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CHALLENGES AFFECTING ORPHANS AND VULNERABLE CHILDREN (OVCS) IN EMBU COUNTY

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Abstract

Purpose: To assess the challenges affecting orphans and vulnerable children (OVCS) in Embu County.

Methods: This study adopted a descriptive research design. The target population was the orphans and vulnerable children support programs in Embu County. Stratified sampling was used to select 10% of orphans and vulnerable children in each location. Data was collected through household interviews, key informant interviews, observation, desk review, case studies and focus group discussions. Descriptive statistics was used to summarize the data, to enable the researcher to meaningfully describe a distribution of scores or measurements using a few statistics.

Results: The findings of the study indicate that the situation of orphans and vulnerable children is escalating. The community suspects that large numbers of people are infected with HIV/AIDS. This study has shown that the family members are currently taking care of over 90% of OVC is under extreme pressure, and unless governments and international development partners redouble their current efforts to increase the capacity of the families to cope, the quality of lives of foster OVC and all children in vulnerable households remain in danger.

Unique contribution to theory, practice and policy: It is recommended that the community be involved in raising awareness of the value of life and support education in improving children future. The government should also make policies and programs that target communities where the epidemic has left the largest numbers of orphans, vulnerable children and affected families.

Key words: *Children, orphans, vulnerable, challenges.*

1.0 INTRODUCTION

1.1 Background of the Study

In 2003 the UN estimated the total number of orphans to be over 43 million that is 12.3% of all children in the region. This is an increase of over 1/3 since 1990. According to Spiegel (2004), the highest concentrations of orphans are in countries that have a high HIV prevalence level or recently have been involved in armed conflict. Even though children lose their parents for many different reasons, the issue of HIV/AIDS is hard to avoid when talking about orphans and vulnerable children. HIV/AIDS is the leading killer worldwide of people between 15-49 years old. Similarly, orphan hood is the most visible and measurable impact this disease has on children's lives. The numbers of orphans in the world would be declining if it were not for HIV/AIDS (UNICEF, 2004). By 2010 UNICEF estimates the number of children orphaned by AIDS in Sub-Saharan Africa to reach 15.7 million. The UN states that "the worst is yet to come", as young adults now living with HIV eventually develop AIDS and die, they will leave behind large number of orphans (UNICEF, 2008; UNICEF, 2003). The number of orphans generally increases with age, hence older orphans greatly outnumber younger ones (UNICEF, 2004).

These children will suffer long before they lose their parents. They may miss out on their education as they may be taken out of school to care for their sick parents. This is especially a problem for girls as they are often the first ones to be given the responsibility of caring for the sick. Studies show that in addition to be deprived of their education, these children often live in households with less food security and have a higher risk of suffer from anxiety and depression (Richter, 2004). Orphaned children may also be forced to relocate and in this process lose their social networks and the community they are familiar with (UNICEF, 2008). There is no doubt that the children orphaned by AIDS and the problems they face needs attention and solutions. However, this focus on children orphaned by AIDS has put the sufferings of orphans of other reasons in the shadow (Foster, 2005), as donor and aid campaigns have often been directed at solely helping children orphaned by AIDS. This study does not make any distinctions between orphans and vulnerable children of AIDS and orphans and vulnerable children of other reasons. The vast majority of children orphaned in Sub-Saharan Africa are cared for by the extended family system, a coping mechanism that have cared for orphans and vulnerable children, aged people and disadvantaged family members for generations.

1.2 Statement of the problem

The extended family system care for most of these children, but there are still many that are left on their own (Ahiadeke, 2003). Like in the rest of Africa, the functioning of the extended family system is changing. It has for generations functioned as a safety-net for orphans and vulnerable children, but due to modernization this is changing. Migration to urban areas creates a distance between people and their extended family and people tend to lose their feeling of responsibility towards more distant family members. The growing idea of the nuclear family also contributes to the notion of the family consisting of mainly

mother, father and children, leaving out “the rest”. Poverty is also a major reason why orphans are rejected by their extended families. The share number of orphans are becoming too much to handle for poor households. They simply do not have the resources to care for them. The children that have been taken in by their extended families sometimes risk abuse and neglect, but as a result of poverty they also risk being sent out to steal or practice prostitution. The latter is especially a problem for girls. Some children are also denied access to basic education, proper healthcare and nutrition (Ahiadeke, 2003). At community level, various community groups have developed a wide range of responses through their own initiative and also through support by NGOs working in their locality.

There are over 12 million Orphans in Sub-Saharan Africa, where it is estimated that 9% of all children have lost at least one parent to AIDS. The UN Children’s Fund (UNICEF 2008) estimated that the number of OVC in sub-Saharan Africa would climb to more than 16 million orphans and vulnerable children by 2011. In Kenya alone, it is estimated that there are 1,100,000 Orphans, with a similar number in South Africa, Tanzania, Malawi and Zimbabwe (UNICEF 2008). This is a relatively high number as it comprises almost 10% of all children in Kenya (UNICEF, 2008). The same report also suggested that the heaviest concentrations of both vulnerable children and children orphaned by AIDS lie in the age segment 10-14 years old (48.6% for boys and 46.8% for girls).

A child who loses one or both parents to AIDS might also be infected with HIV. Orphans often find themselves battling the very disease that took their parents (World Health Organization, & UNICEF, 2010). Orphans are also at greater risk of malnourishment and stunted growth. Young orphans, healthy or not, are often forced into adult roles long before they should be. An eldest child who loses parents to HIV/AIDS might carry the heavy responsibility of caring for brothers and sisters. The loss of one or both parents has serious consequences for a child’s access to basic necessities such as shelter, food, clothing, health and education. Many Orphans find they need to contribute financially to the household, in some cases driving them to the streets to work, beg or seek food. AIDS orphans often leave school to attend to ill family members, work or to look after young siblings. Many children already function as heads of households and as caregivers and need to be supported as part of the solution.

Sanganyi (2012) did a study on challenges facing cash transfers for orphans and vulnerable children programme: The case of Kasarani, Nairobi, Kenya. The findings showed that orphans are more likely to be cared for by households - those that have the means to take on, feed and educate additional members if there is a guarantee of additional support, like the OVC-CT programme. The study recommended that a number of policy initiatives need to be reviewed and clarified, and guidelines for implementation and enforcement need to be drawn up and disseminated to the relevant authorities. Key policy areas that need attention include: inheritance rights; access to education, medical services and accommodation.

Gitobu (2012), studied implications of cash transfer programmes for social relations: Kenya's Cash transfer for orphans and vulnerable children. The study found that the programme has resulted in social capital gains within beneficiary communities; it has also had perverse effects that have simultaneously engendered threats to social cohesion. The negative outcomes are largely seen to emanate from programme processes, particularly the small percentage of households targeted. Ultimately the study highlights the necessity for directing focus towards a comprehensive social protection system with a universal orientation to maximise benefits of transfer programmes. Meanwhile, there is need to expand the evaluative space to take cognizance of the range of impacts engendered by such programmes, including relational outcomes. From the above local studies little has been done on challenges affecting orphans and vulnerable children (OVCS) in Embu County.

1.3 Objective of the Study

To assess the challenges affecting orphans and vulnerable children (OVCS) in Embu County.

2.0 LITERATURE REVIEW

2.1 Orphans

There exists a large number of ways to define orphans depending on the usage of the definition; epidemiologically, legal or as a social and cultural definition (Skinner, 2004). The latter will vary between people and societies. Some people in Embu say that "in Embu we have no orphans". People explained this with the existence of the extended family system and how this ensured that no child was ever left on its own. People did not refer to children that had lost their parents as orphans, because these children still had caretakers and thus were not orphans by their definition. In addition to the usage of various age-groups when defining orphans, there is also the pattern of parental death; maternal, paternal or double orphans. All these different ways of defining orphans have program and policy implications and need to be thoroughly considered and fully understood before set into practice.

2.2 Vulnerable Children

Vulnerable children are those "whose safety, well-being, and development are, for various reasons, threatened" (Subbarao, 2004). Lack of care and affection, adequate shelter, nutrition, education and psychological support are some of the most important factors that accentuate the vulnerability of children. The types of vulnerability children are exposed to, are highly contextual and will vary between different settings.

The definition above is a very broad one and includes a huge number of children for various reasons. It is therefore a difficult definition to use in the field. In this study

however, what children to include as vulnerable have already been determined by the NGOs, and FBOs dealing with OVC programmes in the areas of study. In this study, vulnerable children are those that for one reason or another cannot or do not want to live with their parents or extended family. Like orphans they have in a way “lost” their primary caretakers. Often these children are neglected, abandoned, abused or their parents may simply lack the resources to take proper care of them. Children that have lost their primary caretakers are more vulnerable to health risks, violence, exploitation and discrimination (UNICEF, 2004).

This study uses the term orphans and vulnerable children as one single category. It proved very difficult to separate between the children that were actual orphans and the ones that were not. There are some dangers associated with the usage of labels as it can affect people’s behavior and labeling may have negative and stigmatizing effects (Angermeyer, 2003).

2.3 Theoretical Perspective

The study was based on the theory of structuration developed by Anthony Giddens. The theory of structuration shows the underlying structures in a society and what impact the actions of the agents have on these, is important when trying to understand fundamental problems in a society. The theory of structuration as developed by Anthony Giddens (1995) emphasizes the concepts of “structure” and “agency” and how these work to recreate and reshape each other. The main idea of Giddens’ theory is the duality between “agency” and “structure”; structures shape practices and actions and these can again create and re-create social structures (Gatrell, 2002). The theory of structuration is relevant to the problem under consideration because it is essential in understanding how the material and social structures and supplies that surround the children in the study areas affects aspects of their QoL. The theory of structuration also gives room to see the children as competent social actors that act as individuals rather than a homogeneous group (Skovdal, Ogutu, Aoro, & Campbell, 2009). The children are not passive objects under the structural constraints that surround their lives.

3.0 Methods

This study adopted a descriptive research design. The target population was the orphans and vulnerable children support programs in Embu County. Stratified sampling was used to select 10% of orphans and vulnerable children in each location. Data was collected through household interviews, key informant interviews, observation, desk review, case studies and focus group discussions. Descriptive statistics was used to summarize the data, to enable the researcher to meaningfully describe a distribution of scores or measurements using a few statistics

4.0 DATA ANALYSIS, PRESENTATION AND INTERPRETATION

4.1 General Information on Respondents

4.1.1 Gender of the Respondents

Research shows that there are disparities in education between genders, especially in Africa where more emphasis is put to boy-child than girl-child. EFA Global Monitoring Report (2012) indicates that girls face large obstacles to entering school than boys. Of the 198 OVCs who participated in this study, (51.3%) were female while (48.7%) were male. This phenomenon was observed most homes in the study took place. This finding may signify that there are more girl child orphans than boys.

4.1.2 Age of respondents

The death of a parent, illness, poverty, and moving homes are all sources of great stress for anyone of any age. Children may be especially hard hit by these issues because they often have no control in their lives or say in decisions that are made on their behalf. Majority of the sampled OVCs (48.2%) were aged between 11-13 years, 33.8% were aged between 14-16 years while 1.5% were aged between 17-19 years. The youngest were 16.4% were aged between 8-10 years. Some of those aged between 14-19 years were in secondary schools though there were others in primary schools that were over age. Those that were more than 17 years were too old for them to be in secondary schools.

4.1.3 Number of OVC siblings

Majority of them (24.2%) reported that they had 2 children in their family, 9.1% had 3 children in their family while 15.7% indicated that they had 4 children in their family. Those that had 7 and above siblings were 17.1% while 3.5% had only one child in their families. Large number of family presents challenges in fees payment for the school going children. The larger the family, the more difficult it becomes for the parents to ensure each child receives quality education. More food, clothing and many more basic needs are required. Lack of these basic needs to a child may adversely affect the OVCs. Majority of the OVCs reported that they have siblings some of whom were of school going age.

4.1.4 Source of Household Income

The result from analysis shows that the highest source of income is from the farms as was indicated by 72.2% of the OVCs. This is mainly food for consumption in the homes since the production is low. Small businesses are the second highest source of income in the study region represented 11.6%. The businesses themselves are micro in nature and generate very little income to sustain the community needs. This business includes selling sugarcanes to passersby, selling fruits etc. Casual employment is the third highest source of income to the community at 9.1%.

4.1.5 Adequacy of Family Income

When the respondents were asked whether their income is sufficient to meet all their family needs, 87.2% indicated that what they get is never adequate while 12.8% of the respondent indicated they are able to survive with their income. This indicates the dire needs to support income generating activities and create market linkages to ensure there are sustainable and profitable markets.

Table 1: Source of income in a family

Variables	Items	Percentage
a Gender of the respondent	Male	48.7%
	Female	51.3%
b Respondents Age	8-10 years	16.4%
	11-13 years	48.2%
	14-16 years	33.8%
	17-19 years	1.5%
c class/grade of pupils	Standard 1	14.1%
	Standard 2	15.2%
	Standard 3	11.1%
	Standard 4	11.6%
	Standard 5	10.1%
	Standard 6	9.1%
	Standard 7	10.6%
	Standard 8	10.1%
d Number of OVC siblings	Form 1	4.5%
	Form 2	3.5%
	1 child	3.5%
	2 children	24.2%
	3 children	9.1%

		4 children	15.7%
		7 and above siblings	17.1%
e	Source of Household Income	Farming	72.2%
		Small businesses	11.6%.
		Casual employment	9.1%.
f	Adequacy of Family Income:	never adequate	87.2%
		able to survive with their income	12.8%

Source: field data

4.2 Categories of Challenges Affecting OVCs

The objective of this study was to find out what kind of problems OVCs' face. This section analyzes the vulnerability of orphans before and after the death of parents. The vulnerability of AIDS orphans starts well before the death of a parent. Children living with caregivers who have HIV/AIDS will often experience several negative changes in their lives and can start to suffer neglect, including emotional neglect, long before the death of the parent or caregiver (Angermeyer, 2003).

4.2.1 Level of vulnerability

The majority of OVC (92.4%) indicated that both parents had died while only 7.6% had at least one parent living. AIDS is responsible for leaving vast numbers of children across the study region without one or both parents. The scale of the AIDS orphan crisis is somewhat masked by the time lag between when parents become infected and when they die. According to Subbarao (2004), if as expected, the number of adults dying of AIDS rises over the next decade, an increasing number of orphans will grow up without parental care and love.

4.2.2 Illness of the living parent

About 83.4% of the living parents were sickly while 16.6% were healthy. The main problem with the people living with HIV/AIDS is that they often fall sick despite the use of the ARVs. According to Angermeyer (2003), children whose parents are chronically ill are often more vulnerable than orphans are because they are coping with psychosocial burden of watching a parent wither, and the economic burdens of reduced productivity and income and increased healthcare expenses.

Table 2: Illness and vulnerability of the surviving parent

	Variables	Items	Percentage
a	Level of vulnerability	Both parents had died	92.4%
		One parent living	7.6%
b	Illness of the living parent:	Parents were sickly	83.4%
		Were healthy	16.6%

4.2.3 Poor educational opportunities

The findings of this study indicate that 74.9% orphans were schooling while 21.1% were not. School going orphans are vulnerable to stigma and discrimination at school, where social acceptance is so important to them. In some cases, children are teased or verbally abused by teachers and peers. In some cases, they are described as children who could infect others, or who are not worth associating with or fear of infecting others. Sometimes, these children are excluded as they cannot pay their school fees promptly in secondary schools or buy the school uniform, even though they are often extremely poor and struggling to survive with little or no support. Some of those that were not schooling were either too small to go to school while others had dropped out of school due to lack of school fees or early pregnancy, or to take care of an ailing parent or their siblings.

4.2.4 Poor class attendance by OVCs

About 3.0% had failed to attend classes for more three times while 4.5% failed to attend classes twice per term. However, 1.9% failed to attend classes only once per term. Only 8.1% attended classes without fail. The frequency of class absenteeism was found to apply to majority of them indication that they had failed to attend classes for three times.

4.2.4.1 Factors influencing class attendance by OVCs

Majority of OVCS (69.0%) who did not attend classes regularly said that it was due to sickness. These findings show that most OVC were also HIV positive either infected during birth or when taking care of their sick parents. Lack of school uniform was cited by 7.0% OVCs while 24.0% indicated inability to pay school levies.

4.2.4.3 Causes of school dropout

About 33.3% respondents indicated that there are children who had dropped out of school in their homestead while 66.7% indicated that there was no school dropout. It has been known for many years that young people who fail to complete education are faced with more problems in later life. While national leaders have demanded that schools, communities, and families make a major effort to retain students, the dropout rate remains high.

4.2.4.4 Factors influencing school dropout by OVCs

Majority, 55% indicated that it was due to sickness, 16.0% was due to poor performance, 22.0% was due to lack of school uniform, while 7.0% indicated that it was so as to care for their sick parents/ guardians. HIV/AIDS has forced many children in Embu County to abandon school due to stigmatization from their peers and local communities leading to low enrolment of pupils. Some are born with the virus while others have been infected while taking care of their ailing parent or through sex. They are subjected to recurrent opportunistic diseases that have resulted to 3% boys drop out and 6% girl's dropout. Other reasons of school dropout are: Some didn't like school in general or the school they were attending.. The table below summarizes the findings.

Table 3: Drop outs in schools

Variables	Valuables	Percentage
a Poor educational opportunities	were schooling	74.9%
	Were not schooling	21.1%
b Poor class attendance by OVCs (Frequency of OVC absenteeism)	Once	2.0%
	Twice	4.5%
	Three times	82.3%
	More than three	3.0%
	None	8.1%
Reason for not attending class	Sickens	69.0%
	Inability to pay school levies	24%
	Lack of school uniform	7.0%
School dropout cases at sampled households	Yes	33.3%
	None	66.7%
Causes of school dropout	due to sickness	55%
	Poor performance	16.0%
	lack of school uniform	22.0%
	so as to care for their sick parents/ guardians	7.0%

Source: field data

CASE STUDY: Joyce Mukami

My name is Mukami, I live in Mutunduri village, just outside Embu town, the provincial headquarters for Eastern Province. I am a total orphan living with two of my siblings. I dropped out of school after my parents died of HIV and AIDS related complications so as to care for my brother and sister. I had to go looking for casual work in order to earn an income that I would use to buy food, clothing, medical expenses and other basic needs for siblings. My family was identified and enrolled into the OVC program through a volunteer group. In my village, I among the older OVC who received support to attend vocational training. I was trained in tailoring/sewing and am now able make an income hence impacting of other areas of our lives such as health, food security and the like. I have gone through times without my parents alive; therefore I decided I will help other OVC by sewing school uniform free of charge when they buy the material from my tailoring shop. I have seen my own siblings sent home for not having school uniform so this has relieved other caregivers in one way or another.

She is a great example of how investing in one child can impact the lives of others. What makes Mukami's story unique is that she has also been able to use her new skill to help other children by making uniforms for them, relieving some of the burden on caregivers while removing a major barrier to education for other children in her community affected by the pandemic. The above case shows that some people in the community still do not accept their HIV positive status; this could largely be due to fear of stigma and discrimination at home and in their general environments. Children too are afraid of telling anyone their parent died of AIDS for fear of being called names and being isolated. The community and organizations existing in the community have taken into account all the needs of the family in a holistic manner. Practical support to address their immediate needs for food, clothing and education has been put in place.

4.2.5 Health and Hygiene Challenges Faced by OVCs Long distances to the nearest water source

4.2.5.1 Water Challenges

The findings of this study show that 44.9% of respondents walk a distance of less than ½ KM to fetch water. Those that walk for distances raging between 0.6-1 Km were presented by 32.8% while those that walked longest distance of more than 1.1 Km to get water were 1.5 %. In some areas, water was found to have dried up even in wetland and the community members had dug open wells near them to get water. Average distances covered to fetch water in all areas is 2.78Km. Long distances covered to fetch water hinder its access and places heavy burden on the OVCs who are most often charged with the responsibility of fetching water. In addition, limited access to water affects OVCs health and wellbeing.

The water challenges identified in the area are:-

- i. There are very few permanent springs and rivers on which to construct the protected springs.
- ii. Constructing springs on seasonal springs would be a waste of resources as these would certainly dry up during the dry seasons.
- iii. During the dry spell the water level goes down in the boreholes and springs causing water shortages.
- iv. Poverty- There is a lot of poverty in the area and the members of the community do not have the money to contribute towards construction of the boreholes or the springs. Water borne diseases-due to poverty and continued use of unsafe water, some diseases like diarrhea, intestinal worms etc. still infect the members of the community.

4.2.5.2 Poor hygiene by OVCs

In this study, 5.5% respondent's bath daily, 25.7% twice per week, while 68.9% bathed once week. The major cause of diseases, researchers have found, is poor personal and environmental hygienic conditions and according to one resident, some households in the community are so poor, they can hardly afford a piece of soap.

4.2.5.3 Lack of latrines at OVC homestead

Majority of the OVC households (75.3%) use pit latrines, 1.5% use the bushes and 23.2% use flushable toilets. 46.3% of the respondents washed their hands after visiting toilets while 53.7% did not. Poor disposal of human waste leads to contamination of environment. In some cases the waste is washed downstream polluting rivers. In the immediate environment it may be a source of attraction of flies and other harmful insects that may cause human sicknesses.

4.2.5.4 Lack of a personal bed for OVCs

About 37.9% OVCs did not have their own bed but shared with other children thus being overcrowded this led to lack of oxygen during the night and they complained about frequent headaches in the mornings. The general condition of all OVCs bedrooms was observed to be poor.

4.2.5.5 Access to health services

Despite the efforts made by the Government to bring health facilities closer to the people, the study reveals that there are people who still have to travel for over 3 Km to the health facility. The OVCs indicated that these categories of people were the majority (36.0%). Those who cover between 1.1Km and 2 Km were 17% while 22.0% of the respondents traveled between 2.1Km and 3 Km to the health facility. An average number of times the OVCs get sick were found to be 3 times. Access to health services is also important as it can present an opportunity to improve or regain health.

4.2.5.6 Poor quality of services provided at the health centers

Majority of the respondent's (60.1%) rated the services offered in health facilities as fair, 32.3% rated them poor, while 7.6% rated them good. They cited that the clinic lacks medicine as was indicated by 59.1% and patient had to buy them from a chemist. They also cited that it takes an average of 1 hr to be served at the clinic resulting in time wasting. Most health facilities lack basic requirements for curative and preventative treatments. This includes drugs and qualified doctors. This discourages most people against visiting them. All the identified challenges affect the quality of life of OVCs in terms of health, access to education, shelter and food.

Some of the challenges encountered in health related issues are:-

- i. **Poverty**- the majorities of the respondents are poor and lack money to buy drugs. They also do not have money to buy such items as the mosquito net, water guards, etc.
- ii. **Lack of health facilities**- In some areas, there are no health facilities and the respondents are forced to travel for a long distance to the nearest clinic or hospital
- iii. **Lack of drugs in the hospitals**- In some areas, drugs is not readily available in the health centers. The patients are referred to the next hospital or chemist to buy the drugs which might be too far.
- iv. **Lack of knowledge**- In some areas, people is not aware of the public health requirements. They suffer from poor hygiene related diseases
- v. **Expensive drugs**- some drugs are too expensive that many people cannot afford.

4.2.6 Shelter Challenges Faced By OVCs

The right to shelter or housing is important as protection against threatening elements, like violence, abuse, disturbances and noise. Shelter is also important as an arena for privacy, personal space, dignity and peace. Most houses (89.4%) are roofed using iron sheet while (10.6%) are grass thatched. Grass thatched house are a major problems in this region during rainy seasons. The majority of houses (68.4%) have mud floor. Fully cemented and partly cemented floor houses were represented by 11.7% respectively. The findings of this study indicate that mud (66.7%) is the most commonly used walling material by communities living in the study region. Due to high cost of building materials, transportation, labor involved plus other materials e.g. cement involved in construction of a stone house, only 5.5% of homes in the study region are made of stone. Due to high cost of wood, only 27.5% respondents who had constructed home using wood as walling. The observation made during the study shows that most OVCs were living in deplorable condition. The table below summarizes the findings.

Table 4: A summary of challenges to OVCs

	Walls		Floors		Roof	
	Frequency	Percentage (%)	Frequency	Percentage (%)	Frequency	Percentage (%)
Wood	51	25.8				
Mud	122	61.6				
Stone/bricks	25	12.6				
Mud			178	89.9		
Partly			20	10.1		
Thatch					21	10.6
Iron sheets					177	89.4
Total	198	100.0	198	100.0	198	100.0

Source: field data

When the respondents were asked about the decency of their houses, most of the OVC indicated that their houses are not decent. Some of them have walls that require repair others have leaking roofs. Some widows are waiting for the houses that they live in to fall so that they can build another one since they are not allowed by their traditions to repair that house if the husband happens to have died. Some houses have even fallen and the occupants are very old to be able to repair them.

It was reported by immediate peers and also in the focus group discussions that an undisclosed number of OVC, especially orphans in poor households, did not have adequate clothing. This was especially so in the case of those who lived with old grandparents who had no means to provide for themselves. Some relatives who had taken in these children did not buy them clothes when they bought for their own children. Thus some orphans did not have adequate clothing, as indicated in the following quotation from an interview with an orphan: “We need clothes. Our clothes are now worn out and not fitting properly.”

The guardians revealed that orphans were normally given uniforms but that when the uniform got worn out and torn or no longer fitted properly, it took them a long time to get a replacement. The reasons for this delay were not given. The majority of the carers complained that orphans were not supplied with general clothing. As a result some orphans were seen in tattered clothes or still wearing school uniform even after school.

Case Study: Marclus Mureithi Story

My name is Marclus Mureithi, I come from New Site a small village in Gachoka Constituency, Mbeere district in Kenya. I am 72 years; I live with his six grandchildren. I lost my son in 2006 after a long illness. My son had been treated for opportunistic infections associated with HIV and AIDS, and had been started on ART. Unfortunately, complications due to problems with adherence resulted in his eventual passing. During that same year the mother of the children also fell ill and passed away. The OVC support program in the community identified my family, enrolled the orphans in the program and began to provide regular home visits. After a few visits, the volunteers began to discuss the needs of my family. One obvious need was shelter. My family was living in a one-roomed grass thatched hut. And there was just a single bed for all the children. After discussing, the community volunteers trained by APHIA-II a partner in the area, decided to put to use some of the knowledge and tools they had received from the training on OVC care and support. As a result, they were able to mobilize resources from within the community including labor, nails, posts and timber. Volunteers then approached APHIA-II for a donation of iron sheets because they are more expensive. Combined, the volunteers had what they needed to provide my family with a new home. The success they achieved by supporting me encouraged them to continue to mobilize resources, including food donations for us and other needy households. Beyond meeting our physical needs, the activities of the volunteers also served to reconnect other OVC households with their community members, these made us feel loved, cared for and accepted by our own people.

In this case, the caregiver had to take-in his grand children facing an obstacle of inadequate housing and living conditions common among OVC households. Previous studies have shown that adequate housing is associated with a child's social, emotional, physical and spiritual well-being and development (Horizons, 2003). Trained volunteers came together with the help of APHIA-II to improve the house. This was a great programmatic success for APHIA-II, because it shows how small investments, brought about by effective partnerships can lead to major impacts at the community, household and individual level.

5.0 SUMMARY AND RECOMMENDATIONS

5.1 Summary

It is apparent from the discussions in this report that the situation of orphans and vulnerable children is escalating. The community is concerned about this. Furthermore, the community suspects that large numbers of people are infected with HIV/AIDS. This is a serious situation in that it indicates an increasing number of orphans due to HIV/AIDS.

This study has shown that the family members are currently taking care of over 90% of OVC is under extreme pressure, and unless governments and international development partners redouble their current efforts to increase the capacity of the families to cope, the quality of lives of foster OVC and all children in vulnerable households remain in danger. Interventions aimed at preventing and reducing child vulnerability and those that aim to reduce household poverty and increase household investments will go a long way in reducing the numbers of vulnerable children.

5.2 Recommendations

5.2.1 Community

- i. Community members should aim to raise awareness of the value of education in improving children's future.
- ii. Encourage community members to help with household chores and agricultural work.
- iii. Identify adult mentors in the community who can take interest in the child's educational progress and offer support, guidance.
- iv. Uphold child rights by prohibiting exploitative and harmful labor e.g. establishing community child protection committees
- v. Protect the inheritance rights of women whose husbands have died and children whose parents have died.
- vi. Challenge social norms and myths that increase the risks of HIV infection in children, using methods such as drama, role-play and songs.
- vii. Train children caring for parents with HIV on how to prevent HIV transmission by minimizing contact with blood and body fluids e.t.c.
- viii. Promote home gardens to improve nutrition and food security at household level.

5.2.2 Government

- i. The government should have policies and programmes that target communities where the epidemic has left the largest numbers of orphans, vulnerable children and affected families.
- ii. Assistance should not focus on orphans alone but also on children living with terminally ill parents or families impoverished by HIV.
- iii. Have their programmes provide support to all orphans and vulnerable children rather than 'AIDS' orphans only so as to help challenge stigma and discrimination.
- iv. Develop a multi-sectoral response involving partnerships at all levels.
- v. Build the capacity of children to support themselves i.e. express and meet their own needs

- vi. Have programmes for orphans and vulnerable children integrated into existing services for example, social welfare, agricultural extension and community health services
- vii. Monitor and evaluate the impact of their interventions in order to identify the most effective
- viii. Provide parents and caregivers with practical information about good nutrition, basic hygiene, immunization, and early treatment of illness.

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