure 12: Caregiver Reported Changes in Food production by Provider of Support**



A number factors were reported responsible for the increase in food production, as illustrated in Table 32 below.

**Table 32: Caregiver Reported Reasons for Increased Household Food Production**

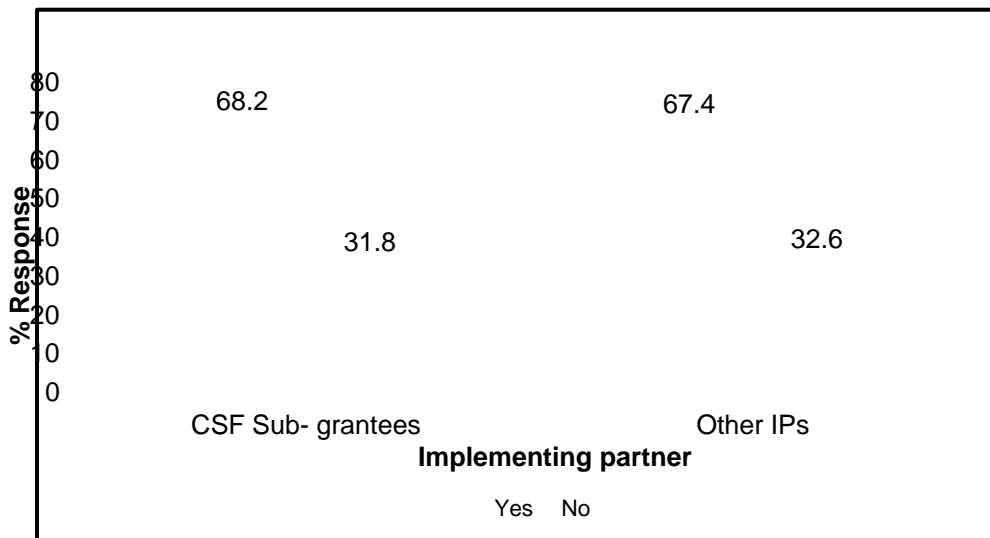
| Reported reasons for the increase in food production | Implementing partner                    |                                 | Total (N=415)<br>% | Number of responses* |
|--|---|---------------------------------|--------------------|----------------------|
|  | CSF Sub-grantees Supported (N=330)<br>% | Other IPs Supported (N=85)<br>% |                    |                      |
| Training in improved farming methods                 | 71.8                                    | 81.2                            | 73.7               | 306                  |
| Use of improved seeds                                | 63.3                                    | 52.9                            | 61.2               | 254                  |
| Accessed/obtained more land                          | 13.3                                    | 11.8                            | 13.0               | 54                   |
| Use of improved breeds                               | 9.4                                     | 10.6                            | 9.6                | 40                   |
| Better agricultural extension/support services       | 9.1                                     | 17.6                            | 10.8               | 45                   |
| Use of manure/fertilizers                            | 7.9                                     | 16.5                            | 9.6                | 40                   |
| Received improved tools                              | 7.0                                     | 2.4                             | 6.0                | 25                   |
| Increased market                                     | 2.4                                     | 5.9                             | 3.1                | 13                   |
| Joined farmer groups                                 | 5.2                                     | 7.1                             | 5.5                | 23                   |
| Other  | 2.4                                     | 1.2                             | 2.2                | 9                    |

\*Multiple responses allowed

The results in the above table indicate that caregivers mainly attributed the reported increase to the support received, mainly training in improved farming methods (73.7%) as well as the use of improved seeds (61.2%).

Indeed results indicate that most (68.2%) of the OVC caregivers interviewed from households supported by CSF sub-grantees and 67.4% other IPs acknowledged having received training in improved farming as illustrated in Figure 13 below.

**Figure 13: Percentage of Caregivers or their Household members who received Training in Improved Farming Practices**



This study noted that majority of the OVC caregivers who received training had put it into practice mainly through planting improved seeds, rearing improved animal breeds. More CSF Sub- grantee supported OVC households planted more improved seeds than IPs as illustrated in Table 33 below.

**Table 33: Application of the Knowledge Acquired through Training amongst OVC Households**

| Application of acquired knowledge through training | Percent (N=589) % | Number of Responses |
|--|-------------------|---------------------|
| Planting/rearing improved seeds/breeds             | 90.7              | 534                 |
| Mobilizing farmers                                 | 4.6               | 27                  |
| Formation of groups                                | 13.2              | 78                  |
| Record keeping                                     | 2.2               | 13                  |
| Nothing  | 6.3               | 37                  |
| Others   | 2.4               | 14                  |

\*\*\* Multiple responses allowed

The following case study by one of the beneficiaries in Gulu District demonstrates how useful the received support to OVC households has not only increased land acreage planted but boasted food security as well.

**Case Study 3: Boosting Food Production and Income through Agricultural Support**

*“I am called George; I live in Patiko Sub County, Gulu District. Last year, TASO offered us agricultural support in form of training. We were 53 beneficiaries and after the training we received seeds among which were beans, maize, ground nuts, potato vines, cassava cuttings among others. Specific training was offered on how to plant these seeds and that’s the bit that I was most interested in because locally here we sow seeds instead of planting systematically. After getting the seeds I decided to come back home and implement. First, I planted ground nuts in lines, planted beans too, and maize one acre, all in neat rows. After the harvest I sold all the groundnuts and beans and bought more seeds. So by the time TASO brought the second round of seeds, I had mine and planted together with the ones TASO brought, I then increased the size cultivated. I cultivated twelve acres for cassava, maize ten acres, beans three acres, ground nuts two acres. After harvesting I decided together with my wife to use some of the proceeds to make bricks, and then opened a bank account where I kept the remainder. This year I withdrew some money and cultivated 15 acres using a tractor, then planted maize as people were telling me that I was wasting time, because it wasn’t raining yet, but the time I was planting the eighth acre it rained, I then proceeded to plant groundnuts I harvested maize, ground nuts, in July and sold beans. This second season, I’ve planted eight acres of maize”.*

**Determinants of Increase in Food Production of OVC Households: Results of a Multinomial Logistic Regression Model**

As already shown, when caregivers were asked whether they have realized food increase during the last 3 years, 47.9% of them reported that their households have realized food increase. In order to understand the factors that underlie this reported increase in food production, a

multinomial logistic regression model was used. The results show that the following factors are statistically significant in explaining the increase in food production:

- OVC household size,
- Education level of the caregiver,
- Age category of caregiver,
- Land ownership or size of land owned by OVC households,
- Application of better farming practices like use of manure/fertilizers, improved seeds/varieties and pesticides,
- Training caregivers in improved farming/agricultural and livestock rearing practices,

**Table 34: Results of the Logistic Regression Model for Food Increase**

| <b>Change in food production amongst OVC households over the support period (Reference = Food production amongst OVC Households reduced)</b> | <b>Risk Ratio</b> | <b>p-value</b> | <b>95% confidence Interval</b> |
|--|-------------------|----------------|--------------------------------|
| <b>Food production amongst OVC Households Increased</b>  |                   |                |                                |
| <b>Age of caregiver (Reference=&gt;50 Years)</b>   |                   |                |                                |
| < 31 Years   | 1.93              | 0.024          | 1.02 – 3.40                    |
| 31 – 40 Years  | 2.05              | 0.002          | 1.31 – 3.21                    |
| 41 – 50 Years  | 1.27              | 0.273          | 0.83 – 1.94                    |
| <b>Education Level (Reference=None)</b>  |                   |                |                                |
| Primary  | 1.57              | 0.018          | 1.08 – 2.27                    |
| Secondary+   | 2.04              | 0.026          | 1.09 – 3.83                    |
| • Household size   | 0.92              | 0.001          | 0.87 – 0.97                    |
| • OVC household received support for food security and nutrition from other implementing partner   | 1.09              | 0.265          | 0.94 – 1.25                    |
| • OVC household owns land  | 1.49              | 0.006          | 1.12 – 1.97                    |
| • Size of land owned by OVC household  | 1.11              | 0.001          | 1.05 – 1.19                    |
| • OVC household used manure or fertilizers   | 1.67              | 0.025          | 1.07 – 2.61                    |
| • OVC household used improved seeds or varieties   | 2.39              | 0.000          | 1.66 – 3.44                    |
| • OVC household used pesticides (chemicals to kill pests)  | 2.01              | 0.016          | 1.14 – 3.55                    |
| • Caregiver trained in improved farming/agricultural and livestock rearing   | 2.37              | 0.000          | 1.60 – 3.51                    |
| • OVC HH received support to improve food storage facilities   | 1.01              | 0.963          | 0.60 – 1.72                    |
| • Caregiver trained or advised on food security  | 1.44              | 0.082          | 0.95 – 2.17                    |
| • Caregiver trained in agro-business management  | 1.34              | 0.129          | 0.92 – 1.96                    |
| <b>Food production amongst OVC Households remained the same</b>  |                   |                |                                |
| <b>Age of caregiver (Reference=&gt;50 Years)</b>   |                   |                |                                |
| < 31 Years   | 1.68              | 0.155          | 0.82 – 3.42                    |
| 31 – 40 Years  | 1.62              | 0.118          | 0.89 – 2.97                    |
| 41 – 50 Years  | 1.64              | 0.088          | 0.93 – 3.91                    |
| <b>Education Level (Reference=None)</b>  |                   |                |                                |
| Primary  | 1.29              | 0.296          | 0.80 – 2.09                    |
| Secondary+   | 1.62              | 0.240          | 0.72 – 3.64                    |
| • Household size   | 0.94              | 0.060          | 0.88 – 1.00                    |
| • OVC household received support for food security and nutrition from other implementing partner   | 1.22              | 0.027          | 1.02 – 1.45                    |
| • OVC household owns land  | 1.48              | 0.020          | 1.06 – 2.06                    |
| • Size of land owned by OVC household  | 0.96              | 0.358          | 0.87 – 1.05                    |
| • OVC household used manure or fertilizers   | 1.03              | 0.926          | 0.55 – 1.93                    |
| • OVC household used improved seeds or varieties   | 1.35              | 0.240          | 0.82 – 2.21                    |
| • OVC household used pesticides (chemicals to kill pests)  | 2.25              | 0.024          | 1.11 – 4.56                    |
| • Caregiver trained in improved farming/agricultural and livestock rearing practices   | 0.78              | 0.300          | 0.46 – 1.25                    |
| • OVC HH received support to improve food storage facilities   | 0.85              | 0.687          | 0.38 – 1.88                    |
| • Caregiver trained or advised on good food security   | 0.92              | 0.783          | 0.49 – 1.71                    |

| <b>Change in food production amongst OVC households over the support period (Reference = Food production amongst OVC Households reduced)</b> | <b>Risk Ratio</b> | <b>p-value</b> | <b>95% confidence Interval</b> |
|--|-------------------|----------------|--------------------------------|
| practices<br>• Caregiver trained in agro-business management   | 1.11              | 0.712          | 0.64 – 1.92                    |

Youthful caregivers had higher relative risk ratios for reporting increased food production compared to elderly caregivers. Relative to those who reported that their food production had reduced, caregivers who were less than 31 years old and those between 31 and 40 years old had significantly ( $p=0.024$  and  $p=0.002$ ) higher relative risk ratios (1.93 and 2.05 respectively) of reporting that food production in their households had increased compared to their counterparts who were more than 50 years old. Relative to those who reported that food production reduced, youthful caregivers (<31 years old) in the group who said food production remained the same also had higher risk ratios compared to elderly ones (>50 years old). However this was not significant likely because there were fewer caregivers who reported that food production remained the same.

Educated caregivers had higher relative risk ratios for reporting increased food production compared to non-educated caregivers. Relative to those who reported that their food production had reduced, caregivers who had primary or secondary (and above) level of education had significantly ( $p=0.018$  and  $p=0.026$ ) higher relative risk ratios (1.57 and 2.04 respectively) of reporting that food production in their households had increased compared to their counterparts who had no education at all. Relative to those who reported that food production reduced, educated caregivers (primary level or more) in the group which said food production remained the same also had relatively higher risk ratios compared to non-educated caregivers.

Caregivers from households that had a big family size revealed reduced relative risk ratios for reporting increased food production compared to caregivers having fewer number of people in their households. Relative to those who reported that their food production had reduced, the relative risk of a caregiver reporting that food production increased was 0.92 per one person increase in the household size. This means that households with fewer members were more likely to report food increase compared to households with many members. The trend was the same in the group which said that food production remained the same.

Households who owned or had larger pieces of land had significantly ( $p<0.007$ ) higher relative risk ratios for reporting increased food production compared to households who did not own or had smaller pieces of land. Relative to those who reported that their food production had reduced, the relative risk of a caregiver who owned land reporting increased food production was 1.49 compared to those who did not have land. In relation to those who said food production had reduced, caregivers who owned land had higher relative risk (1.48) of reporting that food production remained the same compared to those who did not have land.

Training caregivers in better farming methods like improved farming/livestock rearing, use of manure/fertilizers, use of improved seeds/varieties and pesticides had a higher likelihood for increasing food production in the OVC households. This has been demonstrated by results of



the multinomial model that relative to those who said food production reduced, caregivers who were trained in improved farming/agricultural and livestock rearing, used manure/fertilizers, used improved seeds/varieties and pesticides had higher relative risk (2.37, 1.67, 2.39 and 2.01 respectively) for reporting that food production has increased compared to caregivers who were not trained.

There were other factors like support towards improving food storage, advising or training caregivers in agro-business management and food security which revealed high risk of increasing or maintaining food production in the OVC households. However these had no statistically significant influence.

Qualitative interviews conducted among the different informants including project beneficiaries as well as implementers also alluded to the increased food and nutrition security amongst most OVC households as noted;

*“We got maize seeds which we planted and after harvest we got two sacks and sold one to get some money. We took the remaining sack to the maize mill to get posho which helped us for food”, (FGD with men OVC caregivers, Kityerere Sub County, Mayuge District).*

*“People’s food security has improved for example, I have a report that every household in Kiyahura has a garden of Irish potatoes”, (KII Extension Advisor, KDFA Kibaale District).*

*“We no longer go hungry in the village. They have provided us with seeds and banana suckers which some of us have started harvesting and others are yet to start”, (FGD with orphans (girls) at Kiggwa Church of Uganda Primary School, Mityana district].*

*“Food has indeed increased because life has changed for better than before. We can even get some money for educating our children and if we continue to work, we can even be better”, (FGD with women caregivers, Kyebando Sub County, Kibaale District).*

*“To me compared to the state where we found them.... Sometimes the caregiver is sick, very old and no one would go to the gardens but if today they can eat at least two meals I think it is a positive achievement”, (KII with Project Co-ordinator FLEP, Mayuge District).*

#### **4.3.2 Use of better farming practices ever since support was received**

The results in table 35 indicate that the use of better farming methods increased over the last three years. This might be due to the fact that the implementing organizations trained members of OVC households and distributed materials like manure/fertilizers and farm tools.

**Table 35: Change in use of better farming practices since three years ago**

| Farming practice  | Compared to before receiving support |             |          | Number of households using the practice |
|---|--------------------------------------|-------------|----------|---|
|   | Increased (%)                        | Reduced (%) | Same (%) |   |
| Manure or fertilizers                                     | 81.4                                 | 7.4         | 11.2     | 189                                     |
| Other soil fertility management practices                 | 80.8                                 | 5.1         | 14.2     | 156                                     |
| Improved seeds or varieties                               | 79.8                                 | 7.9         | 12.3     | 359                                     |
| Pesticides (chemicals to kill pests)                      | 73.5                                 | 10.9        | 15.7     | 105                                     |
| Bettter post-harvest handling and storage of crop produce | 79.2                                 | 7.2         | 13.7     | 185                                     |

OVC caregivers acknowledged not only having increased the use of improved seeds but also better farming practices especially the use of manure, other soil management practices and the use of pesticides to boost food production. Differences in the application of improved farming practices between OVC households supported by CSF and those supported by other IPs were not statistically significant. The table below shows the proportion of caregivers who reported an increase in the use of better farming practices by district.

**Table 36: Percentage of Caregivers reporting an increase in use of better Farming Practices in the past 3 years by District**

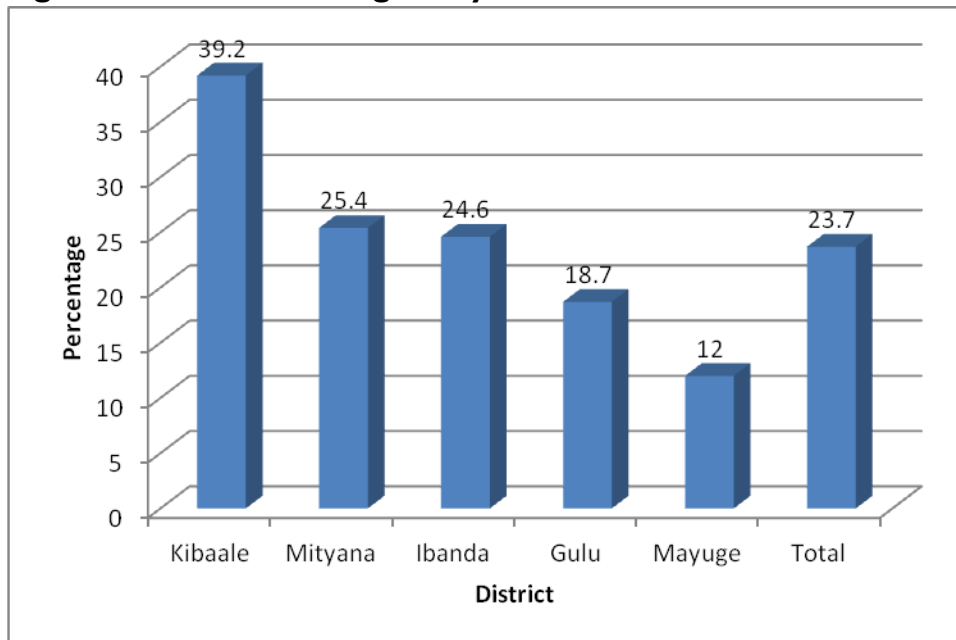
| Farming practice  | District |           |          |          |           | Total Number of respondents |
|---|----------|-----------|----------|----------|-----------|-----------------------------|
|   | Gulu %   | Mityana % | Mayuge % | Ibanda % | Kibaale % |                             |
| Manure or fertilizers                                     | 12.9     | 82.4      | 69.2     | 52.1     | 53.2      | 189                         |
| Other soil fertility management practices                 | 9.9      | 75.1      | 23.1     | 68.2     | 32.2      | 156                         |
| Improved seeds or varieties                               | 96.0     | 86.3      | 63.1     | 82.0     | 87.1      | 359                         |
| Pesticides (chemicals to kill pests)                      | 1.0      | 41.2      | 53.8     | 15.6     | 38.0      | 105                         |
| Bettter post-harvest handling and storage of crop produce | 48.5     | 63.5      | 26.2     | 77.3     | 30.4      | 185                         |

*\*Multiple response allowed*

The results by district above indicate that adoption of better farming practices was not uniform across districts. In most districts, improved seed varieties were the most adopted. However, it can also be observed that a very high proportion of caregivers in Mityana adopted the use of manure/fertilizers, while in Ibanda and Mityana, big proportions also adopted better post-harvest and storage practices.

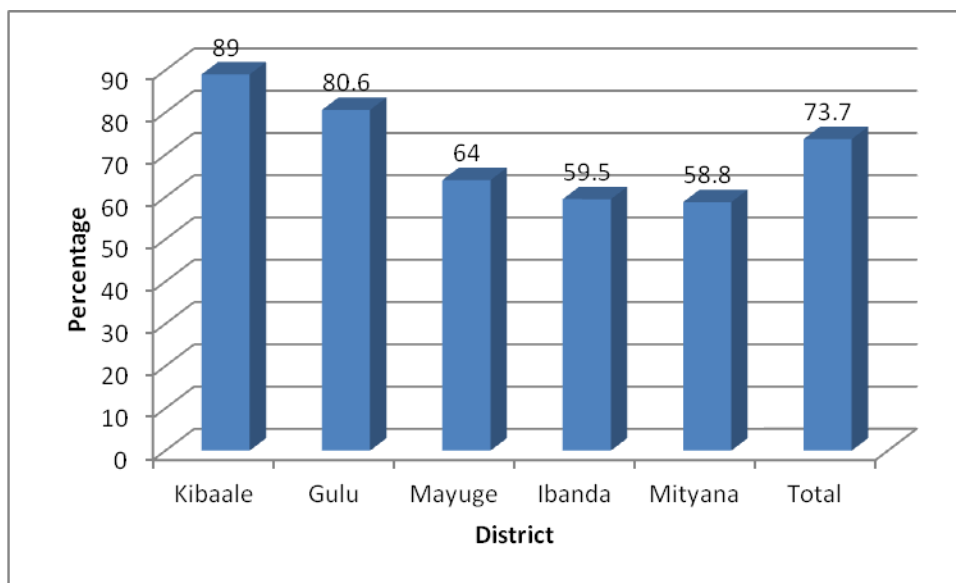
As already shown above, most caregivers also reported an increase in the use of better post-harvest handling and storage practices. The figures below show the possession of a granary or food store:

**Figure 14: Presence of a granary/food store**



The results above indicate that overall, less than one quarter of the households had a food store or granary. Across the districts, caregivers in Kibaale had more food stores compared to other districts, the least being from Mayuge. This study investigated further whether there was food in the stores as shown in the figure below.

**Figure 15: Presence of Food in the Store/Granary**



The results indicate that almost three quarters (73.7%) of the stores had some food. Food was more available in the stores in Kibaale, followed by Gulu.

### **Challenges and limitations in Support to Food production**

The results reveal that whereas some OVC households received improved seeds to plant in a bid to boost food security and nutrition of their household members especially children, the distribution was often not timely and the quantity given out was reported often not enough to achieve the intended objectives as voiced out by informants during qualitative interviews.

*“They gave me only 2kgs of beans and they brought them in a very dry season. We ate it and everything got finished. However, for the egg plants, we are still eating and I just arranged another nursery bed I am going to plant other egg plants”, (FGD Female Caregivers, Kityerera Sub County, Mayuge District).*

*...The quantity of seeds given out was not sufficient to boost the household food production. May be it was given out depending on the land acreage the household had. If a household was given 5 kgs of maize to plant then the harvest would equally be little”, (KII CDO, Mayuge District).*

While some OVC households received livestock, those who especially received birds (chicken) lost out as most them died before they could mature. OVC caregivers as well as volunteers decried this loss as noted;

*“We also got chicken but they all died”, (FGD with men OVC caregivers, Kityerere Sub County, Mayuge District).*

*“For me, I have households that received chicken and they all died and I took back the report to FLEP and they promised that they would give them another set of chicken but this has never come to pass up to now”, (FLEP Volunteers FGD Buwaya Sub County, Mayuge District).*

Respondents attributed the loss to not only carelessness on part of the support recipients but also inadequacy of the extension service as voiced out;

*The beneficiaries who got the chicken were trained on good rearing but they never implemented what they learnt. They were advised for example to put shelter for the chicken but most of the people did not do this. So the chicken died”, (FLEP Volunteers FGD Buwaya Sub County, Mayuge District).*

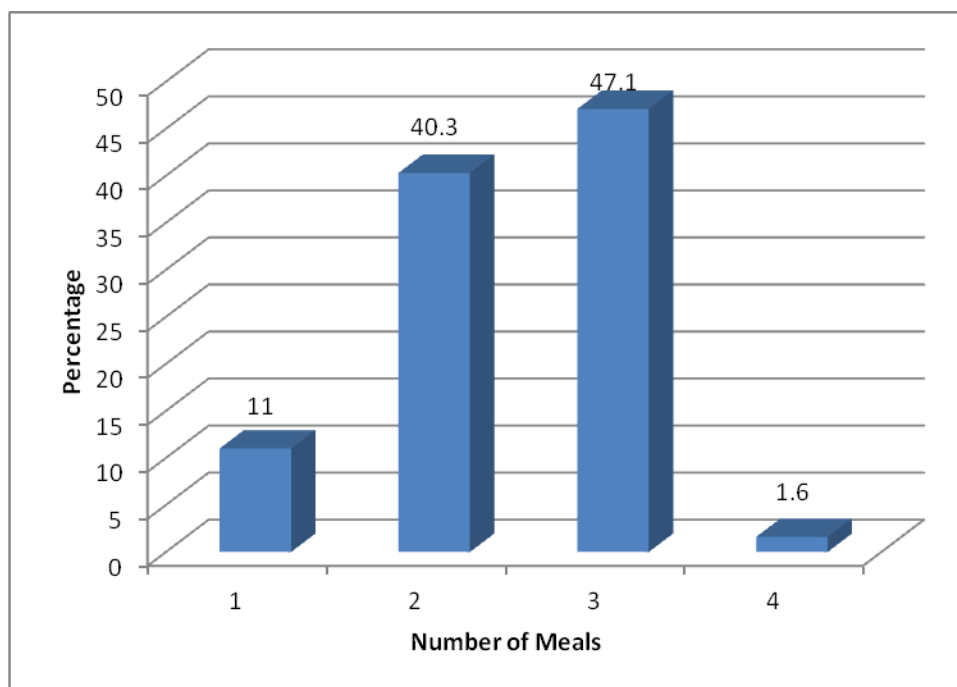
*For us we were not so successful because our chicken died due to lack of medicine, [FGD with orphans (boys), Kyebando Sub County, Kibaale District.*

*“The chicken were given but with no extra support because they did not give the recipients medicine or chicken feeds and thus the chicken could not survive more so if they were not local breeds”, (FGD with FLEP Volunteers, Buwaya Sub County, Mayuge District).*

### **4.3.3 Food Accessibility amongst Supported OVC Households**

Access to food is another component of food and nutrition security which was assessed in order to determine the effectiveness of interventions to support OVC households. Figure 16 below shows the number of meals eaten in OVC households a day preceding the survey.

**Figure 16: Number of Meals eaten in OVC Households 1 day Preceding the Study**



The results in the figure above indicate that overall, more OVC households (47.1%) had 3 meals the day before the interview followed by those who had two meals (40.3%), and only a few (11%) had one meal.

Comparisons by district indicate that OVC households in Mityana and Kibaale had a higher (3) average numbers of meals eaten the previous day to the interview than OVC households from other districts, where the average was 2 meals (see Table 37 below).

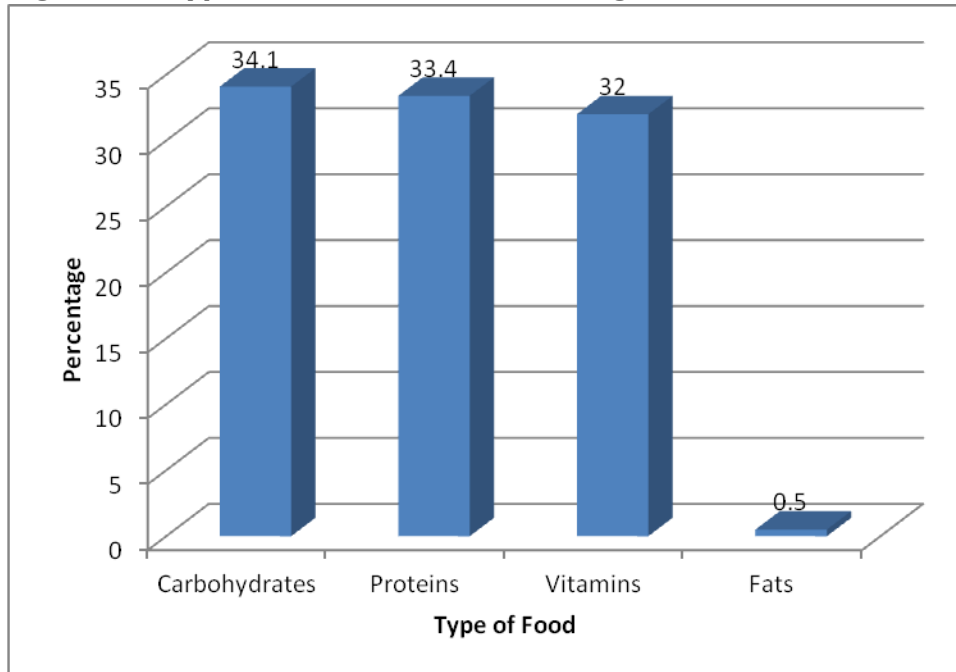
**Table 37: Descriptive Statistics for Number of Meals Eaten in OVC Households by District**

|                       | Gulu | Mityana | Mayuge | Ibanda | Kibaale |
|-----------------------|------|---------|--------|--------|---------|
| Number of respondents | 166  | 134     | 209    | 171    | 186     |
| Mean                  | 2    | 3       | 2      | 2      | 3       |
| Median                | 2    | 3       | 2      | 2      | 3       |
| Mode                  | 2    | 3       | 2      | 3      | 3       |
| Minimum               | 1    | 1       | 1      | 1      | 1       |
| Maximum               | 3    | 4       | 4      | 4      | 3       |

OVC data reveals a similar trend.

A fair picture was noted as far as the consumption of a balanced diet is concerned. The different food nutrients were consumed in relatively fair amounts in the two categories of OVC households during the past week as presented in Figure 17 below.

**Figure 17: Type of Food consumed during the Past Week**



This outcome can be partly attributed to training interventions conducted among OVC households regarding the importance of good nutritional practices as well as eating a balanced diet. The receipt of such training was reported by 25% of the caregivers, although other forms of advice were provided informally and could have been under-reported.

Awareness levels regarding good nutritional practices were found to be relatively high. While the common practices known were; eating a balanced diet (reported by 79.1%), eating fruits (35.9%) and at least having 3 meals a day (31.2%), there was also a significant number of respondents (4.9%) who indicated that they were not sure or did not know any good nutritional practice.

Despite the relatively good picture regarding a balanced diet, qualitative interviews indicated some gaps. Some informants felt the food consumed did not have all the necessary food nutrients as observed;

*“Most of what we eat is mainly energy giving foods they lack other nutrients may be greens (vegetables), the others are not nutritious”, (FGD with male orphans, Patiko Sub County, Gulu District).*

*“I do not think the food is nutritious because we just eat for survival. The food is not nutritious but we eat because we do not have anything to do”, (FGD Female caregivers, Kityerera Sub County, Mayuge District).*

*“For us we eat sweet potatoes with beans or dodo and sometimes with water every day”, (FGD with male orphans, Bisheshe Sub County, Ibanda District).*

Almost half (49.3%) of the OVC caregivers perceived their households to be able to meet all their food requirements through the food they grow. During field work, the research teams often came across harvests being sun dried (see *photograph below*).



**Picture 3:** Maize harvests being sun-dried in Buwaya Sub County, Mayuge District

**Table 38: Caregivers' Responses regarding whether their Households are to meet all their Food Needs**

| Household able to meet all its food needs | District          |                      |                     |                     |                      | Total (N=866) | Number of respondents |
|---|-------------------|----------------------|---------------------|---------------------|----------------------|---------------|-----------------------|
|   | Gulu (N=166)<br>% | Mityana (N=134)<br>% | Mayuge (N=209)<br>% | Ibanda (N=171)<br>% | Kibaale (N=186)<br>% |               |                       |
| Yes                                       | 49.4              | 63.4                 | 36.4                | 28.1                | 58.6                 | 46.2          | 400                   |
| No  | 50.6              | 36.6                 | 63.6                | 71.9                | 41.4                 | 53.8          | 466                   |

The data in the above table shows that a bigger proportion of caregivers in Mityana, followed by Kibaale believed that their households were able to meet all their food needs. The district with the least proportion of respondents reporting this ability was Ibanda. Those who claimed ability to meet their foods needs mostly attributed this to the use of better farming practices, while those who did not believe that their households were able to meet all their food needs attributed this situation to bad weather (38.6%) and ill health of the caregiver (28.8%) respectively.

Caregivers who participated in this study were also asked a number of questions to gauge their households' accessibility to adequate food. The results are presented in Table 39 below:

**Table 39: Caregiver Responses to Questions on Food Accessibility during the Past 6 Months**

| Statement  | CSF Supported Yes (%) | Other IP Supported Yes (%) | Total Yes % (n) | P-value |
|--|-----------------------|----------------------------|-----------------|---------|
| During the past 6 months have you and other household members always had enough food to eat?   | 78.4                  | 83.4                       | 79.4 (688)      | 0.144   |
| In the past 6 months, did any of the people in this household not eat for a whole day because there wasn't enough food?  | 31.0                  | 25.1                       | 29.8 (258)      | 0.132   |
| In the past 6 months, did you or other members in your household ever reduce the amount of food you eat because there wasn't enough food in the home?          | 53.8                  | 50.9                       | 53.2 (461)      | 0.481   |
| Have the children in your household gone to school or to bed hungry in the last 6 months?  | 37.5                  | 30.3                       | 36.0 (312)      | 0.077   |
| In the past 6 months, has there been any time when a child has felt hungry but you have no food to give him/her/them?  | 38.2                  | 37.1                       | 38.0 (329)      | 0.796   |
| In the past 6 months, has there been times when you have in this HH eaten the kinds of food you would not have loved to eat, because there was no alternative? | 65.3                  | 59.4                       | 64.1 (555)      | 0.150   |

The responses above indicate that majority of the caregivers (79.4%) reported that their households always had enough to eat during the past 6 months. However, it is striking to note



that up to 64.1% reported that there were times when they had to eat the type of food they would not have loved to eat because there was no alternative. Similarly, more than half (53.2%) reported that they or other members in the household had to reduce the amount of food eaten because there wasn't enough food in the home. Overall these findings indicate that for some households, food accessibility is still a challenge.

Although other IP supported caregivers overall appear to have better food accessibility on all items of questions compared to CSF supported caregivers, there was no statistical significance as measured by the P-values, between CSF supported and other IP supported households with regard to all the six items of questions that caregivers responded to.

For households that acknowledged spending a day without food, those who said that occurred more frequently were fewer than those who reported that it occurred on sometimes, rarely.

**Table 40: OVC Responses to questions on Food Accessibility in the Past 3 Months**

|   | Yes responses |           |
|---|---------------|-----------|
|   | Percent       | Frequency |
| During the last school term, was there a day you went to school hungry?                                   | 45.4          | 386       |
| In the past 3 months was there a day you spent a whole day without food because there is no food at home? | 29.1          | 247       |
| In the past 3 months, was there a day you went to bed hungry because there was no food at home?           | 28.0          | 238       |
| Have you eaten fruit at home in the last week?  | 76.5          | 650       |
| Have you eaten any vegetables at home in the last seven days?   | 90.0          | 765       |
| Have you eaten any meat, chicken or fish at home in the last one month?                                   | 58.6          | 498       |
| Would you say that your household has enough food to meet your needs?                                     | 53.8          | 457       |

The data in the above table indicate that 45.4% of the OVC interviewed reported that during the previous school term, they went to school hungry at least 1 day; and that during the past 3 months, 29.1% spent at least 1 day without food because there was no food at home.

Despite the consistent perceived trend of increase in access to and availability of food amongst supported OVC households, there was a significant percentage of OVC caregivers interviewed overall who perceived the received support for food and nutrition security not to have been useful. A number of reasons were cited as to why they perceived it so and common amongst these was a popular view of inadequate of food in their households as illustrated in Table 41 below.

**Table 41: Ways in which received support for Food and Nutrition has not been Useful**

| Responses                         | Percent (N=96) % | Number of responses |
|-----------------------------------|------------------|---------------------|
| Household still food insecure     | 68.8             | 66                  |
| Income has remained the same      | 21.9             | 21                  |
| Farming acreage has not increased | 6.3              | 6                   |
| Still the same crops grown        | 18.8             | 18                  |
| Still use the same technology     | 7.3              | 7                   |
| Other                             | 7.3              | 7                   |

Even during qualitative interviews, the inadequacy of food in most OVC households was often highlighted to the extent that some households were rationing the food available to ensure that members especially children can have at least two meals a day. Various informants decried the inadequacy of food in the OVC households as noted.

*“We just eat for survival because food is not enough. We most cases have to be careful with how this food is handled so that we can have access to both lunch and supper”, (FGD with female caregivers, Kityerera Sub County, Mayuge District).*

*“Most families eat only one meal, when they cook supper they have to keep some food for the next day”, (Female Orphans, Bisheshe Sub County, Ibanda District).*

*When it comes to food issues, I am really doing badly. Even right now, I do not have what to give to the children. All my sweet potatoes are finished. I do not have greens (Dodo), all the maize got spoilt. The soil is also very poor and there are times when they sleep hungry”, (FGD with female caregivers, Kityerera Sub County, Mayuge District).*

The inadequacy of food among OVC households was not only voiced by caregivers but orphans as well.

*“Finding food to cook is the problem, it is not easy to get food these days. We eat once in a day after returning from school. For us we eat at 1 pm and sometimes that may be the only meal. When there is food we eat but when we don’t have we go to bed without eating. We dig other people’s gardens in exchange food, in times when we don’t have food at home”, (FGD with Orphans, Paicho Sub County, Gulu District).*

*We eat once after coming from school, if there is food you eat otherwise you stay hungry so food is normally not enough. The food is not nutritious we just eat to fill up the stomach”, (FGD with male orphans, Patiko Sub County Gulu District).*

A number of factors were noted responsible for the inadequacy of food in most OVC households and prominent among these in both categories of OVC households were; bad

weather/pests and crop diseases, inadequate land to practice farming, inadequate incomes as well as ill – health of the family members (see Table 42 below).

**Table 42: Caregiver Reported Reasons for Inadequate Food in their Households**

| <b>Reasons for inadequate food in the OVC households</b> | <b>CSF Sub grantees (N=381)<br/>%</b> | <b>Other IPs (N=85)<br/>%</b> | <b>Total (N=466)</b> | <b>Number of responses</b> |
|--|---------------------------------------|-------------------------------|----------------------|----------------------------|
| Bad weather/pests and diseases                           | 37.5                                  | 43.5                          | 38.6                 | 180                        |
| Ill health of family members                             | 28.3                                  | 30.6                          | 28.8                 | 134                        |
| Inadequate household incomes                             | 17.8                                  | 17.6                          | 17.8                 | 83                         |
| Small pieces of land                                     | 10.0                                  | 3.5                           | 8.8                  | 41                         |
| Large household size                                     | 7.9                                   | 4.7                           | 7.3                  | 34                         |
| Commercialization of food crops                          | 0.5                                   | 0.0                           | 0.4                  | 2                          |

During qualitative interviews, informants decried of poor rains / prolonged droughts, poor soils as well as crop pest and diseases having a big toll of their harvests.

*“Food is not enough. Our soils are so poor so however much you dig a big garden, the production has to be little, the food you harvest does not take you for four months even if you a big garden”, (FGD with men caregivers, Bisheshe Sub County, Ibanda District).*

*“The banana weevil destroyed the entire banana plantations. We no longer have any banana plantations in our community”, (FGD with men caregivers, Bisheshe Sub County, Ibanda District).*

Another key factor relates to access to land which influences the amount of land available for farming. This study established that most OVC households had small plots. As earlier noted, most (84.6%) of OVCs households had small pieces of land less than 6 acres and the average was about 3.5 acres.

*“The land we have got for farming is also small and the yields are always little. We live on a small piece of land. It is really very small”, (FGD with female caregivers, Kityerere Sub County, Mayuge District).*

*“Most people have limited land and here in Bunya South and specifically in my sub-county. People were chased out of the forest and they started living on this plots and they can’t do much on these plots”, (Chairman LC III, Kityerere Sub County).*

Despite the small pieces of land accessed, majority (88.1%) of OVC households owned the land where they lived and hence had full user rights.

The other factor also pointed out contributing to inadequate food among OVC households was ill-health of the household members especially the caregivers which leave them little time to provide for their households. As this study and others have demonstrated, most orphans in Uganda are being cared for in female-headed families, with the caregivers usually being grandparents or surviving mothers who were either too old or weak to provide for the many

dependants in that household. At times the OVC themselves may be immune suppressed and therefore always sick and have to be attended to leaving the other family members little time to engage in productive activities to feed their families.

*“Diseases have made us lack food; one gets sick for a long time. You cannot go out to work and you need a person to take care of you. He too does not work and at the end you sell whatever you have to pay for medical bills and buy food for the family”, (Female caregivers, Ibanda Town Council).*

The other factor relates to low incomes characterizing most of these households as this study has demonstrated. Most caregivers expressed their inability to accord their households with adequate food due to low incomes. Indeed this study demonstrated less than half (49.3%) acknowledged having any savings which was also low (about 60,000) per month to cater adequately provide for their households.

As already noted above, OVC households were noted with large family sizes ranging between 6-10 people with average of about 8 per household which majority were children below 18 year who must be looked after without an input towards what is put on the table. Average each OVC household had 5 children. During qualitative interviews, OVC caregivers and well as orphans decried the big number of dependants to feed as noted;

*“The food would be enough but we are many at home and it’s only caregivers who provide to all of us”, (FGD with male orphans, Bisheshe Sub County).*

One other factor that was repeatedly pointed out responsible for the inadequate food situation in most OVC households relates to the commercialization of food crops where OVC caregivers are sacrificing the dietary requirements of their family members for money to meet other household basic needs. This is a phenomenon that is steadily taking route in Uganda as noted.

*“Families with OVC usually use ½ of their food yields for home consumption, ½ for selling so that we can get income but as I think we wouldn’t be starving but because we have to sell some of the food, we end up remaining with a smaller quantity of food”, (FGD with male caregivers, Kyebando Sub County, Kibaale District).*

#### **4.3.4 Food Utilization amongst OVC Households**

Overall, this study indicated that majority (76.7%) of caregivers as well majority of OVC themselves (76.5%) acknowledged that children had eaten a fruit in the last one week. The consumption of a fruit was high as demonstrated in Table 43 below.

**Table 43: Consumption of a Fruit, Meat, Fish and Greens by Children in the last one Week amongst OVC Households**

| Type of Food eaten by Children                                 | Percent % | Number of Respondents |
|--|-----------|-----------------------|
| Children in the Household ate a fruit in past 1 week           | 76.7      | 664                   |
| Children in the household consumed ate meat in the past 1 week | 35.0      | 303                   |
| Children in the Household ate some fish in past 1 week         | 27.1      | 235                   |
| Children in the household ate some greens in the past 1 week   | 94.1      | 815                   |

**Table 44: Consumption of a Fruit, Meat, Fish and Greens by Children in the last one Week by District**

| Type of Food eaten by Children         | District       |                   |                  |                  |                   |                 | Number of Respondents |
|--|----------------|-------------------|------------------|------------------|-------------------|-----------------|-----------------------|
|  | Gulu (N=166) % | Mityana (N=134) % | Mayuge (N=209) % | Ibanda (N=171) % | Kibaale (N=186) % | Total (N=866) % |                       |
| Children ate fruit in the past 1 week  | 19.9           | 91.8              | 85.2             | 93.6             | 91.4              | 76.7            | 664                   |
| Children ate meat in the past 1 week   | 18.7           | 42.5              | 12.4             | 45.6             | 59.7              | 35.0            | 303                   |
| Children ate fish in the past 1 week   | 16.3           | 36.6              | 42.1             | 14.6             | 24.7              | 27.1            | 235                   |
| Children ate greens in the past 1 week | 97.6           | 85.8              | 96.7             | 97.1             | 91.4              | 94.1            | 815                   |

The above results show that, 35% of the OVC households had eaten meat, while 27.1% had consumed fish in the past 1 week. The consumption of greens by children was very high at 94.1% in the last one week to this study. This could be attributed to the promotion of the cultivation of green vegetables by the OVC support organizations. The study found that more than half (57.4%) of the OVC households had a backyard garden and therefore greens were readily available to most families. Table 45 below, presents the availability of a backyard / kitchen garden amongst OVC households.

**Table 45: Presence and Usefulness of a Backyard Garden in OVC Households**

|   | Total % | Number of Respondents |
|---|---------|-----------------------|
| <b>Availability of a backyard /kitchen garden (N=866)</b>       |         |                       |
| Yes   | 57.4    | 497                   |
| No  | 42.6    | 369                   |
| <b>Has it been useful to have a backyard garden? (N=497)</b>    |         |                       |
| Yes   | 97.6    | 485                   |
| No  | 2.4     | 12                    |
| <b>Ways in which a backyard garden has been useful (N=485)*</b> |         |                       |
| Availability of food/vegetables                                 | 97.2    | 457                   |
| Better quality feeding/balanced diet                            | 20.9    | 98                    |
| Saved money   | 18.5    | 87                    |
| Other   | 4.9     | 23                    |

*\*Multiple Responses Allowed*

Indeed interviews revealed that greens were the main crops grown in the backyard / kitchen gardens. Availability of backyard / kitchen garden was highly appreciated in almost all the OVC household. Ninety seven point six percent (97.5%), of OVC caregivers perceived them useful.



**Picture 4: Vegetable gardens from a caregiver in Ibanda**

Most OVC households appreciated a backyard / kitchen garden because it enables them to have food especially vegetables which are part of body building foods.

A number of reasons were cited as to why more than half (58.1%) of the OVC households were not always able to have any foods they wanted. Table 46 below illustrates disaggregation

by district of reasons for you not being able to eat the kind of food wanted by household members.

**Table 46: Reasons for not being able to eat the kind of food wanted by household members**

| Reasons for you not being able to eat the kind of food wanted by household members | Gulu (N=99)<br>% | Mityana (N=47)<br>% | Mayuge (N=145)<br>% | Ibanda (N=116)<br>% | Kibaale (N=96)<br>% | Total (N=503)<br>% |
|--|------------------|---------------------|---------------------|---------------------|---------------------|--------------------|
| Ill health of family member(s)   | 0.0              | 0.0                 | 1.4                 | 3.4                 | 5.2                 | 2.2                |
| Poor harvest due to bad weather, poor soil/seeds, pests and diseases               | 4.0              | 14.9                | 10.3                | 25.0                | 22.9                | 15.3               |
| Small acreage  | 4.0              | 0.0                 | 4.1                 | 2.6                 | 2.1                 | 3.0                |
| Large household size   | 6.1              | 2.1                 | 4.1                 | 0.0                 | 0.0                 | 2.6                |
| No money to buy good food  | 90.9             | 89.4                | 84.1                | 72.4                | 85.4                | 83.5               |

*Multiple Responses Allowed*

Key among these reasons was lack of money to buy food (83.5%), which was the common reason across all districts.

## 5 CONTRIBUTION OF OVC SUPPORT TO THE WELFARE OF OVC AND THEIR HOUSEHOLDS

### 5.1 Introduction

The fourth objective of this study was to assess the contribution of interventions for OVC in the areas of economic strengthening and food and nutrition security to the welfare of OVC and their households. In this chapter therefore, we present and discuss the findings that link CSO support to OVC households in the two CPAs under study and the welfare of OVC and their households. Welfare is considered mainly in terms of education and health of OVC.

### 5.2 Impact of Support on the Education of OVC

As already reported, majority of the OVC respondents (95%, n=810) were in school, with no significant difference between those from CSF supported organizations and those from other IPs. Up to 39.1% of the OVC thought they would be able to continue in school without external support compared to 52.2% who thought they would not be able to continue. The rest (8.6%) were not sure what would happen. Majority (75%) of those who believed that they would be able to continue in school without external support reported that their caregivers would be able to support their education. Similarly, about one third of the caregivers believed their children would be able to continue in school without external support (see Table 48 below). The beliefs of both the OVC and the caregivers probably reflect the confidence in the economic capacity that the households/caregivers have attained.

**Table 47: Caregivers' Views about Changes in their Capacity to meet the Education Needs of Children under their Care**

| Looking back 3 years ago, what would you say about your capacity now to educate your children | District          |                      |                     |                     |                      | Total           |                |
|---|-------------------|----------------------|---------------------|---------------------|----------------------|-----------------|----------------|
|   | Gulu (N=166)<br>% | Mityana (N=134)<br>% | Mayuge (N=209)<br>% | Ibanda (N=171)<br>% | Kibaale (N=186)<br>% | Percent (N=866) | Number (N=866) |
| Improved  | 51.2              | 49.3                 | 13.9                | 33.9                | 52.2                 | 38.7            | 335            |
| Reduced   | 36.7              | 28.4                 | 67.5                | 46.8                | 40.9                 | 45.7            | 396            |
| The same  | 12.0              | 22.4                 | 18.7                | 19.3                | 7.0                  | 15.6            | 135            |

**Table 48: Caregiver's views about whether Children under their care would continue in school without External support**

| Do you think the children will be able to continue in school without external support? | District          |                      |                     |                     |                      | Total           |                |
|--|-------------------|----------------------|---------------------|---------------------|----------------------|-----------------|----------------|
|  | Gulu (N=166)<br>% | Mityana (N=134)<br>% | Mayuge (N=209)<br>% | Ibanda (N=171)<br>% | Kibaale (N=186)<br>% | Percent (N=866) | Number (N=866) |
| Yes  | 14.5              | 61.2                 | 12.0                | 38.6                | 40.3                 | 31.4            | 272            |
| No   | 74.7              | 15.7                 | 72.7                | 38.0                | 30.6                 | 48.4            | 419            |
| Don't know   | 10.8              | 23.1                 | 15.3                | 23.4                | 29.0                 | 20.2            | 175            |



The results above indicate that caregivers from Mityana were the most confident about their children's likelihood of continuing in school, the least being Mayuge.

Some caregivers who participated in the FGDs also reported how the support received was helping them with the education of their children.

- I borrowed some 60,000 from my group and used the money to purchase clothes and scholastic materials for my children. They are now attending school and they have clothes' to put on and this has given them some sense of belonging in the community.
- When some children are sent away from school, we do not leave them to just keep at home. We provide money and scholastics so that they may be able to go back to school. Whoever gets a problem in the family and in case a child is lacking something, a member can borrow some money, use it to meet the needs of the children and then pay back with time.
- I went to the group and borrowed money and made uniform for the child. Now I am paying back the money.
- Groups have helped us a lot in terms of providing school fees for the children. Whenever a child is sent away from school, you just move to the group and get the money to pay the fees and you can start to pay back this money slowly until you have finished it.  
**(Mixed Caregiver group supported by Ankole Diocese, Bisheshe Sub-county, Ibanda District).**

Similarly, program staff of the implementing agencies confirmed these benefits:

*Children are able to stay in school for a long period of time and others have gone to higher institutions of learning and complete their courses. We have OVC who have gone through our program, others are now pursuing agricultural courses through the support we gave them, and they finished S.4, S.6 and are now pursuing various levels, university, and tertiary institution and so on – (Social Support Officer – TASO Gulu).*

Some key informants also observed that due to the increase in school retention of OVC some other problems such as teenage pregnancies and child marriages that had previously been rampant within particular communities had reduced, as children are kept busy in school.

*Since children are now able to attend and stay in school for a long time, other cases like teenage pregnancies among OVC have been prevented” - Oroma Allan Denis; Social Support Officer – TASO Gulu*

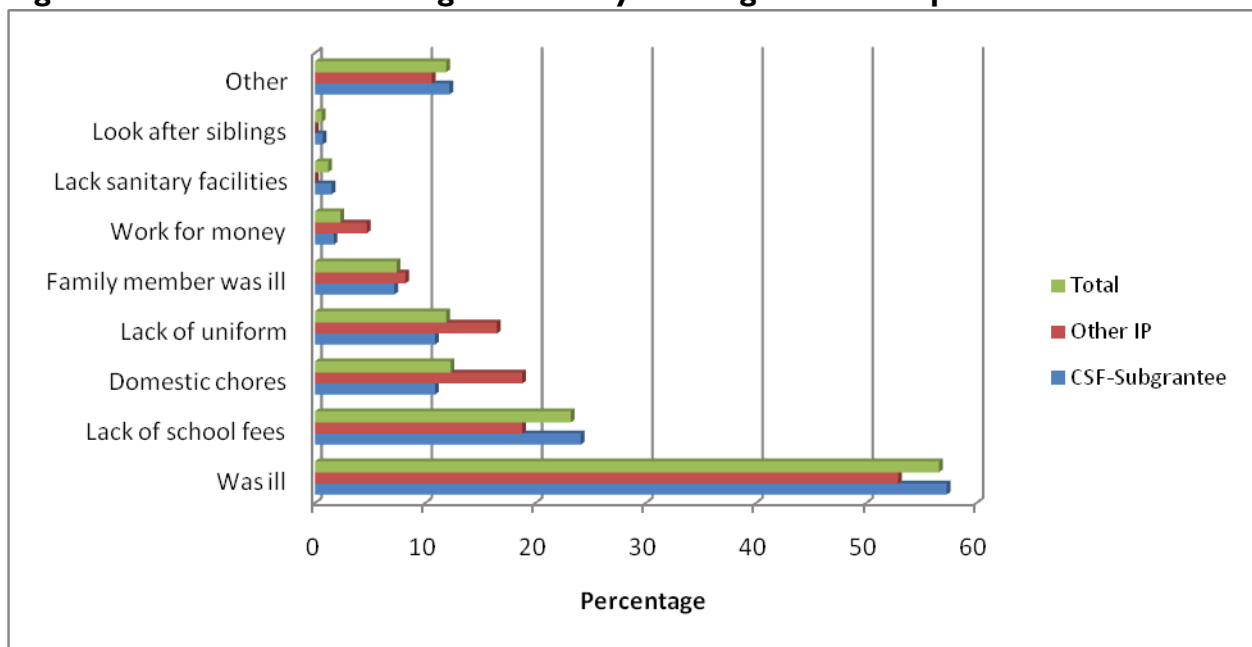
*You would find that parents are marrying off their children at a much earlier age, but as a result of the support which increased household income such cases significantly reduced” - Maganja Munna; Former Social worker, Ankole Diocese*

*We have limited cases of child abuse. The other thing is that as a result of economic strengthening, households are able to take their children to school and this has reduced the problem of child labor. This used to a very big problem where by the children were always involved in stone quarrying and also taking crop produce to the market during school time –(Former Social worker, Ankole Diocese)*

From the above quotations, it is evident that several key informants are witnessing and testifying to the long-term welfare effects of the support.

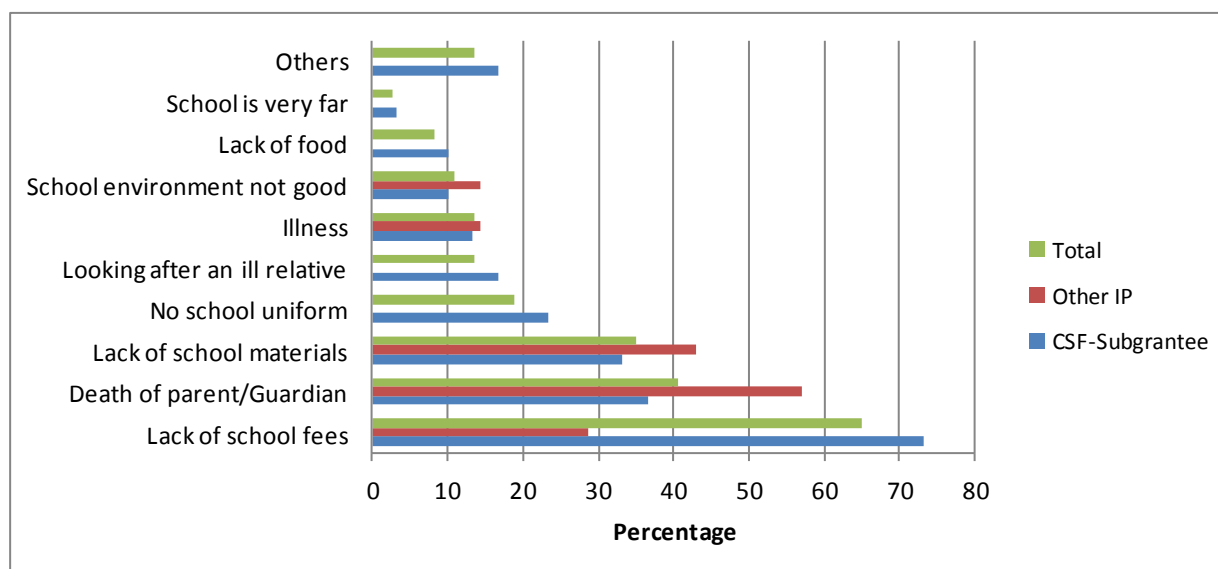
On the other hand, up to 60.9% (n=493) of all the OVC in the sample reported that they had missed at least one school day during the previous school term. The number of schools days missed varied, ranging from 1 day to 71 days, the latter meaning that the child missed a whole term. The mean number of school days missed the previous term was 5. The most (56.6%) reason for missing school was OVC’s ill health followed by lack of school fees (23.2%). The other reasons included lack of scholastic materials like sanitary facilities and uniforms (see figure 22 below), which might indicate lack of adequate income to meet the school requirements of OVC. These reasons were the same across districts/implementing partners.

**Figure 18: Reasons for Missing School Days amongst OVC Respondents**



Among those who were not in school, the common reasons given were lack of fees, followed by death of a parent/guardian – of course the two being closely related.

**Table 49: Reasons for Non-School Attendance among OVC**



### 5.3 Impact of Support on the Health of OVC and their other Household Members

It was found out that economic strengthening interventions had led to improved health outcomes for supported OVC and their households. Caregivers revealed that apart from using the proceeds from the projects to cater for school requirements, they were also attending to medical requirements such as paying for health bills.

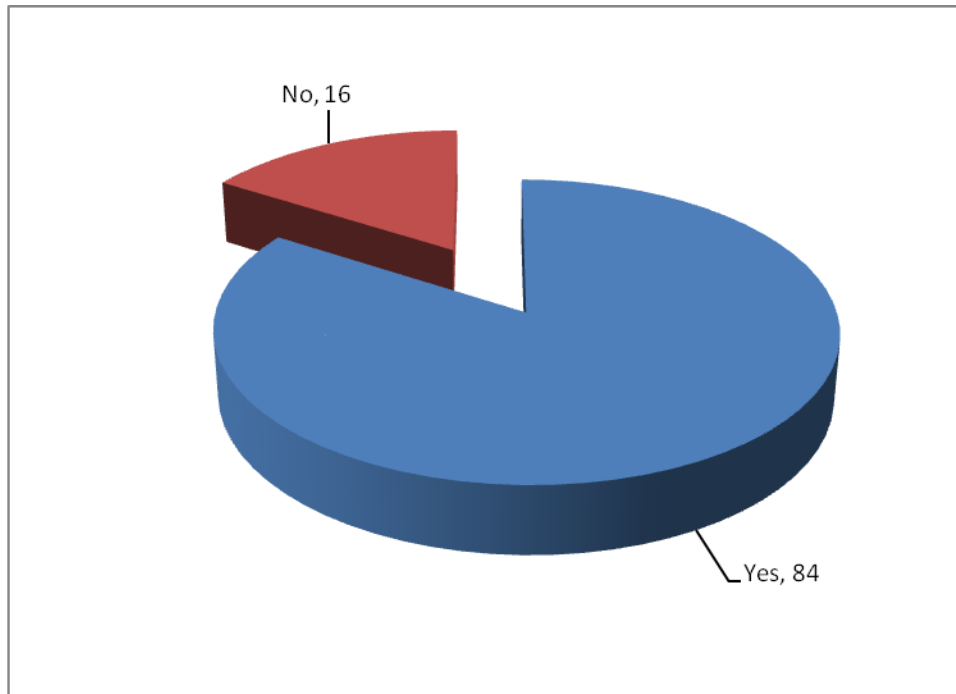
Gambanokora caregiver group in Ibanda was also supporting members to meet their health needs by facilitating them with transport to move to the health facility. Individual group members said they could borrow money from the group and pay their health bills and then they can pay back at a reduced rate of interest.

When children of our members get sick and they need to be taken to the hospital, we avail some money as a group so that the children can seek medical treatment. – **(Chairperson Gambanokora Caregiver Group)**

When children of our members get sick and they need to be taken to the hospital, we avail some money as a group so that the children can seek medical treatment. Whoever gets a problem in the family and in case a child is lacking something, a member can borrow some money, use it to meet the needs of the children and then pay back with time. **(Mixed Caregiver group supported by Ankole Diocese, Bisheshe Sub-county, Ibanda District).**

The study findings indicate that the majority of OVC (84%) that were ill during the 2 weeks preceding the study sought treatment, as shown in the chart below.

**Figure 19: OVC who sought treatment the last time they were ill**



Among those who sought to treatment, more than half (52.9%) reported that they sought treatment from a government or public health facility, followed by those who sought treatment from private clinic, drug shop or pharmacy (34.6%). In more than half of the cases (54.4%) of those who sought treatment, the cost of treatment was born by the caregiver, while in 39.3%, the treatment was free or met by government.

Among those who did not seek treatment, the most dominant reasons given were lack of money for treatment and transport (47.9%), caregiver's failure to take child for treatment (23.3%), or illness not being serious to warrant seeking medical attention (13.7%).

Almost one half of the OVC respondents (44.1%) reported that their caregivers had the capacity to meet the children's health or medical needs, compared to 55.9% who thought they did not. The reason given by the biggest proportion of those who believed the caregiver had no capacity to meet their health needs was that the caregiver him/herself was in poor health.

Besides education and health, caregivers also reported that the proceeds from the received support had enabled them to meet other household expenses that are important for children's and other household members' welfare. Caregivers reported that they used the money from their IGAs and sale of surplus food harvests to buy clothes, beddings, and household basics, all of which are important for their children's day to day well being.

## 5.4 Factors influencing Improvement in Children’s Welfare

Less than half (46.7%) of the caregivers acknowledged that their ability to pay for either their children’s scholastic requirements or medical bills has improved over the last 3 years. There was not statistical significant difference ( $p=0.694>0.05$ ) in proportions of caregivers who acknowledged their ability between CSF sub grantees (46.2%) and other IPs (48.6%).

**Table 50: Distribution of Household’s Capacity to pay for Children’s Education or Medical Bills by District**

| Reported change in Household capacity to pay for children's education and medical bills | District          |                      |                     |                     |                      | Total                |                |
|---|-------------------|----------------------|---------------------|---------------------|----------------------|----------------------|----------------|
|   | Gulu (N=166)<br>% | Mityana (N=134)<br>% | Mayuge (N=209)<br>% | Ibanda (N=171)<br>% | Kibaale (N=186)<br>% | Percent (N=866)<br>% | Number (N=866) |
| Improved  | 56.0              | 60.4                 | 20.6                | 41.5                | 62.4                 | 46.7                 | 404            |
| Not improved  | 44.0              | 39.6                 | 79.4                | 58.5                | 37.6                 | 53.3                 | 462            |

From Table 50 above, it can be seen that reported improvement in children’s welfare was better in Kibaale (62.7%) followed by Mityana (60.4%) and Gulu (56.0%). The least improvement was observed from Ibanda (41.5%) and Mayuge (20.6%) respectively.

The main factor which is driving improvement in children’s welfare was found to be increase in household income accruing from IGAs ( $p=0.000$ ). Comparing the risk estimate test between two cohorts (improved household income versus not improved household income) reveals an odds ratio of 9.037. This means that majority (68.3%) of the caregivers who reported that their capacity to sustain their children in school or pay for their medical bills has improved over the last 3 years also indicated that their household incomes have improved. From the odds ratio above, it can be deduced that households who are earning money from IGA are about 9.037 times more likely to say that the welfare of their has improved over last 3 years as compared to their counterparts who are currently not running IGAs.

**Table 51: Factors Contributing to Household’s capacity to Pay for Children’s Education or Medical Bills**

| Influencing Factors   | Household’s capacity to pay for children's education or medical bills |                           |        |
|---|---|---------------------------|--------|
|   | Capacity improved (%)   | Chi Square value (CI=95%) | Pvalue |
| Food production has increased in the last 3 years                             | 68.7  | 155.3                     | 0.000  |
| Income from sale of surplus food production has increased in the last 3 years | 52.3  | 19.071                    | 0.000  |
| Caregiver is member of farming group/association or SACCO                     | 55.2  | 23.145                    | 0.000  |
| Caregiver/household received support to run an IGA                            | 55.1  | 26.939                    | 0.000  |
| Caregiver/household is currently running an IGA                               | 60.1  | 10.246                    | 0.001  |
| Caregiver/household is currently realizing income from the running IGA        | 65.9  | 5.924                     | 0.015  |

Table 51 above shows percentage, chi square and pvalue of caregivers who said capacity to educate and pay children’s medical bills has improved against selected influencing factors. It can be seen that at 95% confidence level (as indicated by pvalues), caregivers’ involvement in farmers group/association or SACCO and support for IGA have lead to increased income/food production and thus impacting positively on children’s welfare.

Furthermore the bivariate analysis also posted an odds ratio equal to 1.204 ( $p=0.257$ ) for respondent who were heads of household against those who were not. Thus respondents who were heads of household were 1.204 times more likely to say capacity to educate and pay children’s medical bills has improved as compared to respondents who were not household heads. This can be interpreted that household head were more sure about their households’ welfare that counterparts who do not have direct control (not involved final decision making) over the welfare of their children.

### **Sylvia's Story: From Apprentice Back to School**

Sylvia (15), born in a family of 4 children is one of the OVC whose life has been positively transformed by FLEP's Access for Orphans & other Vulnerable Children (AOVC) project socio-economic strengthening programs( apprenticeship skills); which helped her go back and resume school. Sylvia is a resident of Wandegeya village, Wandegeya parish Kityerera Sub County. Sylvia's father passed away in 1997 when she was 3 years old. After the death of her father, life became so hard for the family. The mother remained with all the children but time came when she could not afford providing necessities to all her children any more. This caused Sylvia's 2 elder sisters get married at a tender age. The mother continued struggling with Sylvia and her sibling, however, when Sylvia reached Primary five, life became more harder, the mother could not afford providing scholastic materials to her two children and it resulted into Sylvia dropping out of school and engaged in digging with her mother in order to support the family. In 2009 when FLEP intervened with AOVC project, Sylvia's household was identified as a required house hold which needed immediate intervention to respond to its minimum standards of living. She was counseled by the volunteer who suggested to her to go back to school because there was an opportunity of her being provided with scholastic materials by the project. However, Sylvia did not buy the idea and she insisted on joining apprenticeship skills and gave reasons that she wanted to do something which could earn her a living so as to support herself, mother and sibling. Later she was enrolled on apprenticeship training and chose tailoring course as her choice. The project provided her with a sewing machine and other needed materials as start up kits, trained for six months, and finished successfully. After her training, she became self employed as she started sewing for people and selling clothes, which enabled her start earning a living to look after herself, mother and sibling. In the program year two, 2010 Sylvia suggested to the project staff that she had saved some money to buy herself scholastic materials so that she recommences school so that she is able to have at least a Primary Living Certificate on top of the Certificate she acquired in the apprenticeship training. Due to Sylvia's courage and determination that the project discovered in her, she was provided with scholastic materials together with her sibling and enrolled back to school in Primary six. Next year Sylvia will be among the primary seven candidates *"I'm happy that the skills acquired have made life better for me, at home and school because during weekly days I attend school, weekends, I make money through sewing and able to provide necessities to my family."* Said Sylvia



**Picture 6: Sylvia at her sewing machine**



**Picture 5: Sylvia at school**

## 6 DISCUSSION

### 6.1 Introduction

This section of the report discusses the results presented in the foregoing section. Overall, the findings indicate that the support in the two CPAs had positive results on the lives of OVC and their households. This discussion section is divided into three sub-sections, namely, (i) economic strengthening interventions, (ii) Food and nutrition security interventions, and (iii) contribution of these interventions to welfare of OVC and their households.

### 6.2 The Contribution of Economic Strengthening Interventions

Support towards IGAs represents one of the most visible forms of economic strengthening support extended to OVC households. The findings have indicated that 33.4% of the caregivers received support for IGAs and 51.9% of the recipients of IGA support were reaping income from them. Support to IGAs therefore is an important means of giving hitherto poor households an income.

On the other hand, 28.7% of the IGAs supported were no longer functional at the time of this study. This was mainly attributed to the death of poultry and other animals received by caregivers. OVC caregivers as well as volunteers decried this loss. These incidents not only meant an economic loss to the caregiver and the OVC, but also had the potential to demoralize and frustrate them. These findings point to a need for closer and greater on-going support to caregivers who receive support to run IGAs, especially in the first 6 months after receipt of support. It is therefore worthwhile to highlight that to make the best out of the support provided, IGAs of the animal type need to be accompanied by more reliable and effective agricultural extension support at lower levels especially at Sub County. Most times CSO implementers have relied on district and sub-county based agricultural and extension staff to support beneficiaries of animals and crop-related support. At the same time, however, such government extension staff may not always be available to farmers when needed due to their busy schedules. This calls for re-thinking and widening the options available for farmer beneficiaries to access needed support for their animal and crop projects.

It has been shown that slightly more than a half (51.9%) of the caregivers that received IGA support reported that they realized income from the IGAs. Part of the explanation for those who had not realized income was that some of the IGAs had not yet matured to generate income, while others had collapsed as already mentioned. The delayed maturation of some IGAs was explained by for instance some implementers having distributed very young animals, while in other cases, implementers used the 'revolving animal' approach, in which case some long period of waiting is involved before all the group members receive an animal. It is therefore evident that the gestation period of a particular type of IGA determines how quickly OVC households will realize benefits from that IGA. It can be argued that delayed benefits come with costs or missed opportunities to the OVC household. If an OVC household waits for 2 years before receiving an animal from their group, by that time, their child might have dropped out of school due to failure to meet school requirements. Qualitative findings revealed that pigs were most profitable because they multiplied fast and were easy to sell to get quick



money. Those households that received pigs reported having benefited a lot by selling the piglets and buying other necessary items in homes and paying school fees, compared to those who rotated goats. The implication therefore is that timely or quick benefits from IGAs therefore should be an important consideration in IGA selection.

Despite the potential and actual shortcomings of the 'revolving animal' or 'animal multiplication' approach discussed above, the group IGAs and other group-based interventions such as VSLAs still promise to be a very essential mechanism through which the economic empowerment of OVC households can be pursued. Moreover, caregivers who participated in groups, either as VSLAs or business groups or even farming groups, reported an increase in their incomes, and having some savings, compared to those who were not in groups. The strengths of the groups lie, both in their ability to use norms to instil desired changes, such as a saving discipline, as well as their ability to shield members from failures that otherwise afflict individual undertakings. The VSLAs in particular stand out as an important vehicle for imparting a culture of savings amongst caregivers, enabling them to access low interest loans and giving them an opportunity to multiply their money. On the other hand, individual or household IGAs also have their own strengths. They groom individual responsibility, allow the caregiver to choose an IGA that suits their circumstances or to convert it into another business at will, and in most cases brings faster benefits than group-based IGAs.

The results show a high utility from business skills trainings that were provided to OVC caregivers. Among those who attended the economic strengthening training, majority (89.5%) reported that they acquired new knowledge or skills from the training; majority (82.2%) reported that they were able to use the knowledge and skills acquired; and a corresponding majority (85.8%) reported that the skills acquired enabled the trainee to earn some income. This demonstrates the ability of caregivers to utilize the training received to obtain income.

Some of the challenges cited with respect to the skills training of OVC is the fact that project support often only covered the tuition, while the trainees were left to cater for their transport costs, materials, food while at the training place, and so on. These costs can total up to a huge sum that most OVC enrolled as apprentices may not afford. In fact, staff of the implementing organizations in Mayuge District feared that transport challenges could have contributed to the drop-out of some of the OVC from the training. It can be argued that since most of these children dropped out of formal schools due to inability to raise school requirements, there is no way they can be expected to raise the requirements of vocational, apprenticeship or other training. The additional costs of apprenticeship training and how best they should be covered, therefore are an issue that needs to be looked into.

The findings have shown that the majority of the OVC who trained in vocational skills have acquired skills and some have started earning. Three quarters (75%) of the trainees rated the training received as useful, 58.2% (n=39) of those interviewed stating that the skills given to them during training had enabled them get some income. These findings confirm the utility of skills training as an important and viable tool for equipping out-of-school youth to join the labor market. However, the earnings of trained OVC were quite low, more than half reporting that they earned U.shs. 50,000 or less in a month. At the same time, those in employment reported several challenges at work. These issues call for ways of boosting the earnings of these new

labor-market entrants. It also calls for interventions that continue to support them for some time even after they have completed training and started productive work.

Another key finding by this study is that only 69.0% of those who received the start-up tool kits were actually using them, meaning the rest (31.0%) were not using the kits received. Problems in using start up kits included among others lack of space/premises, lack of spare parts, and lack of materials. The findings also revealed a number of problems with kits including: giving trainees incomplete sets, giving trainees a single sewing machine to several trainees to share and asking trainees to share in the costs of procuring or transporting the kits. All such challenges constitute real barriers to OVC effectively accessing and utilizing kits. Some of the innovative approaches to this issue were found to include going beyond kits, and instead proving start-up grants, that include some cash as well as kits.

### ***Income Growth***

More caregivers reported that that their household incomes had increased over the past 3 years, compared to those who reported that their incomes remained at the same level or decreased. Although the findings show that only 42.1% of the caregivers reported that their incomes increased over the past 3 years, we do not know what would have happened to the 20.8% who reported that their incomes remained the same, if they had not received project support. It is possible that their incomes would have reduced in absence of support, in which case it could be argued that the project support helped them to maintain the level of earnings. At the same time however, it is also not known whether the increase in incomes among the 42.1% can entirely be attributed to the support received. Other factors could have also contributed. From the findings of this study, we know that almost one third (31.6%) reported that the increase in income was a result of selling more farm crops, 23.2% a result of business undertakings, and 11.1% a result of selling animals and animal products. This could mean that the project support positively contributed to the increase in OVC household incomes. On the other hand, it is striking that there were almost as many caregivers reporting a decrease in income as those reporting an increase (42.1% and 37.1% respectively). Since a big proportion of those who reported a decrease in income attributed it to caregiver illness and bad weather, it can be deduced that the reported decreases in income were not project induced. At the same time, it ought to be noted that some of the implementing agencies, including TASO, FLEP and Compassion Uganda targeted families with PLHIV. Such families may often have labor shortages and may account for a big part of the illnesses of the caregiver that were reported. Such families were bound to experience reductions in income.

Bivariate analysis shows that the type of support received, (whether one received only economic strengthening support, only food & nutrition support, or both) influences the increase in income ( $p=0.001$ ). In this respect, up to 51.4% of the households which received both agriculture/farming and IGA support in the last 3 years reported increase in household income, compared to 35.8% among those who received only one form of support. This tells a lot about the complementarity between the two CPAs. It can be concluded that economic strengthening interventions and those in food and nutrition complement each other to raise OVC household incomes.

The results show that almost half (49.3%, n=427) of the caregivers reported that they had some savings. Majority of those who reported savings (61.1%) had savings of not more than 50,000, indicating a very low level of savings. These findings on savings indicate both positive and negative implications. On the one hand, the level of savings is still very low, by any standards. On a positive note the fact that caregivers are able to make even a small saving out of their meager income is a positive development. Group-based approaches are key in helping caregivers to grow savings.

### ***Asset Acquisition and Protection***

Slightly more than half of the caregivers (53.9%, n=467) reported that their households had acquired new assets during the past 3 years. Asset acquisition cannot be separated from earnings and savings, because assets have to be paid for. Furthermore bivariate analysis shows that 63.8% of the caregivers who received both agricultural/food and IGA support also reported that they have acquired assets as compared to 43.3% who acquired assets yet did not get IGA support ( $p=0.000$ ). Thus asset acquisition was influenced by IGA support and type of support. It can therefore be concluded that asset acquisition is related to IGA support. A significant relationship was also established between asset acquisition and receipt of training in economic strengthening (managing IGAs, running business, etc). These results indicate that support to OVC households, both in form of IGAs and training can translate into increase in income and eventually increase in assets of OVC households.

Only slightly more than one third (36.4%, n=315) of those who reported having acquired new assets reported that some measures had been taken to safeguard or protect the assets. Overall, there remains few interventions aimed at assets protection. Overall, this reflects the continuing marginalization of this CPA documented in past studies, such as the OVC Situation Analysis 2010.

The findings indicate that issues of asset protection are also gendered, to the extent that male caregivers believe or perceive themselves better protected compared to female caregivers. Bigger proportions of male caregivers expressed confidence that they had rights to remain in their homes or on their land, and that they would access legal support if they needed it, compared to female caregivers. These beliefs and perceptions also reflect the situation on the ground in a sense that indeed, males are more likely to own land, while females are not certain of their status with respect to the land they occupy. These findings have double implications. On the one hand, they indicate the need to secure the rights of all caregivers and OVC to their land or homes, but more particularly, the rights of female caregivers and female OVC, who are often at risk of being unfairly and unlawfully evicted or cheated. Secondly, these findings highlight the need for providing more information about land rights issues, as well as the available legal support services that caregivers can draw on in case of need.

## **6.3 Contribution of Food and Nutrition Security Interventions**

### ***Food Availability***

Overall most OVC caregivers, assessed the support received in food and nutrition security as having been useful, having enabled them to adopt new food crops and animal breeds, made more food available for home consumption, and contributed to increase in income through the

sale of surplus food. Up to 81.4% of the caregivers reported that the food security situation in their households had improved as a result of the support received, while 46.8% reported an increase in income from crop sales. Almost half (47.9%) of the caregivers reported an increase in their food production. Banana suckers, Irish potatoes, Pineapples, beans, coffee seedlings and rice have made a big impact for those who have already harvested from them and those who are still growing them are expecting to benefit from them. They have increased food availability in OVC homes and they have been able to sell part of the surplus to get money. The results indicate that caregivers mainly attributed the reported increase in food production to the support received, mainly training in improved farming methods (73.7%) as well as the use of improved seeds (61.2%). Due to the trainings in agro-business, a number of households have turned farming into a business and this has helped them have some money to take care of the OVC. These findings indicate the contribution of the support towards the situation of OVC households. The results show that the factors that are statistically significant in explaining the increase in food production include land ownership or size of land owned by OVC households, application of better farming practices like use of manure/fertilizers, improved seeds/varieties and pesticides, and training caregivers in improved farming/agricultural and livestock rearing practices.

Amongst those who did not realize an increase in food production, issues of concern include delays in delivery of the inputs which sometimes would come after the season had started, hence affecting the yield, the quality of pigs and poultry which beneficiaries received, and the amount of seeds that caregivers received. For others, it was ill health. As this study and others have demonstrated, most orphans in Uganda are being cared for mainly in female-headed families, with the caregivers usually being grand-parents or surviving mothers who were either too old or weak to provide for the many dependants in that household. At times the OVC themselves may be immune suppressed and therefore always sick and have to be attended to leaving the other family members little time to engage in productive activities to feed their families.

Some of the innovative practices in agricultural support included the training of model farmers, and working with them as a base to teach improving farming to others, and supporting landless or land-constrained households to rent land for cultivation.

### **Food Access**

Increased food availability in OVC households has translated into improved access to food. Overall, more OVC households had 3 meals the day before the interview followed by those who had two meals and only a few had one meal. Awareness levels regarding good nutritional practices were found to be relatively high. Despite the relatively good picture regarding a balanced diet, some informants felt the food consumed did not have all the necessary food nutrients. Some households also reported inadequate of food in their households. In a bid to cope with such a situation some households were rationing the food available to ensure that members especially children can have at least two meals a day. The inadequacy of food among OVC households was attributed to a number of factors, including bad weather conditions, especially the prolonged drought which could not allow the crops to do well, and inadequate land where to carry on farming. Most OVC households owned small pieces of averaging about 3.5 acres. One other factor which was repeatedly pointed out responsible for the inadequate

food situation in most OVC households relates to the commercialization of food crops where OVC caregivers were reported sacrificing the dietary requirements of their family members for money to meet other household basic needs. This is a phenomenon that is steadily taking root in Uganda and has far reaching implications on the food and nutrition security.

### ***Food Utilization***

The findings of this study indicate that amongst all foods, green vegetables were the most widely consumed. Whereas this could reflect the fact that green vegetables are probably the cheapest food if compared to other foods that were asked about, namely, fruits, meat, chicken, and fish. On the other hand, this study found that the consumption of green vegetables was facilitated by their availability, since most household had, with project education and support established backyard or kitchen gardens. Although most households afford to eat 2 to 3 meals, the households that had one meal indicate a critical area of need that should be targeted for support.

## **6.4 Contribution to Children's Wellbeing**

Given that majority of the OVC respondents 95% were in school, and that caregivers reported that they use the proceeds from IGAs and food interventions to support their children's education and meet other needs, it can be concluded that the support provided has had a positive impact on the welfare of OVC and their families. Some OVC who were trained in skills have worked and saved money that have enabled them to rejoin formal school. Many caregivers are also confident that they have the ability to continue to meet their children's education and health needs without external support.

## 7 CONCLUSIONS, LESSONS AND RECOMMENDATIONS

### 7.1 Conclusions

The overall objective of this study was to assess the effectiveness of OVC interventions towards improvement in food and nutrition security and economic strengthening among targeted OVC households in five selected districts of Uganda. The specific objectives were:

- To establish the efficacy of OVC interventions in improving food availability, access, and utilization in the targeted OVC households
- To determine the extent to which OVC interventions contribute to strengthening assets growth and protection in OVC households.
- To find out the extent to which OVC interventions contribute to income growth in the targeted OVC households.
- To assess the contribution of food & nutrition security and economic strengthening interventions towards improving the wellbeing of OVC and their households

The following conclusions can therefore be drawn in relation to the above objectives:

#### ***Income Growth***

The overall conclusion with respect to income growth is that interventions for OVC in economic strengthening contribute to an increase in income for OVC households. Most caregivers who received, IGA support, training, or participated in VSLAs all report an increase in their income over the past 3 years which indicates a positive contribution of these forms of support. The specific conclusions are:

IGAs can be an important tool to give OVC households a source of income. However, they can be afflicted by a number of challenges which need to be systematically addressed if the intended beneficiaries are to get the most out of them.

The gestation time of an income generating project is an important factor in its usefulness to the OVC household. Projects which bring quick benefits are preferred and have the potential to keep caregivers interested in the project undertaken.

Group IGAs and other group-based activities such as VSLAs and group farming are more associated with increases in incomes, savings and asset growth compared to individual/household IGAs. However, individual IGAs help to meet specific household needs. Beneficiaries who get access to both are enabled to access a wide range of benefits.

Beyond tuition fees, apprenticeship training may be associated with a number of other costs which may pose a barrier to the trainees' regular attendance, completion of training, or gaining fully from the training. This can in turn affect the trainees' future ability to earn.

Whereas skills training for out-of-school OVC provides a good means to give them a productive life, there are several challenges along the way, even after they have started work. Their incomes also remain low, and the need for on-going support stands out. Skills training and

provision of kits alone are not adequate to guarantee a successful transition to productive work.

Households which receive both IGA support and support for food and nutrition security are more likely to realize increase in incomes, and to acquire new assets than those who receive only one form of support.

### ***Assets Growth and Protection***

Economic strengthening interventions for OVC households also contribute positively to assets growth. More than half of the caregivers (53.9%, n=467) reported that their households had acquired new assets during the past 3 years. Asset acquisition was found to be significantly related to IGA support and economic strengthening training. However, there remains little being done to protect the assets and rights to assets of OVC and their households. The need for this protection is greater among female caregivers, and female-headed households.

### ***Food Availability, Accessibility and Utilization***

Interventions in food and nutrition security contribute positively to food availability, accessibility and utilization. They have enabled OVC households to adopt new food crops and animal breeds, made more food available for home consumption, and contributed to increase in income through the sale of surplus food. Caregivers attributed increases in food production to training in improved farming methods, and use of improved seeds, both of which were provided by the OVC support organizations. The key factors significantly associated with increased food production include: land ownership, application of better farming practices, and training of farmers. However, this study notes that to make the best out of food and nutrition interventions, they need to be accompanied by more reliable and effective agricultural extension support.

Despite these interventions a significant number of OVC households remain food insecure. It therefore remains a daunting challenge to ensure adequate food and nutritional security amongst OVC households partly because of limited access to land, poor extension services, and unpredictable weather conditions. Thus, although most households afford 2 to 3 meals a day, there are households that have one meal a day, indicating a critical area of need that should be targeted for support.

### ***Welfare of OVC and their households***

OVC targeted interventions in economic strengthening and food and nutrition security positively contribute to the improvement in the wellbeing of OVC and their households by making income available that is used to meet children's needs for education, medical care, clothing and other basic needs. Beyond these however, the interventions have longer term positive impacts of enabling children to keep in school and thereby shielding them away from risky situations and practices such as teenage pregnancies and early marriages. The main factors which is driving improvement in children's welfare was found to be increase in household income accruing from IGAs, sale of surplus food, and membership to a group.

## 7.2 Lessons

The following lessons can be drawn from the results of this study:

Group-based approaches are critical for raising household incomes, growing savings and generating other benefits to caregivers. Promotion of groups brings with it a number of social norms that help to regulate the conduct of members and thereby facilitates group success in undertaking economic activities and food production activities.

The ‘revolving animal’ or ‘animal multiplication’ approach is best suited working with animals such as pigs which have the potential to produce several off-springs at once, compared to goats or cows. The latter are associated with a longer gestation period before benefits are widely distributed to a big number of beneficiaries.

Transition to employment for trained youths is a complex process with many challenges, and requires much more support going beyond start-up kits.

Interventions in the two CPAs, of economic strengthening, and food and nutrition security complement each other in raising OVC household incomes, assets growth and improving welfare.

## 7.3 Recommendations

### ***Recommendations for Economic Strengthening Support***

In order to reduce or avert the failure rate of IGAs, and the losses associated, especially the animal-based types of IGAs, there is need for more closer and regular extension support services to the beneficiaries. In the past, most organizations have relied on the services of sub-county and district based extension staff. Where they are used, there is need for a strong partnership between them and the implementing agencies provide the much needed extension services to the OVC beneficiary households. However, it is evident that these cadre of staff have worked in some contexts but failed in others. It is therefore recommended that implementers of OVC programs explore other options of making veterinary, agricultural and other extension services available to supported farmers more consistent and reliable. This might include availing contracted extension services to beneficiary farmers for a specific period of time, or employing full-time staff in the field to support beneficiaries on a regular basis.

The gestation period of IGAs should be an important consideration in choice of the IGA approach/model, as well as the specific projects to be implemented. While the benefits of ‘revolving animals’ or ‘animal multiplication’ are recognized, this approach should be used with animals such as pigs that have the potential to produce several off-springs at once, compared to goats or cows, in order to minimize the waiting time for beneficiaries before realizing the benefits of the IGAs. Of course this would also have to take into consideration cultural and religious considerations regarding the type of IGAs acceptable to the community in question. The gestation period of projects can also be reduced by supplying mature breeds rather than young ones.



Given the relative strengths and limitations of individual/household and group IGAs, it is recommended that OVC programs continue to apply both approaches, combining them and where possible, supporting most if not all caregivers to access both. An individual/household IGA might be able to meet specific needs of the children, e.g. milk or eggs everyday, while the group IGA will also serve other needs, e.g. grow savings, support acquisition of assets, promote peer learning about enterprise management, and so on.

OVC programmes should compute the other costs (non-tuition) that go into apprenticeship training (transport, food, materials, etc) and determine the extent to which they are affordable to the trainees. This should then provide a basis for further decisions regarding whether these costs should be met by the child/caregiver, or the programme.

To support better earnings by OVC that have completed skills training and joined employment, there is need for a system of support that continues with them for some time after the completion of training. First, learning from organizations such as TASO – and also given that many OVC trained in skills receive kits but cannot use them due to lack of other requirements such as space, materials etc; they should be given grants that include some start up money, and not just kits. Secondly, those who are in self-employment for instance can be introduced to schools, hospitals, and other institutions where they might obtain small contracts to make uniforms (in the case of tailors), or chairs and desks (in case of carpenters) and so on. Where an OVC program that supported the skills training is also supporting school infrastructure, this can be part of the project design (as an act of affirmative action) such that all small contracts of that nature will be given to OVC trained within the same program. The challenges of machine breakdowns, lack of spares parts for machines, and others which were raised by several working OVC can be addressed through arrangements that provide warranty or after sales service for a certain period. Another alternative would be to identify already existing mechanics and providing them with further tailored training, and then contracting them to provide repair and maintenance services for all tools and machines given out as part of kits for the first year after completion of training. All these options have the potential to provide a good start and transition that will enable OVC trained in skills to effectively put their skills and kits to good use.

There is need for more legal support to secure rights of all caregivers and OVC, but more especially those of female caregivers and female OVC. There is also need to provide information about where and how they can access legal support services if needed.

### ***Recommendations for Food and Nutrition Security Support***

Since one of the factors that significantly influences increase in food production is ownership/access to land, and learning from some of the innovative interventions applied by some of the implementers such as Compassion Uganda, it is recommended that OVC programmes should support landless or land-constrained OVC households to rent land, where they can grow food both for the home consumption and for sale. This intervention has the potential to remove one of the barriers to the expansion of production by OVC households.

The recommendation of extension services made above – also applies for food and nutrition security interventions.

It is also important that OVC caregivers should continue to be supported to form and work in groups. Here they can continue to benefit from each other and share inputs and experiences for improving food and nutrition security amongst their households.

There is need for programs to identify the food insecure households, such as those that report having one meal a day, and specifically target them with more tailored support to improve their food production and nutrition.

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## ANNEX 2: LIST OF SUB-COUNTIES STUDIED

| <b>District</b> | <b>Organizations</b>                               | <b>Sub counties studied</b>  |
|-----------------|--|--|
| <b>Ibanda</b>   | Ankole Diocese                                     | Nyamarebe<br>Bisheshe  |
|                 | Compassion Child Development Centre (CDC)          | Ibanda Town Council  |
| <b>Mityana</b>  | Caritas Kiyinda Mityana Diocese                    | Butayunjja<br>Bulera<br>Busimbi                                    |
|                 | Kireku Health Program (KHP)                        | Busimbi<br>Bulera  |
| <b>Mayuge</b>   | Family Life Education program (FLEP)               | Kityerera<br>Buwaya<br>Basakira<br>Kigandalo                       |
|                 | Child Fund - Mayuge                                | Buwaya   |
| <b>Kibaale</b>  | Kibaale Civil Society Organizations Network (KCSO) | Kagadi<br>Mugarama<br>Kyebando<br>Mabaale<br>Nyamarunda<br>Ruteete |
|                 | EMESCO Development Foundation                      | Kyenzigye  |
| <b>Gulu</b>     | The AIDS Support Organization (TASO)               | Paicho<br>Patiko   |
|                 | Health Alert Uganda (HAU)                          | Lakwana  |

## ANNEX 3: LIST OF KEY INFORMANTS INTERVIEWED

| <b>Ibanda District</b>  |                                |   |
|-------------------------|--------------------------------|---|
| <b>Name</b>             | <b>Organization</b>            | <b>Position</b>                             |
| Muzooro Mathias         | Bisheshe Sub County LG         | Ass Community Development Officer           |
| Adrian                  | Ankole Diocese                 | Child Care Committee Leader                 |
| Patience Katungye       | Ankole Diocese                 | Child Care Committee Leader                 |
| Twinamatsiko Danison    | Ankole Diocese                 | Social worker                               |
| Evas                    | Compassion Ibanda CDC          | Child Development Officer                   |
| Karubanga Benon         | Ankole Diocese                 | Child Care Committee Leader                 |
| Kato Martin             | Compassion Ibanda CDC          | Ag. Project Director                        |
| Muhanguzi John          | Ibaare 2 Cell                  | Chairperson LC I                            |
| Maganja Munna           | Ankole Diocese                 | Social worker                               |
| Nkwasiibwe Kizironi     | Bisheshe Sub County LG         | Chairperson LC III                          |
| Rev Canon Ngabirano     | Ankole Diocese                 | Diocesan Secretary                          |
| Bagambane Emmanuel      | St James C.O.U Bugarama        | Reverend                                    |
| Birekeraho Freda        | Ibanda District LG             | Secretary for Social Services               |
| Nantabo Winnie Kisakye  | Ibanda District LG             | Senior probation and Social Welfare Officer |
| <b>Gulu District</b>    |                                |   |
| Orut Jimmy              | Gulu District Local Government | District Community Development Officer      |
| Adonga Charles          | Ajulu Primary School           | Headmaster                                  |
| Ojok Alfonse            | Olam Village                   | LC I Chairperson                            |
| Okot Peter              | Paicho Sub County LG           | LC III Chairperson                          |
| Anena Jessica           | Gulu District Local Government | Senior probation and Social Welfare Officer |
| Apio Nelda              | Chain of Hope                  | Project Coordinator                         |
| Ocara Emmanuel          | Health Alert Uganda            | Project Officer                             |
| Oroma Allan Denis       | TASO Gulu                      | Social Support Officer                      |
| Walter Chistopher       | Watoto                         | Social worker                               |
| Muzaya                  | TASO                           | Regional Manager                            |
| <b>Kibaale District</b> |                                |   |
| Mulindwa Paul           | KCSON                          | Programme Coordinator                       |
| Kisembo Vicent          | Kisalizi / Kataza Village      | LC I chairperson                            |
| Mukasa James            | Kibaale District LG            | District Community Development Officer      |
| Nfashingabo Stephen     | Kibaale District LG            | Ass District Chairperson                    |
| Byarugaba Dominico      | Mugarama Sub County            | LC III Chairperson                          |
| Muhikire Ignatius       | Extension Advisor              | KDFA  |
| Ahimbisibwe Justice     | RUPAD                          | Community Leader                            |
| Denis Sebugwawo         | KCSON                          | Monitoring and Evaluation Officer           |

|                           |                                   |   |
|---------------------------|-----------------------------------|---|
| Kyamanywa peter           | Kyebando Sub County LG            | Chairperson LC III                          |
| Rev Canon Barugahara      | INCODE                            | Founder / Advisor                           |
| Ngondwe PK                | Kibaale District LG               | Senior probation and Social Welfare Officer |
| Mbawade Joselyn           | INCODE                            | Executive Director                          |
| <b>Mayuge District</b>    |                                   |   |
| Margaret Nanyonga Odeku   | FLEP                              | Project Coordinator                         |
| Mukoli Paul               | Mayuge District LG                | District Community Development Officer      |
| Karim Mulondo             | FLEP                              | Village Volunteers Supervisor               |
| Naguyo Patrick            | FLEP                              | Village Volunteer                           |
| Kamoga Juma               | Kyityereera Sub County LG         | LC III Chairperson                          |
| Musobya Imelda Jesca      | Kyityereera Sub County LG         | NAADs Service Provider                      |
| Tezikoma Sebastian        | Kyityereera Sub County LG         | Community Development Officer               |
| Namaganda Nulliat         | Mayuge District LG                | District Women Councilor                    |
| Nambagi Amos Nelson       | Buwaya Sub County LG              | LC III Chairperson                          |
| Nagumba Fred              | Buwaya Sub County LG              | Community Development Officer               |
| <b>Mityana District</b>   |                                   |   |
| Mukwaya Andrew            | Caritas Kiyinda                   | Programme Officer                           |
| Rose N                    | Mityana District LG               | Probation and Social Welfare Officer        |
| Selemba Daniel            | Mityana District LG               | NAADs Coordinator                           |
| Serwadda John Mary        | Kiggwa Primary School             | Head teacher                                |
|                           | Mityana District LG               | Community Development Officer               |
| Muyingo Ponsiano          | Bulera                            | LC II Chairperson                           |
| Specioza Namusisi         | Bulera Sub County LG              | NAADs Coordinator                           |
| Namirimu Annet            | Bulera primary School             | Deputy Head teacher                         |
| Rev Emmanuel Mukisa       | Kireku Health Programme           | Programme Coordinator                       |
| Mugerwa Ronald            | Kireku Health Programme           | Assistant Programme Coordinator             |
| Desire Semuju             | St. John primary School           | Head teacher                                |
| <b>Civil Society Fund</b> |                                   |   |
| Ruth Nanyonga             | CSF Monitoring & Evaluation Agent | Monitoring and Evaluation Specialist        |
| Peter Kabagambe           | CSF Technical Agent               | OVC Specialist                              |
| Annet Namunane            | CSF Technical Agent               | OVC Programme Officer                       |

## **ANNEX 4: PROFILES OF SAMPLE ORGANIZATIONS STUDIED**

### **(i) CSF Sub-Grantees**

#### ***Ankole Diocese***

Ankole Diocese is a diocese under the Church of Uganda. It runs a faith-based community project founded in 2003 with the aim of supporting the increasing number of vulnerable children under the jurisdiction of the Diocese. Although the organization is run by the Anglican faith, its interventions target all eligible children and their caregivers regardless of their religious affiliation. The vision of the organization is “Empowered people with quality life”; while the Mission is “To Empower people so that they can improve their quality of life and fully become mature, vibrant, evangelistic, loving, caring, worshipping and peaceful community of God.

The organization’s activities are located in South-western Uganda mainly in the districts of Mbarara and Ibanda targeting OVC and their caregivers. The activities of the organization fall in a number of core program areas, including interventions in education, psychosocial support, food security and economic strengthening. Some limited work is also done in the areas of child protection and legal support.

#### ***Kibaale Civil Society Organizations Network (KCSON)***

KCSON is a network organization that brings together NGOs and CBOs in Kibaale district. Its main aim is to provide member CSOs with a collective voice through policy research, lobbying and building their capacity to effectively participate in the development process. The goal of the organization is to harmonize interventions by members and so reduce the duplication of services often caused by lack of an effective and well coordinated mechanism for delivering services to target populations.

Apart from implementing projects to strengthen the technical and institutional capacity of its members, KCSON also implements community based projects in the areas of OVC support, peace building and tribal conflict management.

#### ***The Family Life Education Program (FLEP)***

FLEP is a non political, not for profit making organization founded under the auspices and patronage of the Church of Uganda – Busoga Diocese. FLEP was established in May 1986 as part of the health sector Multi-Sectoral Rural Development program (MSRDP) of Busoga Diocese, Church of Uganda. FLEP’s mission is to serve local communities throughout the Busoga region by promoting and providing an integrated high quality clinical, community based and mobile reproductive health services to local populations regardless of gender, creed or other circumstantial factors, and conducted under the auspices and within the context of Christian principles and through a sustained mutually supportive partnership and dialogue with communities and organizations. Currently, FLEP operates in seven districts of Busoga region namely; Bugiri, Iganga, Jinja, Kamuli, Kaliro, Namutumba and Mayuge.

The organization's activities support interventions in the areas of Immunization, Family planning, Adolescent Sexual and Reproductive health, HIV and AIDS and other STDs as well as Orphans and other Vulnerable Children (OVC). The OVC program mainly works with families by supporting a number of interventions in the areas of economic strengthening and income generation, food and nutrition security and education. In implementing these interventions, PLEP targets the most vulnerable individuals and households especially those headed by women or those headed by children (Child-headed households)

### ***The AIDS Support Organization (TASO) – Gulu***

The AIDS Support Organization (TASO) is an indigenous nongovernmental organization founded in 1987 to support HIV and AIDS affected individuals and families deal with the associated stigma and discrimination. Today, TASO is one of the largest NGOs providing HIV/AIDS services in Uganda and Africa. It cares for over 100,000 people annually through HIV counseling, medical care as well as social support. Since 2004, TASO has provided antiretroviral therapy (ART) to about 1,000 child clients. TASO also supports over 5,000 Orphans and other Vulnerable Children both in and out of school. TASO's mission is to contribute to the process of preventing HIV infection, restoring hope and improving the quality of life of persons, families and communities affected by HIV infection and disease. TASO's philosophy is 'Living Positively with HIV/AIDS'

Through the TASO Training Centre and its four regional offices, TASO has built the capacity of about 3,000 health community workers. The organization has eleven (11) service centres spread in Uganda each operating within a catchment area of 75 Kms within its location. TASO's activities in Gulu district have supported a total of 500 OVC households selected from five (5) sub counties. Support to these OVC households was mainly in the area of household food and nutrition security by supplying an assortment of seedlings, providing farm tools and training beneficiaries in improved farming practices. TASO also supports interventions in Education (mainly in apprenticeship and skills training) as well as economic strengthening by supporting viable IGAs.

### ***Caritas Kiyinda Mityana Diocese***

Caritas Uganda is the socio-pastoral arm of the Catholic Church in Uganda. Under the authority of the Uganda Episcopal Conference, a Caritas desk was first established in 1958, making Uganda the first African Country to embrace Caritas as an Organization. The vision of Caritas is; "Have life to its fullness" with the mission of "Fostering community initiatives that promote integral development". Caritas implements projects in a number of program areas mainly; HIV and AIDS prevention, Peace building, Access to water and sanitation, Environmental stewardship and Enhancement of livelihoods. The organization is also involved in awareness raising on human rights, HIV and AIDS and good governance with a view towards enhancing greater self-sufficiency.

Caritas Kiyinda Mityana is governed under the Central Archdiocesan Province Caritas Association (CAPCA), the overall coordinating body of for socio-economic development of the Catholic Church dioceses. Although the organization is catholic-based, its programmes are inclusive of all eligible children regardless of their gender, religious affiliation, or socio-economic status. The organization works in three sub counties of Busimbi; Mityana and Butayunja;



implementing programmes in the area of food and nutrition security, education and income generation.

## **Other Implementing Partners**

### ***Compassion Ibanda Child Development Centre (CDC)***

Compassion Ibanda Child Development Centre is a Child-centred organization whose mother organization is Compassion International Uganda. As its core mission, Compassion exists to advocate for children to release them from their spiritual, economic, social and physical poverty and enable them to become fulfilled, responsible adult Christians.

Founded in America in 1952, Compassion International activities in Uganda began in 1980 when the first children were registered into the program in Masaka district. In Ibanda district, Compassion's activities started in 2001 under the supervision of Ankole Diocese.

Currently, the Compassion Ibanda Child Development Centre is implementing activities to support OVC and their caregivers in the areas of education, socio economic strengthening, health and HIV/AIDS, regular Christian teaching and learning activities for social development.

### ***EMESCO Development Foundation***

EMESCO Development Foundation is a Ugandan Nongovernmental organization formed in 1988 by concerned community members to improve the standards of living for poor and disadvantaged communities living in Kibaale district, Midwestern Uganda. The acronym EMESCO is derived from the broader organization's philosophy and approach to working with the target beneficiaries. 'E' for Empowering communities to sustain themselves; 'M' for Meeting rural communities' needs in a sustainable way; 'E' for Enabling rural communities to live in harmony and in a healthy environment; 'S' for Supporting rural communities for better livelihoods; 'C' for Cooperating with local, national and international development organizations and other stakeholders to bring about sustainable rural development and 'O' for Offering opportunities for development to rural communities.

EMESCO's Integrated Community Development programme (ICDP) aims to improve the standards of living of the targeted 12,000 rural households with a population of approximately 72,000 people. EMESCO focuses on health, water and sanitation, agriculture, the environment, and primary education activities. EMESCO is currently implementing a number of activities in 20 communities, in 5 sub counties of Kyenzige, Kyanaisoke, Kagadi, Kagadi town council, and Ruteete.

EMESCO's interventions aim at changing the mindset of community members to believe that they can transform themselves and improve their welfare using the pool of resources available both within their immediate environment and beyond.

### ***Child Fund - Mayuge***

Child Fund International was founded in 1938 with an intention to support orphanages for the children who had been left without homes or families during the second Sino-Japanese war.

Currently, the organization works in 31 countries, assisting approximately 13.5 million children and members of their families, regardless of race, creed or gender. The mission of Child Fund is to help deprived, excluded and vulnerable children living in poverty have the capacity to become young adults, parents and leaders who bring lasting and positive change to their communities. Child Fund seeks to promote societies whose individuals and institutions participate in valuing, protecting and advancing the worth and the rights of children. Child Fund's approach entails working with children throughout their journey from birth to young adulthood, as well as with families, local organizations and communities to create the environments children need to thrive.

Child Fund has operated in Uganda since 1980 mainly on development as well as emergency relief and disaster mitigation programmes focusing on children. In Mayuge district, Child Fund has been extending support to targeted families in the areas of food security, economic strengthening and education for OVC. Interventions of Child Fund have also been directed toward supporting training in managing income generating activities (IGAs) managing income generating activities (IGAs), savings, and asset growth.

### ***Health Alert Uganda (HAU)***

Health Alert Uganda is a private nonprofit organization founded in 2004 in Gulu district in northern Uganda. Currently, the work of Health Alert Uganda spans across the districts of Gulu, Oyam, Kitgum, Amuru, Nwoya, Lamwo and Pader. The organization works to promote the rights and participation of children infected and affected by HIV within the target communities. HAU's vision is to provide leadership in community-based HIV/AIDS prevention, care and support services for children infected and affected by HIV/AIDS, while its mission is to increase access to quality community-based care and support services for children between the ages of (0-17) infected and affected by HIV/AIDS in Uganda.

The activities of the organization cover a range of services including: HIV/AIDS counseling and testing (HCT); prevention of mother-to-child transmission (PMTCT); anti-retroviral therapy (ART); as well as care and treatment for children living with HIV (CLWHIV). In addition, the organization provides support for economic strengthening as well as food and nutrition security. All interventions target poor families affected by HIV/AIDS and more especially those living in hard-to-reach areas.

### ***Kireku Health Program (KHP)***

Kireku Health Program (KHP) for OVC is a community initiative that was started by the Late Metropolitan Theodrus Nankyama of Uganda Orthodox Church in 2003 with the major aim of supporting OVC in Mityana district. KHP is located at Kireku Orthodox parish in Busimbi sub-county, Mityana district.

The program's interventions for OVC include support to formal education, vocational/apprenticeship training, psychosocial support, food and nutrition security, and economic strengthening.