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# SOCIO-CULTURAL DETERMINANTS OF CARE OF AIDS ORPHANED CHILDREN AMONG THE ASANTE AND KROBO OF GHANA

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This thesis is submitted to the University of Ghana, Legon, in partial fulfilment of the requirement for the award of PhD Public Health degree

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## DECLARATION

I hereby declare that except where specific references have been made, this thesis is the result of my own research. Under the supervision and tutelage of my team of supervisors, I confirm the originality of this thesis as my own, and that it has not been submitted in part or whole to any institution for an award of a degree.

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# DEDICATION

THIS THESIS IS DEDICATED TO:

JOEL, ENTSIE, ESI BOSUA, GYEDU, AND KODWO AHEN,

AND

ALL ORPHANS AND THEIR CAREGIVERS

INTEGRI PROCEDAMUS

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## ACRONYMS

| | |
|---|---|
| AIDS | - Acquired Immune Deficiency Syndrome |
| ANC | - Antenatal Clinics |
| ART | - Antiretroviral Therapy |
| BCC | - Behaviour Change Communication |
| CBOs | - Community-based organizations |
| DAs | - District Assemblies |
| EFA | - Education for All |
| FBOs | - Faith-based Organizations |
| FCUBE | - Free Compulsory Universal Basic Education |
| FHI | - Family Health International |
| GAC | - Ghana AIDS Commission |
| GDHS | - Ghana Demographic and Health Survey |
| GHS | - Ghana Health Service |
| GNCC | - Ghana National Commission on Children |
| GOU | - Government of Uganda |
| HIV | - Human Immuno-Deficiency Virus |
| HSS | - HIV Sentinel Survey |
| LNGOs | - Local Non-Governmental Organizations |
| MDAs | - Ministries, Departments and Agencies |
| MDG | - Millennium Development Goal |
| MESW | - Ministry of Employment and Social Welfare |
| MMY&E | - Ministry of Manpower, Youth and Employment |
| MoH | - Ministry of Health |
| MOWAC | - Ministry of Women and Children's Affairs |

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| | |
|---|---|
| MTCT | - Mother-to-child Transmission |
| NACP | -National AIDS/STI Control Programme |
| NGOs | - Non-Governmental Organisations |
| NTCA | - National Technical Committee on AIDS |
| OICI | - Opportunities Industrialization Centres International |
| OVC | - Orphans and Vulnerable Children |
| PCD | - Partnerships for Child Development |
| PLWHA | - Persons living with or affected by HIV/AIDS |
| STDs | - Sexually Transmitted Diseases |
| STIs | - Sexually Transmitted Infections |
| UAC | - Uganda AIDS Commission |
| UNAIDS | -United Nations Programme on HIV/AIDS |
| UNDP | - United Nations Development Programme |
| UNICEF | - United Nations Children's Fund |
| UNESCO | - United Nations Education Scientific and Cultural Organization |
| WHO | - World Health Organization |

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# CHAPTER 1

# INTRODUCTION

## 1.1 INTRODUCTION AND BACKGROUND

Acquired Immune Deficiency Syndrome (AIDS) which is caused by the Human Immuno-Deficiency Virus (HIV) was first recognized in 1981. It is an immune system disorder which renders its victims defenceless against many opportunistic infections. In addition to physical illnesses associated with AIDS, HIV can directly attack the brain and nervous system causing mild memory loss, diminished concentration, and other mental disorders (Panos, 1990). HIV transmission could be through unprotected sexual activity, infection of an infant during pregnancy, birth or breastfeeding, or through blood sharing (Whitney *et al.*, 1991). There have been a few instances of transmission in medical environments where either health workers have been pricked accidentally by infected needles or by re-using improperly sterilized needles (UNAIDS/WHO, 1998).

The clinical course of HIV in individuals varies, however, three distinct stages have been identified to mark the progression of the disease. These are (1) Primary HIV and extended asymptomatic incubation, (2) AIDS- related complex and (3) Terminal AIDS (Williams, 1994). AIDS is manifested clinically in the third stage and is characterized by involuntary weight loss, and body tissue wasting which eventually leads to severe protein-calorie malnutrition. In developing countries, malnutrition is

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one of the common manifestations of the disease with a direct correlation between the degree of malnutrition and the time of death.

AIDS is a devastating disease that affects children and adults, young and old, rich and poor, men and women, rural and urban dwellers. More than 20 million people worldwide have died and tens of millions of people, mostly women have been infected with the virus. In 2008, about 33.4 million persons, including children, were living with HIV of whom 22.4 million, representing 67.1%, were found in sub-Saharan Africa (UNAIDS, 2009). New infections in 2008 alone were 2.7 million, and 430,000 of this number were children under 15 years. AIDS-related deaths in 2008 amounted to 2.0 million with 280,000 of them being children under 15 years of age (UNAIDS, 2009).

What is worrying about HIV and AIDS is that it has eluded modern medical science's search for a complete cure, and has therefore left countless numbers of infected and dying adults and children in its wake. Such a deadly disease warrants mobilization and coordination of all activities (including effective orphan care schemes) to mitigate its impacts on both the infected and affected individuals as well as societies.

AIDS is, therefore, acknowledged by many to be the most critical health and developmental challenge facing the world today. It dramatically reduces life expectancy and economic potential in the hardest hit countries. It increases vulnerability of future generations by creating millions of orphans, threatens global stability and security, while diminishing the capacity of public or private sector by

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killing people in the prime of their lives. As knowledge of the HIV and AIDS disease process and its impact has grown over the past few decades, it has become increasingly evident that one of the most tragic results of the AIDS pandemic is the ever-increasing number of orphans it is leaving behind, mostly because it kills young adults between the ages of 15 and 49 years. Reports from UNAIDS and UNICEF in 2002 indicated that before the heavy toll of HIV and AIDS related deaths in the late 1980s, only 2% of children from developing countries were orphans. As at the end of 2002, however, over 14 million children in Sub-Saharan Africa (12% of all children less than 15 years) were total orphans (UNAIDS/UNICEF, 2002). Globally, it was estimated that the number of all orphans under age 15 years would exceed 25 million by 2010, and over 90% of this number would be living in Sub-Saharan Africa (UNAIDS, 2005).

In Ghana, it is estimated that by 2012, AIDS-orphaned children would number 168,907 (NACP/GHS/WHO, 2011), and the care of such orphans would be very challenging to individuals, families, communities and the nation if effective care issues are not anticipated and addressed. Care for these children may be effective if the socio-cultural factors that affect orphan care are known and addressed. It is against this background that this study was worth undertaking. The study therefore attempted to establish the social and cultural factors that impact on care of AIDS orphaned children among the Asante and Krobo of Ghana.

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## 1.2 HIV AND AIDS AND THE ORPHAN CRISIS IN GHANA

HIV and AIDS were first reported in Ghana in 1986. In 1994, HIV prevalence in the 15 – 49 year age group was 2.7%, and currently stands at 2.0% (NACP/GHS/WHO, 2011), and has been projected to rise to 9% by 2014 if no effective interventions are put in place (NACP, DFID, WHO, GHS, GAC, 2007). The corresponding numbers of orphans created as a result were estimated to rise from 36,000 in 1994 (MoH/NACP, 2001) to 168,907 by 2012 (NACP/GHS/WHO 2011). More women are infected than men.

HIV and AIDS are found in all regions of the country, in both rural and urban communities with prevalence rates of 1.6% and 2.6% respectively and regional prevalence rates ranging from 0.7% to 3.2% (NACP/GHS/WHO, 2011). The number of HIV infected individuals and those living with AIDS are increasing daily in the country (NACP/GHS, 2005). In the year 2000, UNAIDS estimated that 330,000 adults and 14,000 children were HIV positive and by the year 2004, an estimated 400,000 Ghanaians were HIV positive. Children under 15 years of age constituted 3% to 5% of reported AIDS cases in the country.

Ghana's national response to HIV and AIDS began in 1985 with the setting up of a National Technical Committee on AIDS (NTCA). This Committee was replaced in 1987 by the National AIDS/STD Control Programme (NACP) based in the Ministry of Health. The NACP served as the coordinating body of the national response and substituted for the absence of a national multi-sectoral arrangement even though it is situated at the Ministry of Health.

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The HIV Sentinel Survey (HSS) system which is cross sectional survey of pregnant women attending antenatal clinics in some selected Antenatal Clinic (ANC) sites was established in Ghana in 1990 to monitor the prevalence and spread of HIV and other Sexually Transmitted Infections such as Syphilis. The HSS is conducted annually and it is based on the premise that the prevalence of HIV among pregnant women is a good and internationally accepted proxy indicator of the spread of the virus among the populace. Thus the HSS data are used as the primary source of data for the National HIV and AIDS estimates. However, since 2005 the HSS data have been calibrated with Demographic Health Survey (DHS) Reports and other programme data to compute the national HIV prevalence rate.

In September 2000, the Ghana AIDS Commission was established to serve as the coordinating body for all HIV and AIDS-related activities in Ghana. The objectives were to reduce further transmission of infection and to mitigate the effects of HIV and AIDS on the infected and affected. Priority interventions initially focused on promotion of safe sex, condom promotion, improved management of sexually transmitted infections (STIs), provision of well screened (safe) blood, infection control, nursing/clinical care and counselling, home-based care and prevention of mother-to-child transmission.

The context of the response has been multi-sectoral, multi-disciplinary and expanded to include all relevant stakeholders. Stakeholders include government sectors, the private sector, non-governmental organisations (NGOs), traditional leaders and healers, persons living with or affected by HIV and AIDS (PLWHA), civil society and

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faith-based organizations (FBOs). To address the HIV and AIDS epidemic in Ghana, five key intervention areas have been defined to guide the development of action plans by all ministries, departments and agencies (MDAs), Non-Governmental Organizations (NGOs), District Assemblies (DAs), Community-based organizations (CBOs), FBOs and other private sector institutions. The intervention areas are: Prevention of new HIV transmission; Care and support for PLWHA (with care and support for OVC as a strong component); Creating an enabling environment for national response; Decentralized implementation and institutional arrangements; and Research, monitoring and evaluation of interventions.

Children, especially those orphaned by AIDS have been identified as a vulnerable group. This is because they have lost their childhood, opportunities for school, health, development, shelter, etc. These orphans may find themselves in situations that encourage behaviours that put them at risk of HIV infection. A growing demand for Orphans and Vulnerable Children (OVC) care and support interventions in the country has therefore been identified, and a number of organisations, institutions, agencies and communities have signed up to.

Situation analysis of OVC in Ghana was commissioned by the GAC and UNDP in 2003 towards the development of a policy paper on OVC which was finalized in 2005. The OVC Policy's goal is to reduce the number of children made vulnerable by orphan-hood and other factors in Ghana and improve on the fulfilment and rights protection. Programme interventions are: Advocacy, BCC and Community Mobilization; Food and Nutrition Security; Increasing Access to Education; Provision

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of Psychosocial Support: Child Protection and Socio-Economic Security: Capacity Development of Caregivers and Stakeholders: and Monitoring and Evaluation.

The Ghana AIDS Commission has declared that HIV and AIDS awareness rate among Ghanaians is almost universal, however, the percentage of young people aged 15 – 24 years who correctly identify ways of preventing HIV infection is 44% for males and 38% for females (UNAIDS, 2007). Thus, infection rates continue to increase with serious impact on individuals, families, communities and all sectors of the Ghanaian society due to difficulties in attaining matching behavioural change levels. Many factors have been identified to contribute to this situation including economic, social, cultural, religious and political factors among others.

## 1.3 STATEMENT OF THE PROBLEM AND RATIONALE FOR STUDY

> *"When HIV/AIDS enters a household by infecting one or both parents, the very fabric of a child's life falls apart"* (UNICEF, 2004)

Almost three decades after the discovery of HIV and AIDS, the impact of AIDS on populations has been enormous considering the fact that it affects the reproductive age of most countries. Key among these impacts is the growing orphan crisis affecting most families and communities, especially in Sub-Saharan Africa where the epidemic has already orphaned a generation of children.

Problems of children in AIDS affected households are many and varied and these problems begin to emerge even before a parent dies. These children are vulnerable in almost all aspects of their lives. They suffer emotional and psycho-social distress and

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become anxious as they watch the failing health and death of their parents and other members of their families. Some of the many problems faced by orphans are depression, absence of support and love, increased malnutrition, lack of schooling, absence of immunization and health care, loss of inheritance through "property grabbing", early entry into paid or unpaid labour, homelessness, early marriage, exposure to abuse, and increased risk of HIV infection ( Hunter and Williamson, 1998b)

Research from Uganda (Gilborn *et al.*, 2001) has provided evidence that children orphaned by AIDS suffer physical, emotional and educational setbacks which begin even before parental death. According to these researchers, the death of parents deepens the effects of orphaning, and this depends on a number factors including: the availability of a reliable and resourceful guardian to care for the orphans, willingness of kin to take good care of the orphans, and availability of support organizations such as NGOs, government institutions, churches, and other beneyolent institutions to provide care and support for the orphan.

HIV and AIDS impoverish affected households in that resources are mostly used to care for the sick before their death leaving few or no resources for the upkeep of orphans. This situation forces some family members to migrate in search of lucrative jobs, some take up sex work, which increase their risk of HIV infection. This leads to the breakdown of the cohesion of families and communities, thus, weakening the traditional restraints on commercial sex work (Godwin, 1997). Thus, in this era of

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HIV and AIDS, our society is confronted with a generation of children growing up without adequate adult role models, adult support and protection.

AIDS orphans who are malnourished, uneducated, marginalized and stigmatized represent a great threat to the country's security and stability as their very survival and meaningful future are threatened. As these orphans grow up in such harsh environments, our communities stand the chance of paying dearly through crime and lawlessness that would emerge as a consequence. While ensuring the safety, wellbeing, and development of these orphans is challenging, the risks of a generation without adequate family support, education and opportunities are too great to be ignored.

Some children and youth have no hope for a better tomorrow because of limited resources. Higher education has become unaffordable luxury for many of these young ones, and improvements in poverty and literacy levels made over the past generation is rapidly being eroded. Prevention of HIV transmission and effective treatment for HIV and AIDS can halt this downward spiral, but the impact of the current HIV epidemic will linger for decades because of its consequences on the present generation of children.

Even if HIV rates should be stabilized significantly in the near future, the number of orphans will continue to increase and remain high for decades. Table 1.1 although depicts that the total population of orphans as a percentage of all children in Ghana is declining (9.5% in 1990 to 8.2% in 2010), the percentages of orphans as a result of

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HIV and AIDS continues to increase (4.2% in 1990 to 35.8% in 2010), with absolute numbers of AIDS orphans as 27,000 in 1990 and 263,000 by 2010.

**Table 1.1: Orphan Estimates by Year and Category of Orphan – Ghana (1990 – 2010)**

| YEAR | 1990 | 1995 | 2001 | 2005 | 2010 |
|---|---|---|---|---|---|
| Number of Children 0 – 14 (1,000) | 6,863 | 7,555 | 7,985 | 8,399 | 8,952 |
| Total Number of Orphans (1,000) | 655 | 726 | 7,59 | 750 | 734 |
| Total Orphans as a percentage of all Children (%) | 9.5 | 9.6 | 9.5 | 8.9 | 8.2 |
| Total Number of Orphans due to AIDS (Absolute #) | 27,000 | 111,000 | 204,000 | 237,000 | 263,000 |
| *Orphans due to AIDS as a Percentage of Total Orphans (%)* | *4.2* | *15.3* | *26.9* | *31.5* | *35.8* |

**Source: Hunter and Williamson, 2002**

Internationally, Uganda is considered a leader in responding to HIV and AIDS and many countries are keen to learn from the approaches which are behind Uganda's success and where possible, replicate them. These approaches are cited as political commitment which provides grounds for community mobilization, harnessing of donor support and efforts of civil society and government, together with multi-sectoral approach. It is noted, however, that these same approaches have been applied by some other countries in Africa, but have not led to similar success as seen in Uganda. It is therefore believed that only country and context specific factors such as social

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patterns and cultural norms of people and communities could have played significant roles in Uganda's success ( Asiimwe, *et al*., 2003).

HIV transmission in Ghana is primarily through sexual contact. This, however, happens within a broader social and cultural context; therefore, HIV and AIDS cannot be separated from socio-economic development and culture. The issue of HIV and AIDS must thus be viewed within an intricate cycle of determinants and impacts. Studies on HIV and AIDS have concentrated mainly on behavioural aspects, transmission issues, AIDS progression rates as well as patient care (Serwada *et al*., 1992). Work on impact of AIDS is focused mostly on the economy, health systems and mortality (Gregson, *et al*., 1994). Available work on orphans has concentrated mostly on dimensions of the orphan plight and comparison of different forms of living situations in many locations across Africa such as physical health, schooling, bereavement process and psychological well-being (Zimmerman, 2005; Masmas *et al*., 2004; Monash, and Boerma, 2004; Makami, Ani, and Grantham-McGregor, 2002; Safman, 2004; Nyamukapa, and Gregson, 2005; Sarker, Neckermann, and Muller, 2005).

Although these are essential, the impacts of social and cultural factors on care of children orphaned by AIDS are equally important if meaningful interventions can be achieved. Nyambedha *et al*., (2003) hold the conviction that although community-based interventions are urgently needed as the most appropriate way of addressing the rising orphan problem, the complex local reality in which cultural factors, kinship ties and poverty are interwoven needs to be taken into consideration if sustainable solutions are to be found. Unfortunately, data of this nature are limited in Sub-Saharan

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Africa where problems of AIDS orphans are most prevalent. It is against this background that this study has been undertaken to contribute to the body of knowledge on orphan care.

## 1.4 AIM AND OBJECTIVES OF THE STUDY

### 1.4.1 Aim of Study

The main aim of the study was to determine the social and cultural practices among the Asante and Krobo that affect care of AIDS orphans in Ghana.

### 1.4.2 Specific Objectives

The specific objectives of the study were:

1. To establish the extent to which inheritance system, age of caregiver, and orphan status influence the care of children orphaned by AIDS.
2. To determine the social and cultural practices that impact on the care of Asante and Krobo orphans.
3. To determine how AIDS orphans perceive the care they receive, and
4. To determine the current level of orphan care.

## 1.5 RESEARCH QUESTIONS

Based on the objectives of the study, the following questions were addressed in the course of the research:

1. Is care of AIDS orphans influenced by system of inheritance, age of caregiver and orphan status?

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2. What are the socio-cultural determinants of AIDS Orphan care among the Asante and Krobo of Ghana?
3. How do AIDS Orphans perceive/rate the care they receive?

## 1.6 STUDY HYPOTHESES

The study was set out to test the following hypotheses:

1.0. $H_0$: Orphans under patrilineal system of inheritance are not better cared for than those under matrilineal system of inheritance

$H_1$: Orphans under patrilineal system of inheritance are better cared for than those under matrilineal system of inheritance.

2.1. $H_0$: Paternal orphans do not receive better care than maternal orphans

$H_1$: Paternal orphans receive better care than maternal orphans

2.2. $H_0$: Single orphans do not receive better care than double orphans

$H_1$: Single orphans receive better care than double orphans

3.0. $H_0$: Age of caregiver does not affect the care of orphans

$H_1$: Age of caregiver affects the care of orphans

## 1.7 CONCEPTUAL FRAMEWORK

In developing the conceptual framework for the study, ideas were borrowed from two theories; (1) The McCubbin and Patterson (1982) 'double ABCX' model and (2) The Bowlby (1969) Attachment Theory. The McCubbin and Patterson (1982) 'double ABCX' model was used to explain the possible stressful situation that caregivers and

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their families experience when they take on additional responsibilities of caring for orphans as a function of how well caregivers carry out care-giving responsibilities.

In the double ABCX model as applied to this study, 'A' is the precipitating stressful event or stressor which is the assumption of care-giving responsibilities by caregivers as a result of death of children's biological parents due to HIV and AIDS. 'B' is the complex of internal and external resources available to the family or caregiver. These resources are financial or economic as well as social support within and outside the family.

The 'C' in the model refers to how the caregiver perceives or appraises his or her care-giving role, this determines the impact of additional responsibility as an orphan caregiver and; 'X' is the outcome from the stressful event taking into account the ABC. That is, the sense of strain or stress felt by the caregiver stemming from orphan care. This is the predictor as to whether the caregiver would adequately cater for the needs of the orphan or not, depending on the double factor which is how the caregiver copes with his or her new role as an orphan caregiver with the resources available to him or her.

The 'double ABCX' model suggests that caregiver appraisals of their new care-giving roles occur on two fronts. First, how the new responsibilities are manageable or upsetting to the caregiver, and second, the caregiver's perceived acceptability of the alterations that occur in his or her life when new care-giving roles are taken up. The outcome of which is influenced by the resources available to the caregiver, and the presence or absence of effective coping strategies.

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The Attachment Theory (Bowlby, 1969/1982) was also used to explain how disruptions in relationships and attachment formation on the part of the orphan can influence the care that the orphan receives from his or her caregiver and vice versa. According to the theory, a child's maintenance of proximity and availability of attachment figures from infancy through the first early years of life is crucial to the child's normal social and emotional development. During these early years of life, the child develops an internal working model on life expectations and how relationships with significant others should proceed. Thus disruptions in relationships occur when the dominant attachment figure, usually the parent (mother) is not accessible or when there is discontinuity of care (Bowlby, 1973).

AIDS orphaned children who have lost one or both parents usually experience social, psychological and economic disruptions which can lead to maladjustment, and altered or revised relationships between these orphans and their caregivers (Poehlmann, 2003). A child's potential to develop secure attachment with non-biological parents decreases as the child grows (Bowlby, 1969/1982; Stovall & Dozier, 1998), but this would be dependent on whether or not attachments were secured with biological parents prior to parental death. Orphan-caregiver relationship which may be determined by the level of attachment between the orphan and caregiver may be deemed necessary to determine the level of responsiveness of caregiver to the needs of orphan, amidst the resources available to the caregiver, as well as the orphan's compliance.

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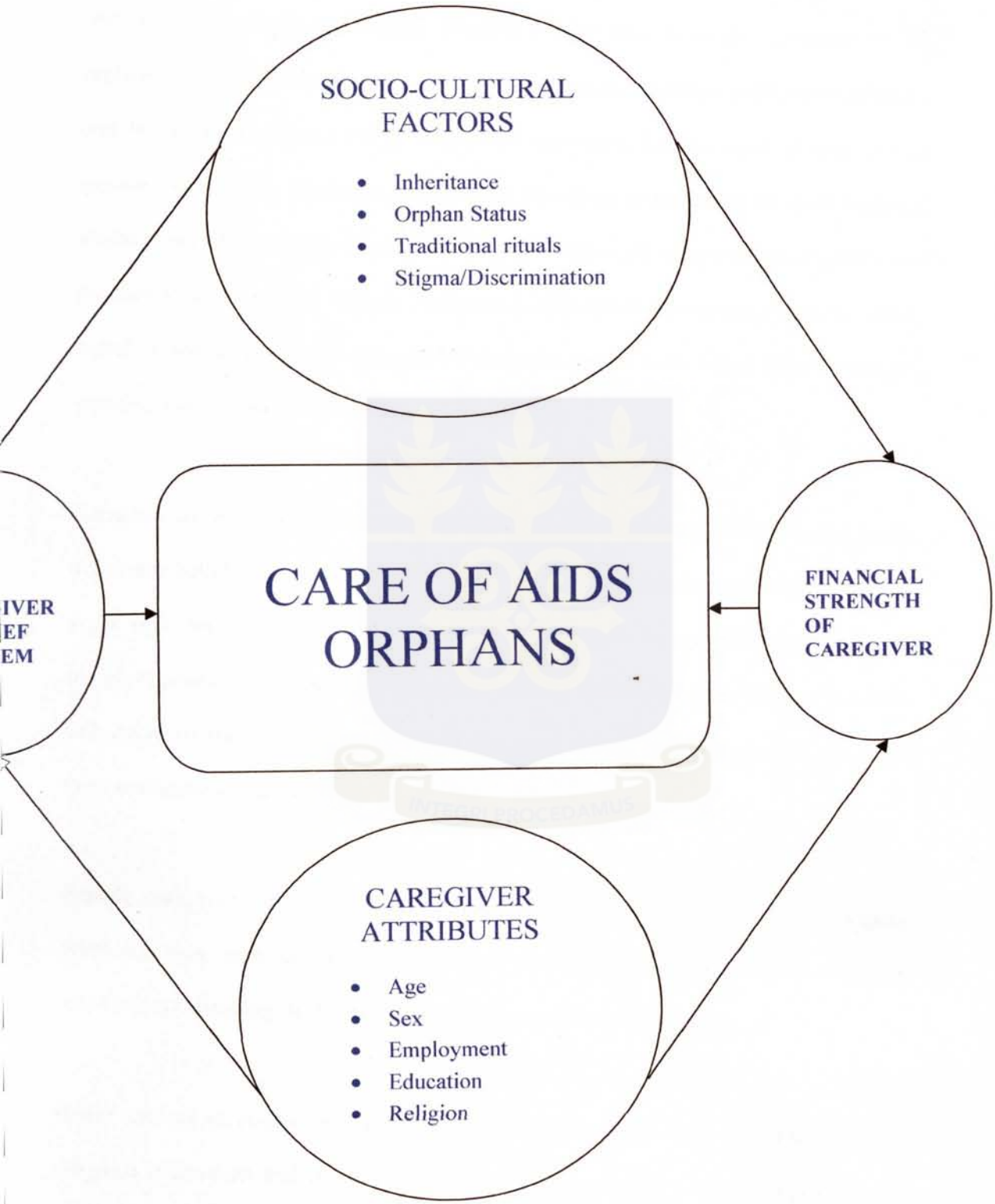
**Figure1.1** **Conceptual Framework of Factors Influencing Orphan Care**



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Orphan care is measured in this instance by the ability of the caregiver to consciously and willingly provide and satisfy Maslow's first three hierarchy of needs of the orphan. These are: basic physiological needs, safety and security, and love or affection and belonging (Maslow, 1970), which are necessary for the survival and normal growth of the child. These are measured in this study as provision of food, clothing, shelter, education, health (health seeking behaviour of caregiver for orphan) and psychosocial state of the orphan. Such care is dependent on two main factors namely belief system and financial strength of caregiver (figure 1.1). When these factors are positive, care is delivered in a satisfactory manner.

Caregiver attributes which have broadly been classified as biological and social, partly determine belief system and financial strength. For example, persons younger than 65 years and older than 18 years (age) are more likely to be gainfully employed and therefore possess the financial wherewithal to offer satisfactory care but this would be influenced by their belief systems regarding such endeavour which would determine their willingness to do so.

Female caregivers are more likely to receive assistance from family and society relative to their male counterparts in respect of caring for orphans. Social activities like funerals, drinking, festivals, etc, also influence financial strength.

Belief system in respect of orphan care is influenced by level of education and religious inclination and its intensity. This would be further impacted upon by the paradigm to HIV and AIDS causation and death as to whether it is a curse or it is

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related to sexual promiscuity. Attribution to curse which may be passed on to offspring may have a negative impact on the care of AIDS orphans in the form of stigma and discrimination against them from the society. Religion may espouse benevolence and promotion of care of orphans as a vulnerable group and may have a positive impact on the care of AIDS orphans. Siblings and relatives of a deceased male person would be more willing to offer assistance to the deceased's children if they ascribe to a patrilineal system of inheritance because the children are viewed as belonging to them as opposed to a matrilineal system where the orphans would be perceived as belonging to their mother and vice versa. This is related to orphan type which may be maternal, paternal, or double. Household size is related to care through its ratio to the amount of money available (financial strength), orphans may represent additional burden.

## 1.8 RELEVANCE OF STUDY

HIV and AIDS is a global problem with adverse implications directly or indirectly on many aspects of the lives of people. AIDS has struck Africa the hardest, especially Sub-Saharan Africa, and this has led to the obvious situation of the region having the highest numbers of children orphaned by AIDS and all its associated problems. Although the orphan situation in Ghana is not as serious as it is in other parts of the continent (Eastern and Southern Africa), it still demands that as much attention as possible is given to the current situation of orphans in the country so as to ensure that it does not reach a crisis state.

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This research, therefore, was aimed at providing an in-depth view of the situation of the AIDS orphan, taking into account, the social and cultural peculiarities of the Asante and the Krobo, and for that matter, Ghanaians. It utilized ethnographic methods to capture and present findings from the study groups' own perspectives, and in the light of their own social and cultural characteristics. It is hoped that findings from this study would:

i. Contribute to the body of knowledge on care of orphans in Ghana
ii. Provide baseline information on socio-cultural determinants of care of AIDS orphaned children
iii. Provide scientific basis for policy change on orphan care where necessary
iv. Suggest new areas of interventions
v. Input into health and education planning for children
vi. Potentially improve the quality of care of AIDS orphans
vii. Inform future research on priority issues

## 1.9 PUBLIC HEALTH IMPLICATIONS OF STUDY

What is done about a problem largely depends on the way the problem is understood. It is, therefore, hoped that the information generated from this study would have many implications for public health interventions regarding orphans. Knowing and understanding the socio-cultural determinants of care of orphans and their health implications on orphans would assist public health officials to amend health-related policies on orphans, plan, implement, and provide health services that would be accessible, effective and efficient to orphans and their communities. Public health

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workers can make informed decisions that would lead to improved health of the orphan population in the country.

Findings suggesting associations between certain cultural practices and certain health conditions of orphans would help orphans in making choices that would affect their own health throughout their entire lives.

## 1.10 DEFINITION OF TERMS

### 1.10.1 Who is an Orphan?

In most international and national instruments, children are defined as boys or girls up to the age of 18 years (UN Convention on the Rights of the Child). The age of 18 years is the universally accepted age of legal adulthood although there are legal exceptions in individual countries regarding the age at which a person may be married, make a will, or consent to medical treatment. In Ghana this is 18 years, but in Ethiopia for example, a child may make a will alone when he attains the age of 15 years and in South Africa, a minor may consent to medical treatment, such as an HIV test without parental consent from the age of 14 years.

The definition of an orphan stems from two main variables, age and parental loss, i.e. loss of mother, father or both parents; thus, an orphan is a child who has lost one or both parents. Different categorization of orphans is used by different authors, organizations, and sources. Barnet and Blaikie (1992), placed orphans under two main categories as:

1. Single orphans with one parent dead and

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2. Double orphans with both parents dead

Single orphans are sub-divided into maternal orphans (children who have lost only their mothers) and paternal orphans (children who have lost only their fathers). Hunter and Williamson, however, classify maternal orphans as children under 15 years whose mothers and perhaps fathers are dead (includes double orphans) and paternal orphans as children under age 15 years whose fathers and perhaps their mothers are dead (includes double orphans). Table 1.2 shows the AIDS orphan projection and estimates for Ghana by orphan type from 1990 to 2010.

**Table 1.2: Estimates of AIDS Orphans by type: Ghana 1990 - 2010**

| YEAR | Orphans due to Maternal AIDS | Orphans due to Paternal AIDS | Double Orphans due to AIDS |
|---|---|---|---|
| **1990** | 7,000 | 24,000 | 5,000 |
| **1995** | 45,000 | 82,000 | 21,000 |
| **2001** | 99,000 | 135,000 | 38,000 |
| **2005** | 117,000 | 151,000 | 40,000 |
| **2010** | 129,000 | 164,000 | 38,000 |

**Source: Hunter and Williamson, 2002.**

UNAIDS defines AIDS orphans as children below age 15 years who have lost their mothers (maternal orphans) or both parents (double orphans) to AIDS (UNAIDS, 2003). This definition is used by many writers as well as many Sub-Saharan African states including Ghana This definition is used by the NACP in collecting data on

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orphans, making projections, as well as making recommendations and provisions for AIDS orphans. The appropriateness and relevance of this definition have, however, been questioned because it is argued that it underestimates the extent of the phenomenon by excluding paternal orphans and orphans between the ages of 15 and 17 years.

In most African communities, many individuals are not considered adults until they are age 18 years and above, are married, or are able to provide for themselves and leave their parents' homes. Thus, AIDS orphans who are above age 15 years but younger than 18 years who are regarded as children in their societies are not recognized as such using the UNAIDS category of AIDS orphans.

The UNAIDS definition is skewed towards the female gender with respect to childcare responsibility, thus supporting the culturally-defined gender roles in most African communities where the mother is perceived as the one with the sole responsibility to care, love, and nurture her children. This places less importance on the role of fathers in the upbringing of their own children, and housework. In most African societies the man is regarded as the sole breadwinner of the household. Where this is the case however, the loss of fathers to HIV and AIDS would worsen the situation of the children more than the death of their mothers. This point is reiterated by UNAIDS in 2001 (World AIDS Campaign, 2001:2) when it stated: "When the man – the perceived income earner – is HIV infected, a higher percentage of the family's budget is spent on his health than other members of the family who may be infected. Often, by the time of his death, the family's savings have been spent, leaving the wife

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and the children without money and without source of income". Obviously, children in such households may suffer the effects of orphanhood more than those who have lost only their mothers and it would be highly inaccurate to exclude such children from the AIDS orphan category.

On the other hand, Yamba (2003) in his analysis of the UNAIDS definition of an orphan argued that the logic in this categorization of the orphan lies in the fact that problems of orphaned children seem much more acute with the loss of the mother, and it may not only be trivial to point out that while the mother is always determinable, we can never be absolutely certain as to who the genitor of the child is. He concluded that although some empirical evidence have cited instances where the death of the man of the house has had impact on children, "fatherhood is a social role, something that might be easily provided by any close relative of the mother", suggesting that the AIDS death of a child's genitor may not have an overwhelming effect on the child as that of the mother. But where the genitor of the child is the main income earner of the household, his death would have even more devastating effects on the child than the death of his mother. Thus, the UNAIDS definition of the orphan needs to be re-examined to include paternal loss.

USAID, however, defines children orphaned by AIDS as those who have lost their mothers, fathers or both parents as a result of death from AIDS (GAC, UNDP, 2003), and defines a child as a person below the age of 18 years (UN Convention on the Rights of the Child, 1999 Constitution, Children's Act 560, Ghana, 1998).

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The disparity in categorizations of AIDS orphans yields differences in estimation of figures on AIDS orphans. Table 1.3 depicts these differences clearly.

**Table 1.3: UNAIDS and USAID Orphan Estimates for Ghana, 2000 - 2014**

| Definition | 2000 | 2005 | 2010 | 2014 |
|---|---|---|---|---|
| **UNAIDS** | 170,000 | 210,000 | 280,000 | 387,000 |
| **USAID** | 270,000 | 303,467 | 334,888 | -- |

**Source: Ghana National AIDS Control Programme, Annual Report - 2001**

Children on the Brink (2004) which is a joint report by USAID, UNAIDS, and UNICEF on Orphan Estimates and Framework for Action, contains the most current and comprehensive statistics on AIDS orphaned children. It provides data for children below 18 years unlike the previous editions that provided data on children below 15 years. This change brings the statistics on orphans in line with the international definition of childhood. It also recognizes that Orphans and Vulnerable Children are not necessarily young children and that problems caused by orphaning extend well beyond age 15 years, and in actual fact, available data suggest that adolescents make up the majority of orphans in all countries. This situation might be due to the fact that young children who might be born with HIV or acquire it during the early days of their lives mostly through breastfeeding die before they reach adolescence.

For the purpose of this study however, and in keeping with the Convention on the Rights of the Child (GNCC, 2000; Children's Act 560, Ghana, 1998), the following orphan definitions have been used:

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- An AIDS orphan is a person under 18 years of age who has lost at least one parent to AIDS.
- A maternal orphan is a person under 18 years of age who has lost only her mother to AIDS.
- A paternal orphan is a person under 18 years of age who has lost only her father to AIDS
- A double orphan is a person under 18 years of age who has lost both parents to AIDS.
- The terms orphans, orphans due to AIDS, AIDS orphans, and children orphaned by AIDS would be used interchangeably in this study, unless otherwise indicated

### 1.10.2 Defining Culture

Culture is a fluid concept, and numerous definitions of it have been attempted by many scholars. However, few of these definitions if any have gained universal acceptance or have escaped damaging criticism, not because the various definitions are wrong, but the problem lies in the polysemous nature of the concept (Awedoba, 2005).

The World Conference on Cultural Policies (MONDIACULT, 1998) defines culture as "that whole complex of distinctive spiritual, material, intellectual and emotional features that characterize a society or social groups. It includes not only arts and letters, but also modes of life, the fundamental rights of the human being, value

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systems, traditions and beliefs." It is important to state here that UNESCO takes the position that: each culture has its dignity and value, which must be respected and valued; and the diversity of national cultures, their uniqueness and originality are essential basis for human progress and development of world cultures.

Many definitions of culture allocate primary importance to ideology as is reflected in the emphasis on norms and values. One of such definitions is that proposed by Ember and Ember (1981), who describe culture as 'a set of learned beliefs, values, and behaviours generally shared by the members of a society or population'. They go on to list the components of culture as comprising language, general knowledge, laws, religious beliefs, food preferences, music, work habits, taboos, etc.

In more simplified terms culture can be defined as "the totality of a people's way of life". An elaboration of this concept of culture is the definition advanced by E.B. Tylor (1924). He defined Culture as: "that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society". Awedoba (2005) points out that describing culture as a 'whole' might seem perplexing to some people, since culture is also an abstraction. The remark by Fieldhouse (1986), that the term culture is a convenient shorthand for an ill-defined entity which might be described as a way of life is reiterated by the fact that Tylor begins his definition by enumerating what comes under culture, and then realizes that the list might not be conclusive, thus he rounds up the definition with the phrase 'and any other capabilities acquired by man as a member of society'.

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This study therefore recognized the fluid nature of culture, and the fact that the list of attributes of culture is unending, and identified, recognized, and analyzed appropriately, any cultural feature that has some influence on care of AIDS orphans at the community level.

### 1.10.3 Defining Care

To define care, one can begin by looking at two basic features of the phenomenon (noun and verb). First, as a noun, care is a culturally objectified notion and is related to local morality about proper allocation of resources including emotions, material support and knowledge (Christiansen, 2003).

As a verb, 'to care' is an interpersonal phenomenon, a fundamental component in the relationship between at least two human beings where one is paying attention to the other and is behaving towards the needs and well-being of that person.

These two features of care, according to Christiansen (2003) are so intertwined that separating them would be an exercise for analytical purposes. Thus, in order to understand the concerns about the changing patterns of care for orphans in this era of HIV and AIDS, these two aspects of care must both be taken into consideration.

Care being a social phenomenon involves many aspects of life. According to Weisner (1997), care taking of children has certain universal features such as affection, physical comfort, assistance, share solving of problems, provision of food and other resources, protection against harm and coherent moral understanding of appropriate

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ways to provide this support. It is therefore possible to recognize certain features of childcare around the globe. However, this ramification of showing emotions, allocating material resources, taking action (for example when a child is ill) and passing on values is expressed differently in different cultures.

Perceptions of care also differ between and within localities, because such notions are related to ideas about gender and intergenerational relations, practices of marriage, priorities of schooling, or farming, and to the social, economic and demographic circumstances. Thus notions about childcare are deeply embedded within the local context and relate amongst others to children's general position in society, and to the caregivers' ideas about the children's future as adolescents and adults (Swadener, 2000; Weisner, 1997; Kilbride & Kilbride, 1990; Goody, 1982). The study therefore viewed care as a dimension of cultural ideas as well as part of social relationship where the reciprocity of the actual relationship between the caregiver and the orphan is recognized in addition to the provision of basic and physical needs.

### 1.10.4 Components of Care

In the study, care of orphans (the dependent variable) was assessed by observing the following as the components of care:

1. Feeding practices of caregivers: example, number of times orphan is given food to eat in a day.
2. Health seeking behaviours of caregivers when orphan is ill.

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3. Schooling/Education of orphan (Absenteeism from school; school drop-outs; ownership of school uniforms; shoes; bags; books; and other school requirements)
4. Provision of clothing: (number of clothes – (more than one piece of clothing apart from school uniform – a pair of shorts/trousers and a shirt/t-shirt for boys and a frock/skirt and blouse/t-shirt for girls; other footwear apart from school scandals)
5. Provision of adequate shelter: (sleeping place – number of persons living/sleeping in the same room rooms, veranda, kitchen, etc.; mattresses, mats, floor)
6. Emotional/psychological care (counselling)
7. Love and affection (closeness to caregiver, reciprocal love for caregiver)

### 1.10.5 Proxy for Care of Orphan

It is a well-known fact that a child is well cared for when the child is well fed, promptly treated when ill, and is free of much physical and psychological stress, such a child would not be stunted, and vice versa. Research has further proven that vulnerable children are better able to cope with their problems when their caregiver is healthy and capable of providing love and cognitive stimulation (Richter, Foster and sherr, 2006). It has also been shown by research that when the caregiver of a child is related biologically to the child, the child's nutritional status, health and educational status fare better. Hence the nutritional status of orphans (stunting – height-for-Age Ratio) which is an outcome of care was used as the proxy for care of orphans in

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testing the hypotheses of the study. Thus, care of orphans and nutritional status of orphans have been used interchangeably throughout the study.

## 1.11 ORGANIZATION OF THE THESIS

Chapter one gives an introduction to the study by providing background information on HIV/AIDS and the orphan crises globally; and narrowing it down to Ghana. The chapter also defines the research problem; states the research objectives; research questions; conceptual framework of the study; hypotheses; and outline of the thesis write-up.

Chapter two presents the review of relevant documentation and available literature on AIDS orphans and their care.

Chapter three presents excerpts of the culture of the Asante and Krobo. The chapter describes Ghana country profile, gives brief demographic characteristics of the study districts, and discusses the historical backgrounds of the Asante and Krobo, their traditional systems of inheritance, kinship, and certain social and cultural practices such as initiation rites, marriage, domestic organization, traditional provisions for orphans, and other values and norms that are pertinent to these two groups of people.

Chapter four presents the detailed research design and methods used for the study and how data were analysed beginning with the description of the study area. The chapter ends with the assumptions underlying the study and study limitations.

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Chapter five looks at the emerging issues from the study, analyses and presents the results of the study in line with the set objectives and hypotheses.

Chapter six discusses the main study findings, paying particular attention to the findings related to the study hypotheses and other important socio-cultural determinants of orphan care among the study groups.

Chapter seven concludes the thesis with conclusions drawn from the study, recommendations for orphan care interventions and recommendations for future research on orphans in the country.

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# CHAPTER 2

# LITERATURE REVIEW

## 2.1 PREVENTION OF HIV INFECTION AND BEHAVIOUR CHANGE

With no known cure for HIV/AIDS, the only response to the epidemic and its impacts is prevention, primarily through behavioural change in all aspects of the disease. In the area of HIV/AIDS prevention and behavioural change among the youth, a study commissioned by UNDP and Ministry of Finance and Economic Planning in Uganda in 2002 on social and cultural factors impacting on HIV/AIDS indicated that social and cultural factors have significant impact on HIV/AIDS-related behaviour (Asiimwe, *et al*., 2002). Among the social and cultural factors reported in this study to impact on HIV/AIDS-related behaviour among the youth are traditional dances, film shows, religious gatherings, games and sports, wedding parties, discos, alcoholism, early marriages, twin ceremonies, widow inheritance, appeasement of spirit, traditional rituals, cleansing ceremonies and funeral rites. It is interesting to note that the study reported that some of the social and cultural practices reported to be enhancing HIV transmission were at the same time contributing to reduction of the risk of HIV transmission, in that marriage ceremonies, religious gatherings and funerals were reported to be major avenues for intensive HIV/AIDS education. Cultural norms such as virginity until marriage, culturally arranged marriages and the paternal aunt institution promote abstinence and mutual faithfulness among the youth, thus reducing their vulnerability to HIV infection.

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In Mozambique, a study initiated by UNESCO in 2002 listed the socio-cultural issues contributing to the spread of HIV/AIDS among young people to include polygamous marriages, traditional medicine, witchcraft, taboos substitution of wives, commercial sex work, divorce, multiple sex partners, migration, unemployment, sex with teachers, drugs, among others and suggested that a socio-cultural approach to stem the increase of the HIV epidemic should critically analyze these issues (Bukali de Graca, 2002).

## 2.2 VULNERABILITY OF ORPHANS

Literature on OVC care in Ghana is limited. Available reports on OVC in the country commissioned by the Ghana AIDS Commission, UNDP and other stakeholders touched on the situation of OVC in the country towards the formulation of the National Policy on OVC. The Ministry of Employment and Social Welfare (MESW) in collaboration with UNICEF Ghana have also documented the situation of OVC in Ghana in drawing up a National Plan of Action for OVC for the period June 2010 to June 2012. Other Ghanaian writers have studied the factors that contribute to vulnerability of children in the country but have not looked critically at the impact of socio-cultural factors on the care of OVC. However, extensive research discussing the plight of the orphan and comparing different forms of orphan living situations in other locations in Sub-Saharan Africa exists.

With regards to factors that contribute to vulnerability and spread of HIV in Ghana, Anarfi recorded in 2000 that rural-urban migration contributes to the risk of spread of HIV in Ghana. He noted that the anonymity of urban life coupled with reduced parental supervision often result in promiscuous behaviour among the youth. In

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another study by Anarfi and Pappoe (1999), they found out that one of the contributory factors to the high level of HIV in the Krobo area in the Eastern Region of Ghana is the history of out-migration to Cote D' Ivoire as a result of poverty, lack of arable land and unemployment in the area. According to them, two thirds of the Ghanaian migrants in Abidjan are females of whom a large proportion are commercial sex workers since that is the easiest identifiable occupation for them especially because of language barrier.

Hampton (1991), observed in Agomanya – a town in the Eastern Region of Ghana that HIV-related OVC in the area have low nutritional status, they receive less attention and are less likely to be immunized. These factors increase their vulnerability to diseases as well as their exposure to opportunistic infections.

Dzokoto *et al.* (2002), identified child labour as contributing to vulnerability of children to HIV infection in the country. According to them, children working in the hospitality industry are often lured by men they serve into unsafe sexual practices that often result in the girls resorting to commercial sex work. The general opinion gathered from focus group discussions with children on child labour however was that they perform economic activities to earn money to supplement family incomes as well as take care of their own basic needs (GNCC, 2000).

## 2.3 GENERAL SITUATION OF ORPHANS

Available literature on children that have been orphaned by AIDS suggest that orphans are generally disadvantaged than their non-orphan counterparts, and in Sub-

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Saharan Africa where the numbers of orphans have increased greatly, studies have shown that orphans are most frequently cared for by members of the extended family. But orphans usually find themselves in households that are ridden with financial hardships, and have less favourable dependency ratios (Nyambedha, Wandiba, and Aagaard-Hansen, 2003a; Nyambedha, Wandiba, and Aagaard-Hansen, 2003b; Monash, and Boerma, 2004; Safman, 2004; Oleke, Blystand, and Rekdal, 2005).

Thus, orphans have lower school completion rates, and are less likely to be at the age appropriate class than non-orphans (Bicego, Rustein, and Johnson, 2003; Nyamukapa, and Gregson, 2005; Makame, *et al.* 2002; Nyambedha, Wandiba, and Aagaard-Hansen, 2003b; Monash, and Boerma, 2004). Mixed reports also suggest differences in health care access and physical health among orphans and non-orphans (Lindblade, Rosen, Odiambo, and DeCock, 2003; Wandiba, and Aagaard-Hansen, 2003a; Sarker, Neckermann, and Muller, 2005; Masmas, *et al.*, 2004; Crampin, *et al.*, 2003). In addition to the numerous physical problems that confront orphans, are psychological problems (Atwine, Cantor-Graae, and Bajunirwe, 2005; Cluver, and Gardner, 2006; Makame, *et al.* 2002; Pelton, and Forehand, 2005), some of which manifest at clinical levels even before maternal death (Pelton, and Forehand, 2005)

## 2.4 CARE OF ORPHANS BY EXTENDED FAMILY

In 1997, the issue of orphan care was addressed by Foster, touching on the changing definition of orphans in the face of the AIDS epidemic, and stressed on some additional needs of children orphaned by AIDS, specifically stigma. In his study, Foster found that AIDS orphans were just as sociable as their non-orphaned

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counterparts, and that the mechanisms already in place through kinship ties were sufficient for caring for the growing numbers of orphans (Foster, 1997).

Other researchers realized later that the traditional system of kinship ties were not going to accommodate the growing orphan population indefinitely. One researcher noted that "Due to the depletion of family resources in an attempt to prolong the life of the affected parents or family members and loss of productive time due to prolonged illness and death of breadwinners, families are increasingly unable to care for Orphans and Vulnerable Children. In developing countries, high levels of poverty and inadequate public government services aggravate the situation" (Kinder Not Hilfe, 2004, p.7). Agyeman observed in 1993 that in the past, the extended families of Africa absorbed orphans without any problem. However, because of the increasing numbers of orphans due to AIDS, and lack of external support from government, NGOs and others, the extended family can no longer cope with the problem (Ntozi and Mukiza-Gapere, 1995), thus, increasing numbers of orphans are slipping through the extended family safety net, leading to child headed households, street children and child labour. These children have increased risk of physical, social, economic and psychological morbidity and vulnerability to HIV infection (Foster, 2000).

Studying the situation of orphans within the extended family system in Northern Uganda over a period of thirty years, Oleke *et al.*, (2005) realized that 63% of the households caring for orphans were no longer headed by resourceful paternal kin in a manner deemed culturally appropriate by the patrilineal Langi Society, but rather by marginalized widows, grandmothers or other single women receiving little support

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from the paternal kin. This situation was linked partly to the abrupt discontinuation of the Langi widow inheritance practice. Hunter (1990) also found that in the Rakai District of Uganda that 23% of the children in the district did not have both parents alive and she predicted that the usual coping mechanism of the extended family would not be adequate to handle the orphan problem there. Another study by Barnett and Blaikie (1992) in the same district stressed that despite the existence of the extended family system in the area, some of the orphans were found to be stunted and malnourished because they could not cope with orphanhood. They then concluded that most orphans were deprived of education, parental care, shelter, nutrition, clothing and the legal protection of their parents' property.

A study by Runanga and Aggleton (1998) in Zimbabwe confirmed that the traditional family base was fast disintegrating resulting in erosion of family and social values. Chigwedere (1996) in his book entitled the "the Abandoned Adolescent" cited some of the major African traditional values as respect for: elders; the omnipotent spirit who is God; family, village and tribal unit; norms of society and human life; authority and people's property; politeness, obedience and industry; economic sufficiency; marriage and success in marriage; moral probity, physical fitness and cleanliness; and a perpetual life through children. These values according to Maraike (1997) are best nurtured and cultured by the family. These good values, which despite the disintegration of the family mentioned by Runanga and Aggleton in 1998 could still be revisited and incorporated into HIV and AIDS prevention among the youth for effectiveness.

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Other researchers have claimed that although the traditional extended family system finds it difficult to cope with the increasing numbers of orphans, the system in itself is not breaking down, its effectiveness in caring for orphans depends on the wider society (Lund and Agyei-Mensah, 2008) [see also Abebe and Aase, 2007]. Wiseman, (2002) also documented that new approaches to orphan care in Malawi indicate that the argument put forward by development practitioners that society is totally breaking down due to the impacts of HIV and AIDS is exaggerated. Evidence from his studies suggests that despite the social strains caused by the effects of HIV/AIDS, families and social support systems are developing adaptive capabilities with varying degrees of success and failure, and that new strategies are being adopted while others are abandoned.

## 2.5 FOSTERING

In Ghana, fostering is mostly seen as a way of lightening the burden of poor parents who cannot cope with the economic responsibility of child care. However, Ardayfio-Schandorf (1995) pointed out that fostering could also be a useful system of assisting families who find themselves in crises such illness and poverty, death, and divorce that distort the normal peaceful environment in the nuclear family, but noted that fostering has become more prevalent among low-income families in Ghana. Huber (1963) indicated that among the Krobo of Ghana, fostering is an ancient practice where a child is given out temporarily to a relative or a friend as a "messenger", so that the child would receive good training or correction of bad character. The Krobo foster parent is expected to be a wise and experienced male who would give the same care and education to the foster child as his own children.

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Evidence from AIDS research in the last one and a half decades has strengthened the view that the health state of any group of people is related to its living conditions, the socio-cultural context in which people are socialized and operate, and the respect for basic human rights (Mann, 1992), and in most part of the world, the vulnerable in society are the hardest hit by the AIDS epidemic (Mann *et al.*, 1994). Among the systems of care available to orphans is fostering. Gaber and Dean, (1955) have reported that where younger children are fostered, they react by appetite loss leading to Kwashiorkor. Bledsoe, Ewbank, and Isiugo-Abanihe (1998) found evidence in Sierra-Leone that, among the Mende, fostered children were apt to be nutritionally disadvantaged and had reduced access to modern medicine when they were ill; consequently, their mortality was higher than average.

According to Ntozi and Mukiza-Gapere (1995), the death of both parents within a short time span worsened the situation of orphans in Uganda. They also reported that the social stigma on healthy widows and widowers ended the practices of widow inheritance and the marriage of widowers to sisters-in-law which used to ensure the efficient orphan care. Muller and Abass (1990) found out that 47% of the households in Kampala supporting orphans did not have enough money to send their own children to school, compared to only 10% of the households without orphans. It is therefore logical to expect that at the same time a much higher percentage of orphans was not going to school since they take second place to the parents' own children in priority for education.

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## 2.6 CAREGIVER AGE AND ORPHAN CARE

Researchers claim that grandmothers can provide orphans with continuity, a secure environment and emotional support. Additionally, their funding does not depend on external sources (Gilborne, *et al.*, 2001; Nyamdebha, *et al.*, 2001; Caldwell, *et al.*, 1993; Anarfi *et al.* 1994).

Hunter (1990) found out that 43% of the guardians of orphans in Rakai district of Uganda were over 50 years of age and 31% of orphans were being taken care of by their grandparents, and because the grandparents may be too weak to create the necessary resources needed to cater for the orphans' requirements, these children receive little material assistance which puts their future welfare in doubt. It was also recorded in Zimbabwe in 1999 that over 50%f of the orphaned youth lived with their grandparents compared to 15% of non-orphans (Bicego, *et al*). This situation has been described by the authors as problematic as they state: "Grandparents find it difficult to provide care, and they themselves frequently need care".

Furthermore, grandparents may not be conversant with modern ways of meeting the health and development needs of children (Kindernothilfe, 2004, p. 8. The work of Atobrah (2005) in the Manya Krobo District of Ghana also revealed that the role of grandmothers in the care of AIDS orphans has been overstretched as they cannot adequately ensure that the orphans in their care get the basic necessities of life like food, clothing, and shelter. Ochola-Ayayo, (2000) attributed the situation where most AIDS orphans are left in the care of their aged, weak, and tired grandparents to the causes current socio-cultural changes such as migration, urbanization, modernity, and

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monetization of economies which have dwindled family care for one another especially the aged and needy children.

A study in Malawi however found that despite the compromised ability of grandparents to care for their grandchildren, orphans frequently ask to be placed in their care after the death of their parents, which indicates that orphans prioritize love and respect for the diseased parents over material situation (Mann, 2002).

Barnett and Blaikie (1992) found out that in the homes of their diseased parents, orphans aged below 18 years were looking after their younger siblings and the reasons for this were that the orphans were afraid that: if they left their parents' homes, their land could be seized by greedy landlords, neighbours or relatives; secondly, because of the rampant internal migration in many parts of the country (Uganda), close relatives are often too far away to help take care of the orphans; thirdly, the wills of some parents insist that their children live in their ancestral homes. According to two researches conducted in Zimbabwe in 1995 and 1996, child-headed households, or those households run by individuals aged 15 years or younger are increasing and that the increasing number of orphans acting as the sole caregiver for younger siblings is an indicator that the traditional family system for orphan care is under stress (Foster, *et al.*, 1995; Foster, *et al.*, 1996).

## 2.7 ORPHAN MOBILITY

Ntozi and Mukiza-Gapere in their study in 1995 found a large number of orphans on the streets. Some had ran away from their relatives' homes, some were forced by

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economic conditions to leave and fend for themselves, and others had been thrown out by their parent's landlords or unscrupulous successors to dead parents.

A study in Blantyre, Malawi found out that, 22 of the 65 orphans they interviewed had experienced multiple migration, some as many as five. The reasons for these migrations are diverse, including sickness, remarriage, unemployment, death of a guardian, the chance to attend school, and circumstances in other households that require their help (Ansell, and Young, 2004). The researchers again reported that most street children in Blantyre said they left their homes because they "were made to work harder than they considered reasonable, or to engage in work during school hours that deprived them of their education" (Ansell, and Young, 2004, P. 6)

When orphans do not find care within their immediate families or communities they leave their communities and try to make a living elsewhere either by begging in the streets or by engaging in sex trade (Salaam, 2004). In his study Salaam noted that between 2002 and 2004, Blantyre, Malawi, witnessed a 150% increase in the number of street children and documented that Human Rights Watch in several parts of Africa has recorded children as young as nine years engaging in sex trade (Salaam, 2004).

Some changes in the living conditions of orphans that cause orphans to leave their household have been found to be the result of neglect. Mann found in 2002 in Malawi that orphans face abuse and discrimination in some homes, and some caregivers justify their actions by claiming that "orphaned children should appreciate the financial challenges by their arrival in the household and should fell grateful for this

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act of generosity" (Mann, 2002, p.6). A study in the Democratic Republic of the Congo in 1994 found that while the average number of children in the households without orphans was 3.5, the average number of children in foster homes was 4.7. In addition, the employment rate of the adults was 100% in the households without orphans and 54% among the foster homes (Ryder, 1994). In a study in Zimbabwe in 1999, it was also found that 35.5% of orphans live in households headed by an individual with no education, whereas 14% of non-orphans live with caregivers who have little to formal education. Orphans are also more likely to live in poverty-stricken households: 50.2% of orphans and 44.3% of non-orphans live in poverty (Bicego, *et al.*, 2003).

Succession planning is the idea of allowing parents who are ill to discuss and plan for their children's care after their death, however, the issue of succession planning and its cultural appropriateness has been masked. A study in Zimbabwe revealed that it was not culturally appropriate to discuss imminent death, and that in 8% of cases, children were not told of their parents' death (Foster *et al.*, 1995). In any case, the cost of treating an AIDS patient has also been documented to be a problem (Berkley, 1992), thus, some sick parents have sold their properties such as land and livestock to pay for treatment such that by the time of death, even the rich patients have spent a lot of their riches on treatment and very little or none is left to care for the orphans left behind.

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## 2.8 CARE OF PATERNAL ORPHANS VERSUS CARE OF MATERNAL ORPHANS

In most African cultures, patriarchal thinking gives men a lot of power in sexual relationships (Adomako Ampofo, 1998b, Dodoo and Adomako Ampofo, 2001), and the number of children to be born to a family. It is thus reasonable to expect that the appropriate mechanisms for orphan care in Africa should be based predominantly on patrilineal kinship ties, however, the situation is different in some Ghanaian cultures, and even in other African traditional cultures where the traditional mechanisms for orphan care are solely based on patrilineal kinship ties, the high numbers of orphans due to HIV and AIDS has overwhelmed the system to the extent that other categories such as matrilineal kin and strangers have taken on the role of orphan care (Nyambedha, Wandibba, and Aagaard-Hansen, 2003)

Some studies have unveiled a difference in issues confronting orphans depending on which parent had died, and if both parents had, on which other family members were alive. A study conducted in Kenya claimed that maternal orphans were considered more vulnerable than paternal ones because in the Kenyan culture, when the mother died, the father was likely to remarry, which would worsen the situation of the orphans, because the woman would favour her own biological children. Widowed mothers on the other hand, are less likely to remarry (Nyambedha, *et al.*, 2003).

Another research group working in the same country discovered that surviving fathers caring for maternal orphans fed them diets that were nutritionally unbalanced. These children reflected weight-for-height ratios that were almost 0.3 standard deviations

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lower than those of non-orphans, reflective of hypothesized malnutrition (Lindblade, *et al*., 2003). It has also been shown in Tanzania by Ainsworth and Semali (2000) that the death of a mother was associated with an average decline of one standard deviation in height-for-age, whilst the death of a father was associated with a decrease of one-third of a standard deviation. The authors therefore concluded that while the impact of paternal death is felt only among poor households, the impact of maternal death is severe irrespective of household assets.

Another study by Nyamukapa and Gregson (2005) revealed that maternal orphans but not paternal or double orphans have lower primary school completion rates than non-orphans in rural Zimbabwe. According to the researchers, these patterns reflected the adaptations and gaps in the extended family orphan care arrangements. They also found that sustained high primary school completion amongst paternal and double orphans, particularly for girls resulted from increased residence in female headed households and greater access to external resources, and that low primary school completion amongst maternal orphans was the result of lack of support from fathers and stepmothers and ineligibility for welfare assistance due to higher socio-economic status households. A study of maternal orphans by Taha *et al* (2000) in Malawi also found that there was no association between the mother's HIV positive status or the child's orphanhood status, and the orphan's risk of stunting, wasting or reported ill health. The authors attributed these findings to non-discrimination on the part of fostering extended families.

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## 2.9 INSTITUTIONAL VERSUS HOME-BASED CARE

In comparing institutional care with foster care, one study found institutional care or group homes to meet the material needs of orphans better than foster care, but to deprive the orphans of autonomy and personal contact with their caregivers (Wolff, 1998). Another research found that orphans housed in group homes suffer from psychological issues such as delayed cognitive development and impaired social functioning. It must however be pointed out here that the control group in this case was non-orphans, not orphans in foster care (Drew, 1998).

A quantitative study conducted near Blantyre in Malawi also revealed interesting findings about the health of orphans in orphanages, orphans in foster homes, and non-orphans. It was found that children in orphanages face a 54.8% prevalence rate of malnutrition, as compared to 33.3% for village orphans and 30% for non-orphans. However, children admitted to an orphanage for more than a year were less malnourished, which is perhaps explained by the fact that only those orphans who have faced severe neglect are eligible to be placed in an orphanage. The same study also indicated that younger orphanage children (less than 5 years old) had lower height-for-age ratios than either their non-orphan or foster home orphan counterparts. However, older orphanage children (greater or equal to 5 years old) had higher height-for age ratios, and only 6.6% of orphanage children had diarrheal disease, as compared to rates of 10.8% of village orphans and 30% of non-orphans (Panpanich *et al.*, 1999).

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For some researchers, while orphanages may seem to be the simple answer to the increasing orphan problem at first glance, thoughtful scrutiny suggests otherwise (Foster and Williamson, 2000; Leyenaar, 2005). Orphanages, according to them are not an inherent part of many cultures. They take significant resources from already overstretched economies, and they remove children from their familiar culture and surroundings, as well as further stigmatize children who already carry a heavy burden (Leyenaar, 2005; Zhao, *et al.*, 2009)

A study in rural Zimbabwe, a country with an adult HIV prevalence of 25%, and in which one in five children is an orphan (UNAIDS, 2006), suggested an alternative approach to keeping orphans in orphanages. On the basis of interviews with community-based orphan caregivers, the researchers noted the importance of providing even limited financial assistance, such as school fees; development of community programmes to identify and support children in need; evaluation and strengthening of individual families' capacity to provide orphan care; development of programmes to help the youth, especially young girls to leave the street; and initiation and support of orphan placement in the home community when family members cannot manage (Howard, *et al.*, 2006)

According to UNICEF (2003) and Barnet and Blaikie (1992), there is much evidence to support the fact that among all the caregiver options available to orphans in Africa, the most conducive and only place where orphans can receive appropriate and effective care (with the caregiver playing the role of surrogate parent at the death of the real parent of the child), love, and be effectively socialized is the traditional home

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of the grandmothers, maternal aunts or possibly community members rather than institutions. However Clocotan, (2009) claims that in poor countries care in orphanages is most of the time just as good as that provided by families who take in orphaned or abandoned children, and that the question of how orphans can be cared best is becoming more and more urgent as numbers of orphans are huge and continue to grow because of AIDS.

A workshop report on "Best Practice in Orphan Care issued in 1998 in Malawi observed that the growth of the AIDS problem and its resultant orphan crises has led to the proliferation of orphan care programmes of various organizational structure, style and activities (Ntata, 1998). Analysts have however observed that while all such organizations may have the interests of orphans at heart, limited knowledge levels on the real issues affecting orphans may result in a situation where in some areas, the needs of orphans may not be met in the best possible way.

## 2.10 SYSTEMS OF INHERITANCE IN GHANA

Before the enactment of the first intestate succession law of 1884, the devolution of self-acquired intestate property was by customary law (Ollenu, 1966). The property owned by every Ghanaian by custom, belonged to the family which in Ghanaian law is "an extended group of lineal descent of a common ancestor or ancestress" (Kludze, 1983, 60). If a person is of sound mind and is of age of maturity, he/she has total control of his/her personally acquired property and can handle or deal with it the way he/she deems fit. However, on death intestate, self-acquired property becomes family

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property, devolving to the members of the immediate family (Ollennu and Woodman, 1985, 38).

Every individual Ghanaian automatically becomes a member of the group into which he or she is born. The group may be bound by a common blood and flesh acquired through the mother or a common controlling spirit derived from the father (Ollennu, 1966; Opoku, 1982). The belief is that a sacred blood sustains and maintains the physical body, while a sacred spirit is responsible for the development of one's full personality and being. The former forms the basis of matriliny and the latter patriliny. Thus, Ghana has both matrineal and patrilineal family systems. One can therefore succeed to intestate property through either the matriclan, the patriclan or in some special cases to both (Goody, 1973; Ollennu, 1966).

## 2.11 NUTRITIONAL ANTHROPOMETRY

Nutritional anthropometry as explained by Jelliffe (1966) involves the measurement of the variation of the physical dimensions and gross composition at different age levels and degree of nutrition. It is a method of assessing nutritional status, and it is effective because nutrition has influence on the physical dimensions of the body. Thus, selected body measurements provide valuable information on certain types of malnutrition in which gross body composition and body size are affected. Nutritional anthropometry is widely used to assess and predict performance, health and survival of individuals, and reflect the social and economic well-being of populations (Scrimshaw, 1997). In fact, it has gained popularity over the other methods of assessing nutritional status such as biochemical test, clinical observation, and dietary

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assessment (McLaren, 1981), and its increasing popularity roots from the fact that it is the most portable, inexpensive, non-invasive, and universally applicable method available for assessing the proportion, composition and size of the human body.

There are several uses of anthropometric assessment ranging from indirect assessment of body composition (Whitney, 1987), through national planning and identification of individuals at risk (WHO,1986), to forming part of screening to provide a means to quickly and reliably identify individuals whose developments are below normal for their age, and thus requiring special attention (Fuller and Schaller-Ayers, 1990). The advantages of anthropometry for the assessment of nutritional status as mentioned by McLaren (1976) include accuracy of method, and the fact that results obtained are numerical and have considerable reproducibility. In addition, it is an appropriate method for obtaining on the amount and localization of body muscle and fat mass, thus, providing physicians with the needed information for identifying malnutrition, defining therapeutic objectives and monitoring effects of nutritional treatment.

Despite the many advantages and uses of anthropometry over other methods of assessing nutritional status, it has certain limitations: the technique becomes more predictive only when one's condition has gone worse; growth is influenced by many factors besides nutrition, thus, status assessment is entirely non-specific and nutrient deficiencies cannot be made out in general growth; Growth and physique can also be affected by bacterial and parasitic infections (Jelliffe, 1966).

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### 2.11.1 Anthropometric Measurements

There are almost unlimited numbers of possible body measurements, however only three were selected based on relevance of measurement to study, privacy, and cultural appropriateness. The three selected nutritional anthropometric measurements are: weight, height, and mid upper arm circumference (MUAC'). Weight and height when combined with other variables like age and sex provide useful indices for assessing the nutritional status of the orphans involved in the study.

**Weight**: Weight consists of bone, blood, water, muscles and mineral mass. It is a simple measure of total body components, and it indicates how well an individual feeds (Jeejeebhoy, 2000). The average weight of typical males is 70 kg, while that of females is 65-68 kg. Determining weight is very easy, thus, it is the most widely used anthropometric indicator of size determination and best indicator of growth (Watson and Lowry, 1967). Body weight is probably the best index of nutrition and growth in any group of anthropometric measurements especially among infants. Weight's potential value according to Jelliffe (1966) especially for children is appreciated by both health personnel and less educated parents, for whom it is a useful source of health education. The prevalence of protein calorie malnutrition (PCM) and growth failure in children in developing countries appear to be best indicated by weight deficiency in all age groups. Lartey *et al.* (2000) have shown that a strong relationship exists between weight of mothers before and during pregnancy and birth weight of infants.

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Weight in itself as an anthropometric parameter is however argued to give no information on the relative changes in the body components, because loss of muscle may be masked by residual fat, especially in obese individuals (Heymsfield and Casper, 1987). According to Jelliffe (1966), the increase in total body water for individuals with oedema masks the body weight deficits that occur as a result of loss of fat and/or muscle. Besides food intake, other factors such as constitutional or genetic make-up also determine body weight, thus the weighing scale alone cannot be used to determine nutritional status, other anthropometric parameters are also required.

**Mid Upper Arm Circumference (MUAC):** The MUAC consists of muscle and bone of the upper arm. Poor muscle development or muscle wasting are important features of all forms of PCM especially in children, hence direct anthropometry of the limb is a useful measure of muscle mass assessment. MUAC is therefore a useful measure in assessing thinness and therefore advanced malnutrition particularly under field conditions when weighing is impracticable. The region is easily accessible, and in conditions like kwashiorkor, the upper arm is not usually clinically oedematous while the mid arm is markedly wasted (Jelliffe, 1966), the parameter can thus be used to assess total muscle mass and is frequently used as such in field surveys (Gibson, 1993). MUAC enables an indirect determination of Arm Muscle Area (AMA) and Arm Fat Area (AFA) when combined with triceps skin-fold. AMA is a good indicator of lean body mass and thus, skeletal protein reserves, it has also been shown to accurately reflect actual muscle area measured by computed tomographic scanning and is interpreted as a measure of both muscle mass and lean body mass. Thus, its

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assessment is important in a person who may be protein-calorie malnourished as a result of chronic illness, inadequate diet, and stress.

It has been shown in several studies that weight and height measurements have more measurement error than MUAC due to confounding factors in the independent measurement errors in weight and height to variations in posture, levels of stomach content, etc. during measurement (Kanawati, 1976). In a related study, Kanawati (1976) claimed that the superiority of MUAC in community assessment of nutritional status may be due age confounding and cited a study in Northern Malawi where results based on specific analysis confirms that simple MUAC out-performed weight-for-age, whereas use of age adjusted MUAC produces results comparable to weight-for-age. The MUAC has therefore been proposed by WHO (1995) as an alternative index in nutrition for use where measurements of height and weight are difficult, including emergency situations like famine or real crises. The measurement of MUAC can be used as a screening method for underweight or as an additional criterion with Body Mass Index (BMI) to identify the preferential loss of peripheral tissue stores of fat and protein. Ferro-Luzzi and James (1996) have classified grade 4 malnutrition as MUAC less than 200 millimetres for males and that for females as MUAC less than 190 millimetres.

**Height-for-age:** Height-for-age is a measure of cumulative linear growth, and deficit in height-for-age is an indication of past or chronic inadequacies in nutrition and/or chronic or frequent illness. Low or extreme cases of low height-for-age indicate growth retardation represented by shortness or stunting, and it is used as a

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population indicator rather than for individual short-term growth monitoring. Using growth standards published by WHO in 2006, height-for-age as a nutritional status indicator is expressed in standard deviation units (Z-score) from the median of the WHO Child Growth Standards. Children whose height-for-age Z-score is below minus two standard deviations are considered short for their age and are therefore stunted or chronically malnourished, and those whose Z-scores are below minus three standard deviations (- 3 SD) are severely stunted.

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# CHAPTER 3

# EXCERPTS OF THE CULTURE OF ASANTE AND KROBO OF GHANA

This chapter was included in the thesis because, an account of the analyses of the cultural practices of the Asante and Krobo provided the background to the understanding of the unique cultural attributes of the study groups, and also helped in examining orphan care issues within the traditional contexts and from the point of view of the people.

## 3.1 EXCERPTS OF ASANTE CULTURE

### 3.1.1 Historical Background of the Asante People

Historical geographers and cultural anthropologists classify the indigenous people of Ghana into five major groups on the basis of language and culture. These groups are: the Akan, Guan, Moledagbane, Ga-Adadangbe, and the Ewe. The Akans practically occupy the whole of southern Ghana and the western part of the Black Volta. Historical accounts suggest that the Akan groups migrated from the northern part of the country to occupy the forest and coastal areas of the south as early as the Thirteenth Century. Some of them ended up in the eastern section of Cote D'ivoire and created the Baule community (Monthly Archives, July 2007).

The Asante Kingdom forms part of the big Akan society (the Akans form about 50% of the total population of Ghana). This society consists of ten sub-groups which are the Akyem, Bono, Kwahu, Asin, Fante, Sehwi, Denkyira, Wassa, Akwamu, and the Akuapim. The Adanse who presently form part of the Asante Kingdom, formed the

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first ruling kingdom, and they governed most of the Akan states. The Adanse Kingdom rose to its peak during the reign of its King Awurade Basa, and was then toppled by the Denkyira Kingdom.

According to Osei Kwadwo (2002), the Denkyiras ruled the other Akan groups with iron hands, they paid heavy taxes to the Denkyiras, and they were not allowed to travel to the south to trade with the Europeans. Thus, some of the other Akan groups came together to form a strong union aimed at overthrowing the Denkyira Kingdom, and was led by Osei Tutu. This union was referred to as *esa nti fo* (people because of war), and this became the name of the states that came together with the sole aim of fighting their tyrannical lords. Hence, the name *asantefo* (Asante). The Asante group consisted of Mampong, Nsuta, Bekwai, Asumegya, Kokofu, and Dwaben. Osei Tutu became the first *Asantehene* (Asante King). He was a wise king who ensured that the Asante kingdom would last for a long time, for example, he built a capital town for the Asante kingdom close to Tafo and Amakom and called it Kumasi, which is still the capital of Asante. Osei Tutu also agreed with the chief priest of Asante at the time, Okomfo Anokye who used his magical powers to create the Golden Stool as the greatest symbol of power and unity for Asante.

Osei Tutu created a national army which was very well trained and obedient and he used this army to conquer nearly all the people living in modern Ghana. He organized his kingdom and made good laws for them to obey, thus, the Asantehene's court in Kumasi became the most important court in Asante. He also made sure that the chiefs who did not belong to his clan (Oyoko clan) would stay united in Asante kingdom, so he assigned these chiefs to important positions. The *Mamponghene* (Mampong chief)

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for instance who belonged to the Bretuo (Twidan) clan was made the most important chief after Asantehene. He presided over the meetings of Asantehene's court in his absence. He also led the Asante army when the Asantehene did not go to war. Hence, while the Asantehene sits on the Golden Stool, the Mamponghene sits on a silver stool (Fynn, 1975). After the Asante had gone through their unity plan, they went ahead and fought the Denkyira and conquered them. This urged them on to fight and extend their boundaries, and they gave several reasons for fighting against their neighbours which included: freeing themselves from bondage; acquiring more land and more people to increase their population; punishing people for their wrong-doing against Asante nation; allowing them to trade directly with Europeans at the coast instead of passing through middlemen; and creating a vast empire under the Asantehene (Osei Kwadwo, 2002).

Although the Asante were able to wage external wars with success, the State was not internally stable since the great chiefs jealously guarded their regional autonomy against encroachment by the Asante king. This sometimes led to armed rebellion, but the king's forces were helped by those of the other great chiefs, and they always succeeded in suppressing a rebellious chief. This was because the necessity of unity was recognized by the great chiefs of the Asante confederation, and they had the backing of powerful religious sanctions (Fortes, 1950). Fortes further described the political history and structure of Asante as dominating the whole social order of Asante. The fact that large degree of autonomy was reserved by component chiefdoms of the confederacy led to emphasis on local allegiance of individuals and groups and not to citizenship of the confederacy. Fugitives and captives from defeated tribes were

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added to slaves, and these introduced alien elements into chiefdoms. Subjects of rebellious chiefs sought refuge in other chiefdoms, and individuals often emigrated from chiefdom to another despite the legal priority of local allegiance for several reasons which included marriage, economic factors such as trade, religious affiliation such as the desire to become adherent to a famous god. These influences according to Fortes (1950) are reflected in the kinship institutions of the Asante.

The Asante continued to expand (even after the death of Osei Tutu in 1717) throughout the Eighteenth Century, under the leadership of Opoku Ware, Kusi Obodum, Osei Kwadwo, etc. and survived as the imperial power until the end of the Nineteenth Century when it succumbed to British rule. Presently, the Asante kingdom is ruled by Asantehene Osei Tutu taken after his predecessor Osei Tutu I.

### 3.1.2 Asante Kinship System

Asante kinship is characterised by the recognition of both matrilineal and patrilineal descent, but as a rule, matrilineal descent is the basis of Asante social organization (Rattray, 1923). Thus, every *odehye* (a person of free matrilineal descent) is a member of his/her mother's *abusua* (lineage) by birth, and a matrilineal descendant of a slave woman or an alien is a member of the lineage into which that woman was tacitly incorporated by right of birth, but such a person is subject to disabilities which can never be wiped out altogether (Fortes, 1950). Such persons are treated as true members of the lineage for most social purposes, but they do not qualify for any office held by the lineage, for they are still known to be of alien origin and are not entitled to call themselves *odehye*. It is however an offence, socially and legally for anyone to

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refer to their origins in public, because for the Asante, *obi nkyere obi ase* (there is both a moral injunction and a legal rule that no one should reveal the another's origin).

The Asante would not admit to outsiders that lineage kinship is a matter of degree because they insist on identifying with each other as lineage kin, however, in personal matters and in relations of lineage members among themselves, they observe closely degrees of matrilineal connexion. Thus, although the lineage is divided somewhat in form, it is dominated by the rule of inclusive unity, *abusua baako mogya baako*, that is one lineage, one blood (Fortes, 1950). All recognised members of the lineage are therefore treated equally irrespective of their true origin, except when it comes to the headship of the lineage that non-true members are excluded mostly because they do not have direct access to the lineage ancestors.

There is a high degree of equality among the Asante between males and females of the same lineage, this is demonstrated by the fact that the *abusuapanin* - male head of a lineage (who is chosen by consensus of whole body of the lineage based on personal qualities of tact, intelligence, leadership, and knowledge of affairs) is almost always assisted by an *obaa panin* (senior woman) who is informally chosen by him and his elders. Her duties are: to supervise feminine matters such as puberty celebrations, watch over the morals of women and girls in the clan, assist in making peace in family disputes, and she often serves as the best genealogical authority in the lineage.

According to Fortes (1950) the Asante describe children of one womb (*yafunu*) as consisting of the uterine descendants of an ancestress not more than four or

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occasionally five generations antecedent to its living adult members. That is *yafunu* consists of matrilineal kin whose female parents and grandparents grow up in a single matrilineal household as a group of siblings. Hence the maximal lineage one can find in a community is the widest local extension of the *yafunu* segment and the kinship terms used in such a matrilineal household apply to all who are members of the maximal lineage. Men and women of the same generation call one another *nua* (sibling), all women of the mother's generation are referred to as *maame, ena or ni* (mother). Men of this generation are called *wofa* (mother's brother), whilst *nana* (grandparent) refers to the men and women of the mother's mother's generation.

A woman refers to the members of her children's generation including her own children *ba* (child), whilst a man calls them *wofase* (sister's children), but calls his own child *ba*. A wofa cannot discipline his *wofase* (sister's children) unless the parents ask him to do so, but he is expected to cater for their needs. Both men and women call their fellow members of their grandchild's generation *nana* (this time referring to grandchild), and the conventional norms of behaviour attached to these terms and relationships apply throughout the lineage, but more strictly to the *yafunu* segment. Male members of one's father's generation are called *agya* (father), and female members of his generation are called *sewa* (female father). The term *nana* is also used to refer to any member of the one's father's father's generation and vice versa.

The position and status of Asante grandparents on both sides are of great importance in the social system, as such they are the most honoured of all the kinsfolk. The

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maternal grandmother is the female head of the domestic group, as a result she is very influential in the upbringing of children, and she is regarded as the guardian of morals and harmony in the household. Both maternal and paternal grandparents have the special role of taking care of young children. Their grandchildren are their greatest pride, and hence they show a lot of love and affection for them.

The Asante stress on equality and solidarity among siblings, and consider the bond between siblings as being stronger than those of all other kinship relationships except that between mother and child. Age is the most important socially recognised difference between siblings, thus the younger brother or sister can be reprimanded or punished by the older sibling and he is at the same time expected to assist them when they are in trouble. The younger ones in turn are also to treat or relate with their older siblings with respect. The mother's *piesie* (first born) is seen as the head of his/her sibling group and is usually considered to have a special place in the nuclear family by the parents. An Asante woman is expected to treat her sister's children like her own. This must be done to the extent that orphans are not supposed to know whether their apparent mother is their true mother or their mother's sister. A sister has claims on her brother because she is the only source of continuity of his decent line and his female equivalent. Hence, a brother has legal power over his sister's children. *Sewa* however has no authority or legal claim over her brother's children.

All Akans, and for that matter, Asantes belong to one of the eight Matrilineal Clans of the Akans. These clans which can be found among all Akan tribes are: Bretuo; Ekuona; Asona; Aduana; Oyoko; Agona; Asakyiri; and Asenie. Thus, Akans believe

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that people of the same clan are children of one but forgotten ancestress, no matter where they come from, and marriage is forbidden amongst them. It therefore means that an Ekuona man from Fante cannot marry an Ekuona woman from Asante, because they all descended from a common ancestress. Hence, in all Akan states where matrilineal inheritance is practised, the children of the female members of the clan are recognized as the members of the clan. The term *abusua* is also used to refer to clan among the Asante.

The belief that people of the same clan descended from one common ancestress is so cherished that if for example in the past, an Ekuona man from Asanteland travels to Fanteland and reveals his clan identity, people of Ekuona clan in Fanteland accept him as a brother and would protect him as such. If this person should die on Fanteland, the *Ebusuapanin* (Clan Elder) would only send a messenger to go and inform the *Ebusuapanin* in Asanteland of the death of their son and he could go ahead and perform all the necessary rites and bury the deceased even in the absence of the people from the deceased's hometown. The clan system according to Fortes (1950) is an important force of unity in the political and cultural organization of the Asante.

In the past, Asante villages and townships were divided into *brono* (wards), the occupants of each of which were majority of the members of a single lineage. All Asante states/towns/villages are governed by two people simultaneously, a Chief and a Queenmother. Chiefs and Queenmothers are selected from the Royal Clan of the various states/towns/villages. If the founder of the state/town/village is of the Bretuo Clan, chiefs and queenmothers of that particular state/town/village are selected from

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the Bretuo Clan. People from other clans of the state/town/village are considered non-royals. Thus, if the chief dies, his maternal clan member is enstooled to succeed him. If no one is found suitable in this clan to succeed him, a member of a branch of the lineage who has lived outside their natal chiefdom for several years may be invited to take up the office, or the elders may contact a sister town to nominate a clansman to occupy the local vacant stool.

### 3.1.3 Asante Parent – Child Responsibilities

The bond between mother and child is regarded by the Asante as the keystone of all social relations. Bearing children is therefore a very important duty of an Asante woman. She boasts of her achievement when she brings forth ten children and a public ceremony is performed to congratulate her. Thus, prolific child-bearing is honoured, and childlessness is felt as the greatest of all personal tragedies and humiliation by both men and women (Fortes, 1950).

The Asante mother has the sole responsibility of taking care of her young child. She usually seeks assistance from her mother or her closest female maternal kin. She is to work selflessly for the good of her children, provide them with food and clothing and to educate them. By doing so, a typical traditional Asante woman would importune her husband and would impress upon her brother to discharge his duties as the legal guardian of her children faithfully. A mother is to show love and affection to her children especially her daughters, and she is to protect and assist them in all aspects of their lives. Mothers are expected to be very close to their daughters, and teach them all feminine skills. It is thus said that a woman derives her character from her mother.

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The Asante believe that the bond that exists between a child and his father is unique in the sense that the child's *ntoro* (spirit) which is the source of his life and destiny is transmitted to him by his father. Thus, all a man needs to do to have a child is to acknowledge paternity of the child by accepting the responsibility of maintaining the woman throughout her pregnancy, giving her and the child some customary gifts immediately after delivery, and naming the child on the eighth day (or soon after the eighth day) of delivery. When he refuses to do these, the woman, her child and maternal kin suffer disgrace. However, such a child is regarded legitimate as far as his/her maternal kin are concerned.

Although the Asante claim that children should grow up in their father's house, fathers do not have legal authority over their children, they cannot compel their children to live with them nor claim custody of them in the event of divorce or death of their mother. It is however the duty and pride of an Asante father to feed, clothe, educate, and set his children up in life. Asante fathers are particularly responsible for the moral and civic training of their sons, and this gives them the right to punish their sons when necessary. A father is said to have no hold on his children except through the children's love for him and their conscience, and these he gains by caring for them, and making them gifts of property, money or land during his lifetime or by written will.

Asante parents also have the responsibility of establishing their children as socially responsible beings by seeing to it that they are properly married. Although it is not

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legally compulsory, the consent of both parents is deemed indispensable for any marriage to take place. A father has the responsibility of providing his son with a wife or a son should seek his father's approval for his own chosen bride. It is also the duty of a father to make sure that the suitor of his daughter would be able to support her. Asante children in turn are taught and expected to be obedient and be of good behaviour, and this according to Nana Kofi Osono Ampem, Breman Kyerebio *Hene*, is reflected in the way and manner they talk to the elderly and their fellows. They are expected to be respectful and affectionate to their parents (oral tradition). An Asante man's first ambition is to work and earn enough money to be able to build a house for his mother if she does not own one, so that she can be a mistress of her own home with her children and her daughters' children around her since this is the highest dignity an Asante woman aspires to. Although there is no legal obligation on children to look after their father in old age, it is regarded as an evil and shameful act if they fail to do so. It is also the responsibility of one's own children to provide the coffin for his burial with assistance from his classificatory (maternal nieces and nephews) children. In the case of a woman it is her own children and her brother's children that provide coffin for her burial.

### 3.1.4 Asante Puberty Rites

Puberty may be described as the period in life in which a person becomes capable of reproduction. In many African cultures where puberty rites are observed, they are usually highlighted for girls and not for boys. Thus, among the Asante and other tribes of Ghana puberty rites are for girls only, though boys usually are instructed by their fathers in sex matters and are warned not to masturbate (Rattray, 1927).

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*Bomso Hemaa*, Nana Agyeman however claimed that formal education, Christianity, and urbanization have influenced the people of Asante to the extent that the performance of puberty rites has dwindled to the barest minimum. As a result, teenage pregnancy has become very common among Asante youth with a lot of children on the street. She reiterated that puberty ceremony was good and kept a lot of girls from becoming pregnant at an early stage in life, most girls looked forward to the day they would attain the status of an adult and would be congratulated and honoured with the ceremony for keeping her virginity intact. Increases in divorce rates among Asante marriages are also attributed to the absence of puberty rites and ceremonies.

### 3.1.5 Asante Marriage

The Asante view marriage as a natural connection between a man and a girl who has gone through puberty rites, thus, no laborious ceremonies are required to contract a marriage. Illicit and casual unions are therefore very common among the Asante. There are however certain prohibitions with regard to Asante marriage and these are in accordance with the Asante concept of incest. Thus, marriage is not allowed between individuals whose sexual relations are regarded as sin of incest. An Asante man or woman is forbidden to marry any member of his/her matrilineage including his/her accessory lineages that have been attached to the true lineage for four or more generations. In other words an Asante cannot marry any member of his/her matrilineal clan or blood (Fortes, 1950). Along patrilineal lines, marriage is prohibited with any patrilineal descendant up to the fourth generation, because they are regarded as *emanom* (siblings).

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Marriage can however be contracted between a man and his father's sister's daughter (paternal cousin); and his mother's brother's daughter (*wofa ba*) who belongs to her mother's clan. Some people approve of marriage with *wofa ba* on the basis that it creates an additional bond with their maternal uncles which make the marriage a more secure one than marriage with an unrelated woman. Women usually prefer marrying their maternal uncles because it strengthens their claims on their husbands and their children's claims on both maternal and paternal kin, but for the older people at whose insistence and in whose interest *wofa ba* marriages are arranged, the basis is on the grounds of property and wealth. They argue that it ensures that a man's daughter and her children derive some benefit from the property he is obliged to leave to his *wofase* (sister's son); or where a man's son marries his sister's daughter, his son's children get much benefit from his property (Fortes, 1950).

Betrothal marriage used to be common among the Asante in the past, where a married couple would promise a child yet to be born or an infant girl to a friend as his future bride. The future husband of the girl in turn would present small gifts to his future parents-in-law. The child would be brought up to consider herself already married to the man her parents had promised her, and six days after the end of her second menses the union is completed with little additional ceremony or without any ceremony at all (Rattray, 1929). Any other man who has a sexual relationship with a betrothed girl is considered to have committed adultery and is subject to a fine (adultery charges) determined by the husband of the girl. The husband may then decide to take the girl as his wife or refuse her. In contemporary times betrothal marriage is fading away since individuals prefer to make their own choice when it comes to life partners. An Asante

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marriage may begin with a cohabitation period which is accepted and approved by the parents of both the man and woman as a marriage in its true sense for all practical purposes. The man however has no right to adultery charges if his 'wife' commits adultery and has no paternity rights over a child conceived in adultery. In such a marriage couples may 'divorce' by mutual agreement.

A marriage is considered legal only when the man presents *tiri nsa* (head wine) – two bottles of wine or its equivalent in cash to the woman's family through the head of his lineage. This may be done before or at any time a couple begin to cohabit. *Tiri nsa* is usually presented to the lineage head of the woman through her parents or legal guardian and this is done in the presence of representatives of both parties who serve as witnesses to the fact that man has presented the *aseda* (thanking) gift to the family of his wife. Half of the *tiri nsa* is sent to the father of the woman by her lineage head and the other half is shared among the representatives present at the ceremony.

In addition to *tiri nsa*, the bride is usually presented with a gift of money from her husband, her lineage head, father, mother and brothers are also given some customary gifts, but these may be waived. The bride in turn cooks a delicious meal for her husband and his family and other community members to mark the occasion of her marriage ceremony (Osei Kwadwo, 2002).

The husband acquires exclusive sexual rights over his wife and the legal paternity of all children born to her by paying *tiri nsa*, he is thus expected to satisfy her sexually, provide her and their children with food, clothing and shelter, take care of her in times

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of illness, pay for any debts she contracts, and obtain permission from her if he wants to take on an additional wife. The wife is also expected to provide for her husband essential domestic and economic services. Failure on the part of a spouse to fulfil any of these rights and obligations may constitute grounds for divorce which both the man and woman have equal rights to demand. If a properly married woman commits adultery, the husband has the right to sue his wife's lover and demand for compensation from him, he can also claim the paternity of a child born in adultery. A divorce is only legal when *tiri nsa* is returned through the same channels by which it was received.

An interesting and peculiar aspect of Asante marriage is the payment of *tiri sika* (head money). This is demanded from the husband at any time during the marriage when there is urgent need for money in the wife's lineage segment, and it could be any amount of money. It is regarded as a loan for an indefinite period which may serve as a pledge of the fidelity of the wife, and it is only returned on the termination of the marriage by death of the wife or by divorce. The husband may however choose to make the *tiri sika* a free gift to his wife and her lineage some years after the marriage, if the wife dies, or on divorce (Fortes, 1950).

Polygyny is allowed among the Asante, and a polygynist is expected to be consciously fair in sharing equally among his wives his sexual attention, time, and the material provisions he makes. Although polygyny is legal among the Asante just like many other tribes in Ghana and Africa as whole, it is rare for commoners to have more than

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three wives probably because of economic reasons, but very common for Asante chiefs to have more than three wives.

### 3.1.6 Asante Inheritance and Provision for Orphans

Among Asante the right of inheritance is confined to the matrilineage, but men take precedence over women in the inheritance of a man's property and vice versa. Thus, when a man dies, his own children do not have rights to his personal acquired property, it is his brother or *wofase* (sister's son/nephew) that inherits him, but the preference is the nephew with whom the deceased share the same lineage. Traditionally, it is the closest clan member that inherits the dead. It is believed that clan property belongs to the woman's line and powers are invested in men to act as caretakers only. Thus, though one's paternal sister (father's daughter) is considered his sister, her child cannot inherit the uncle since the child is not from the same clan as the uncle. When a woman dies, she is inherited by her sister or one of her daughters.

If a clan owns farmland clan members (both men and women) have the right to use it for farming activities. Wives of the men may join their husbands in using the land. If however a man dies, his wife is given a time period of one year to quit the land and hand it over to the deceased husband's sisters. In the event of divorce, the wife is forbidden to enter her divorced husband's farm, she is granted a short period to take whatever she has planted on the land. Her children are however permitted to take over their mother's farm because they are regarded as their father's property (Osei Kwadwo, 2002).

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According to Nana Kofi Osono Ampem, Breman Kyerebio *Hene* (March 2008), there have been rare occasions where children have inherited directly from their fathers. This at times happens when a man's only sister is barren and he does not want his mother's sister's son (cousin) or cousin's son to inherit him, the sister would demand acknowledgement as heir or would advise him to look for a wife from the neighbouring tribes that inherit patrilineally and bear children with her, and because such children cannot inherit their maternal uncles, they become part of their father's family and are allowed to inherit their father directly.

When a woman has children by two or more men, the children from same father usually form a group and insist that when one of them dies, the inheritor of the deceased should come from within their group, although the deceased is equally related matrilineally to his/her other siblings, and this can create family conflicts.

As a rule, the eldest nephew (the eldest of the sons of a man's direct sisters, those of the same *yafunu*) inherits his uncle. He is only by-passed if he is known to be irresponsible and of bad behaviour that might cause the family to lose its property. In fact, the heir of the deceased must be formally approved by the lineage head and his elders, for it is said that the heir does not only inherit his uncle's property but his debts as well. The inheritor is regarded as the owner of whatever property he inherits till he dies. As such, he has the liberty to use the property in acquiring his own personal property, at the same time, he is expected to take care of other family members by providing them with their needs, including caring for his predecessor's young children and widow. The inheritor is usually summoned to account for inherited property when

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he is found to be engaged in behaviours such as alcoholism, gambling and womanizing.

Widowhood inheritance also exists among the Asante, in which case the heir of the deceased is asked to marry the widow so that she and her children can be well taken care of. The inheritor in this situation can agree to marry the widow, but the widow even though may be willing to marry the inheritor cannot do so without the consent of her lineage head and his elders. In actual fact the widow cannot remarry any other man without the consent of her lineage head and his elders. A widower on the other hand cannot marry the heir of his deceased wife. This is only allowed when the widower happens to be a chief, and when a marriage pact exists between the stool and the family of the deceased. In such case, the deceased is replaced by her sister or cousin to be the wife of the chief. The reality nowadays is that most young people are averse to *kuna aware* (widow marriage), and they prefer going their own way in seeking for life partners, although the formalities of inviting the widow to accept her husband's heir are still part of the final funeral ceremonies after burial.

Orphans, especially those who are left motherless in early childhood are given to their mother's sister to bring them up. The maternal aunt is supposed to treat them like her own and by so doing, the children would also respond to her like their real mother.

Matrilineal inheritance creates a lot of problems for widows and their children because some families demand and take all personal acquired property of the deceased without giving any to his widow and children, leaving them with nothing to live on.

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Thus there exists a law among the Asante that a man must give a portion of his acquired property to his wife and children before he dies, and he must inform his family of whatever property he has given to his wife and children. The wife and children would also provide some items and drinks to the man and his family in a ceremony called *aseda* to thank the man and his family for giving them the property. When this is done, the property becomes the bonafide property of the wife and children even when she is divorced (Nana Kofi Osono Ampem, Kyerebio *Hene*).

Provisional National Defence Council (PNDC) Law 111 (Intestate Succession Law) was prompted by the matrilineal system of inheritance and how some widows and their children have been maltreated when men die intestate. This law spells out clearly the way property should be shared when death occur intestate, but even with this law in place, some widows and their children fail to seek redress from the law courts when they face problems with inheritance. It thus behoves that everyone not only the Asante prepares a legal document (will) regarded how he wants his property to be shared in his absence.

## 3.2 EXCERPTS OF KROBO CULTURE

### 3.2.1 Historical Background of the Krobo People

Krobo indigenes use the *Klono* (singular) and *Kloli* (plural) to refer to themselves. However, the name Krobo has become the official designation of the ethnic group. The term *Kloma* is used to refer to the Krobo town. Whereas the origin of the name is uncertain, some claim that it is derived from *klo* (tortoise) referring to their tortoise-shaped mountain home, while others claim that the name was derived from the word

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owl, explaining that Akro Muase, the legendary hunter who discovered the town at night was met on his way by several owls (Huber 1993: 15).

The Krobo are believed to have first migrated from northwest Nigeria through the south western part of Nigeria and the Volta and settled around the Krobo Mountain in the Fourteenth Century (Oral Tradition by Okyeame Buatey, the Krobo Paramount Chief's Linguist). According to Okyeame Buatey, the area was already occupied by some Akan-speaking settlers who as a way of protecting their territories from being invaded by foreigners, continued to attack the Krobo, who finally moved to settle on the Mountain. The Mountain was found to be safer because of its steep and rocky ends and there were only two entrances to the top which made it difficult for attackers to get to them.

However, Azu (1974) recounts the early migration of the Krobo from "*Samch* an island situated on the southwest of the river *Ogum* adjoining Lada and Dahomey" (Huber 1993: 17) and thence to the Krobo Mountain under their leader *Akro Muasi* or *Akro Natchi*. According to Azu (1974), the original Krobo and the settlers are the three *Dzebiam* clans (*Nam, Agbom, and Yokwenya*) in the Manya Krobo area. It however appears that the present day Krobo are descendants of various groups of people and individuals who at different times and from different places arrived to settle or seek refuge on the Mountain. Strangers were received on the Mountain on condition that they adopt Adangme as their language, circumcise their males and perform *dipo* rites for their daughters. They were also made to name their children

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with Krobo names and had to agree that they would not send messengers anywhere without their permission (Azu 1974).

The importance of the Mountain to the Krobo cannot be overemphasized because it is their original habitat (Huber 1994). The mountain was the real home of the Krobo where they kept the shrines of their gods, buried their dead, and where their daughters were initiated into womanhood under the supervision of their priestesses and aged women. According to Huber (1994), the Krobo also committed annual ritual cruelties and murders in connection with the worship of their war gods – *Nadu* and *Kotokla* during the pre-colonial era. This was brought to the knowledge of the British Authorities. Thus when *Kono* Sakitey (the paramount chief of the Manya Krobo traditional area) died on January 19, 1892, the Governor announced at the enstoolment of the new ruler, certain drastic measures that his government had taken to halt the ritual cruelties and murders.

The Governor followed up his announcement with a visit in July the same year, and he severely rebuked the Krobo for their cruelties, after which he announced in the presence of the chiefs and large gathering of people, the following decisions he had taken: severe punishment would be imposed on anyone; chief, priest, or commoner who would promote further or take part in human sacrifices; severe punishment would be imposed on anyone who organizes 'fetish' festivals on the mountain; it was forbidden to bury the dead on the mountain. The Krobo were also forbidden to perform puberty rites for their daughters. These decisions were afterwards codified in

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the 'National Customs Ordinance' and they greatly affected the sentiments of the Krobo people.

The seriousness of this proclamation was marked by three days ultimatum for the Krobo to move all belongings from their mountain home which had become their stronghold in times of war for centuries. One hundred soldiers were posted to the Mountain to enforce their evacuation and also to destroy the towns with the shrines of their gods. They resettled on the plain, which later developed into towns. They built new centers of worship on the outskirts for their gods, and eventually, Odumasi and Somanya became the central towns of Manya and Yilo Krobo respectively. The neighbouring people surrounding the Krobo tribal area are: the Adangme-speaking Osu on the east, the Akim Akuapim and some small originally Guan-speaking groups on the west and to the south, the Se (another Adangme group) on the south, and the Akwamu – an Akan group which formally dominated the area on the north.

The Krobo are politically divided into two districts with local governments and two traditional states with traditional rulers, which are organized along male-oriented power structures. These are the Manya and Yilo traditional areas which are ruled by two different paramount chiefs (*kono)*. Each paramount chief has six divisional chiefs (*wetso mantse*). *Wetso* is the largest social unit or grouping within Krobo Society. All the divisional chiefs have a female ruler – *manye* (queen mother) beside them. Social grouping among the Krobo is based on patrilineal descent, thus *wetso* means 'family tree'. For Manya Krobo the six major divisions (*wetso*) are: *Dzebiam, Susui, Akwenor, Manya, Piengua* and *Dom*. Similarly, Yilo Krobo also has six major units which are:

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*Bonya, Plan,Ogome, Bunase, Nyewe,* and *Okpe*. Each *Wetso* has an average of five clans or *Kasi* under it. A clan may have up to six localities under it.

Changes in the organization of Krobo were caused by colonial government and the influence of Christianity. The works of the early Christian missionaries affected Manya Krobo more than Yilo Krobo. Huber (1993) has recorded that when the first two adults were baptized in September 1856, Odonko Azu, the *Konо* (paramount chief) himself was among twenty people who were ready to become Christians. Though he never got baptized, he remained a friend of the priest.

There are no major differences in the social and local groupings of the people of Manya and Yilo Krobo, their traditional economy, crafts and industries, kinship and marriage, or in general forms of social contact and conventional behaviour.

### 3.2.2 Krobo Kinship System

Like the Asante, the Krobo have agnatic kin groups, but the Krobo reckon membership of these lineages by descent in the male line. In addition to this, they recognize members of both matrilateral and patrilateral kin groups as relatives (just as the Asante) referring to them as *wekuno* (singular) or *wekuli* (plural) which literally mean family member/members. The importance of family relationships is expressed in this Krobo proverb '*nyemi hi pe hwe*' (meaning a relative is more reliable than a friend). The basic kinship relationships consist of the father (*tsɛ*), mother (*nyɛ*), and child (*bi*). *Tsɛ* refers to one's rightful genitor, who by custom should be properly married to the mother of the child at the time of, or before its conception. Hence a

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man who begets a child without marrying the mother of the child has no paternity rights over the child (Huber 1993: 77). Classificatorily, the term *tsɛ* could also be used to refer to paternal or maternal uncles. In the same vain *nyɛ*, the term used for one's mother could be used to refer to one's mother's or father's sisters. *Bi* refers to one's own child and it may also be used to refer classificatorily to one's bother's or sister's children.

The classificatory use of the terms *tsɛ* and *nyɛ* could be distinguished from one's real parents by qualifying them with the terms *ngua* (big) or *wayo* (small) depending on whether the particular aunt or uncle in reference is older or younger than the real mother or father and vice versa. For example, *tsɛ ngua* or *nyɛ ngua* could mean an uncle or an aunt older than one's own father or mother and vice versa. Huber (1993: 77), in his account, further notes that although the terms *tsɛ* and *nyɛ* have their classificatory application, the parent-child (biological procreators) relationship is the most deeply felt and expressed naturally within the nuclear family. Thus, a child's parents are his/her own mother and her legitimately and fully married husband.

Among the Krobo, marriage confers on the man the authority over the procreative power of the woman. A Krobo man cannot claim paternity of a child whose mother he did not fully marry before the child's conception, unless he performs an elaborate and expensive rite. In spite of this precondition for paternity rights, premarital conceptions have been very common among the Krobo (Huber 1993).

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Like other ethnic groups in Ghana and elsewhere in Africa, the perception that children are gifts from God, while childlessness is one of the most tragic incidents that could ever happen to a person exists among the Krobo. A childless woman in Dagbon suffers deprivation in life, death and even at burial (Oppong 1973: 34), and among the Asante, as noted earlier, both men and women regard childlessness as the greatest of all human tragedies and afflictions, as such prolific childbearing is very much cherished and honoured (Fortes 1950). Likewise, if a Krobo woman does not bear a child, it is felt as a great affliction and this may cause her husband to take on an additional wife (Huber 1993: '82). The Krobo believe that the child's biological dependence on the mother determines the close affectionate relationship between them, especially during the first couple of years after delivery. Krobo children are trained to be humble and respectful to the authority of their parents.

### 3.2.3 Krobo Parent-Child Responsibilities

Children are seen as blessing from God thus, when a couple brings forth it gives them a lot of happiness and it counts among their deepest fulfilments of life. The upbringing of children is therefore the concern of both parents who naturally show love and affection for their children because they are their own flesh and blood and would not be cruel to them although they would punish them when necessary (Huber,19930. However, unlike the Asante who regard the bond between mother and child as the keystone of all social relations (Fortes, 1950), the father-child bond is the keystone of all social relations among the Krobo. Hence, the main financial responsibilities of rearing and educating children fall on the man. He is also responsible for the customary performances of his children during their lifetime. Such performances are

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those at birth, puberty, marriage and death. The role of the father, according to Huber (1993) with regard to his children appears to be the most prominent in marriage negotiations among the Krobo, in that he plays a significant role in the choice of a partner as well as gives his daughter in marriage.

Sons are usually expected to assist their father on the farm or in his career, and also serve as his messenger. Thus in the past, sons who were respectful to their fathers and willingly assisted them on the farm had all their marriage expenses paid for by their fathers.

Mothers on the other hand have the responsibility of being close and affectionate to her children. A mother is expected to nurture and nurse her children, bath, feed, assist them to clean and hygienic lives and properly socialize them. Thus the Krobo would say *maa-yo le wo nmo be wa he* (mother has brought us up with care). She is also expected to give full attention and guidance to her daughters during their critical years and ensure that they pass through initiation rites (*dipo*) successfully. Thus the praise of a girl who successfully passes her puberty rites without blame is equally her mother's who protected her against seducers (Huber, 1993), for girls who become pregnant prior to *dipo* do not pass the rites successfully.

Although Krobo children are taught to be respectful to both parents, and are expected to willingly and happily assist their parents in their vocation and at home, sons naturally become close to their fathers and vice versa.

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### 3.2.4 *Yobi* (Woman's Child)

An aspect of Krobo culture which is absent among the Asante but worth looking at in this study is the issue of *yobi* (woman's child). *Yobi* is a child who is born to a woman or a girl for whom the necessary marriage ceremonies have not been performed. (There is nothing like woman's child among the Asante, a man only has to accept responsibility as the father of a child and he is seen as such). Such children are considered legitimate among the Krobo (no child is regarded as illegitimate) because children and large families are very much cherished. This is probably due to the part that children played traditionally in farming activities and the assistance they provide in the home. Hence, fathers could even encourage and induce their daughters who are ripe for marriage but are not married to bear children for them (referred in Krobo language as *efo bi ha etsɛ*).

Thus, all children born by unmarried women deliberately or undeliberately to increase the number of children in her family lineage (*weku*) are *yobimɛ* (woman's children). These children belong to their maternal grandfather and are named by him. The maternal grandfather therefore exercises paternity rights and responsibilities over the child, as a result the child refers to the grandfather as *i-tsɛ* (my father) and not his grandfather.

An unmarried Krobo girl can therefore conceive without being questioned by her parents or any member of her family as to who impregnated her provided she has gone through *dipo* (puberty rites). The man responsible for the pregnancy may only introduce himself to the parents of the girl and would then be expected to give the girl

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some food items, some money and a half piece of cloth during the pregnancy period. He would be made to bear all costs involved in antenatal care, and also give the woman a fowl, plantain, some palm fruits, palm wine, and some money on the day she delivers. These however do not give the man paternity rights over the child, because he has not performed the marriage ceremony that confers on him power over the procreative ability of the woman. Thus, he is not even allowed to give the child a name.

The child would still belong to the maternal grandfather even if the man marries the woman after the child's birth and continues to provide for the upkeep of the child. This was usually frowned at by the man's family and would despise him for taking care of the child since such acts are fruitless. He is therefore encouraged to claim ownership of the child by performing *la po mi* (cut bead- the bead that is tied on the right wrist of the child when being named by its maternal grandfather) rite. This ritual is quite expensive and deters a lot of men from going through it. It involves the presentation of a big sheep, payment of all costs incurred by the maternal grandfather from the day the child is born to the claiming day as computed by the maternal grandfather plus a fine. Once the rites are performed the man is allowed to fix a date for the naming ceremony of his child during which a new name is given to the child by his real father (Personal Communication with Ebenezer Sackey, 70 year old blind caregiver).

This custom was intended to protect Krobo women in that it was instituted to deter men from having sexual relations with women they had not married, and because

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children were cherished so much, large families were essential for farming purposes and other social activities, men in those days would rather wait and marry before having sexual relations and bearing children than make babies for other lineage. Also, because parents spend a lot of resources on *dipo* for their daughters, marriage was seen as a way of getting back some of the lost resources through bride price or wedding gifts, thus parents feel cheated when their daughters are impregnated without being married, thus the woman's family keeps the child (Personal Communication with Rose Okley – Assembly woman of Odumasi Mampong Electoral Area, and Headteacher of Odumasi Akro Kindergarten/Primary School).

### 3.2.5 Krobo Puberty (*Dipo*) Rites

Among the Krobo there is the conviction that a girl can become a mature Krobo woman and a wife worthy of a Krobo man only when she successfully passes through *dipo* and can show on her body and on her hand the visible marks of her initiation. Thus amidst modernization, urbanization, migration and education, most Krobo still highly cherish and strictly adhere to *dipo* rites. If a girl is found to be pregnant prior to or during her initiation ritual, she is regarded as an outcast and is driven away from her parental home, after which the whole compound is cleansed through elaborate purification rites. In the past, such a girl was never given the permission to return to her tribe for fear that great misfortune might come upon them (Huber, 1993). It is also an abomination for a Krobo girl who has not gone through *dipo* to commit abortion, such a girl if found is also treated as an outcast. Performance of *dipo* qualifies the Krobo girl to be officially recognized as an adult who can maintain her full rights and responsibilities as a woman in her cultural group. Thus, *dipo* is of greatest importance

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in the life of Krobo females and parents whose daughters successfully pass through the ritual are usually filled with joy and pride and become very much relieved.

Changes in the original practices of the *dipo* rites have made it lose its significance to some extent. For example, in the past it was only done for girls who were 18 years and above or for those who had had their menses at least for the first time since the rites also signified that a girl was of age for sex and parenting, but now it is even performed for children as young as 3 years old. All that parents of today do is to pay an amount of about five Ghana Cedis to *dipo* priests and priestesses and they have the rituals performed for their daughters. This has led to increases in incidences of teenage pregnancy, maternal and child deaths resulting in poor quality of life and increasing numbers of orphans. Again mature girls were kept in *dipo* shrines for over a year where they were very well prepared for marriage, parenting and house-keeping, thus, marriages in Kroboland thrived very well in the past than they do now.

### 3.2.6 Krobo Marriage

According to Okyeame Buatey (Personal Communication), the Krobo regard marriage as the union between a man and a woman for the purpose of procreation and companionship. This union is also seen as a link between two kinship groups, thus in the past, the immediate families of both the man and the woman played an extremely important and decisive role in the choice of a partner for their wards. Customary marriage among the Krobo had some regulations and prohibitions, for example, girls who have not gone through *dipo* are not supposed to be married by Krobo men, and it is an abomination for a Krobo woman to marry an uncircumcised man. Also, a Krobo

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man/woman is forbidden to cohabit or marry his/her paternal or maternal aunt (since they are socially identified with his/her parents), neither is he/she allowed to marry any daughter of his/her brothers or sisters because they are his/her 'children'.

Because marriage is as a lifelong affair, it is required among the Krobo that both sexes get well prepared before they enter into it, thus, the traditional Krobo man must start learning how to farm, hunt and rear animals by age 15 years. He is usually given a sheep to care for by his father and he is to take care of the mother sheep to produce about three generations before he gets married. These were for him to learn how to love and care for a woman and children. The woman on the other hand must also learn some household chores like cooking, cleaning, fetching water, personal hygiene, singing songs and lullabies for crying babies, taking care of his father's meals and clothes, assisting her mother on the farm, harvesting of vegetables and selling some on the market, making bead, etc.

Betrothal marriage among the Krobo was common in the past since parents could arrange for partners for their children. In this type of marriage an infant child is promised in marriage, sometimes even before the child is born, such a promise is sealed by the performance of infant engagement which is regarded as only a promise but not legal marriage. The parties involved could refer to each other as 'husband' and 'wife' as they grow up, and the 'husband' of a girl had specific roles and obligations towards the performance of *dipo* for his 'wife'. Whilst the main motive behind this type of marriage was to nurture good moral virtues in the parties involved and to ensure that children marry from good families, betrothal marriages have become

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unpopular in modern times, since individuals of today may want to have a hand in the choice of their own partners for life.

Unlike the Asante, marriage ceremonies among the Krobo are elaborate, thus, they are performed in stages. The first stage is the *agbo-sim* (knocking the door) or the *hesi-dzem* (introduction) ceremony. This involves the introduction of the husband-to-be and his family and their intentions to the prospective wife and her family.

*Agbo-sim* is followed by the *fiaa* ceremony. This ceremony according to the Manya Krobo customary law is the most important ceremony in constituting a legal marriage (Huber 2003). *Fiaa* is traditionally performed by a representation of close relatives from the family groom-to-be on a Sunday morning at the bride-to-be's paternal house. The ceremony involves the presentation of few bottles of rum and the performance of other traditional rituals. Pieces of advice are rendered to the groom and the bride by the groom's representation and because Krobo customary law sanctions polygyny, the father of the groom is expected to advice his daughter on the occasion of her wedding not to protest when her husband decides to take on additional wives, although practically no man who is not that 'wealthy' would want to go through such an elaborate ceremony for the second time. The date for the next ceremony which is the *yo-kpeem* (presentation of the dowry) is then fixed.

*Yo-kpeem* is considered by both the Yilo and Manya Krobo contemporary law as an essential for constituting a full legal marriage union. The ceremony consists of presentation of marriage gifts and payments of bride wealth to the bride and her

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family, followed by the presentation of various gifts and money to the father and mother of the bride (real or classificatory) and other members of her family. In the past, such gifts included loin-cloth (*subue*), cloth (*ho*), waist-cloth (*hale*), kerchief (*duku*), some beads and jewellery for the bride, and bride parents and family gifts included such drinks as palm-wine and rum, and various sums of money. Following the presentation and exchange of marriage gifts is the official handing over of the bride to the groom which is done amidst sharing of drinks and other formalities.

The *yo-kpeem* was followed in the olden days by the *yo-se-dam* (presentation of wedding drinks), which was performed on the *yo-kpeem* (wedding day) or shortly afterwards. This ceremony was performed to officially inform the whole locality that the wedding had taken place. It involved the husband sending a big pot of palm-wine to the clan-chief (*asafoatsɛ*), who would in turn inform the whole locality of the wedding by pouring libation amidst other rituals, and would inform the community then that the husband is entitled to claim *ayefale* (adultery fine) from anyone who would have intercourse with his wife, and that he the *asafoatsɛ* would completely back such a claim at any time.

In the past there was also the *tsoku hio* (white stick) ritual which was regarded as a blessing and simultaneously a sanction of the marriage, but this ritual is almost phased out among the Krobo of today. This ritual is performed during the climax of the whole marriage ceremony when the wife is introduced to her husband's house, and this takes place on the day of the presentation of wedding gifts or three days after. The ritual is performed to solicit the blessing of the ancestors and the gods of the land upon the

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newly wedded couple and also to establish that once the performance of all the customary ceremonies and presentation of gifts and payments have been made, the union between the man and the woman has been legalized. As such, all issues/offspring of the man including those from extra marital affairs from that time belong to the man's agnatic lineage.

In modern times a lot of Christian couples subscribe to church wedding in addition to traditional marriage, by this they agree to go by monogamous principles of marriage, and their marriage is regarded as such by the church and the state.

Traditionally, a fully married man may expect that his wife willingly cooks for him, contributes to household expenses, and takes care of his home and children as he provides both financial and physical security to his wife and children. These, she is expected to perform them diligently and wholeheartedly, and failure on her part may warrant her husband to divorce her and vice versa.

### 3.2.7 Krobo Inheritance and Provision for Orphans

Krobo inheritance is patrilineal, unlike that of the Asante which is matrilineal. This means that a child belongs to, enjoys first rights, and owes first duties to his paternal agnatic kin. According to Okyeame Buatey (Oral Tradition, March 2009), the Krobo had very few farmlands which were inherited by their sons, as a results their daughters were encouraged to marry early, and once married they belonged to their husbands and their husbands' family. Though marriage creates a link between the man and the woman's families, the married woman has very little to do with her own family. The,

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Krobo therefore cherish sons so much that if the first wife is not able bear him a son, he would have to take on additional wives who would bear him sons, because it is the sons that would marry and have children who would assist in tilling their inherited land. The first son usually inherits directly from his father, but if the father happens to be wealthy, he can decide to share his property the way he desires to all his sons. If the father has unmarried daughters, they are usually left in the care of the son(s) who inherit him.

According to Ebenezer Sackey (a 70 year old blind caregiver), if a properly married man dies, his property belongs to his wife and children and vice versa. If on the other hand the man did not perform all the necessary marriage rites, but lived with the woman and bore children with her and dies, the relatives of the deceased would have to arrange with the family of the 'wife' for the necessary rites to be performed before the wife and children can bury him and his property can be transferred to the wife and children. If the woman dies under such circumstance, the 'husband' and his family would have to arrange with the family of the deceased to perform the necessary rites (*yokpemɛ*), before he can bury his wife, and for very strict families, the man would then have to perform the necessary rites to claim his children (*lapomi*), since the children are considered to be woman's children (*yobimɛ*). When these rites are not performed, the deceased woman's family will bury her and claim the children (*yobimɛ*) into the deceased's family.

Mr. Sackey explained that if a child is born by a woman or a girl who is not married, this child – *yobi* (woman's child) belongs to the woman's father or his/her maternal

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grandfather, but this child does not inherit from the grandfather. he/she is usually cared for by maternal uncles when the grandfather is no more or too weak to play the father role. This is because the real father of the child could reclaim the child by performing the necessary rites – *lapomi*, and if this child happens to be a boy, then he can inherit directly from the real father. He added that *yobi* inherited from the paternal grandfather in the past.

Huber (1993) however records that even when a daughter is given in marriage to another lineage, her membership with regard to her own paternal home does not cease. This is expressed in the Krobo axiom: *'kɛ otsɛ fo mo, ne onye otse weo mio, lee opeewe nokpa, se opeo eweo mi no'* (if your father has given birth to you, and you are in his house, you do not belong to someone else, but you belong to his house). Belonging to paternal house implies that one is incorporated into his/her patriliny from infancy, in which he/she enjoys full living and home rights, and above all, the right to be buried according to custom. Tradition therefore demands that the married woman be buried by her father, not by her husband, and the only exceptional case for which these basic rights could be denied are daughters who become pregnant prior to their puberty rituals.

Fathers and paternal kin play key roles in the performance of important rites such as naming, puberty rites, marriage and death. Thus the rule that inheritance and succession is mainly through the male line (except in cases of married daughters) applies strictly to land inheritance. When a man dies, his next senior kinsman in the descent group takes over his charge, this is usually the younger brother (full or

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classificatory) of the deceased. Inheritance rules guiding the sharing of properties are that, funeral expenses must be deducted from all personally acquired properties of the deceased, the remainder must be equally shared among the first-born sons of each of the deceased's wives and those of his unmarried daughters. Ancestral property is however entrusted to the next senior kinsman of the descent group who can claim possession of the property. Most of the time, disputes arise between the sons of the deceased's wives and the sons of his unmarried daughters (*yobima*), since both categories of orphans have legitimate claims to inheritance (ibid p.210).

It is impossible for *yobima* to inherit any properties from their fathers since their fathers are unknown, and although they may legitimately inherit from their maternal grandfathers, conflicts between them and their maternal uncles may exempt them from inheriting such property. Such orphans are exposed to all forms of vulnerability especially at the death of their mothers when they do not have any one from their father's family to take up the challenge of nurturing and caring for them.

There is also a customary rule among the Krobo that when a man dies, his wife and children must be taken care of by a close paternal relative, usually a younger brother of the deceased. This according to Huber stresses the unity of the agnatic group (Huber, 1993:87). The successor may continue in the deceased's conjugal role and take care of the widow and her children. If the widow agrees, he may marry her (*valo-gba* meaning widow marriage). The choice of the widow for the successor is usually made by the elders of the house, and communicated to the widow for her consent. The consent of the widow's patrilineage is not sought because it is believed that once her

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patrilineage has given her out in marriage, they have also agreed to her widowhood marriage within her husband's lineage. This is in sharp contrast to Asante widowhood inheritance or marriage where the widow cannot remarry without the consent of her matrilineal lineage head and his elders. The Krobo widow however has the right to refuse *yalo-gba*, and she may decide to remarry from outside her late husband's lineage, and when this happens, all marriage payments are made to the late husband's lineage as refund for their initial marriage payments. But until this has taken place, the successor has the obligatory responsibility of caring for both the widow and her children.

When a married woman dies, a ritual is performed at the closing of ceremony of the funeral rites by which the widower is made to pour a libation promising to feed and care for his maternal orphans so that they may grow healthy and become responsible to take up the place of the deceased wife in society (Oral Tradition by *Okyeame* Buatey)

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# CHAPTER 4

# RESEARCH METHODOLOGY

The preceding chapter discussed excerpts of the cultures of the two ethnic groups selected for the study, from both literature and the perspectives of the study groups. This chapter focuses on the research methods and procedures adopted for the study. The chapter begins with the demographics of the study area.

## 4.1. THE RESEARCH AREA

### 4.1.1. Ghana – Country Profile

Ghana is located in the West African Sub – Region on the Gulf of Guinea, a few degrees north of the equator. It is bordered on the east by Togo; the west by Cote d'Ivoire; the north by Burkina Faso; and the south by the Atlantic Ocean. It has a total area of 238,540km$^2$, and a land area of 230,020km$^2$, slightly smaller than the size of Oregon in the United States of America.

Half of the country lies less than 152 metres above sea level. The highest point is 883 metres. The 537 kilometre coastline is mostly a low, sandy shore backed by planes and scrub and intersected by several rivers and streams, most of which are navigable only by canoe. A tropical rain forest belt, broken by heavily forested hills and many streams and rivers, extends northwards from the shore, near the Cote d'Ivoire frontier. The southern belt is gradually being encroached upon by the advancing savanna. North of this belt, the country varies from 91 to 396 metres above sea level and is covered by low bush, park-like savanna, and grassy plains.

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The climate is typically tropical. The eastern coastal belt is warm and relatively dry; the southern corner, hot and humid; and the north, hot and dry. There are seemingly two distinct rainy seasons in the south: May to June (major season) and August to September (minor season). In the north, the rainy seasons tend to merge. A dry north-eastern wind, the harmattan, blows in January and February. March is usually excessively hot and dry and it is the period for the outbreak of meningitis especially in the northern part of the country. This weather pattern appears to be changing.

**Figure 4.1: Map of Ghana Showing Study Regions**


**Study Regions**

**Source: www.mapsofworld.com**

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The Volta Lake, which is a man-made lake, extends from the Akosombo dam in south-eastern Ghana to Yapei, 520 kilometres to the north. The lake provides inland transportation, and it is the main source of hydro-electric power to the country. It is also a valuable resource for irrigation and fishing. The hydroelectric power generation from the Akosombo dam was severely constrained from the last quarter of 2008 to September of 2009 due to the poor rainfall in the previous year and a consequence of the changing weather pattern. The socio-economic implications of this cannot be over emphasized.

## 4.2 DEMOGRAPHIC OVERVIEW OF KUMASI METROPOLIS AND SEKYERE EAST DISTRICT OF THE ASHANTI REGION

### 4.2.1 Kumasi Metropolis

Kumasi metropolis is the most populous district in the Ashanti Region. During the 2000 Population Census it recorded a figure of 1,170,270, and this accounts for a third of the region's population. The Metropolitan Area has a total surface area of 254 sq km (2000 population census) with a population density of 5,419 persons per square kilometre, the second to Accra metropolis with 5,530 persons per square kilometre. The Metropolis has attracted such a large population partly because it is the regional capital, and also the most commercialised centre in the Ashanti Region. It has however been estimated that 48%, 46% and 6% of the Metropolis are urban, peri-urban and rural respectively (Metro Agric. Directorate).

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The age structure of the population in the metropolis is skewed towards the youth (2000 Population census). The highest proportions of the population are in the age cohorts 0 – 4 years (13.2%) and 5 – 9 years (12.4%). Cumulatively, 39.9% of the population is below 15 years, in contrast to other districts, which range from 40% to 47%. Thus, children constitute 34.0%, the highest proportion of household members in the metropolis. There are more males (50.2%) than females (48.8%) in the metropolis. The 2000 census results indicated that 76.9 percent of the population aged 15 years and older in the region is economically active. The proportion of the economically active population that is those who worked, for at least one day, in seven days prior to the census was 71.4% in the Kumasi metropolis. The proportion of the unemployed population in the Kumasi Metropolis is 16.0%. The unemployment rates are more pronounced in the metropolis than the remaining urban areas. Students form the highest proportion of those who are not economically active in the metropolis, followed by the aged

Although the Metropolis attracts a number of migrants from several parts of Ghana and neighbouring African countries such as Togo, Burkina Faso, Mali, Nigeria, Ivory Coast and abroad due to its strategic location its status as a brisk administrative and commercial centre, the Asante dominate all tribes in the metropolis.

### 4.2.2 Sekyere East District

Sekyere East District was created in 1988 with Effiduase as the capital. It covers a total area of 4,516 square kilometres and is located in the north-eastern part of the Ashanti Region. The district has now been divided into two districts, but the old

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demarcation was used for the study. It shares boundaries with Sekyere West District in the west, Sene District in the Brong Ahafo Region on the north-east; Afigya Sekyere and Kwabre Districts on the south west, Ejisu-Juaben District on the south, Afram Plains District in the Eastern Region on the south-east and Asante Akim North District on the south.

The total population of the district was 157,396 in the year 2000 and accounted for 4.4 per cent of the Ashanti Region's total population (GSS, 2005). The males and females formed 52 per cent and 48 per cent respectively. The district is sparsely populated with density of 35 persons per square kilometre compared to 148 persons per square kilometre for the Ashanti Region. The sex ratio based on the 2000 census was 108.5 males to 100 females. The district's population growth rate of 3.5 per cent per annum is higher than both the regional and national averages of 3.4 per cent and 2.7 per cent respectively. Similarly, the district's fertility rate of 7.5 children per woman was remarkably higher than the averages for the Ashanti Region (4.8) and Ghana (4.0) in 2000. The age distribution of the population is as follows: 0-14 years (45.9%), 15- 64 years (44%) and over 64 years (8.1%). The population dependency ratio was 117.6 in 2000 relative to 92.6 for the Ashanti Region. The district is predominantly rural with 33.7% of the population being urban dwellers. Agriculture is the main source of employment in the district accounting for about 60% of the labour force. Important crops cultivated include yam, cocoa, oil palm, maize, tomatoes onion, etc. Livestock rearing is also carried out in some parts of the district.

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An overwhelming majority of the population (95%) speaks Asante-Twi and the remaining five per cent speak other Ghanaian languages in addition to Asante-Twi.

## 4.3 DEMOGRAPHIC OVERVIEW OF MANYA AND YILO KROBO DISTRICTS OF THE EASTERN REGION

### 4.3.1 Manya Krobo District

Manya Krobo has recently been divided into two main districts, Lower and Upper Manya, however the study covered the old boundaries of the Manya Krobo District. The district covers an area of 1,476 square kilometres which forms about 8.1% of the total land area of the Eastern Region.

The 2000 Population and Housing Census recorded the population of Manya krobo district of the Eastern Region as 154,301 with about a thousand less usually residing in the district. This number forms about 7.3% of the total population of the Eastern Region. The urban population was 61,477 as against the rural population of 92,824. The sex ratio for the district was 75,254 males to 79,047 females. The most populous localities among the several localities of the district are Kpong (14, 725 people); Krobo Odumasi (13,903 people); Agomanya (13,503 people); and Asesewa (7,314 people).

The census report groups the Krobo among the Ga-Dangme ethnic group and the Krobo are the most numerous of the Adangme-speaking tribes of south-eastern Ghana. Farming is the main economic activity of the majority of the people in the district followed by bead making.

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### 4.3.2 Yilo Krobo District

Yilo Krobo District, also of the Eastern Region covers an area of 805 square kilometres constituting of about 4.2% of the land area in the region. The 2000 Population and Housing census recorded a population of 86,043 for the district.

The district is bounded in the north and East by Manya Krobo district in the south by Akuapim North and Dangme District, and on the west by New Juaben Municipal, East Akim Municipal, and Fanteakwa District. However, there are conflicts over some resources among Manya, Yilo, and Akuapim North districts due to unclear demarcation of districts. Like the inhabitants of Manya Krobo District, the main economic activity for the majority of people residing in the district is farming.

## 4.4 THE RESEARCH PROCESS

The research began with a review of literature on work done in the area of care of orphans with particular emphasis on care of AIDS orphans. This review assisted the researcher to ascertain some of the real orphan care issues pertaining at the community level. This was followed by a review of work on the study regions and the districts, looking at the traditional systems of inheritance, kinship, and some social and cultural practices such as initiation rites, marriage, domestic organization, traditional provisions for orphans, and other values and norms of the Ashanti and the Krobo. The analyses of these cultural practices provided background for the understanding of the unique cultural attributes of the study groups and also helped in examining orphan care issues within the traditional contexts and from the point of

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view of the people. Data collection instruments were then developed in line with the study objectives

## 4.5 RESEARCH DESIGN

The research was two-fold; first, was a cross-sectional study that employed quantitative methods in attempt to establish associations between Inheritance System (Patrilineal/Matrilineal), Age of Caregiver, and Orphan Status (Paternal/Maternal), and Care of Children Orphaned by AIDS. Second, was an empirical study using both quantitative (quantitative analyses of some of the relevant responses on the questionnaire) and qualitative methods to generate information on other socio-cultural factors impacting on orphan care. The study was conducted in two regions among two distinct ethnic groups in Ghana, namely Asante and Krobo.

## 4.6 STUDY POPULATION

The study was targeted at Asante and Krobo orphans aged between five and seventeen years and their caregivers. Relevant information were also gathered from organizations, individuals, families and communities involved in AIDS-Orphan care activities. These included governmental organizations (Ministries, Agencies and Departments), non-governmental organizations (international, national or civil society), donor agencies, traditional leaders/representatives, chiefs, queen mothers, PLWHA, and other key informants.

Orphans included in the study were those who have lost at least one parent to AIDS, and have been under the care of their current caregivers for a minimum period of one

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year. This was to allow enough time space to assess the care being received by orphans from their caregivers.

## 4.7 SAMPLE SELECTION

Considering the fact that AIDS orphans as well as their caregivers represent a clearly defined and relatively small group, purposive sampling technique was used throughout the study. Study regions and districts were purposively selected based on the availability of the study groups and their diverse cultural backgrounds. Study participants were recruited into the study based on their situation as orphans or caregivers directly, and for the others, on their knowledge about the cultural arena, as well as their willingness to participate in the study.

To ensure some diversity in terms of social and cultural backgrounds, and availability of adequate numbers of AIDS orphans, two regions namely, the Ashanti and Eastern Regions of Ghana were selected purposively. Factors determining the choice of Ashanti and Eastern Regions include the following:

1. Ashanti and Eastern Regions have consistently had high HIV prevalence rates since the inception of HSS system. The Eastern Region had the highest prevalence of 4.2% followed by the Ashanti Region with a prevalence of 3.8%, whilst the national prevalence was 2.6% in 2007. Agomanya (a sentinel site) in the Eastern Region had the highest prevalence of 8.9% whilst Obuasi (a sentinel site) in the Ashanti Region had the fifth highest prevalence of 5.0% (NACP, 2007)

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2. These two regions have seen huge numbers of orphans resulting from high numbers of AIDS deaths as a result of high prevalence rates over the years.
3. As a result of (2) above, various NGOs and Civil Society Organizations (CSOs) are working in these regions to mitigate the impact of HIV and AIDS and the orphan crisis, thus access to information and identification of orphans are relatively easier in these regions
4. The people of these two regions are known to be insistent on certain cultural practices that affect their lives. These include puberty rites, marriage and funeral rites. An important factor in the selection of these two regions and hence ethnic groups is their uniqueness with regard to the existence social norms such as Inheritance System which is deemed to impact significantly on care of orphans.

The study was conducted in two selected districts from the Eastern Region, and one Metropolitan area and one district from the Ashanti Region making a total of three study districts and one study metropolis. These are: Manya and Yilo Krobo Districts of Eastern Region (where a lot of Krobo reside) and Kumasi Metropolis and Sekyere East District (old demarcation) of Ashanti Region. Within each selected district and metropolis, two communities were selected, yielding a total of eight study sites. The communities are: Nhyiaeso and Amanfrom in Kumasi Metropolis; Kumawu and Senkyi in Sekyere East District; Mampong and Hwekpe in Manya Krobo District; and Plau and Sawer in the Yilo Krobo District. Rural and urban communities were selected to ascertain how AIDS orphans are cared for in both settings.

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**Table 4.1: Study Communities by Region, District/Metropolis**

| *REGION* | *DISTRICTS/METROPOLIS* | *COMMUNITIES* | |
|---|---|---|---|
| **Ashanti** | Kumasi | Nhyiaeso | Amanfrom |
| | Sekyere East | Kumawu | Senkyi |
| **Eastern** | Manya Krobo | Mampong | Hwekpe |
| | Yilo Krobo | Plau | Sawer |
| **Total 2** | 4 | 8 | |

**Source: Field Data**

AIDS orphans and their caregivers were identified in the Ashanti Region through some NGOs working on HIV and AIDS and Orphan Care in the study district and metropolis. In the Eastern Region they were identified through some staff of the District Hospital, PLWHA and an NGO working with them.

## 4.8 SAMPLE SIZE

No rigorous calculation of sample size was made in the study because no probability sampling technique was employed. A purposive/convenience sampling technique was used throughout the study. The number of orphans and caregivers used depended on the availability of orphans in the selected districts and metropolis, the length of stay with caregiver (a minimum of one year stay with primary caregiver), as well as their willingness to participate fully in the study. Thus, two hundred and ninety two (292)

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orphans (of school-going age, i.e. 5 years to 17 years), one hundred and fifty one (151) from the Eastern Region, identified through PLWHA attending clinic at the Atua hospital, and one hundred and forty one (141) from the Ashanti Region, identified through NGOs working with PLWHA and orphans, were interviewed and their anthropometric measurements taken. These measurements were used as surrogate for care in testing the hypotheses. Orphan categories involved in the study are: Maternal, Paternal, and Double orphans. These orphans were interviewed, observed and assessed to determine the quality of care they were receiving.

The primary caregivers of these orphans were also interviewed to ascertain the factors that influence their care giving activities and, also to authenticate responses by orphans. Two hundred and eighty five (285) caregivers were involved in the study, one hundred and forty five (145) from the Eastern Region and one hundred and forty (140) from the Ashanti Region. The number of caregivers was less than the number of orphans because some caregivers were taking care of more than one orphan, but where the caregiver was responsible for more than two orphans only two of the orphans were allowed to take part in the study. This was done to recruit into the study as many orphans as possible from different households. Thus, the total number of respondents for the quantitative study was five hundred and seventy seven (577).

## 4.9 DATA COLLECTION METHODS AND INSTRUMENTS

The data for the research were collected using five main methods which are: Interviews (using questionnaires and Anthropometric Measurements of Orphans); In-depth Interviews; Focus Group Discussions; Key Informants Interviews; and

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Documents Review. The first method was used to collect quantitative data from orphans and their caregivers to assess the care being received by orphans and also to test the hypotheses for the research. The second, third, and fourth methods were used to collect qualitative data from orphans, caregivers, community members, organizations, and local leaders, and the last method was used to gather related and relevant information from other studies and reports to supplement empirical data from the field. In addition to these, field observation of Asante funeral rites and celebrations, and a Friday night at Somanya (Appendix X), and general observation of the physical appearance of orphans and their living conditions played an important and useful role throughout the study.

### 4.9.1 Interviews using questionnaires and Anthropometric Measurements of Orphans

All orphans aged 8 to 17 years involved in the study answered questionnaires that sought information on their background; their general living conditions such shelter, clothing, educational status and needs; emotional/psychosocial care; health-seeking behaviour of caregivers when they are ill; general need for love and affection needs; general nutritional status by measuring three anthropometric parameters (weight, height, and mid upper arm circumference). Primary caregivers of orphans aged 5 to 7 years answered questionnaires on behalf of orphans, but orphans were made to answer questions on assessment of their psychological state and also to rate care from primary caregivers. Similar questionnaires were administered to primary caregivers of all orphans to gather data on caregivers, and their care-giving activities to cross check responses from orphans with those of their caregivers, and also gather relevant

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information on deceased parents of orphans that were thought to be unethical to ask orphans about. Further, caregivers could provide information that orphans might not know about, such as inheritance issues and deceased parent(s)' property.

The questionnaires from the Children's Needs Assessment Tool Kit (CNAToolkit, version 3, March, 2002) developed for the Early Child Development Team of the World Bank by the Task Force for Child Survival and Development aimed at assisting organizations in assessing the needs of children in areas that are heavily affected by HIV and AIDS were adapted in line with the objectives of the study and used to collect information on the basic needs, education, health and psychological needs as well as support systems available to the orphans involved in the study.

**Anthropometric Measurement:** Three nutritional anthropometric measurements were taken on all orphans involved in the study to assess their nutritional state and as a proxy for care, used to objectively test the hypotheses. These were:

**Weight**: This was measured to the nearest 0.5 kilogram with portable electronic seca scales with a digital screen. The scale was calibrated daily to ensure reliability. The orphans were weighed without any footwear and in minimum clothing. Body weight was taken because it indicates how well an individual feeds; it is the best index of nutrition and growth especially in infancy (Watson and Lowry, 1967); and it is very easy to measure.

**Height**: Height was also measured using a portable microtoise to the nearest 0.1 centimetre. The microtoise was hung 2 metres on a vertical wall, and as described by Jelliffe (1966), orphans were made to stand upright on bare feet with arms inside the

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body and feet together. Then with the back of the head, the shoulders, buttocks and the heels touching the vertical wall, the head was steadied and held comfortably erect. The headpiece of the microtoise was then lowered gently to touch the hair making contact with the head, and the height was measured to the nearest 0.1 centimetre.

**Mid Upper Arm Circumference (MUAC)**: Using a tape measure, MUAC was measured at the mid-point of the left arm. The mid-point of the arm was determined by locating the mid-point between the bony protrusion of the upper shoulder (the acromion process of the ulna) and the tip of the elbow (the olecranon process) and marking with a marker, and with the arm hanging loosely at the side of the body, the MUAC was read on the tape (Jelliffe, 1966). MUAC was taken because it is used as a screening method for underweight; and it is a useful measure of assessing malnutrition and thinness.

### 4.9.2 In-Depth Interviews

In-Depth interviews were also held at the community level with orphans aged between 10 and 17 years, and caregivers. In each of the study districts ten (10) in-depth interviews were conducted, five (5) with orphans and five (5) with caregivers. Thus a total of forty (40) in-depth interviews were organised. The purpose of these interviews was to gather in-depth information from orphans and caregivers on how orphans are cared for, their needs, feelings, perceptions and experiences as a follow-up to some of the questions in the interview questionnaires. (Table 4.2)

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**Table 4.2: In-Depth Interviews Conducted by Region, District/Metropolis and by Type of Respondents**

| REGION | DISTRICT/METROPOLIS | IN-DEPTH INTERVIEWS CONDUCTED |
|---|---|---|
| **Ashanti** | Kumasi | (5) – Orphans |
| | | (5) – Caregivers |
| | Sekyere East | (5) – Orphans |
| | | (5) – Caregivers |
| | **Total** | **20** |
| **Eastern** | Manya | (5) – Orphans |
| | | (5) – Caregivers |
| | Yilo | (5) – Orphans |
| | | (5) – Caregivers |
| | **Total** | **20** |
| **OVERALL TOTAL** | | **40** |

**Source: Field Data**

### 4.9.3 Focus Group Discussions

In each of the two selected regions (within the districts and metropolis, and the selected communities within these areas), six groupings made up of nine to twelve persons were selected purposively for Focus Group Discussions (FGDs) with adolescents and adults. For the two selected districts in each of the study regions, two FGDs were conducted among adolescents (one for girls 12 - 17 years, and one for boys 12 – 17 years) were conducted. Two FGDs were conducted among adults, one for women 18 years and above majority of whom were caregivers, and one for men 18

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years and older. One FGD was conducted for orphans, and one for PLWHA. Thus, a total of 12 FGDs were conducted in the four selected districts in the two study regions (Table 4.3).

The FGDs were used to collect spontaneous and general information on issues pertinent to orphans in the community such as how they are cared for or treated by the community; prevailing social, cultural and traditional practices and how they affect the care of orphans; differences in care of orphans and non-orphans; differences in care of paternal and maternal orphans and factors responsible for observed differences; inheritance systems and how they affect orphan care; general community perceptions, roles, and strategies for orphan care; needs of orphans, and suggestions for improving orphan care.

**Table 4.3: FGDs Conducted by Region, Distict/Metropolis and by Type of Participants**

| REGION | DISTRICT/METROPOLIS | FGDs CONDUCTED |
|---|---|---|
| **Ashanti** | Kumasi | (1) - Adult Men |
| | | (1) - PLWHA |
| | | (1) - Adolescent Boys |
| | | (1) - Adolescent Girls |
| | Sekyere East | (1) - Orphans |
| | | (1) - Adult Women |
| | **Regional Total** | 6 |

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| | | |
|---|---|---|
| Eastern | Manya Krobo | (1) - Orphans |
| | | (1) - Adolescent Girls |
| | | (1) - PLWHA |
| | | (1) - Adult Men |
| | Yilo Krobo | (1) - Adult Women |
| | | (1) - Adolescent Boys |
| | **Regional Total** | **6** |
| | **OVERALL TOTAL** | **12** |

**Source: Field Data**

### 4.9.4 Key Informants Interviews

In each of the study regions two traditional leaders were purposively selected for Key Informant Interviews (KIIs). These were Breman Kyerebio hene and Bomso hemaa in the Ashanti Region and in the Eastern Region, Queenmother of Krobo Traditional Area and Linguist of the Paramount Chief of Krobo Traditional Area. Thus, four (4) KIIs were conducted at the Regional level. Interviews with these persons were aimed at gathering information on the cultural norms and practices of their respective ethnic groups such as historical background, marriage, puberty rites, child rearing, inheritance issues, and their implications for orphan care.

At the district level, Twenty (20) KIIs were held with district officials whose responsibilities had a bearing on HIV and AIDS and on orphan care, NGOs, FBOs, PLWHA, and Assemblymen. In the Kumasi Metropolitan Area, these consisted of the Director, Regional Health Directorate; Public Health Nurse, Kumasi Metropolitan

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Health Directorate; Social Welfare Officer in charge of HIV and AIDS, Kumasi Metropolis; the Project Director of Nyame Tease (NGO); the Regional Chairman PLWHA; and the Directors of Sheikina Needy Foundation (NGO); and Onuado Kuo (FBO). A total of seven (7) KIIs were conducted in Kumasi Metropolis. In Sekyere East District, KII interviewees were the CEO, Akyerema Foundation – an NGO; PLWHA; and Public Health Nurse in the district, making a total of three (3) KIIs in Sekyere East District.

In the Manya Krobo district, KII interviewees were a Principal Nursing Officer of Atua District Hospital; Assembly woman and educationist; Assistant Programme Officer for Eastern Region Opportunities Industrialization Centres International (OICI) – an NGO; the District Social Welfare Officer in charge of HIV and AIDS; the wife of the owner of Nector Home in the absence of the owner, an Orphanage; and a PLWHA, a total of six (6) KIIs in Manya Krobo District. In the Yilo Krobo District, KIIs were held with an Assemblyman; Public Health Nurse of Somanya Polyclinic; PLWHA; and the Project Officer of Orphan Aid Africa, an NGO, a total of four (4) KIIs in Yilo Krobo District. Interviews with these persons were intended to generate information on the gravity of the orphan problem, possible programming and policy issues, support systems available for orphans, and suggestions for improvement in orphan care. In all, twenty Four (24) KIIs were held (Table 4.4)

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**Table 4.4: Key Informants Interviews Conducted by Location and Type of Key Informant**

| LOCATION | KEY INFORMANTS INTERVIEWS HELD |
|---|---|
| **Ashanti Region** | - Breman Kyerebio hene<br>- Bomso Hemaa |
| **Eastern Region** | - Queenmother, Krobo Traditional Area<br>- Linguist of the Paramount Chief of Krobo Traditional Area |
| **Kumasi Metropolis** | - Director, Regional Health Directorate<br>- Public Health Nurse<br>- Social Welfare Officer in charge of HIV and AIDS<br>- Project Director of Nyame Tease (NGO)<br>- Regional Chairman of PLWHA Group<br>- Director, Sheikina Needy Foundation (NGO)<br>- Director, Onuado Kuo (FBO)<br>- CEO, Akyerema Foundation(NGO)<br>- PLWHA |
| **Sekyere East** | - Public Health Nurse<br>- Principal Nursing Officer |
| **Manya** | - Assembly woman and educationist<br>- Assistant Programme Officer (OIC1)<br>- District Social Welfare Officer, HIV and AIDS<br>- Wife of Nector Home Owner<br>- PLWHA<br>- Assemblyman<br>- Public Health Nurse |

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| | | |
|---|---|---|
| | Yilo | - PLWHA<br>- Project Officer, Orphan Aid Africa (NGO) |
| **TOTAL** | | 24 |

**Source: Field Data**

### 4.9.5 Document Review

In addition to the extensive Literature Review, ranging from varied publications on Asanti and Krobo Culture, to relevant publications and documents on HIV and AIDS and the orphan crises and various responses within and outside Ghana, other policy and strategic documents from the study districts, Ministry of Health (NACP), Ghana AIDS Commission, UNAIDS, WHO, and UNICEF Annual Reports, Demographic and Health Survey Report, National Census Reports and relevant library materials were also used.

The document review assisted in gaining clear and broad understanding of the cultural dynamics of the study groups and how these affect the care of orphans as well as the dynamics of the HIV and AIDS epidemic and its impact in Ghana and elsewhere. It was also useful in collecting relevant and related information from journals and survey reports that supplemented the empirical findings of the study.

### 4.9.6 Data Collection Instruments

For the quantitative aspect of the study, Questionnaires made up of structured and semi-structured (open and close ended) questions, as well as Checklists of anthropometric assessment were used for information gathering. For the qualitative

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aspect of the study. Interview Guides were used for KIIs and In-Depth Interviews, and a Discussion Guide for the FGDs. In all, six different sets of instruments were used in collecting both quantitative and qualitative data. Qualitative data were recorded using MP3 Recorder. The instruments are:

i. Questionnaires for Orphans 8 – 17 years old;
ii. Questionnaires for Primary Caregivers of Orphans;
iii. In-depth Interview Guide for Orphans;
iv. In-depth Interview Guide for Caregivers of Orphans;
v. Key Informants Interview Guide for Organizations at District and Metropolitan Levels; and
vi. Focus Group Discussion Guide which was used for all the focus group discussions (The instruments are included as appendices I - VI).

Tape measure, Weighing Scale, and Microtoise were used in taking anthropometric data on orphans.

## 4.10 ETHICAL CLEARANCE

The social effects of HIV and AID are as dangerous and debilitating as their physical effects, and until the stigma and discrimination suffered by people living with HIV and AIDS and their families are addressed, the pandemic will continue to grow. Fear and prejudice prevent people from seeking proper care and getting participating in studies like this. For those infected, there is little incentive to be open about their condition if the result would mean isolation and hostility. However, openness, acceptance and support are essential for the containment of the disease.

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Therefore, necessary steps were taken to obtain approval from the Ethical Review Committee of the Ghana Health Service (GHS). Thus, the research protocol met the guidelines for research involving human subjects of the GHS (*ID NO: GHS-ERC: 13/3/08*).

Consensus was built with all parties involved in the study, and written and verbal informed consent were obtained from all literate and illiterate participants respectively. Letters introducing the researcher in the study regions, districts and metropolis were written by her head of department and addressed to appropriate authorities to enable her carry out the study in the proposed sites (appendix VII). At the level of identifying participants, agreement was made with local health facilities, NGOs, and other key informants to seek consent from PLWHA, caregivers, orphans (those who understand their plight/school going orphans), and households affected by the disease to participate in the study before they qualified to do so. No individual was coerced to be part of the study. The study looked out for, and worked with PLWHA who have already come out openly to declare their status and have joined HIV and AIDS Support Groups. Research procedures and purpose were explained carefully and thoroughly to allay the fears of all participants. Confidentiality was assured and maintained for all participants throughout the study. The study did not involve any kind of physical risks to participants. It was for academic purposes aimed at informing individuals, organizations and the government in planning interventions to improve the care and living conditions of orphans and their families.

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Three separate Consent Forms were designed: one for eligible orphans, that is those orphans above age 12 years who were willing to participate directly with consent from their parent or caregiver; one for orphans 5 to 11 years who needed assistance from their parents or caregivers to participate in the study, in such instances the parents or caregivers had to agree and sign the consent form on behalf of the orphan to enable the orphan to participate; and one for caregivers. The consent form detailed the purpose of the study to all participants; stated that participation was voluntary and participant could quit if he/she decided to at any point. The form also specified the length of time needed for the interview; indicated the fact that there are no physical risks involved in participating in the study, and the potential uses and benefits of the study. Participants were asked to sign the form or agreed that the interviewer put their initials on the form before the interviews started. The contact address and telephone numbers of the researcher were all provided on the form (see appendix VIII).

Among the Krobo, the researcher counselled three orphans who showed signs of emotional distress about their plight during the in-depth interviews, and these were referred to the district department of social welfare through their teachers for local professional assistance. Among the Asante, two of such orphans were referred to NGOs for assistance.

## 4.11 DATA QUALITY CONTROL MEASURES

### 4.11.1 Training of Data Collection Team

The data collection team included four research assistants and one supervisor in each region. They were trained to assist the researcher in the field during the data collection

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phase of the research. In the Ashanti Region, the supervisor was the Metropolitan Statistician whilst the other four were Higher National Diploma (HND) graduates working at the Statistics Department of the Kumasi Metropolitan Assembly. In the Eastern Region, the supervisor was the District Bio-Statistician of the Lower Manya Krobo District, and the other four were HND graduates working at the Records Department of Atua Hospital.

The team members were trained in data collection techniques, the facts and dynamics of HIV and AIDS in Ghana, and orphan care. In general, the training covered basic concepts of research, objectives of the study, techniques of interviewing, problem-solving during interviews, and recording of responses. Other training issues that were discussed included: the interviewer's role, the identification and selection of respondents and how to handle issues of consent. They were also taught how to take anthropometric measurements of orphans using the weighing scale, microtoise, and tape measure and they were made to practice the use of these instruments on some children during the training session. They were also taught how to calibrate the weighing scale to ensure reliability of readings. The training lasted three days.

### 4.11.2 Pre-testing of Data Collection Instruments

The FGD and KII data collection instruments were pre-tested in purposively selected districts close to the study districts to determine their appropriateness for collecting the desired data. This exercise was used to test clarity, suitability as well as logical flow of questions. The instruments were refined on the basis of issues that were raised and noted during the pre-testing exercise. The pre-test also helped to adapt the tools to

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the study objectives, and improve on the data collection techniques of the data collection team. Following the pre-test and subsequent revisions, the tools were rehearsed in Asante Twi language in the Ashanti Region and in Adangme language in the Eastern Region before they were used for the actual data collection.

### 4.11.3 Execution of Field Work

Each region had a team of five Research Assistants who interviewed the orphans and their caregivers using the interview questionnaires designed for orphans and caregivers. Each district had a team of two Research Assistants who were assigned to each district and one of them in each region worked as a supervisor. At the end of each day, the teams reported their day's activities to their respective supervisors. In the Ashanti Region, the supervisor was based in the office of the Kumasi Metropolitan Assembly (KMA) in Kumasi, and in the Eastern Region, the supervisor was based at Atua Hospital. Almost all the interviews with orphans and their caregivers were conducted on weekends since most of the orphans were school pupils. The Researcher and the supervisors made follow up and support visits especially in the first two weeks of field work to ensure the accuracy and completeness of the data being collected.

All the qualitative data were collected by the Researcher with assistance from three Research Assistants in each region. This was to ensure accurate recording of data and adequate participation of target respondents. The entire process of data collection lasted approximately eight months.

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### 4.11.4 Response Rates

Initially the plan was to interview three hundred (300) orphans and their caregivers, hundred and fifty (150) from each of the study regions, but this target was not reached due to unavailability of some orphans and their caregivers and unwillingness of some to participate in the study. Two hundred and ninety two (292) orphans and their caregivers participated in the study; one hundred and fifty one (151) from the Eastern Region, and one hundred and forty one (141) from the Ashanti Region. The total number of caregivers involved in the study was two hundred and eighty five because some caregivers had more than one orphan in their care. However, where a caregiver had more than two orphans in his/her care, only two of the orphans were interviewed. Also, in testing the hypothesis on caregiver age and orphan care, one orphan was paired with one caregiver, thus the younger orphan was paired with the caregiver with more than one orphan in his/her care.

All Key Informants targeted for the study were reached and interviewed with one exception. The Social Welfare Officer in charge of HIV and AIDS in the Manya Krobo District was new, and did not have much information on interactions between his department and the orphans in the district. He was replaced by his immediate boss who indicated that they normally attend to all children in need but orphans are usually referred to the Queenmothers Association or OICI depending on their needs.

### 4.11.5 Data Processing

The Researcher collated all completed questionnaires from the field, and cross-checked responses for completeness, consistency, and accuracy. Two independent

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data entries of responses were made by two separate clerks for all questionnaires after coding before they were analysed. Content analysis was used to analyse qualitative data on the basis of emerging themes and sub-themes within the context of the study objectives. This was useful in identifying the major issues for each of the study objectives. It also facilitated comparisons and contrasts of participants' views within and between the two ethnic groups studied.

## 4.12 DATA ANALYSES

### 4.12.1 Analyses of Quantitative Data

Responses from structured (close ended) and semi-structured (open-ended) questions were first entered into Epidata to form a data base for future reference. Some of the responses from open-ended questions such as employment status of caregivers, age of orphans and caregivers, number of dependants on caregiver, etc were coded, and data were then exported to SPSS version 18 for cleaning and analyses.

WHO AnthroPlus, a software that is used to assess nutritional status of children aged five years and above was used to determine the nutritional status of orphans using their birth dates, sex, height, and date of interview. The software compares the nutritional status of the child in question (orphan) to that of a standard child of the same sex and age from a reference population to determine if the orphan is stunted or not stunted. Thus the nutritional state of all orphans included in the study was determined using AnthroPlus which generated a Z-score or standard deviation score (which is the difference between the value for the orphan and the median value of the reference population for the same age or height divided by the standard deviation of

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the reference population) for each orphan. An orphan with a z-score greater or equal to -2 is considered not stunted, but an orphan with a Z-score less than -2 is stunted. The degree of stunting of orphans was not emphasized because for the purposes of the study, all orphans were put into two categories (Stunted or Not Stunted) using their nutritional assessment, and these were used as the proxy for care in testing the study hypotheses.

Chi-Square ($\chi^2$) tests of the components of the dependent variable (care of Orphans, using nutritional status as proxy for care) and each of the independent variables (orphan status; inheritance system; and age of caregiver) were done to test hypotheses. The level of significance was set at a probability less than 5% ($p<0.05$). Chi-Square tests were used because data were categorical and nominal.

Regression analyses of the independent variables on the dependent variables were also done to determine the influence of the independent variables on the dependent variables. Odds ratios and confidence intervals were also used to interpret the results.

### 4.12.2 Analyses of Qualitative Data

Responses from the semi-structured questions and discussions from Key Informant Interviews, in-depth interviews and Focus Group Discussions were transcribed. Qualitative data were analysed on the basis of emerging themes and sub-themes in the context of the study framework. No statistical software was used in the analysis of the qualitative data.

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Descriptive statistics were used to analyse continuous and categorical variables. Other Socio-Cultural factors found to impact on AIDS Orphan Care were listed and discussed based on quantitative parameters and the qualitative aspect of the study.

## 4.13 ASSUMPTIONS UNNDERLYING THE PRESENTATION OF STUDY RESULTS

The assumptions made in the course of the study were:

i. All orphans involved in the study were HIV sero-negative

ii. Caregivers who were on some kind of regular income (professionals) are more empowered economically to better care for orphans in their care than those on irregular income (artisans, traders, farmers) and the unemployed.

iii. Research Assistants and researcher (author) were not attracted to certain households by any means, but strictly adhered to the rules guiding convenience sampling techniques, thus the orphans and their caregivers voluntarily participated in the study.

iv. Interviews and questionnaires administration were generally similar in all cases under all circumstances.

v. Study participants and respondents provided correct and unambiguous answers to the questions asked.

vi. The information provided by the respondents was the truth and represented the true state of affairs of orphans and their caregivers

vii. Orphans involved in in-depth interviews and FGDs were not in any way influenced by any persons as to the kind of responses they should give

viii. Interviewers recorded just as they were told by study participants

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ix. Anthropometric measurements of orphans were accurately taken.

## 4.14 STUDY LIMITATIONS

1. The small numbers of AIDS orphans and their caregivers involved in the study do not warrant the generalization of results to all children orphaned by AIDS in the country
2. The study did not test the HIV status of orphans which could influence the nutritional state of orphans, though such effect could cancel out since AIDS orphans were involved in the study across the two ethnic groups
3. The plight of general orphans in the study districts and metropolis is unknown, and this makes the comparison of the plight of the AIDS orphan to that of the general orphan difficult.
4. Findings of the study reflect that of the Asante and Krobo and may not necessary apply to other matrilineal and patrilineal societies elsewhere.

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# CHAPTER 5

# RESULTS

## 5.1 SOCIO-CULTURAL FACTORS AND CARE OF AIDS ORPHANS

In the previous chapter, the study design and methods employed in data collection including how data were analysed were described. Study limitations were also outlined. In this chapter, both quantitative and qualitative findings on orphan care among the Asante and Krobo of Ghana are presented using the following outline:

1. Background characteristics of the study population;
2. Nutritional Status of Orphans (used as surrogate of care in testing hypotheses)
3. Hypotheses testing
4. Level of care of orphans, and
4. Findings from empirical studies.

### 5.1.1 Background/Socio-Demographic and Socio-Economic Characteristics of Orphans and their Caregivers

This section describes the socio-demographic and socio economic characteristics of the orphans and the caregivers involved in the study. Tables 5.1.1 and 5.1.2 summarize the socio-demographic and socio-economic characteristics of the participants. The ages of orphans ranged from 5 to 17 years with a mean age of 12.2 years. 141 (48.3%) were males and 151 (51.7%) females. The majority of them, 257 (88%) were in-school, the remaining 35 (12%) were out-of school. All Krobo orphans were Christians, and overwhelming majority of Asante orphans – 135 (95.7%) were also Christians. In all 286 (98%) of the study orphans were Christians and the

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remaining 6 (2%) were Muslim. Seventy three percent (73%) of orphans had one parent alive and the remaining 27% had lost both parents. (Refer to Table 5.1.1).

**Table 5.1.1: Socio-Demographic and Socio-Economic Characteristics of Orphans**

| | KROBO | | ASANTE | | ALL | |
|---|---|---|---|---|---|---|
| **AGE OF ORPHANS** | | | | | | |
| AGE | Freq. | Percent | Freq. | Percent | Freq. | Percent |
| 5-9 | 23 | 15.2 | 38 | 27 | 61 | 20.9 |
| 10-14 | 82 | 54.3 | 70 | 49.6 | 152 | 52.1 |
| 15 -17 | 46 | 30.5 | 33 | 23.4 | 79 | 27.1 |
| N | 151 | 100 | 141 | 100 | 292 | 100 |
| **SEX OF ORPHAN** | | | | | | |
| Male | 66 | 46.8 | 75 | 49.7 | 141 | 48.3 |
| Female | 75 | 53.2 | 76 | 50.3 | 151 | 51.7 |
| Total | 141 | 100 | 151 | 100 | 292 | 100 |
| **ORPHAN STATUS** | | | | | | |
| Single: Maternal | 49 | 32.5 | 45 | 31.9 | 94 | 32.2 |
| Single: Paternal | 63 | 41.7 | 56 | 39.7 | 119 | 40.8 |
| Double | 39 | 25.8 | 40 | 28.4 | 79 | 27.0 |
| Total | 151 | 100 | 141 | 100 | 292 | 100 |
| **SCHOOL STATUS** | | | | | | |
| In-school | 129 | 85.4 | 128 | 90.8 | 257 | 88 |
| Out of school | 22 | 14.6 | 13 | 9.2 | 35 | 12 |
| Total | 151 | 100 | 141 | 100 | 292 | 100 |
| **RELIGION OF ORPHAN** | | | | | | |
| Christian | 151 | 100.0 | 135 | 95.7 | 286 | 97.9 |
| Muslim | | | 6 | 4.3 | 6 | 2.1 |
| Total | 151 | 100 | 241 | 100 | 292 | 100 |

**Source: Field Data**

As presented in table 5.1.1, the ages of caregivers ranged from 21years to 94 years with 83% of caregivers aged between 21 and 60 years, whilst 16% were over 60 years of age, 2 (1%) Asante caregivers did not indicate their ages because they did not know exactly how old they were. One hundred and thirty eight (138), that is 48% of caregivers were widowed; 106 (37%) married; 19 (7%) had never married before; and the remaining 22 (8%) were either divorced or separated from their spouses. An

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appreciable number (163 (53%)) of caregivers as indicated in table 5.1.2 had some level of formal education. Among these only 12 (4%) had tertiary education, the majority of them, 83 (29%) had either junior or senior high education whilst 68 (24%) had only primary education. A significant proportion of caregivers, 43% (122) did not have any form of formal education.

**Table 5.1.2: Socio-Demographic and Socio-Economic Characteristics of Caregivers**

| | KROBO | | ASANTE | | ALL | |
|---|---|---|---|---|---|---|
| **AGE OF CAREGIVERS** | | | | | | |
| 21-30 | 18 | 12.4 | 12 | 8.7 | 30 | 10.6 |
| 31-40 | 47 | 32.4 | 46 | 33.4 | 93 | 32.9 |
| 41-50 | 39 | 26.9 | 30 | 21.7 | 69 | 24.4 |
| 51-60 | 24 | 16.6 | 18 | 13.1 | 42 | 14.8 |
| 61-70 | 10 | 6.9 | 22 | 15.9 | 32 | 11.3 |
| 71& above | 7 | 4.8 | 10 | 7.2 | 17 | 6.0 |
| Total | 145 | 100 | 138 | 100 | 283* | 100 |
| **SEX OF CAREGIVERS** | | | | | | |
| Male | 28 | 19.3 | 14 | 10 | 42 | 14.7 |
| Female | 117 | 80.7 | 126 | 90 | 243 | 85.3 |
| Total | 145 | 100 | 140 | 100 | 285 | 100 |
| **MARRITAL STATUS OF CAREGIVERS** | | | | | | |
| Married | 62 | 42.8 | 44 | 31.4 | 106 | 37.2 |
| Never Married | 5 | 3.4 | 14 | 10.0 | 19 | 6.7 |
| Divorced | 10 | 6.9 | 3 | 2.1 | 13 | 4.6 |
| Separated | 3 | 2.1 | 6 | 4.3 | 9 | 3.2 |
| Widowed | 65 | 44.8 | 73 | 52.1 | 138 | 48.4 |
| Total | 145 | 100.0 | 140 | 100.0 | 285 | 100 |
| **NO. OF DEPENDANTS ON CAREGIVER** | | | | | | |
| 1-3 | 20 | 13.8 | 36 | 25.7 | 56 | 19.6 |
| 4-6 | 76 | 52.4 | 52 | 37.1 | 128 | 44.9 |
| 7 & + | 49 | 33.8 | 52 | 37.1 | 101 | 35.4 |
| Total | 145 | 100.0 | 140 | 100.0 | 285 | 100.0 |

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| | | | | | | |
|---|---|---|---|---|---|---|
| **EDUCATIONAL BAKGROUND OF CAREGIVERS** | | | | | | |
| No formal education | 46 | 31.7 | 76 | 54.3 | 122 | 42.8 |
| Primary | 37 | 25.5 | 31 | 22.1 | 68 | 23.9 |
| Junior high | 41 | 28.3 | 20 | 14.3 | 61 | 21.4 |
| Senior high | 11 | 7.6 | 11 | 7.9 | 22 | 7.7 |
| Tertiary | 10 | 6.9 | 2 | 1.4 | 12 | 4.2 |
| Total | 145 | 100 | 140 | 100 | 285 | 100 |
| **EMPLOYMENT STATUS OF CAREGIVERS** | | | | | | |
| Professional** | 7 | 4.8 | 3 | 2.1 | 10 | 3.5 |
| Artisans*** | 30 | 20.7 | 3 | 2.1 | 33 | 11.6 |
| Traders | 86 | 59.3 | 62 | 44.3 | 148 | 51.9 |
| Farmers | 12 | 8.3 | 45 | 32.1 | 57 | 20.0 |
| Unemployed | 10 | 6.9 | 27 | 19.3 | 57 | 13.0 |
| Total | 145 | 100.0 | 140 | 100.0 | 285 | 100.0 |
| **RELIGION OF CAREGIVERS** | | | | | | |
| Christian | 145 | 100 | 135 | 96.4 | 280 | 98.2 |
| Muslim | 0 | 0 | 5 | 3.6 | 5 | 1.8 |
| Total | 145 | 100 | 140 | 100 | 285 | 100 |
| **RELATIONSHIP OF CAREGIVER TO ORPHAN** | | | | | | |
| Maternal Aunt/Uncle | 22 | 14.6 | 34 | 24.1 | 56 | 19.2 |
| Paternal Aunt/Uncle | 19 | 12.6 | 17 | 12.1 | 36 | 12.3 |
| Maternal/Paternal Grandparent | 50 | 33.1 | 34 | 24.1 | 84 | 28.8 |
| Sibling | 3 | 2.0 | 12 | 8.5 | 15 | 5.1 |
| Mother | 42 | 27.8 | 37 | 26.2 | 79 | 27.1 |
| Father | 15 | 9.9 | 7 | 5.0 | 22 | 7.5 |
| Other | | | | | | |
| Total | 151 | 100.0 | 141 | 100.0 | 292 | 100.0 |

**Source: Field Data**

*2 Asante Caregivers did not provide their ages.

**Teachers, office clerks, dental assistants, civil servants, pastors.

***Carpenters, stone crackers, tailors, auto mechanics, miners, blacksmith, drivers, cooks, tailors, seamstresses, Hairdressers, masons.

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Data collected on employment status of caregivers revealed that the majority of caregivers, 148 (52%) were traders; 57 (20%) were farmers; 37 (13%) were jobless individuals or housewives; 33 (12%) were artisans; and only 10 (4%) were on regular monthly income (professionals).

Thirty one percent (31%) of orphans were living with their maternal or paternal uncles and aunties, 28.8% were with their grandparents, 34.6% were with either parent and 5.1% were living with their siblings. During the in-depth interviews with caregivers and orphans, it was however realised that some caregivers were friends of the deceased parent or parents or friends of the family of the orphans, but the questionnaires did not make allowance for these, such caregivers were categorised as maternal or paternal aunts and uncles.

## 5.2. INDEPENDENT SAMPLE T-TEST BETWEEN ASANTE AND KROBO ORPHANS AND THEIR CAREGIVERS

The independent sample t- test was performed between Asante and Krobo orphans and their caregivers to find out whether there were biases in the data with respect to age, sex and schooling status (for orphans), and age, sex, educational background, and employment status (for caregivers). As indicated in tables 5.2.1 and 5.2.2, no biases were observed among these variables between Asante and Krobo orphans and their caregivers ($p>0.05$ for all the variables indicated)

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**Table 5.2.1: Independent Sample T-Test between Asante and Krobo Orphans**

| Test variables | t | P- value | Confidence interval | |
|---|---|---|---|---|
| | | | Lower boundary | Upper boundary |
| Sex | 1.484 | 0.139 | -.032 | .227 |
| Age | -1.151 | 0.251 | -1.218 | .320 |
| Schooling status | -1.676 | 0.095 | -.150 | .012 |

**Source: Field Data**

**Table 5.2.2: Independent Sample T-Test between Asante and Krobo Caregivers**

| Test variables | t | P value | Confidence interval | |
|---|---|---|---|---|
| | | | Lower boundary | Upper boundary |
| Sex | 0.352 | 0.720 | -2.843 | 4.113 |
| Age | -0.803 | 0.423 | -0.128 | 0.054 |
| Educational background | -0.990 | 0.323 | -0.579 | 0.192 |
| Employment status | 0.521 | 0.603 | -0.223 | 0.384 |

**Source: Field Data**

## 5.3 CARE OF ORPHANS USING NUTRITIONAL STATE (STUNTING) AS PROXY OF CARE OF ORPHANS

Nutritional state (stunting status) of orphans may be viewed as an outcome of care of children where food nutrients intake is one input, but other individual, household, and community variables also come into play. Stunting which is low height-for-age relative to a child of the same sex and age in a reference population may indicate compromised health or nutritional well-being (Alderman 2000, WHO 1995). A Healthy child is one that is well cared for by his parent or caregiver, this child is both physically and psychologically healthy and is not stunted. On the other hand, a stunted

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child is one that does not receive good care from his parent or caregiver. Hence, the nutritional state of orphans (stunting status) was used in determining whether an orphan is receiving good care from his parent or caregiver or not. Nutritional status and care of orphans are therefore used interchangeably in the presentation of the study findings.

Table 5.3 shows the nutritional status of orphans. The majority of the orphans, 187 (64%) were not stunted, in other words, this number had good nutritional status, however, 105 (36%) were poorly nourished and as a result had stunted growth. More Asante orphans had stunted growth, 47.5% (67 out of 141) than Krobo orphans, 25.2% (38 out of 151).

**Table 5.3: Nutritional Status of Orphans**

| | KROBO | | ASANTE | | ALL | |
|---|---|---|---|---|---|---|
| NUTRITIONAL STATUS | Freq. | % | Freq. | % | Freq. | % |
| Stunted | 38 | 25.2 | 67 | 47.5 | 105 | 36.0 |
| Not Stunted | 113 | 74.8 | 74 | 52.5 | 187 | 64.0 |
| Total | 151 | 100.0 | 141 | 100.0 | 292 | 36.0 |

**Source: Field Data**

## 5.4. AGE OF ORPHANS AND NUTRITIONAL STATUS OF ORPHANS

The proportion of younger orphans – those aged between 5 and 14 years that were stunted is greater than those aged between 15 and 17 years. As presented in table 5.2.1, 41% of those aged 5 – 9 years were stunted as against 35.5% for the 10 – 14 age

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group and 32.9% for those aged 15 – 17 years (Table 5.4). This trend was also true for Krobo orphans, for Asante orphans the highest proportion of those stunted were in the age group 15 – 17 years (63.6%).

**Table 5.4: Age of Orphans and Nutritional Status of Orphans**

| Nutritional Status | Age Group of Orphan (Years) *(OVERALL)* | | | | | | Test of Association | | |
|---|---|---|---|---|---|---|---|---|---|
| | 5 - 9 | | 10 – 14 | | 15 - 17 | | $\chi^2$ | df | P-Value |
| | Freq. | Percent | Freq. | Percent | Freq. | Percent | | | |
| Stunted | 25 | 41.0 | 54 | 35.5 | 26 | 32.9 | 1.000 | 2 | 0.607 |
| Not Stunted | 36 | 59.0 | 98 | 64.5 | 53 | 67.1 | | | |
| Total | 61 | 100 | 152 | 100 | 79 | 100 | | | |
| ***KROBO*** | | | | | | | | | |
| Stunted | 7 | 29.2 | 24 | 29.6 | 5 | 10.9 | | | |
| Not Stunted | 17 | 70.8 | 57 | 70.4 | 41 | 89.1 | 6.132 | 2 | 0.047 |
| Total | 24 | 100 | 81 | 100 | 46 | 100 | | | |
| ***ASANTE*** | | | | | | | | | |
| Stunted | 18 | 48.6 | 30 | 42.3 | 21 | 63.6 | | | |
| Not Stunted | 19 | 51.4 | 41 | 57.7 | 12 | 36.4 | 4.124 | 2 | 0.127 |
| Total | 37 | 100 | 71 | 100 | 33 | 100 | | | |

**Source: Field Data**

The test of association between age of orphans and nutritional status of orphans at 5% significance level and 2 degrees of freedom however revealed that although the overall differences observed in nutritional status of orphans observed among the various age groups were not statistically significant (p=0.607), the differences observed among the Krobo orphans were significant (p=0.047). The differences in nutritional status of orphans among the different age groups of Asante orphans were not significant statistically (p=0.127)

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## 5.5 EMPLOYMENT STATUS OF CAREGIVER AND NUTRITIONAL STATUS OF ORPHAN

When nutritional status of orphans was studied with respect to the employment status of their caregivers, it was observed that the highest proportion of stunted orphans (41.7%) had caregivers who had no fixed and regular income, followed by caregivers who were traders (37.8%); and farmers (33.3%). The caregivers with the lowest proportion of stunted orphans were artisans (29.3%); followed by caregivers who were 'professionals' (30.0%), (Table 5.5).

**Table 5.5: Employment Status of Caregiver and Nutritional Status of Orphan**

| Nutritional Status | EMPLOYMENT STATUS OF CAREGIVERS *(OVERALL)* | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Professionals | | Artisans | | Traders | | Farmers | | Unemployed | |
| | Freq. | Percent | Freq. | Percent | Freq. | Percent | Freq. | Percent | Freq. | Percent |
| Stunted | 3 | 30.0 | 12 | 29.3 | 56 | 37.8 | 19 | 33.3 | 15 | 41.7 |
| Not Stunted | 7 | 70.0 | 29 | 70.7 | 92 | 62.2 | 38 | 66.7 | 21 | 58.3 |
| Total | 10 | 100 | 41 | 100 | 148 | 100 | 57 | 100 | 36 | 100 |
| $X^2 = 1.858$; $df = 4$; $P\text{-}Value = .762$ | | | | | | | | | | |
| ***KROBO*** | | | | | | | | | | |
| Stunted | 2 | 25.0 | 3 | 13.6 | 25 | 29.8 | 3 | 12.5 | 3 | 23.1 |
| Not Stunted | 6 | 75.0 | 19 | 86.4 | 59 | 70.2 | 21 | 87.5 | 10 | 76.9 |
| Total | 8 | 100 | 22 | 100 | 84 | 100 | 24 | 100 | 13 | 100 |
| $\chi^2 = 4.594$; $df = 4$; $P\text{-}Value = .332$ | | | | | | | | | | |
| ***ASANTE*** | | | | | | | | | | |
| Stunted | 1 | 50.0 | 9 | 47.4 | 31 | 48.4 | 16 | 48.5 | 12 | 52.2 |
| Not Stunted | 1 | 50.0 | 10 | 52.6 | 33 | 51.6 | 17 | 51.5 | 11 | 47.8 |
| Total | 2 | 100 | 19 | 100 | 64 | 100 | 33 | 100 | 23 | 100 |
| $\chi^2 = 0.125$; $df = 4$; $P\text{-}Value = .998$ | | | | | | | | | | |

**Source: Field Data**

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Krobo orphans whose caregivers were traders had the highest proportion of stunting whilst the highest proportion of Asante had caregivers who were unemployed. These differences are, however, not statistically significant in all instances as indicated in table 5.5.

## 5.6 EFFECT OF INHERITANCE SYSTEM, ORPHAN STATUS, AND AGE OF CAREGIVER, ON NUTRITIONAL STATUS OF ORPHANS

This section presents the result of the hypotheses that orphans under patrilineal system of inheritance are better cared for than those under matrilineal system of inheritance, that age of caregiver affects orphan care, that paternal orphans are better cared for than maternal orphans, and that single orphans are better cared for than double orphans. Thus the impact of inheritance system, orphan status (maternal or paternal, and single or double), and age of caregiver on care of orphans as found out by the study are presented.

### 5.6.1 Inheritance System and Care of Orphans

Among the two ethnic groups studied, inheritance is regarded as a social norm that is strictly adhered to especially when there is death. As was hypothesized there were differences in the level of care given to orphans depending on whether they belong to a patrilineal or matrilineal society. These inheritance systems are represented by the Asante (who practice matrilineal system of inheritance) and the Krobo (who practice patrilineal system of inheritance).

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This section presents the results on the hypothesis that orphans under patrilineal system of inheritance are better cared for than orphans under matrilineal system of inheritance. In other words it corresponds to the result of Krobo orphans receiving better care than Asante orphans. Table 5.6 presents results on the relationship between inheritance system and the Nutritional Status (Care) of Orphans. The results indicate that the proportion of children malnourished (stunted) under matrilineal system of inheritance is about twice that of those under patrilineal system of inheritance (25.2% and 51.5% respectively).

**Table 5.6: Inheritance System and Nutritional Status of Orphans (Overall Data)**

| Nutritional Status | System of Inheritance | | | | | | Test of Association | | |
|---|---|---|---|---|---|---|---|---|---|
| | Matrilineal | | Patrilineal | | Don't Know | | | | |
| | | | | | | | $\chi^2$ | df | P-Value |
| | Freq. | Percent | Freq. | Percent | Freq. | Percent | | | |
| Stunted | 52 | 51.5 | 38 | 25.2 | 15 | 37.5 | 18.253 | 2 | .000 |
| Not Stunted | 49 | 48.5 | 113 | 74.8 | 25 | 62.5 | | | |
| Total | 101 | 100 | 151 | 100 | 40* | 100 | | | |

**Source: Field Data**

*40 interviewees and their caregivers among the Asante did not indicate the inheritance system of their families.

It is also indicated from table 5.6 that the proportion of orphans that receive good care (not stunted) under patrilineal system of inheritance is greater (74.8%), than those who receive good care under matrilineal system of inheritance (48.5%), and these observed differences are statistically significant ($\chi^2$ = 18.2523; p = 0.000) with 2 degrees of freedom and 95% confidence interval.

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Forty (40) orphans and their caregivers though indicated that they are Asante, they could not indicate the system of inheritance applicable to them, thus, they were excluded in testing the hypothesis in relation to inheritance system and nutritional status of orphans. They were however included in other areas of interest as Asante since they categorically indicated so.

When system of inheritance alone was tested against nutritional status (that is, excluding those who did not know the system of inheritance applicable to them), the difference observed was also significant statistically with a chi-square value of 18.260 and a p-value of .000, with 1 degree of freedom as indicated in table 5.6.1.

**Table 5.6.1: System of Inheritance and Nutritional Status of Orphans**

| | System of Inheritance | | | | Test of Association | | |
|---|---|---|---|---|---|---|---|
| **Nutritional Status** | Matrilineal | | Patrilineal | | $\chi^2$ | df | P-Value |
| | Freq. | Percent | Freq. | Percent | | | |
| Stunted | 52 | 51.5 | 38 | 25.2 | 18.260 | 1 | .000 |
| Not Stunted | 49 | 48.5 | 113 | 74.8 | | | |
| Total | 101 | 100 | 151 | 100 | | | |

**Source: Field Data**

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Thus, the alternate hypothesis ($H_1$) that orphans under the patrilineal system of inheritance receive better care than those under the matrilineal system of inheritance is maintained.

### 5.6.2 Orphan Status and Orphan Care

One would always perceive that when a child loses one parent, the other parent is alive to take care of the child. However, whether the single orphan receives good care or not would depend on which of the parents is alive. In the same vein, care of orphans who have lost both parents (double) may be perceived to differ from care of single orphans. Thus, sections 5.6.2.1 and 5.6.2.2 present the results in relation to the hypotheses that (i) paternal orphans (those who have lost their fathers) are better cared for than maternal orphans (those who have lost their mothers) and (ii) single orphans receive better care than double orphans respectively.

#### 5.6.2.1 Orphan Status (Paternal/Maternal) and Orphan Care

As presented in table 5.6.2.1, greater proportion of paternal orphans was stunted (37.8%) than the proportion of maternal orphan stunted (34.0%). This difference is however, not statistically significant, implying that paternal orphans do not receive better care than maternal orphans ($\chi^2$=0.324; p = 0.569) at 0.5 significance level and 1 degree of freedom. Hence, the Null Hypothesis ($H_0$) that paternal orphans do not receive better care than paternal orphans is maintained.

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**Table 5.6.2.1: Orphan Status (Paternal and Maternal) and Nutritional Status of Orphans**

| | Orphan Status *(OVERALL)* | | | | Test of Association | | |
|---|---|---|---|---|---|---|---|
| | | | | | $\chi^2$ | df | P-Value |
| **Nutritional Status** | Maternal | | Paternal | | | | |
| | Freq. | Percent | Freq. | Percent | | | |
| Stunted | 32 | 34.0 | 45 | 37.8 | 0.324 | 1 | 0.569 |
| Not Stunted | 62 | 66.0 | 74 | 62.2 | | | |
| Total | 94 | 100 | 119 | 100 | | | |
| ***ASANTE*** | | | | | | | |
| | Freq. | Percent | Freq. | Percent | | | |
| Stunted | 17 | 37.8 | 29 | 51.8 | 1.974 | 1 | 0.160 |
| Not Stunted | 28 | 62.2 | 27 | 48.2 | | | |
| Total | 45 | 100 | 56 | 100 | | | |
| ***KROBO*** | | | | | | | |
| Stunted | 15 | 30.6 | 16 | 25.4 | | | |
| Not Stunted | 34 | 69.4 | 47 | 74.6 | 0.375 | 1 | 0.541 |
| Total | 49 | 100 | 63 | 100 | | | |

**Source: Field Data**

When the data were split to determine the relationship between Orphan Status (Maternal/Paternal) and Care of Orphans separately for Asante and Krobo, it was found that among the Asante care of orphans was independent of whether the orphan is a maternal or paternal orphan, although table 5.6.2.1 depicts that greater proportion

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of maternal orphans were better cared for (62.2% not stunted) than paternal orphans (48.2% not stunted).

This was also seen in the proportion of maternal orphans that were stunted (37.8%) and the proportion of paternal orphans stunted (51.8%). This difference, however, was also not significant statistically ($\chi^2 = 1.974$; p=0.160) implying that among the Asante, paternal orphans do not receive better care than maternal orphans.

Among the Krobo (Table 5.6.2.1), greater proportion of paternal orphans were well cared for (74.6% not stunted), than the proportion of maternal orphans that were well cared for (69.4% not stunted). This observation is also statistically insignificant as indicated in table 5.4.2.1 ($\chi^2 = 0.375$; p = 0.541) at 5% significance level and 1 degree of freedom. Thus, paternal orphans are not better cared for than maternal orphans among the Krobo.

Although, statistically, the results did not show any difference between the care of paternal and maternal orphans, all informants and FGD participants except one orphan from the Manya Krobo District, expressed the perception that the paternal orphan is better cared for than the maternal orphan. Explanation from both ethnic groups indicated that most mothers feel responsible for their children and would do all they can to seek the welfare of their children. When the mother of a child dies, the living father would re-marry, they claimed, with the intention of having a woman to help him care for his maternal orphan, but in most instances, the step-mother maltreats the orphan. She usually loves her own children more than the orphan and would use all the resources of the household to benefit her own children neglecting the orphan in

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many ways. Step-mothers who really assist their husbands in taking care of maternal orphans according to participants are very few.

> *"Orphans suffer maltreatment from step-mothers, they do a lot of hard work, yet, they are the last to be considered for anything when resources are limited. Some orphans become depressed and they never recover" (FGD, Women, Yilo Krobo District).*

> *"My 'mother' takes better care of her children than me, because I do most of the work in the house, so I always go to school late, and I am the last to be given anything, including food"(Female Orphan,13years, Manya Krobo District).*

> *"My grandmother always advices me not to divorce my wife under any circumstance and re-marry because my new wife would maltreat my children, and she says this because of the situation in which my elder brother's two children find themselves. My elder brother divorced his wife who later on died, so he had to remarry, unfortunately his two children have been maltreated by his new wife ever since she joined them in their home" (FGD, Men Kumasi Metropolis).*

Most participants and informants had the perception that the worst misfortune that could befall a child is for him/her to lose his/her mother. This was expressed in many terms especially among the Asante.

> *"Ena bewuo dee, agya nwu (For a mother to die, a father should die)"(FGD,Men, Kumasi Metropolis)*

> *"Eboo pae a yenntumi mpam se nye saa dee a anka meko makoyi eno (the mark that the death of a mother leaves can never be amended, otherwise I would mend it). For example, when one is ill, the way the mother would take care of him is never the same as the way the father or any other person would"(FGD, Men, Kumasi Metropolis)*

> *"Wo na wu a na w'ebusua asa (The death of a mother is the end of a true family" (FGD, Men, Kumasi Metropolis*

> *"Had it not been my mother, I would be dead by now because my father wanted me dead even before I was born, but my mother managed to keep me up till now. I don't know my father, so I cannot say how life would be like if I*

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*lose my mother, but if my father is alive or dead, I don't care. (FGD, Adolescent Boys, Kumasi Metropolis)*

Participants and informants again pointed out that mothers love their children and spend more time with them than their fathers, and would always encourage their children to become successful in life.

*"When your mother dies, your father does not give you money but gives money to other women" (FGD Orphans, Sekyere East District).*

*"Some caregivers take good care of their own giving them more food, clothing, and other things and more attention than us" (FGD, Orphans, Manya Krobo District)*

*"If the man dies and the woman re-marries, the new husband will help her take care of the paternal orphans because in our traditional setting, when a man marries the entire family of his wife becomes his responsibility" (FGD, Women, Yilo Krobo District)*

*"Even in our culture where children are seen as belonging to their paternal family, the family of the woman is still more responsible when it comes to taking care of orphans than the family of the man" (Caregiver, Manya Krobo District)*

The orphan who perceived that it is better for a child to lose his or her mother than to lose the father narrated her story as follows:

*"I did not know my mother before she died, I was only told that she died in Abidjan, and I have never seen any maternal family member in my life. My father has been very protective of me and would do anything to ensure my welfare. I am a female, and because our family practice paternal inheritance, my aunt who I stay with presently does not like me because the family property is in the hands of my father who is to hand it down to me. She goes to the extent of calling me all sorts of names. My aunt says, my father should try and have a male child or will have to hand down the family property to her son. In all situations my father will approach me and assure me that he will make sure that nothing evil happens to me. Where is my mother's family, do they care about me? My only hope is my father". (Orphan, Female, 15years, Manya Krobo District)*

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### 5.6.2.2 Orphan Status (Single/Double) and Orphan Care

The results showing the relationship between orphan status (single or double) and Nutritional Status of orphans indicated that the proportion of double orphans who receive good care was greater than the proportion of single orphans who receive good care by about 1% (64.6% and 63.8% respectively). The same result was obtained with stunting where the proportion of single orphans that were stunted was about 1% greater than the proportion of double orphans that were stunted (table 5.6.2.2). This finding was also not statistically significant as depicted by table 5.6.2.2 ($\chi^2 = 0.013$; p = 0.911), indicating that single orphans do not receive better care than that obtained by double orphans, the Null Hypothesis ($H_0$) is again maintained in this instance.

When the influence of Orphan Status (Single/Double) on Orphan Care was explored separately for Asante and Krobo, the results as presented in table 5.6.2.2 indicated that among the Asante, the proportion of double orphans who were stunted was higher (52.5%) than that of single orphans (45.5%). In other words, more single orphans are better cared for (54.5% not stunted) than the proportion of double orphans that are better cared for (47.5%). The difference observed here, however, is not statistically significant ($\chi^2 = 0.556$; p= 0.456) at 5% significance level and 1 degree of freedom (Table 5.6.2.2), indicating that among the Asante, the care given to single orphans is not different from that given to double orphans.

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**Table 5.6.2.2: Orphan Status (Single and Double) and Nutritional Status of Orphans**

| | Orphan Status *(OVERALL)* | | | | Test of Association | | |
|---|---|---|---|---|---|---|---|
| **Nutritional Status** | Single | | Double | | $\chi^2$ | df | P-Value |
| | Freq. | Percent | Freq. | Percent | | | |
| Stunted | 77 | 36.2 | 28 | 35.4 | 0.013 | 1 | 0.911 |
| Not Stunted | 136 | 63.8 | 51 | 64.6 | | | |
| Total | 213 | 100 | 79 | 100 | | | |
| ***ASANTE*** | | | | | | | |
| Stunted | 46 | 45.5 | 21 | 52.5 | | | |
| Not Stunted | 55 | 54.5 | 19 | 47.5 | 0.556 | 1 | 0.456 |
| Total | 101 | 100 | 40 | 100 | | | |
| ***KROBO*** | | | | | | | |
| Stunted | 31 | 27.7 | 7 | 17.9 | | | |
| Not Stunted | 81 | 72.3 | 32 | 82.1 | 1.454 | 1 | 0.228 |
| Total | 112 | 100 | 39 | 100 | | | |

**Source: Field Data**

The relationship between orphan status (Single or double) and Nutritional Status among the Krobo was, however, the opposite of the Asante. As shown in table 5.6.2.2, more single orphans were stunted than the proportion of double orphans who were stunted (27.7% and 17.9% for single and double orphans respectively).

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This difference is also not statistically significant as presented in table 5.6.2.2 ($\chi^2$ = 1.454; p = 0.228), at confidence interval set at 95% with a degree of freedom of 1, implying that among the Krobo, there are no differences in the care given to single and double orphans.

### 5.6.3 Age of Care-Giver and Care of Orphan

Where AIDS is the cause of orphanhood, studies from East Africa have shown that care of orphans usually falls on old people who are grandparents or on older siblings who are orphans themselves, since HIV and AIDS most often claim the lives of persons in their productive ages. This situation has been described as problematic because both groups of caregivers find it difficult to provide care as they themselves may frequently require care from others (Biego, *et al* 1999). Thus the hypothesis that age of caregiver affects orphan care was conceived against this backdrop.

When the relationship between Caregiver Age and Orphan Care was analysed, the results indicated that orphans being taken care of by caregivers between the ages of 21 and 60 years were better cared for than those whose caregivers were 61years and above. The best cared for orphans had caregivers aged between 41 and 50 years (76.8% not stunted), and the worst cared for orphans had caregivers aged between 61 and 70 years (53.1% stunted). The effect of caregiver age on care of orphans observed in table 5.6.3 is, however, insignificant statistically at 5% level of significance with 5 degrees of freedom ($\chi^2$ = 9.602; p = 0.087). Thus the results indicate that age of caregiver has no effect on care of orphans, the Null Hypothesis ($H_0$) is therefore maintained.

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**Table 5.6.3: Age of Caregiver and Nutritional Status of Orphans**

| Nutritional Status | AGE OF CAREGIVER (YEARS) *(OVERALL)* | | | | | | | | | | | | Test of Assoc | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 21-30 | | 31-40 | | 41-50 | | 51-60 | | 61-70 | | 71 & above | | $\chi^2$ | df | P |
| | Freq | % | Freq | % | Freq | % | Freq | % | Freq | % | Freq | % | 9.602 | 5 | 0 |
| Stunted | 10 | 33.3 | 36 | 38.7 | 16 | 23.2 | 15 | 35.7 | 17 | 53.1 | 7 | 41.2 | | | |
| Not Stunted | 20 | 66.7 | 57 | 61.3 | 53 | 76.8 | 27 | 64.3 | 15 | 46.9 | 10 | 58.8 | | | |
| **Total** | 30 | 100 | 93 | 100 | 69 | 100 | 42 | 100 | 32 | 100 | 17 | 100 | | | |
| | *ASANTE* | | | | | | | | | | | | | | |
| Stunted | 7 | 58.3 | 23 | 50.0 | 10 | 33.3 | 9 | 50.0 | 14 | 63.6 | 3 | 30.0 | | | |
| Not Stunted | 5 | 41.7 | 23 | 50 | 20 | 66.7 | 9 | 50 | 8 | 36.4 | 7 | 70 | 5.690 | 5 | 0.3 |
| **Total** | 12 | 100 | 46 | 100 | 30 | 100 | 18 | 100 | 22 | 100 | 10 | 100 | | | |
| | *KROBO* | | | | | | | | | | | | | | |
| Stunted | 3 | 16.7 | 13 | 27.7 | 6 | 15.4 | 6 | 25.0 | 3 | 30.0 | 4 | 57.2 | 4.759 | 5 | 0.4 |
| Not Stunted | 15 | 83.3 | 34 | 72.3 | 33 | 84.6 | 18 | 75.0 | 7 | 70.0 | 3 | 42.9 | | | |
| **Total** | 18 | 100 | 47 | 100 | 39 | 100 | 24 | 100 | 10 | 100 | 7 | 100 | | | |

**Source: Field Data**

When the data were analysed to determine the influence of Caregiver Age on Orphan Care separately among the two ethnic groups studied, it was observed that (table

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5.6.3) among the Asante the highest proportion of orphans that were stunted (63.6%) were cared for by care-givers who were aged between 61 and 70 years, followed by those who had caregivers aged between 21 and 30 years (58.3%). Fifty percent (50%) of orphans who had caregivers aged between 31 and 40 years; and 51 and 60 years were malnourished (stunted), whilst 33.3% and 30.0% were the proportions of stunted orphans cared for by persons aged between 41 and 50 years; and 71 years and above respectively. These differences were, however, insignificant statistically as depicted by Table 5.6.3 ($\chi^2 = 6.665$; $p = 0.248$), at a level of significance of 5%, and 5 degrees of freedom. Hence, caregiver age does not affect orphan care among the Asante.

For the Krobo, 24.1% of the orphans studied were stunted. The highest proportion of stunted orphans (57.2%) had caregivers aged 71 years and above followed by those whose caregivers were aged 61 to 70 years (30.0%). The caregiver age group with the least proportion (15.4%) of malnourished (stunted) orphans was 41- 50 years. It was revealed that orphans with caregivers aged between 21 years and 60 years were better cared for than those under the care of caregivers aged 61 years and above. Table 5.6.3 also indicates the effect of age of caregiver on the care received by orphans among the Krobo. The differences shown are, however, not significant statistically ($\chi^2 = 6.860$; $p = 0.231$), indicating that among the Krobo, Caregiver Age has no effect on the care of orphans.

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## 5.7 INHERITANCE SYSTEM, ORPHAN STATUS, AND CAREGIVER AGE ON NUTRITIONAL STATUS OF ORPHANS

The test of association between inheritance system, caregiver age, and orphan status with nutritional status of orphans is presented in table 5.7. The test revealed statistically insignificant association between orphan status (single/double) upon several iterations, thus it was omitted. Only inheritance system showed significant association with nutritional status of orphans. Orphans under matrilineal system of inheritance were about twice more likely to be stunted than those under patrilineal system of inheritance (OR = 2.392; 95% CI = 1.268 – 4.411).

**Table 5.7: Effect of Inheritance System, Caregiver Age and Orphan Status (Paternal/Maternal) on Nutritional Status of Orphans**

| Determinants | Percentage | OR | 95% Confidence Interval (C I) | | P- Value |
|---|---|---|---|---|---|
| | | | Lower bound | Upper bound | |
| *OVERALL* | | | | | |
| **Age of Caregiver** | | | | | |
| 21-30 | 11.5 | 0.634 | 0.142 | 2.829 | 0.550 |
| 31-40 | 33.0 | 0.570 | 0.156 | 2.086 | 0.395 |
| 41-50 | 26.9 | 0.361 | 0.095 | 1.374 | 0.135 |
| 51-60 | 14.8 | 0.661 | 0.161 | 2.709 | 0.565 |
| 61-70 | 7.1 | 0.921 | 0.182 | 4.684 | 0.920 |
| 71&above | 6.6 | 1.000 | Referent | Referent | Referent |
| **Inheritance** | | | | | |
| Matrilineal | 39.0 | 2.392 | 1.268 | 4.511 | 0.007 |
| Patrilineal | 61.0 | 1.000 | Referent | Referent | Referent |
| **Orphan Status** | | | | | |
| Maternal | 46.2 | 0.778 | 0.398 | 1.519 | 0.462 |
| Paternal | 53.8 | 1.000 | Referent | Referent | Referent |

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| | | | | | |
|---|---|---|---|---|---|
| *ASANTE* | | | | | |
| **Age of Caregiver** | | | | | |
| 21-30 | 9.7 | 0.140 | 0.010 | 1.992 | 0.147 |
| 31-40 | 33.3 | 0.805 | 0.142 | 4.548 | 0.806 |
| 41-50 | 26.4 | 1.061 | 0.183 | 6.165 | 0.947 |
| 51-60 | 12.5 | 0.947 | 0.129 | 6.962 | 0.957 |
| 61-70 | 8.3 | 0.757 | 0.084 | 6.793 | 0.084 |
| 71&above | 9.7 | 1.000 | Referent | Referent | Referent |
| **Orphan Status** | | | | | |
| Maternal | 50.0 | 1.232 | 0.453 | 3.354 | 0.683 |
| Paternal | 50.0 | 1.000 | Referent | Referent | Referent |
| *KROBO* | | | | | |
| **Age of Caregiver** | | | | | |
| 21-30 | 12.7 | 9.741 | 0.923 | 102.764 | 0.058 |
| 31-40 | 32.7 | 4.239 | 0.597 | 30.106 | 0.149 |
| 41-50 | 27.3 | 8.168 | 1.042 | 64.053 | 0.046 |
| 51-60 | 16.4 | 3.006 | 0.389 | 23.235 | 0.291 |
| 61-70 | 6.4 | 1.785 | 0.167 | 19.030 | 0.631 |
| 71&above | 4.5 | 1.000 | Referent | Referent | Referent |
| **Orphan Status** | | | | | |
| Maternal | 43.6 | 1.335 | 0.501 | 3.560 | 0.563 |
| Paternal | 56.4 | 1.000 | Referent | Referent | Referent |

**Source: Field Data**

Orphan status (maternal or paternal) [which is expected to show some association with nutritional status of orphans, where maternal orphans would be more likely to be stunted than paternal orphans], showed no significant association with nutritional status of orphans (OR = 0.778; 95% CI = 0.398 – 1.519). Surprisingly, the test of association between caregiver age and nutritional status of orphans among the Krobo showed a statistically significant association of caregiver age range 41 – 50 years with nutritional status of orphans, where the orphans with such caregivers were about 8 times more likely to be stunted (OR = 8.168; 95% CI = 1.042 – 64.053), than those among the other age groups.

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## 5.8 FEEDING OF ORPHANS

Sixteen (80%) orphans out of the 20 in-depth interviews with orphans across both ethnic groups indicated that food was their primary need when they were asked to indicate what their needs were;

> *"I need money to buy food at school, I always go to school with an empty stomach. I'm given food once a day, only in the evenings." (Male Orphan,13 years, Manya Krobo District)*

> *"I want my sister to give me money for Lunch. I eat twice a day, morning and evening, so I feel very hungry in the afternoons." (Male Orphan, 12 years, Yilo Krobo District)*

> *"My step-mother gives me little food, so I'm hungry most of the time. When I go to school, I stir at my friends when they are eating, wishing that I had money to buy something to eat" (Female Orphan, 14 years, Kumasi Metropolis)*

Figure 5.1 indicates that about 66% of orphans sat down thrice a day to eat during the month prior to the interview whilst 33% ate twice a day. Only 1 Asante orphan indicated that he ate once in a day, and another also indicated that his eating pattern was irregular. A greater proportion of Krobo orphans had 3 regular meals per day (76.2%), than the proportion of Asante orphans who ate 3 times in a day (55.3%).

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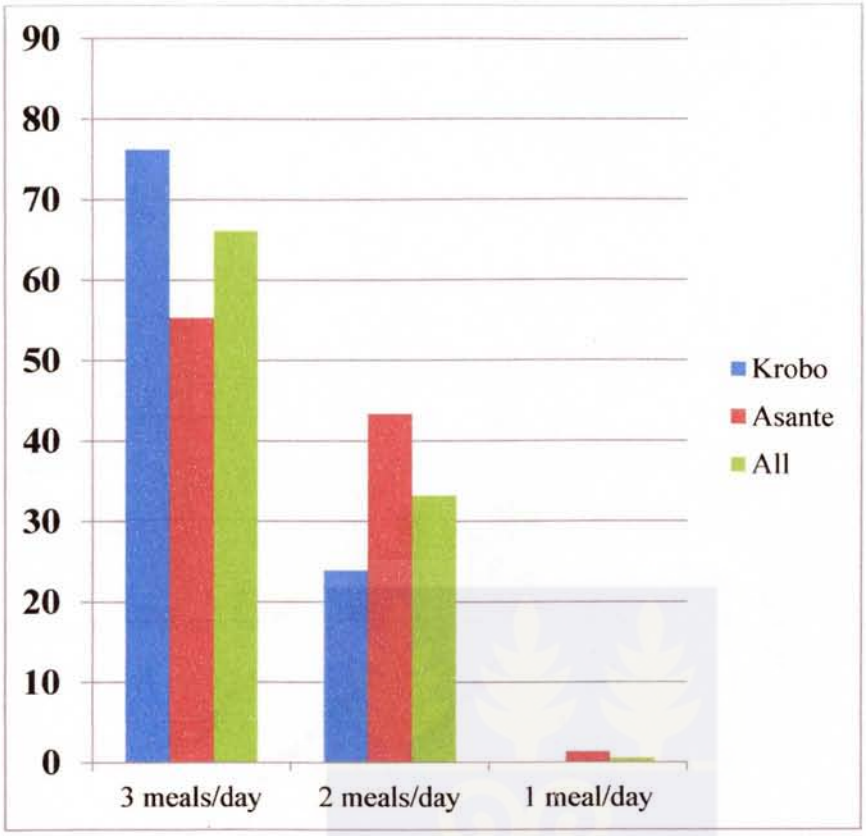
**Figure 5.1: Number of Meals/day by Orphans in the Month Prior to Interview**




**Source: Field Data**

From figure 5.2, almost 42% of orphans reported not having enough food to eat during the month prior to the interview, this consisted of about 20% not having enough food to eat two to six times a week, 4% seven times in a week, about 14% of orphans did not have enough food two to six times in the month and 4% four times in the month. Fifty eight percent (58%) of orphans, however, had enough food to eat in the month. More Asante orphans went hungry (46%) than the proportion of Krobo orphans that went hungry (38%) in the month. Thus a greater proportion (62%) of Krobo orphans reported having enough food to eat, than Asante orphans (54%).

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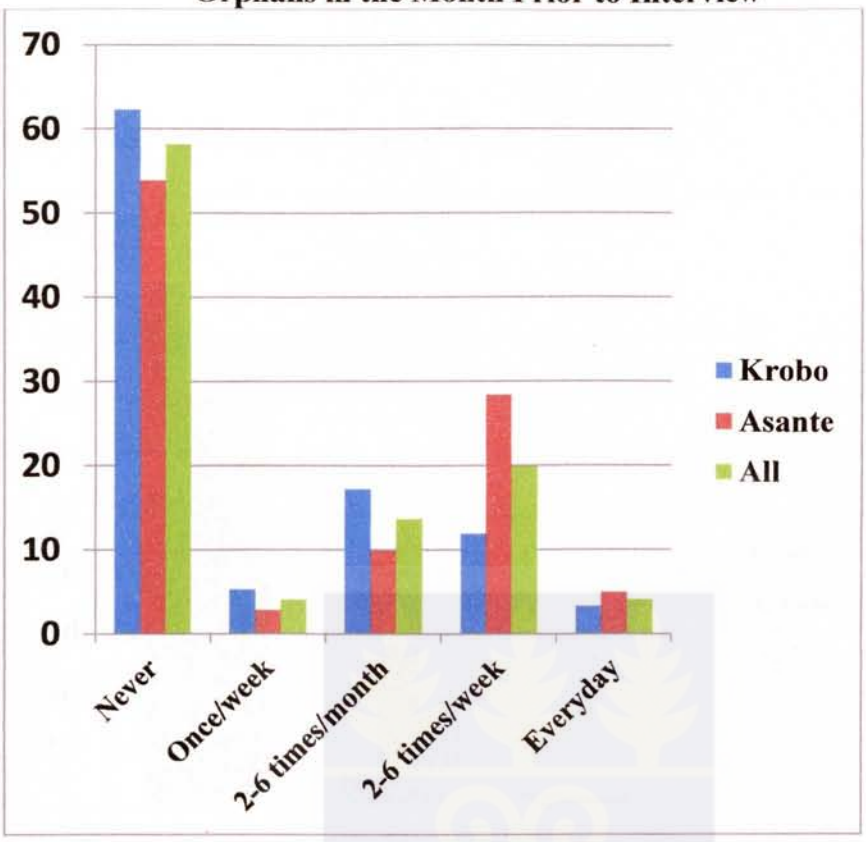
**Figure 5.2: Number of Times without Enough Food for Orphans in the Month Prior to Interview**




**Source: Field Data**

## 5.9 SHELTER OF ORPHANS

The median number of rooms occupied by households of orphans is 2, and the median number of persons that orphans sleep in the same room with is 3.

### 5.9.1 Sleeping Places of Orphans

The majority of orphans sleep in a bedroom or hall (97.6%), and 2.4% sleep in a kitchen or on a veranda. The proportion of Asante orphans that sleep in bedroom or hall is greater (98.6%) than the proportion of Krobo orphans that sleep in bedroom or hall (96.7%) by about 2%. Thus, whilst 1.4% of Asante orphans sleep in either kitchen

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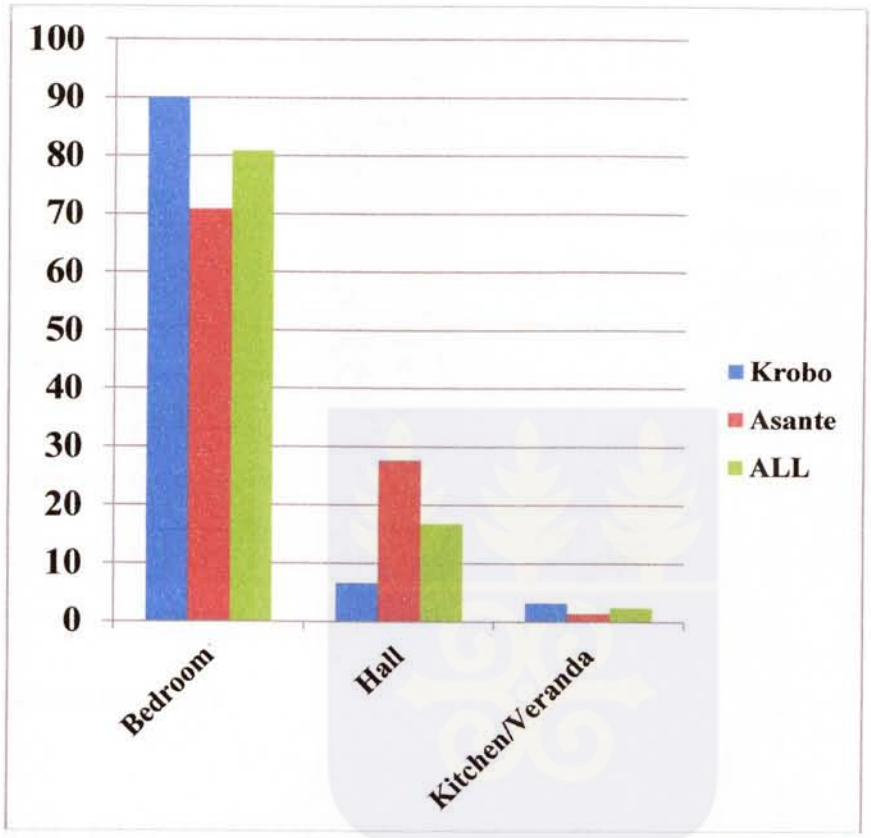
or veranda, the proportion of Krobo orphans that sleep in such places is 3.3% (Figure 5.3).

**Figure 5.3: Sleeping Places of Orphans**




**Source: Field Data**

### 5.9.2 Beddings of Orphans

The majority of orphans (64%) sleep on a mat, blanket, or cloth, whilst about 2% sleep on the bare floor, and the remaining 36% sleep on mattress (Figure 5.4). Thirty five percent (7 out of 20) of orphans involved in in-depth interviews expressed dissatisfaction with their beddings, and where they sleep.

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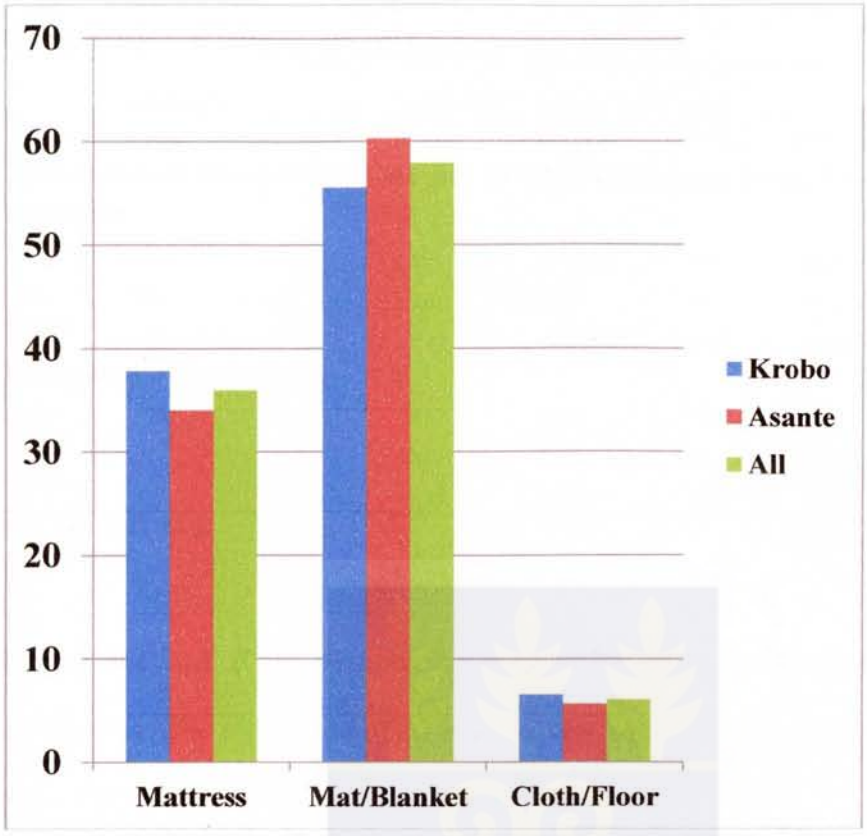
**Figure 5.4: Beddings of Orphans**




**Source: Field Data**

## 5.10 CLOTHING OF ORPHANS

Orphans that had more than one set of clothing apart from school uniform formed 80.8% of all the orphans studied. The remaining 19.2% had only one set of clothing apart from their school uniform (Table 5.10). The proportion of Asante orphans who had only one set of clothing apart from school uniform was about five times greater (32.6%) than that of Krobo orphans (6.6%).

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**Table 5.10: Clothing of Orphans**

| | KROBO | | ASANTE | | ALL | |
|---|---|---|---|---|---|---|
| | Freq. | Percent | Freq. | Percent | Freq. | Percent |
| **Possession of More Than One Set of Clothing Apart from School Uniform** | | | | | | |
| YES | 141 | 93.4 | 95 | 67.4 | 236 | 80.8 |
| NO | 10 | 6.6 | 46 | 32.6 | 56 | 19.2 |
| Total | 151 | 100.0 | 141 | 100.0 | 292 | 100.0 |
| **Possession of Footwear** | | | | | | |
| YES | 122 | 80.8 | 85 | 60.3 | 207 | 70.9 |
| NO | 29 | 19.2 | 56 | 39.7 | 85 | 29.1 |
| Total | 151 | 100.0 | 141 | 100.0 | 292 | 100.0 |

**Source: Field Data**

From Table 5.10, 70.9% of orphans had footwear, whilst 29.1% did not have any kind of footwear. The proportion of Asante orphans who did not have footwear was about twice (39.7%) that of Krobo orphans (19.2%).

## 5.11 EDUCATION OF ORPHANS

The need for school items was very high among orphans involved in in-depth interviews. Fourteen (70%) out of 20 orphans indicated the need for school items ranging from money to pay for printing of exam materials and extra classes to school gadgets and clothing for school. Table 5.11 presents information on schooling status of the orphans involved in the study. The majority of orphans 257 (88%) were in-school, out of this, about70% had their school charges paid; and had at least one pair of school sandals appropriate for school; more than 80% of orphans had books for school and were in possession of at least one school uniform. However, only 104 (40%) had school bags.

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## Table 5.11: Information on Schooling of Orphans

| ORPHANS | KROBO | | ASANTE | | ALL | |
|---|---|---|---|---|---|---|
| | Freq. | Percent | Freq. | Percent | Freq. | Percent |
| **Schooling Status** | | | | | | |
| In-School | 129 | 85.4 | 128 | 90.8 | 257 | 88.0 |
| Out-of-School | 22 | 14.6 | 13 | 9.2 | 35 | 12.0 |
| **Total** | 151 | 100.0 | 141 | 100.0 | 292 | 100.0 |
| **Reasons for Being Out-of-School** | | | | | | |
| School fees | 9 | 40.9 | 3 | 23.1 | 12 | 34.3 |
| No Reason | 13 | 59.1 | 10 | 76.9 | 23 | 65.7 |
| **Total** | 22 | 100 | 13 | 100 | 35 | 100.0 |
| **Payment of School Charges up to date** | | | | | | |
| Yes | 92 | 71.3 | 88 | 68.8 | 180 | 70.0 |
| No | 35 | 27.1 | 40 | 31.2 | 75 | 29.2 |
| Don't know | 2 | 1.6 | | | 2 | 0.8 |
| **Total** | 129 | 100.0 | 128 | 100.0 | 257 | 100.0 |
| **School Attendance per week** | | | | | | |
| 5 times | 121 | 93.8 | 100 | 78.1 | 221 | 86.0 |
| 4 times | 2 | 1.5 | 12 | 9.4 | 14 | 5.4 |
| 3 times | 2 | 1.5 | 3 | 2.3 | 5 | 1.9 |
| 2 times | 1 | 0.8 | 3 | 2.3 | 4 | 1.6 |
| Once | 3 | 2.4 | 10 | 7.9 | 13 | 5.1 |
| **Total** | 129 | 100 | 128 | 100 | 257 | 100 |
| **Possession of School Items** | | | | | | |
| **Books:** Yes | 119 | 78.8 | 90 | 70.3 | 209 | 81.3 |
| No | 10 | 6.6 | 38 | 29.7 | 48 | 18.7 |
| **Total** | 129 | 85.4 | 128 | 100 | 257 | 100 |
| **Uniform:** yes | 117 | 90.7 | 109 | 85.2 | 226 | 87.9 |
| No | 12 | 9.3 | 19 | 14.8 | 31 | 12.1 |
| **Total** | 129 | 100 | 128 | 100 | 257 | 100 |

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| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Sandals:** | yes | 104 | 80.6 | 80 | 62.5 | 184 | 71.6 |
| | No | 25 | 19.4 | 48 | 37.5 | 73 | 18.4 |
| **Total** | | 129 | 100 | 128 | 100 | 257 | 100 |
| **Bag:** | yes | 56 | 43.4 | 48 | 37.5 | 104 | 40.5 |
| | No | 73 | 56.6 | 80 | 62.5 | 153 | 59.5 |
| **Total** | | 129 | 100 | 128 | 100 | 257 | 100 |

**Source: Field Data**

Thirty five (12%) of orphans were not attending school, and 12 (34.3%) out of the 35 claimed that they were out of school because their school charges could not be paid for, the remaining 23 (65.7%) did not give any reason for not attending school. For those in school 221 (86%) go to school every day of the week except on public holidays, the remaining 36 (14%) were absent from school at least once a week. The proportion of Krobo orphans that were not going to school was more (14.6%) than that of Asante orphans (9.2%).

## 5.12 HEALTH OF ORPHANS

In-depth interviews with orphans revealed that 15 (75%) out of 20 caregivers would seek health service for the orphan only when the orphan's health condition is very poor, and only 6 out of 20 orphans had health insurance cards. Thirteen (65%) of caregivers involved in in-depth interviews also indicated that what hinders them from taking orphans to hospital when ill is money to pay for transportation and hospital bills, four (20%) indicated that a lot of time is spent in the hospital, and will only take the orphan to the hospital when it is very necessary.

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**Table 5.12: Information on Health of Orphans and Health-Seeking Behaviours of Caregivers for Orphans**

| | KROBO | | ASANTE | | ALL | |
|---|---|---|---|---|---|---|
| | Freq. | Percent | Freq. | Percent | Freq. | Percent |
| **Health Condition of Orphan** | | | | | | |
| Very good | 61 | 40.4 | 19 | 13.5 | 80 | 27.4 |
| Good | 62 | 41.1 | 76 | 53.9 | 138 | 47.3 |
| Fair | 16 | 10.6 | 37 | 26.2 | 53 | 18.2 |
| poor | 8 | 5.3 | 5 | 3.6 | 13 | 4.4 |
| Don't Know | 4 | 2.6 | 4 | 2.8 | 8 | 2.7 |
| **Total** | 151 | 100 | 141 | 100 | 292 | 100 |
| **Possession of Health Insurance Card** | | | | | | |
| Yes | 98 | 64.9 | 51 | 36.2 | 149 | 51.0 |
| No | 51 | 33.8 | 75 | 53.2 | 126 | 43.2 |
| Don't know | 2 | 1.3 | 15 | 10.6 | 17 | 5.8 |
| Total | 151 | 100 | 141 | 100 | 292 | 100 |
| **When Orphans Receive Treatment When Ill** | | | | | | |
| Same Day | 81 | 53.6 | 18 | 12.8 | 99 | 33.9 |
| Two/Three Days Later | 43 | 28.5 | 40 | 28.4 | 83 | 28.4 |
| WhenVery Ill | 16 | 10.6 | 57 | 40.4 | 73 | 25.0 |
| Treatment not sought at all | 3 | 2.0 | 10 | 7.1 | 13 | 4.5 |
| No Response | 8 | 5.3 | 16 | 11.3 | 24 | 8.2 |
| **Total** | 151 | 100.0 | 141 | 100.0 | 292 | 100.0 |
| **Health Needs of Orphans** | | | | | | |
| Met | 36 | 23.8 | 24 | 17.0 | 60 | 20.5 |
| Not Met | 93 | 61.6 | 60 | 42.6 | 153 | 52.4 |
| Don't Know | 22 | 14.6 | 57 | 40.4 | 79 | 27.1 |
| **Total** | 151 | 100.0 | 141 | 100.0 | 292 | 100.0 |

**Source: Field Data**

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Table 5.12 presents information on how orphans rate their health, possession of insurance card, health needs, and how their health needs are catered for by their caregivers.

The majority of orphans, 218 (74.7%) perceive their general health condition to be very good or good, however over 20% of them indicated that their general health condition was fair or poor, and that they have some kind of health needs that were not met. The Health Seeking Behaviour of caregivers indicated that a sizeable percentage (57.9%) of orphans were being taken care of by caregivers who will only seek treatment for orphan when the orphan's physical health condition worsens, and about 34% of orphans were being taken care of by caregivers who will seek treatment for orphan immediately that orphan complains of ill-health to avoid health complications.

## 5.13 WORKING STATUS OF ORPHANS

Figure 5.5 indicates that about 40% of the orphans were doing some kind of work, however, only 12% of them were working for money.

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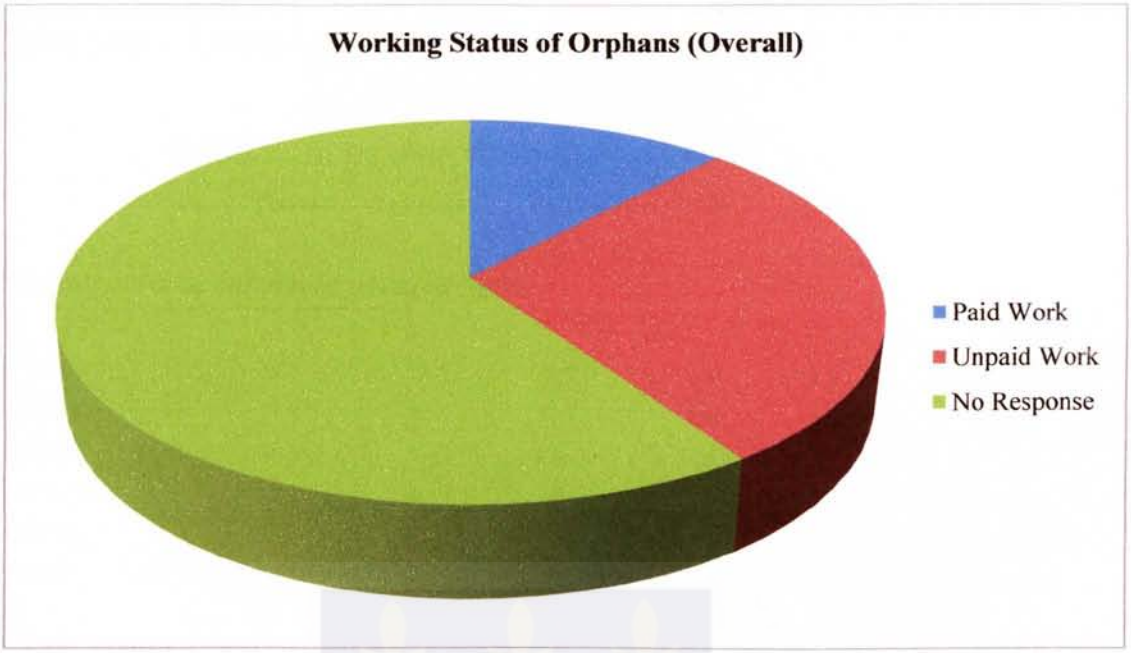
**Figure 5.5: Working Status of Orphans**




**Source: Field Data**

Those engaged in paid work indicated that they use the money to buy food, and to pay for school expenses when the need arises. They also indicated that they do so to assist their caregivers financially.

## 5.14 PSYCHO-SOCIAL STATE OF ORPHANS

In assessing the psycho-social wellbeing of orphans, they were asked to indicate how often they stay close to their primary caregiver; whether they perceive themselves to be withdrawn; unhappy, sad, or depressed most of the time; whether they are too fearful or anxious; or whether or not they have trouble sleeping. The responses are indicated in table 5.14.

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Table 5.14: Psycho-Social State of Orphans

| | KROBO | | ASANTE | | ALL | |
|---|---|---|---|---|---|---|
| | Freq. | Percent | Freq. | Percent | Freq. | Percent |
| **Staying close to caregiver when at home** | | | | | | |
| Very often | 78 | 51.7 | 52 | 36.9 | 130 | 44.4 |
| Quite often | 51 | 33.8 | 75 | 53.2 | 126 | 43.2 |
| Rarely | 16 | 10.6 | 9 | 6.4 | 25 | 8.6 |
| Don't stay at home | 6 | 4.0 | 5 | 3.5 | 11 | 3.8 |
| **Total** | 151 | 100.0 | 141 | 100.0 | 292 | 100.0 |
| **Being withdrawn/Preferring to be alone** | | | | | | |
| Yes | 35 | 23.2 | 27 | 19.1 | 62 | 21.2 |
| No | 116 | 76.8 | 114 | 80.9 | 230 | 78.8 |
| **Total** | 151 | 100.0 | 141 | 100.0 | 292 | 100.0 |
| **Unhappy, sad/depressed most of the time** | | | | | | |
| Yes | 58 | 38.4 | 60 | 42.6 | 118 | 40.4 |
| No | 93 | 61.6 | 81 | 57.4 | 174 | 59.6 |
| **Total** | 151 | 100.0 | 141 | 100.0 | 292 | 100.0 |
| **Being too fearful or anxious** | | | | | | |
| Yes | 52 | 34.4 | 59 | 41.8 | 111 | 38.0 |
| No | 99 | 65.6 | 82 | 58.2 | 181 | 62.0 |
| **Total** | 151 | 100.0 | 141 | 100.0 | 292 | 100.0 |
| **Trouble sleeping** | | | | | | |
| Yes | 14 | 9.3 | 34 | 24.1 | 48 | 16.4 |
| No | 137 | 90.7 | 107 | 75.9 | 244 | 83.6 |
| **Total** | 151 | 100.0 | 141 | 100.0 | 292 | 100.0 |

**Source: Field Data**

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The results indicated that the majority, 256 (87.6%) of orphans stay close to their caregivers when they are at home, and the remaining 36 (12.4%) do not stay at home or rarely stay close to their caregivers. About 21% indicated that they prefer to be alone most of the time; 40.4% were unhappy or depressed most of the time; 38% said they were too fearful or anxious; and 16.4% said that they could not sleep as well as they should. In all cases the majority of orphans were alright psycho-socially.

## 5.15 SUPPORT FROM EXTERNAL SOURCES OTHER THAN PRIMARY CAREGIVER

Orphans were asked to rate the support they receive from other sources apart from their caregivers. These included support from their own extended family, and those outside their extended family – friends, individuals from the community, NGOs, Government, etc. Responses are shown in table 5.15

The majority of orphans rated the support they receive from both their extended family and external sources as poor, that is 203 (69.5%) and 223 (76.4%) orphans respectively. Only 2 (0.7%) Krobo orphans felt that the support they receive from their extended family was excellent; 51(20.9%) orphans rated their extended family support as either very good or good whilst 36 (12.3%) rated it as satisfactory. Again only 1(0.3%), Krobo orphan rated support from external sources as excellent; 20 (6.9%) rated it as either very good or good; and 48 (16.4%) orphans rated support from external sources as satisfactory.

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**Table 5.15 External Support Rating by Orphans**

| | KROBO | | ASHANTI | | ALL | |
|---|---|---|---|---|---|---|
| | Freq. | Percent | Freq. | Percent | Freq. | Percent |
| **Support from Extended Family** | | | | | | |
| Excellent | 2 | 1.3 | | | 2 | .7 |
| Very good | 15 | 9.9 | 1 | .7 | 16 | 5.5 |
| Good | 19 | 12.6 | 16 | 11.3 | 35 | 12.0 |
| Satisfactory | 10 | 6.6 | 26 | 18.4 | 36 | 12.3 |
| Poor | 105 | 69.5 | 98 | 69.5 | 203 | 69.5 |
| **Total** | 151 | 100.0 | 141 | 100.0 | 292 | 100.0 |
| **Support from External Sources.** | | | | | | |
| Excellent | 1 | .7 | | | 1 | .3 |
| Very good | 7 | 4.6 | | | 7 | 2.4 |
| Good | 7 | 4.6 | 6 | 4.3 | 13 | 4.5 |
| Satisfactory | 2 | 1.3 | 46 | 32.6 | 48 | 16.4 |
| Poor | 134 | 88.7 | 89 | 63.1 | 223 | 76.4 |
| **Total** | 151 | 100.0 | 141 | 100.0 | 292 | 100.0 |

**Source: Field Data**

## 5.16 RATING OF CARE FROM PRIMARY CAREGIVER BY ORPHANS

Table 5.16 shows how orphans rated the care they were receiving from their primary caregivers. About 21% (61) of orphans indicated the care they receive from their primary caregiver as excellent, out of this 93.4% (57) are Krobo orphans. One hundred and seventy six (60.3%) orphans rated primary caregiver care as very good or good and the remaining 4.8% (14) of orphans indicated the care they receive from their primary caregiver as satisfactory.

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Table 5.16: Care from Primary Caregiver Rating by Orphans

| | KROBO | | ASANTE | | ALL | |
|---|---|---|---|---|---|---|
| | Freq. | Percent | Freq. | Percent | Freq. | Percent |
| **Care Received From Primary Caregiver** | | | | | | |
| Excellent | 57 | 37.7 | 4 | 2.8 | 61 | 20.9 |
| Very good | 47 | 31.1 | 38 | 27.0 | 85 | 29.1 |
| Good | 35 | 23.2 | 56 | 39.7 | 91 | 31.2 |
| Satisfactory | 5 | 3.3 | 36 | 25.5 | 41 | 14.0 |
| Poor | 7 | 4.6 | 7 | 5.0 | 14 | 4.8 |
| **Total** | 151 | 100.0 | 141 | 100.0 | 292 | 100.0 |

**Source: Field Data**

However, 11 (55%) out of 20 orphans involved in in-depth interviews felt unloved by their primary caregivers, whilst the remaining 9 (44%) felt the way their caregiver takes care and relate to them is satisfactory, though they felt that more could be done for them by their caregivers.

> *"My caregiver does not like me because she insults and beats me a lot, she also gives me little food. I am not being taken care of well at all. I don't feel loved by her, so I also don't like her." (Orphan, Female, 15, Manya Krobo District).*

> *"My sister should stop beating me, stop insulting my dead father, and treat me with a little respect, then will I know that she is my sister." (Orphan, Male, 13, Manya Krobo District).*

> *"The care we receive from grandmother is not enough, she must try and provide us with all we need and make sure that I have continuous education." (Orphan, Male, 12, Yilo Krobo District).*

> *"My aunt does not take good care of me, she did not take me to school, and does not give me enough food." (Orphan, Female, 14, Sekyere East District).*

> *"I know I'm not loved by my aunt, and that is why she does not take good care of me. I see my cousins happy, because their mother attends to their needs, but as for me I still use floor sack to cover myself when I'm sleeping." (Orphan, Female, 13, Kumasi Metropolis).*

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*"If my caregiver likes me, she wouldn't let me work for long hours before I'm given something to eat. I'm still living with her because I don't have anybody to assist me. All I'm waiting for is the day I can be independent and can have some happiness. I'll be very grateful to God." (Orphan, Male, 14, Kumasi Metropolis).*

The section that follows presents findings on community awareness of HIV and AIDS and their impact; the general care of children; community definition and perception of the orphan and who should care for him or her; among the Asante and Krobo of Ghana

## 5.17 COMMUNITY KNOWLEDGE, ATTITUDES AND PERCEPTIONS OF HIV AND AIDS

### 5.17.1 Knowledge, Attitudes and Perceptions of HIV and AIDS

In the Focus Group Discussions, participants were asked if they knew of the disease called AIDS, how it is transmitted and how it can be prevented. The findings indicated an almost universal understanding of HIV and AIDS across the socio-demographic characteristics of the study respondents, that is, sex (male and female); residence (urban and rural communities); and age cohorts (adolescents and adults).

Knowledge on HIV and AIDS was expressed mainly in terms of how it is spread. All the focus groups mentioned sexual intercourse as the main mode through which the disease is spread. They also mentioned transmission from infected persons through sharing of needles and other sharp objects like razor blade, transfusion, getting infected in accident situations and transmission of the infection from an infected mother to her child. The preventive measures mostly mentioned were abstaining from

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sex when young and unmarried, using condoms during sexual intercourse, sticking to one sexual partner for both the married and unmarried, avoiding sharing of sharp instruments, blood screening before transfusing, knowing one's HIV status through counselling and testing, use of sterilised gadgets in the hospital, avoiding the company of bad peers, becoming a committed Christian and remaining faithful to the word of God. Some participants especially from the urban areas and a few rural areas (Nhyiaeso, Kumawu, Mampong and Plau, and Hwekpe) had accurate knowledge of HIV as the causal agent of AIDS.

Although knowledge on HIV and AIDS was very good in all the study communities, there were a few misconceptions on the cause of the disease, its spread, prevention, and cure. There were beliefs among some persons in rural communities that the disease is a curse for those who have sinned, and that to attach such a disease to something that he has created for enjoyment and procreation, it would be too cruel on God's part. Others believed the source is witchcraft, and this was seen to influence the way the infected and AIDS orphans are supported and cared for. Some participants also believed that some herbalists have a cure for AIDS.

> *'The main cause of AIDS is sin, and not sex, because God himself created sex for us to enjoy and have children, how can he attach such a deadly disease to it, is it to destroy mankind? Infact, AIDS is the devil's disease' (FGD, Women, Sekyere East District).*

### 5.17.2 Perceived HIV and AIDS-Related Problems

When Key informants and Focus Group participants were asked about AIDS-related problems that exist in their communities, they enumerated problems stemming from

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illness and disease and death of persons in their productive ages as poverty, problems of orphans, stigma, and deviant behaviours, among others.

**Poverty:** Participants indicated that when people fall ill with HIV and AIDS, they spend a lot of money and time seeking for treatment which is nowhere to be found, they eventually drain all the family's resources leaving nothing even for their own funeral and for the care of children that are left behind. Other family members spend a lot of time taking care of the sick which leads to reduced economic productivity and hence decreased or diminished household income. This eventually creates a vicious cycle of family poverty which persists over long periods of time especially if the disease affects more people in the family. Poverty was also mentioned as the main deterrent of extended families' willingness to take on orphans.

**Orphans:** HIV and AIDS and their associated orphan problems were mentioned in all the FGDs as well as Key informants. Participants explained that orphans in most cases are seen as additional burden for other family members. As a result, a lot of them do not receive adequate care from their caregivers especially when the caring family's income is reduced because of ill members. It was also mentioned that when a parent dies of AIDS, the other parent that is left to take care of the orphans also falls sick and becomes weak, so the care of orphans usually falls on grandparents who are old and economically inactive, and can therefore not adequately take care of the orphans. Some of these children often end up on the street and become wayward, leading to increased prostitution, pilfering, drug and alcohol abuse, child abuse, etc which follow inadequate or lack of parental guidance and care.

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**Stigma:** It was reported that people stigmatize PLWHA and their families especially when they begin to show signs and symptoms of AIDS resulting from opportunistic infections like diarrhoea and tuberculosis leading to drastic loss of weight. When this happens, PLWHA suffer stigma from both family members and community members. This may cause the PLWHA to withdraw and become isolated leading to rapid degeneration of his/her physical and psychological condition, some commit suicide to end it all.

> *"When I was first diagnosed as having HIV, my elder sister whom I was living with told me she could no longer cater for me and my daughter, so I had to beg for food from friends who did not know of my HIV status, things are very tough for me and my daughter, I at times feel like killing my daughter and I'll kill myself as well to end it all" (PLWHA, Kumasi Metro).*

> *"When my husband died and I was also diagnosed as HIV positive, my family members put me in a separate room where I slept alone, they would throw a bottle with water at me when I'm thirsty. The stigma I experienced from my family alone nearly killed me, so I ran away to Kumasi where I joined a support group, and now I feel better without any family member around me, they don't even know where I am and I don't want them to know" (PLWHA, Kumasi Metro).*

Participants also reported maltreatment of widows and orphans by the deceased's family and taking away their property especially in urban areas. Some families of the deceased accuse the widows of killing their husbands because of property.

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### 5.17.3 General Care of the Child

This section presents findings on how children are generally cared for in the communities, so as to ascertain community perceptions on how every child should be cared for. Thus, Key Informants and FGD participants were asked to talk about how children are generally cared for.

In both ethnic groups a child was defined as someone who is taken care of by someone older, usually the parent, and once an individual has not started working that person continues to be a child and should be cared for. Some also believed that a child should be cared for until he or she finishes schooling. In defining who a child is using age, some felt that after 18 years, a person is no more a child, some also felt that by age 18 years some persons may still be in school and until they complete they should be regarded as children. Others also felt that whether one is in school or not by age 25, no one should be regarded as a child.

Most people believed that a child should be cared for by his or her own parents, because parents love their own children and would surely take good care of them. Hence, parents have the responsibility to provide all basic needs of their children - nutritious food, good clothing, shelter, and education, and they do so willingly. Some train their children to be religious; guide their ways by protecting them from bad friends, and teach them the right manner of behaving and talking. Among the Asanti, it was stressed that culture demands that every child is taught how to speak to the elderly, hence children are taught how to use words appropriately, so they can fit well into their society, since a parent is regarded as a bad parent if his child misbehaves

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outside the home. Parents portray that they love their children, counsel them regularly; make sure that the child is always tidy, and healthy by attending to its health needs.

### 5.17.4 Community Definition of Orphan

The Krobo defined an orphan as a child who has lost one or both parents. According to the Asante, an orphan (*agyanka)* is someone who has lost both parents, when one parent is alive, the person is not an orphan, because the living parent can take care of him, such a child is called *'awisia'*. However, both ethnic groups believed that in addition to death of parent, one can be viewed or treated as an orphan under two conditions: (i). when his or her parents have abandoned him and are not taking care of him; and (ii). When a child has been disowned by his or her father because of divorce and the mother is incapable of taking care of him or her.

### 5.17.5 Community Perception on Who Should Care for Orphans

When Focus Group participants and Key Informants were asked who they perceive should be taking care of orphans, participants gave a wide range of responses ranging from the household level through the community level to Government level. The family or next of kin of the deceased was mentioned by all the FGDs and all key informants as having the primary responsibility of caring for its orphans. Specifically maternal aunts, and grandparents were mostly mentioned. Some participants stressed that those who inherit the deceased should bear in mind that the orphans are also part of the property they inherit, and as such should be responsible for their care as well.

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*"Some people are only interested in inheriting property from the dead, forgetting that they also have the responsibility of taking care of the orphans with what they have inherited, but rather perceive the care of the orphans in their care as a burden, some even maltreat them forgetting that the property in their possession belongs to the orphans" (Assemblyman, Manya Krobo District).*

*"Yes, the one who inherits the dead parent should be responsible for the orphans' care, but often, they use the property and money inherited from the dead for their own use and neglect the orphans, some even maltreat them and take all that belong to the orphans instead of handing them over to the orphans when they are grown. In fact, they squander everything before the child grows up. In this instance, the orphans do not inherit anything" (NGO Director, Kumasi Metro)*

Some informants in the Manya Krobo District explained that care of orphans can also be arranged by the family of the deceased.

*"A woman died the same day that she delivered, and although the father of the child was alive, he was nowhere to be found, so the family of the deceased arranged with a woman whose husband agreed to take care of the family, so the family of the deceased supports this new family to take care of the child. Also, when the mother of a child dies, and the father is alive, he can decide on who he wants to care for his child (Assemblyman, Manya Krobo District).*

Some participants also felt that it is the responsibility of all community members to take care of their orphans especially the affluent in the community, because when these children become wayward, it is a disgrace to the family as well as the whole community and it is the community that suffers the consequence. Other organizations mentioned include Churches, Mosques, NGOs, Clubs and associations. All participants of focus groups and informants also mentioned the government as having the responsibility of assisting orphans in their care, by providing facilities like orphanages where orphans can be sheltered, fed, and clothed, recreational grounds

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where they can play with their peers, enforce policies in favour of orphans, for instance orphans should have free education up to the university level. A few FGD participants however felt that orphan care should be the sole responsibility of the family of the deceased and no other individual, organization or government.

> *"For me once the orphan belongs to a family, it is the sole responsibility of that family to take care of the orphan, not the government or any other individual outside the family" ( FGD,Men ,Manya Krobo District)*

## 5.18 SOCIAL PRACTICES, CULTURAL NORMS AND CARE OF ORPHANS

Findings on social practices and cultural norms and how they affect orphan care are grouped and presented in two main sections. The first section presents the cultural practices and norms whilst the second section looks at the social factors reported to impact on orphan care among the two ethnic groups involved in the study. Findings are also presented in a bi-dimensional manner where possible, that is, social and cultural factors inherent in the study communities on the part of the caregiver that affect his/her ability to care for the orphan, and those on the part of the orphan that do not auger well for his/her care and wellbeing.

Table 5.18 presents the frequencies of the social and cultural factors that were mentioned by participants involved in FGDs, Key Informants Interviews, and in-depth interviews as affecting orphan care.

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**Table 5.18. Socio-Cultural Factors Impacting on Orphan Care**

| Factors Affecting Orphan Care | Focus Group Discussions | | Key Informants Interviews | | In-Depth Interviews | |
|---|---|---|---|---|---|---|
| ***Cultural Factors*** | *Freq.* | *%* | *Freq.* | *%* | *Freq.* | *%* |
| Traditional Ceremonies: Funeral Rites | 12 | 100.0 | 23 | 95.8 | 36 | 90.0 |
| Marriage Ceremonies | 10 | 83.3 | 14 | 58.3 | 22 | 55.0 |
| Out-dooring of Babies | 10 | 83.3 | 14 | 58.3 | 20 | 50.0 |
| Traditional Rituals: Festivals | 8 | 66.7 | 16 | 66.7 | 15 | 37.5 |
| Puberty Rites | 10 | 83.3 | 18 | 75.0 | 25 | 62.5 |
| Traditional Norms: Inheritance | 12 | 100.0 | 19 | 79.2 | 20 | 50.0 |
| Polygyny | 7 | 58.3 | 12 | 50.0 | 13 | 35.0 |
| ***Social Factors*** | | | | | | |
| Alcohol and Hard Drugs | 12 | 100.0 | 22 | 91.7 | 34 | 85.0 |
| Social Eating and Drinking | 8 | 66.7 | 14 | 58.3 | 21 | 52.5 |
| Extravagant Living | 6 | 50.0 | 13 | 54.2 | 23 | 57.5 |
| Fashion | 12 | 100.0 | 21 | 87.5 | 34 | 85.0 |
| Sports and Games | 10 | 83.3 | 16 | 66.7 | 15 | 37.5 |
| Films/Video/Drama | 7 | 58.3 | 15 | 62.5 | 18 | 45.0 |
| Night Clubs/Discos | 9 | 75.0 | 15 | 62.5 | 16 | 40.0 |
| Traditional Dances | 5 | 41.7 | 12 | 50.0 | 11 | 27.5 |
| Market Days | 7 | 58.3 | 14 | 58.3 | 24 | 60.0 |
| Church Worship | 6 | 50.0 | 13 | 54.2 | 14 | 35.0 |
| Peer Influence | 8 | 66.7 | 8 | 33.3 | 8 | 20.0 |
| Stigma and Discrimination | 10 | 83.3 | 17 | 70.8 | 28 | 70.0 |

**Source: Field Data**

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### 5.18.1 Cultural Practices and Norms and their Impact on Orphan Care

Study participants in all the study districts viewed traditional rites and cultural ceremonies as factors that affect orphan care in their communities. These include Funerals; Inheritance; Marriage ceremonies, Polygyny; naming ceremonies; puberty rites (especially among the Krobo); festivals and other traditional rituals.

**Funeral Rites and Other Traditional Ceremonies:** Traditional rites in Ghana usually cover the rights of passage of child-birth, puberty, marriage and death. These celebrations are considered important and memorable in the lives of people, and provide fulfilling moments to many families and communities (MOFPED/UNDP Uganda, 2003). However, funeral rites and marriage ceremonies (engagements and weddings) were reported to particularly affect orphan care in that a lot of money is spent in organizing such traditional activities.

Funerals are celebrated in honour of the dead, thus both the Asante and Krobo view funerals as such and therefore place a great deal of importance on the funeral ceremonies of family members and loved ones. The Asante believe that a person's worth is unveiled at his funeral, hence, when an individual loses a relative he is expected to perform a befitting funeral rites and if he is not able to do so, he is looked down upon by his community (Osei Kwadwo, 2002). It is therefore not surprising that people attach much importance to funeral rites and would use money to buy clothes, shoes, bags, drinks, etc and for public donations instead of buying food for orphans and even their own children or taking them to school.

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The Asante identified about five phases of death, funeral rites and ceremonies that are all money and time consuming. These phases were mentioned as imminent death, where the initial announcement of a person's death involves purchasing of drinks and travelling long distances to inform distant relatives and significant others, printing of posters and the one-week celebration. Phase two involves pre-burial and mourning when the place where the corpse will be laid in state is refurbished and decorated with expensive materials among other rituals. During this phase, community members are expected to make cash donations to the bereaved family. Study participants mentioned that if you are a community member and do not make donations towards other people's funerals, when you are bereaved, no one will make cash donations to support you, because '*wo yɛ a na yɛyɛ ma wo*' (when you do it for others, they will also do it for you).

Phase three of Asante death funeral rites and ceremonies is the interment which involves stuffing the coffin of the dead with expensive gifts from the widow, orphans, family and even friends. FGD participants indicated that some family members demand very expensive coffin and other items from the widow and her children to the extent that the widow is usually left with no money to immediately care for the needs of her orphans. Phase four was described by the Asante as the grand funeral which begins the day following the burial with widowhood rites and other preparations towards the grand funeral. Participants lamented that during these times heavy sums of money are spent especially on the part of the widow and her children as well as the family of the deceased which may impoverish the widow for the rest of her life, thus:

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*"She may never be able to educate her children afterwards, even what to eat may be a problem for the rest of their lives" (FGD, Women, Kumasi Metropolis).*

The last phase is the periodic mourning where the dead is remembered during festive seasons like Easter, and Adae festivals where funerals are held for all the dead members of the community.

Reports indicate that some people borrow money to perform funeral rites because they want to be respected socially, and they have to pay afterwards at times with interest, leaving them with little or no money to care for their families. Among the Asante, it was also reported that there is one week celebration of the dead which involves heavy spending on making posters, buying drinks, food and other necessities to gather family members and others before the real date for the funeral is set. New clothes are purchased for almost every funeral, engagement/wedding or naming/out-dooring ceremonies, and because these festivities occur almost every day, spending on new clothing, making donations, and other related expenses continue unabated. Such expenditures diminish the physical money (on the part of the caregiver) to be spent on caring for orphans and other family members.

*"It is traditionally acceptable to sometimes borrow money to organize extravagant funerals and pay for funeral donations, while the needs of children haven't been provided for. Some people would buy new cloth for funerals, out-dooring, engagements and weddings and their children do not have presentable school uniforms" (FGD, Caregivers, Sekyere East District)*

*"My mother (aunt) buys every cloth for every occasion, and I feel that is why she always complains of not having enough money to cater for the house and my schooling" (Orphan, Sekyere East District).*

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It was also reported by both ethnic groups that funerals are organized over long periods of time and some caregivers hop from one funeral to another spending a lot of time with friends chatting and engaging in other social activities like drinking and eating with friends and other family members. they spend very little time with their children and orphans. Thus these children are left on their own without adequate supervision. In addition when more hands are needed in the preparation and organization of funeral rites and traditional ceremonies, some orphans are asked by their caregivers to assist instead of going to school.

It was also reported especially among the Krobo that the week-long funeral activities of drumming and dancing both day and night finds a lot of children including orphans entertaining themselves and engaging in casual sex with peers and elderly men with resultant teenage pregnancies and HIV infections among the youth. Some orphans place priority on such activities because it is their source of enjoyment and would even forego attending school during funerals and other traditional ceremonies.

> *"Orphans leave school almost every week-end for funerals, and at times do not return to school, so we are forced to look for some other orphans to replace them in school, for us we have to meet our target" (NGO Worker, Manya Krobo)*

It was also mentioned that it is during such activities that adolescents and the youth learn how to take in strong alcoholic drinks, because they are usually free. This can also jeopardise their future if not controlled.

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**Traditional Rituals**

Two main traditional rituals reported by both ethnic groups to affect orphan care are puberty rites and festivals.

**Festivals**: In Kumasi Metro, it was reported that a lot of preparation is made towards the celebration of the *Adae Kese* festival which is held to climax the celebrations of some specific achievements and milestones of the Asante Kingdom. FGD participants and informants in the Sekyere East District mentioned both the *Adae Kese* and the *Papa* Festival as the festivals observed by the people in the area that seem to affect orphan care. Among the Krobo, the festivals mentioned were *Ngmayem, kloyom sikplemi*, and *Easter*. In all cases participants explained that throughout the year people including the youth work, prepare, and set aside money to celebrate these festivals. New and expensive clothing are worn during festivals, a lot of tobacco and alcohol are consumed, traditional dishes are prepared and served, a lot of time spent drumming and dancing. In fact, to a lot of people, the festival provides them the opportunity to re-unite with their loved ones and hence they must be very well prepared for that. As a result, money saved for festivals would not be used on other things like schooling of orphans, feeding or paying for health services of orphans or other family members in need.

On the part of the orphan and the youth, it was pointed out that they look forward to meeting old and new friends and having fun. They dress purposely to attract men which consequently increase the spread of HIV and other sexually transmitted infections. Teenagers get pregnant and they never set eyes on the father of their babies, some commit abortion and die, others die out of the stress of being single

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mothers and increase the burden of orphans in the community. The orphan is especially vulnerable during the time of festivities if he/she is not very well supervised at home

> *"A girl came to Manya from a nearby village to witness the festival, when she went back to the village, she realised she was pregnant but could not identify the man who impregnated her because she slept with a lot of men. Infact, the Ngmayem Festival for the Manya area and the Kloyom Sikplemi for the Yilo area are presently doing more harm than ever to the youth especially orphans" (NGO Worker, Manya Krobo District)*

> *"My niece became pregnant during the 1998 Ngmayem festival and could not tell who impregnated her, so the burden of care of the child has fallen on me, unfortunately I do not have enough money to take him to senior high school when he completes his basic education" (FGD Men, Manya Krobo District).*

**Puberty Rites:** In both Asante and Krobo cultures puberty rites are performed for girls to mark the beginning of their maturity for marriage and sexual activity. Effects of puberty rites on orphan care were mostly mentioned among the Krobo. It was explained that once puberty rites are performed, orphans are especially left to cater for themselves. Some of these girls then resort to men for their basic needs, some stop schooling, and travel outside their usual places of residence and practice prostitution, some contract HIV and come back home to die. Dipo was also reported as becoming a negative practice which is now exposing girls as young as seven years old to sexual activity with all its attendant problems.

> *"Dipo is having negative effects on educating the girl child, because parents go for the children from school for dipo, so these children absent themselves from school for more than three weeks, and some are never able to catch up with school work" (NGO Worker, Yilo Krobo District)*

> *"Immediately after dipo, my aunt (uncle's wife) refused to give me anything I ask for, and I tell from all indications that she feels I'm of age for a relationship with a man, so she does not see why I should continue bothering*

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*her and the husband financially, but I still go to school" (Orphan,16 years, Yilo Krobo District)*

*"I know of a nice girl in this community who vanished only a few months after dipo had been performed for her, and now reports reaching us indicate that she is a sex worker in Abidjan" (School Teacher, Manya Krobo District)*

*"My sister's daughter is of the same age as my daughter, so the family asked for dipo to be performed for them, but I refused, so they started calling me names, I was forced to give my niece out for dipo because I was the care giver, and refused it for my daughter. Soon after, my niece travelled to Lome, and about two months ago, she came back very ill, she is dead now, but my daughter is in the university" (Assemblyman, Manya Krobo District).*

Some of the girls were reported to become rude and insolent after the rites have been performed for them, so their parents/guardians or caregivers drive them away from their homes.

*"My elder brother asked my niece who is an orphan to leave his home because she was very disrespectful and rude to him after dipo, who knows, she may now have a boy friend who gives her money" (FGD, women, Yilo Krobo District).*

Dipo was also reported to negatively affect the schooling of girls because, as soon as it is performed, men start chasing the girls, and most of them end up becoming pregnant and they stop schooling. Another traditional ritual that was mentioned among the Krobo which impacts on orphan care is *lapomi*, which involves the performance of the necessary rites on the part of a man who did not fully marry a woman before having children with her, to claim his children since the children are regarded as belonging to the woman's family. *Lapomi* can be very expensive and if this is done at the death of the mother of the children, the man is usually left with nothing to adequately cater for the orphans for sometime.

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**Traditional Norms**

The traditional norms reported to affect orphan care among the two ethnic groups studied were Inheritance and Polygyny.

**Inheritance**: Among the Krobo, study participants reported that the patrilineal system of inheritance in itself is not a bad thing since children are supposed to inherit whatever property that belongs to their father, but what really happens unfortunately is that, if parents especially the father dies whilst his children are young, the inheritor usually uses the inherited property for his own benefit and that of his own children. The inheritor sometimes totally neglects the widow and the orphans, thus, property that is to be handed over to orphans when they grow up is taken up by the inheritor and he keeps the property for his own children, so the orphan continues to suffer, to a point of even becoming wayward and rebel when he grows up.

> *"Patrilineal inheritance in itself is not a bad thing but most inheritors are greedy and use all the property for themselves and their own neglecting the orphans who should actually own the property had they not been children" (FGD Men, Yilo Krobo District).*

It was also indicated among the Krobo that patrilineal inheritance is good for the orphan only when the deceased left behind some property that the caregiver can fall in taking care of the orphan, otherwise it places financial difficulties for the caregiver.

> *"Patrilineal inheritance is good, because if the dead father of the orphans has any property, it goes to his children, but if he leaves nothing behind as in the case of my brother and his wife, then the caregiver who might be the father's relative as I am should struggle to take care of the orphans" (Blind Caregiver, 70 years, Manya Krobo District)*

Reports again indicated that if the deceased did not fully marry the woman with whom he had children, his property and wealth are all transferred to his family, that is the

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inheritor and his children, in this case the orphans suffer neglect from the deceased's family. Hence the care of the orphan in this situation falls directly on the maternal family, and if the woman also dies the care of the orphan becomes the responsibility of the direct inheritor of the woman.

> *"Properties belonging to dead mothers of fatherless children by custom belong to the orphans, but are inherited by their maternal grandfather who may use the property for himself and his own children. Where there are farmlands he usually gives empty land which yields nothing to the orphans" (Male Caregiver, Manya Krobo)*

The Asante on the other hand practice a matrilineal system of inheritance, and hold the belief that when a man dies, his children belong to their mother, as such the deceased's family neglect the orphans. Reports indicated however that tradition demands that the one who inherits the dead should also take care of the widow and orphans, but most people do not because they think that the orphans do not belong to the deceased's maternal family and that the rightful owners of the deceased's property are his nieces and nephews. It is therefore the responsibility of the widow and her family to take care of the orphans since the orphans belong to their maternal family, would inherit from their maternal uncles. Thus, the Asante hold the perception that if any property of the deceased is transferred to the orphans, that property would be lost forever to the widow's family. Consequently, the paternal family usually feels reluctant to assist the widow in taking care of the orphans. This situation is captured in the following quotes:

> *"Ohene ba ne nea ne papa te ase, egya bi wu a egya bi te ase dee, yede duadaa awisia" (The king's child is the one whose father is alive. The saying that when one's father dies, there is another one alive is only to woo the paternal orphan) (Focus Group, Men, Kumasi Metropolis)*

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*"I am taking care of two orphans, but the person who inherited their father does not care about the orphans and would not assist me in anyway" (caregiver who is the maternal grandmother of orphans, Sekyere East District).*

*"Our father's family do not take care of us, because they say we belong to our mothers family, so the only person who cares for us is our mother's sister" (Orphan, Sekyere East District).*

*"Sometimes, the one who inherits the dead father takes all the material things without taking care of the children, the maternal system of inheritance is really worrying" (Caregiver, Sekyere East District).*

*"I will say that matrilineal system of inheritance is very bad, because when my father died his father threw us out of the house that we were living in as a family, now my mother is very ill, and cannot take care of us. It is my aunt (mother's sister) who is taking care of my mother and me. The remaining three of my siblings are living with people who are not family members. I recently heard that one of my paternal uncles wants to sell my father's house, so I decided to inform another paternal uncle abroad. When I told him about it, his response was that when the house is sold, he has a share in it because my father owed him some money. I was very disappointed and sad"*
*(Orphan, Male, 15 years, Kumasi Metropolis).*

Reports also indicated that under the matrilineal system of inheritance, if the man leaves a will or gives some property to the wife and children before he dies, then the widow and orphans can have something to fall on otherwise the paternal family takes everything from the widow and orphans and ends (deceased's family) relationship with the widow and the orphans. Thus it was apparent in the study that in some cases,

*"Even if the orphans greet them, they may not respond" (FGD, Caregivers, Kumasi Metropolis)*

Inheritance was reported in the Kumasi Metropolis to breed a lot of conflict in families. Some informants however indicated that when the cause of death of parent is AIDS, the ill parent usually sells all his/her property to manage the disease leaving no

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property after his/her death, the orphans in this instance are regarded as additional burden on the inheritor.

**Polygyny:** Polygyny was reported by both ethnic groups as a cultural practice existent in their communities that affects the care of orphans. It was explained that some men who are caregivers of orphans marry more than one woman, limiting their resources to adequately take care of their own children and the orphans under his care. When this happens it is the orphan that suffers most because he is the least of priorities. It was also reported that the man with more than one wife spends little time with each of his wives and children, as such the children under his care do not have adequate supervision and engage in all kinds of bad behaviours.

> *"Gone are the days when men married many women so they can have a lot of children to assist on the farm, presently every child is going to school, and the economic situation is difficult, so if you marry more than one wife and have many children, you cannot send them to school. If you happen to have an orphan in your care, you will not be able to look after him well" (Caregiver, Sekyere East District)*

### 5.18.2 Community Social Practices and their Impacts on Orphan Care

The social practices reported to impact on care of orphans include alcohol use, tobacco and hard drug use, social eating and drinking, fashion, films, night clubs, games and sports, religious gatherings, stigma and discrimination.

**Alcohol and Hard Drugs:** Alcohol use is common in many communities in Ghana, it is used for entertainment purposes, said to promote unity and togetherness, and for some alcohol and drug use takes their minds off their problems or minimizes their

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hindrances, so they can do things that they would normally feel shy to do. In all the twelve FGDs conducted among the Asante and Krobo, and about 90% of informants of in-depth interviews indicated that alcohol, tobacco and other drugs use impact heavily on orphan care. Actions and corresponding behaviours of alcoholics were identified and discussed among both ethnic groups. Reports indicated that when people, especially men get drunk or are under the influence of hard drugs, their judgements and reasoning get impaired, become wild, and many women and children including orphans fall victim to some of their unintended actions, some even get raped and infected with HIV.

It was also indicated that such drugs are addictive and once an individual is addicted he/she will do all in his power to get it. Thus, when a caregiver is a drunkard or drug addict, his priority is to work and use his money for that and not for the care of the orphan in his/her care. Drunkards usually lose control over the orphans, and do not cite any good examples for the orphans to emulate, some of the orphans turn out to become alcoholics and drug addicts as well. Some women and orphan girls who abuse drugs and alcohol are usually taken advantage of by men who regard them as 'loose'.

It was mostly reported by orphans that alcoholic care givers usually maltreat them because they see them as an economic burden. Some orphans reported that they are even afraid of going back home from school, because their drunkard caregivers may beat them, shower insults on them, blame them unnecessarily, and even curse them sometimes.

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*"It is very difficult living with an alcoholic father, because when he gets drunk, he doesn't know where he puts his money, or whether he's already spent it, he wakes up in the morning accusing you of stealing his money and starts beating you" (FGD, Boys, Kumasi Metro).*

**Social Eating, Drinking and Extravagant Living:** It was reported especially among the Asante urban dwellers that people find it very entertaining spending time with friends in restaurants, and bars eating and drinking. People have developed habits for such living and it is very difficult for them to stop when they marry and bear children or when they are supposed to be responsible for orphans. This lifestyle leaves them little money and time to take care of their dependants. Reports also indicated that for those who engage in such social activities they prefer showing off to their drinking and eating counterparts by buying them food and drinks, some women were reported to give money to their boyfriends for such purposes at the neglect of their dependants including orphans. Ostentatious spending on buying favourite food from restaurants and bars were reported by some orphans as the reason why their caregivers cannot provide them with some of their needs.

*"My 'mother' likes sandwich and eggs, and she finds money to buy everyday, but my school uniform is worn out and she never finds money to buy me a new one" (Orphan, Kumasi Metropolis)*

It was mentioned by both the Asante and Krobo that spending too much money and time on social activities renders caregivers economically unable to provide the needs of the orphans in their care, it also takes them away from spending time with their dependants and playing their supervisory role. This makes some orphans vulnerable to many bad practices including pilfering and other social vices.

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Placing priority on building houses was also mentioned by both ethnic groups as having effect on care of orphans. FGD participants from urban areas in both ethnic groups mentioned the fact that some people place priority on acquiring physical properties than providing the needs of their dependants. When this happens orphans especially are affected and resort to other means of satisfying their needs.

> *"My uncle has not been able to buy me books the whole of this year, but he is building a house that we go there to work at times, he always complains of not having enough money" (Orphan, Male, 13 years, Yilo Krobo District).*

**Fashion:** In the study district and communities fashion was mentioned as a factor that affects the care of children and orphans. Informants and FDG participants reported that women especially follow fashion and spend a lot of money on their hair, bleaching creams, new cloth and *kaba* styles, shoes, bags and the like. This puts a strain on the limited financial resources and negatively affects care of children and orphans. A number of orphans whose caregivers are women felt that this is the main reason why they do not have adequate attention from their caregivers in the provision of their basic needs especially food, clothing, education and health.

> *"My mother buys every cloth in fashion and makes all the new styles available in town, but we do not have the freedom of eating what we yearn for like rice and chicken stew, because for her that is luxury that she cannot afford quite frequently, so we only eat it in the house during Christmas or when there is funeral in the family" (FGD, Young Boys (Kumasi Metropolis)*

**Sports and Games:** Sports and games were reported to affect the care of children in the sense that some parents and guardians are addicted to them. Football was mostly mentioned and it was explained that those who like watching football usually spend a lot of time with friends watching football in the evenings and on weekends when they could spend that time with their children, and help and supervise their 'home work'.

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In the rural areas draught was mentioned more than football, and FGD participants and informants explained that most people who play draught will spend the whole day playing without doing any work to assist their dependants economically.

> *"My uncle plays dame (draught) the whole day, and wouldn't do anything apart from that, so when you ask him money for school, he will always refer you to his wife, because she is a petty trader" (FGD, Young Boys, Sekyere East District)*

Participants also explained that orphans and other children who play a lot of football and other games often neglect their school work, and do not do well in school. Some make bad friends who influence and woo them into doing all kinds of bad things, and because they do not stay at home, they tend to steal to buy food outside the home. On the other hand, some participants felt that football and other games help take the minds of children off doing bad things like engaging in casual sex.

**Films/Video Shows and Drama:** Film shows and drama are very entertaining and for caregivers who like watching them, they buy all the new films in town, or go to the theatre and pay and watch. These monies, FGD participants of both ethnic groups explained, could be used to cater for the needs of children to enhance their quality of life.

Drama especially on television was mentioned as affecting the welfare of children in the sense that what is watched is not usually screened and these children watch and learn bad behaviours from the films and drama they watch. Nigerian movies were particularly mentioned to portray violence. Children who watch television a lot also

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neglect their school work and usually do not do well in school, though it keeps them in the home most of the time.

**Night Clubs/Discos and Traditional Dances:** Dancing is viewed by most people as a social event that indicates happiness and unity. Some FGD participants and informants across both ethnic groups mentioned night clubs and traditional dancing as having effect on care of children and orphans. For caregivers who indulge in such activities their finances are affected, since such activities involve drinking as well. In most night clubs and discos, the youth especially girls tend to dress indecently, and the dances are usually sex provocative, leading to sexual activities afterwards, and increasing the spread of HIV and other STIs among the youth. Among the Krobo it was reported that Fridays and Sundays are the days for 'chilling' for young people including orphans, and because some caregivers have lost control over these orphans they engage in drinking and having sex indiscriminately after night clubs.

Traditional dancing was especially reported among participants and informants in rural Asante where it was indicated that during moonlit nights, the youth sing, play and dance. During such times, some people dance and jump into the hands of their friends, and this can go on throughout the night. Children who engage themselves in these activities spend little time with their books and do not perform well in school. Orphans who have little or no supervision from their caregivers fall prey to such activities and their attendant problems.

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**Market Days:** Market days were particularly reported by informants among the Krobo to affect orphan care because, most caregivers who are traders would ask the children under their care to assist them sell their goods on market days. As a result, such children miss school at least once a week, and this affects their schooling. Seven (7) orphans (35% of those involved in in-depth interviews) indicated that they go to school three or four times a week because they have to sell on market days to support themselves or their caregivers.

> *"There is a very brilliant girl (orphan) in this school who misses school every Wednesday and Friday, because she has to assist her elder sister she is living with to sell tomatoes on the market at Agomanya" (School Teacher, Manya Krobo District).*

> *"I go to school 3 times in a week because I sell toffees in the market on market days, this I do to assist my grandmother to take care of me" (Orphan, Manya Krobo District).*

> *"My grandmother who I live with is 74 years, so I have to sell corn-dough on market days, so I go to school three days in a week, if I don't sell, there will be no money in the house for anything" (Orphan, Manya Krobo District).*

> *"I go to the market on Wednesdays and Fridays to sell so I can have some money to buy food and other things for school since my sister cannot provide for me all the time" (Orphan, Female, 12 years, Manya Krobo District).*

One Key Informant mentioned that some children intentionally refuse to go to school and opt to go to the market on market days only to meet their boyfriends and girlfriends.

> *"Young girls are particularly vulnerable. On market days, men usually target them on the market, make friends with them, and have sex with them afterwards" (NGO Worker, Manya Krobo District).*

**Church Worship:** About 50% of FGDs and some informants applauded church worship as having good influence on orphan care because churches teach their

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members to treat orphans well and even ask them to make donations towards the care of orphans. It was however reported that worshipping throughout the night during all night services takes caregivers from their homes at nights and the children under their care are left alone to cater for themselves. This gives the young boys and girls the opportunity to stay out of the home throughout the night, some join friends at funeral grounds, discos and night clubs, and drinking and sexual activities go on.

It was also reported that some young people who profess to be born again Christians gather at all-night prayers and worship and have sex afterwards. Caregivers would usually allow these children out the whole night thinking that they are out for prayers. Some reiterated that some pastors are involved in sexually exploiting women and young girls especially orphans and vulnerable children.

> *"Some pastors use sweet words to convince the young girls to have sex with them, impregnate them and even infect them with HIV destroying their future lives" (FGD, Men, Kumasi Metropolis)*

**Peer Influence:** When FGD participants and Informants were asked to look at the social factors on the part of orphans that negatively affect the care provided by caregivers, almost all of them mentioned peer influence. Peers are found wherever teenagers go, school, funeral, night clubs, discos, and they constantly make friends. Participants explained that teenagers learn both bad and good behaviours from their peers. For those who find themselves in the company of good peers, they are influenced to become good children and they are liked by their caregivers, as such they also receive good care, but for those who have bad friends they are influenced to

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become evil, such orphans are uncontrollable, disrespectful, and ungrateful to their caregivers, thus the caregivers feel reluctant to provide them with their needs.

> *"It is very difficult to live with a child who trusts his friends more than you, even when you have good intentions for him, he does not appreciate it, and would point fingers at you as the bad one, this hurts too much" (Caregiver, Sekyere East District).*

Some participants also pointed out that some caregivers are also influenced by their peers, and this affects the care they give to the orphans they live with. Participants explained that some caregivers take instructions or suggestions from their friends as to how they should care for the orphans and this could be good or bad for the orphan.

**Stigma and Discrimination against Orphans:** FGD participants and Informants from both ethnic groups mentioned stigma and discrimination in the homes where orphans live as affecting the wellbeing of orphans because where they exist, orphans are depressed. This affects their school work and their participation in other social activities. Among the Asante, they explained that orphans are often discriminated against by their caregivers and their children when they go wrong, some receive severe punishment which non-orphans do not receive for similar offences. Orphans are regarded as poor people, and do not deserve to use certain things in the home like a set of cutlery, some even take different food from what the rest of the family are eating. Some orphans eat for example, *waakye* or *koko* bought from the roadside every morning, whilst the rest of the family eats cooked food from the home.

Participants of FGDs and informants also mentioned that some orphans are discriminated against by their play mates, especially when they know that the parents

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died of AIDS. Some accuse these orphans of being witches that is why they have lost their parents.

> *"A child in our area is fond of telling an orphan they live with not to eat with a spoon because poor people don't eat with cutlery, constantly reminding the orphan that she is poor and does not have to behave like other people whose parents can fend for them" (FGD, Men, Kumasi Metro).*

> *"Someone insulted the child I am taking care of that he does not have parents, when the child did not know, and he came home crying bitterly" (Maternal grandmother, Sekyere East District).*

> *"Some friends make fun of us when they have something we don't have, some even go to the extent of telling us that we are the cause of our parents' death, so they refuse to talk to us, and that can be very embarrassing"(FGD, Orphan, Sekyere East District ). "*

> *"We are often beaten in the house, insulted at the least provocation" (FGD, Orphan, Sekyere East District)*

The Krobo also explained that orphans are discriminated against in the way things are shared in the home, for instance, food, clothing, and education. They are discriminated against as to who should go to school amidst limited resources and who to continue to the highest educational level possible.

> *"I feel so much unloved by my caregiver because she often insults and beats me, she also gives me little food, I'm much worried about this situation in the home" (Orphan, Manya Krobo District)*

> *"In Krobo land, orphans are easily identified in the way they dress, schooling, feeding, etc. This is because most people including caregivers complain of limited financial and material resources and most of what they have are used on their own children first before the orphan is considered"(FGD, Adolescent Boys, Yilo Krobo District)*

> *"There is strong discrimination between orphans and non-orphans. We wear old and torn uniforms the whole year whiles our colleagues have new ones on. We are not given enough money for feeding at school. We do not have new clothing on occasions such as Christmas, Easter or even for Sunday church. We are teased by friends because we are poor and do not have parents. We at*

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*times are exposed to very bad things in the environment and we become confused and worried if we feel we need all these things" (FGD, Orphans, Manya Krobo)*

Some Caregivers however claimed that the character of the orphan is also important in determining whether he/she would be discriminated against or not, according to them some orphans are very bad/wicked children and it is difficult for the caregiver to consider spending money on them, especially when resources are limited.

*"Whether an orphan would be discriminated in the household or not also depends on his/her character and the availability of resources, at times there is very little money for the household, so the one that is obedient and respectful is considered first"(Caregiver,Yilo Krobo District).*

Eleven out of the 20 (55%) orphans involved in in-depth interviews felt that they are discriminated against physically by their caregivers and peers whilst 45% felt that they are not discriminated physically by anyone.

*"I don't feel discriminated against except that I feel I'm too poor, and that makes me uncomfortable in the midst of my peers." (Orphan Female,14, Manya Krobo District)*

*"I don't feel stigmatised or discriminated against by my aunt or peers. I feel that my aunt genuinely does not have the money to pay for my school expenses." (Orphan, Female, 12, Yilo Krobo District).*

*"I am discriminated against by my brother's wife, because when I need something, she will tell my brother not to give it to me because she feels I don't need it, but her children are always given whatever they ask for."(Orphan, Male, 14, Manya Krobo District).*

*"I am discriminated against by my aunt, because I'm not given what I need like school uniform. She often beats and insults me. I sleep on cloth on the floor whilst her children sleep on mattresses. Her children also insult me at times." (Orphan, Female, 13, Kumasi Metropolis).*
*"I feel discriminated against by my aunt, because I am the only one in the house who wear old clothes during Christmas, she buys new ones for her children claiming that their father bought the clothes for them, yet I do all the hard work on the farm." (Orphan, Male, 12, Sekyere East District)*

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## 5.19. Needs of Asante and Krobo Caregivers

Money was indicated by all 20 (100%) caregivers involved in in-depth interviews as their primary need in carrying out their care-giving activities. Thirteen (80%) of caregivers mentioned jobs that would provide them with regular monthly income as their need as well.

> *"With money, I can provide for the needs of these children without any problem, but as at now, I must say it is very difficult for us" (Caregiver, Sekyere East District)*

> *"I will say that we need more food, and clothing, but what is most pressing is money, since money can buy all that" (Caregiver, Manya Krobo District)*

> *"I need a job to enable me earn some money, so that life can be a little bit easier for us" (Caregiver, Kumasi Metropolis)*

For those who are HIV positive, they requested in addition to money 'Good Health' to enable them take good care of the orphans in their custody.

> *"My worst fear is that, if I'm no more, who will take of the children? I need good health, I need to be strong, so I can take care of the children, till they will be independent" (PLWHA Caregiver, Manya Krobo District)*

The next chapter discusses the main findings of the study making references, where appropriate, to findings from other places. It also makes inferences to the social and cultural norms of the study groups where applicable.

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# CHAPTER SIX

## 6.0: DISCUSSION OF RESULTS

### Introduction

Children may lose one or both parents to natural or unnatural causes – accidents, natural disasters, and health-related problems. Orphan status acquired as a result of these causes may be referred to as general orphans. Orphan status arising specifically out of AIDS is referred to as AIDS orphans. The onset of HIV and AIDS about three decades ago in the country has compounded and multiplied the burden of orphans especially in the regions that have witnessed relatively high prevalence rates over the years. AIDS orphans unlike general orphans are often discriminated against and stigmatized in the societies in which they live (Atobrah, 2005).

Apart from stigmatisation, the tendency of AIDS orphans to lose both parents is high compared to orphan status acquired through some other means. Absence of biological parents or guardians has financial implications and could lead to a myriad of problems related to poor supervision with its attendant consequences. Inheritance laws and other related issues that inure to the well-being of orphans are often not adhered to nor enforced by individuals responsible for their implementation. These factors interact to create problems for this group of people that demand special attention.

Every society has a system in place for taking care of its orphans. In most Ghanaian societies as in other African societies, care of orphans falls heavily on traditional systems. In more recent times, community care in the form of orphanages is evolving, but the situation is lagging behind that of the western world where social welfare

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systems are more developed and integrated (Abebe, and Aase, 2007). Notwithstanding, in communities where the impact of AIDS in terms of increased numbers of orphans is being felt, the traditional system of orphan care becomes weak and inadequate (Howard *et* al, 2006; Ntozi, and Mukiza-Gapere, 1995; Foster, and Williamson, 2000; UNAIDS, UNICEF, & USAID, 2004).

The Government of Ghana, as well as Non-Governmental Organizations (NGOs), Faith-Based Organizations (FBOs), bilateral agencies, donors and individuals have identified the need to support orphans. In Ghana, every child whether an orphan or not, belongs to a recognised household or family. In any given community where a child lives, he or she derives an identity, a sense of cultural roots, of belonging, of a clan, of blood ties, and a particular mother tongue that connects the child to that particular community. Thus, orphans in need cannot be isolated or uprooted from their communities to the extent that, the government, individuals and organizations that have the goodwill to assist needy orphans cannot reach the orphans without first going through the home that has taken the orphan in and the community where the orphan lives. Williamson (2004) has argued that the local customs and practices of the communities to which orphans belong need to be considered for effective response to the orphan crisis. Therefore, orphan care interventions can never be effective if the dynamics of the cultural, social, traditional and economic contexts of care of the targeted orphans are ignored (Nyambedha *et al.*, 2003).

The Asante and Krobo people of Ghana were chosen for the study based on the reported high prevalence rates of HIV and AIDS in their regions and by extension the

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large number of orphans. For instance Agomanya representing the Krobo had a prevalence rate of 13.4% in 1997, whilst Kumasi had 5.5% in the same period (NACP, 2008). These societies are expected to have a high burden of AIDS orphans as of now due to the passage of time as infected parents die off. This chapter discusses the findings of the study documented in the previous chapter guided by the following thematic areas:

1. Socio-Demographic and Economic Characteristics of Orphans and Caregivers,
2. Feeding Patterns, Health and Nutritional Status of Orphans,
3. Inheritance Customs and their Effects on Care of Orphans,
4. Impact of Caregiver Age on Care of Orphans,
5. Effects of Orphan Status on Care of Orphans,
6. Other Socio-Cultural Factors and their Impact on Orphan Care,
7. Education of Orphans,
8. Psychosocial state of Orphans, and Perception of Care from Primary Caregivers, and
9. The Conceptual Framework

## 6.1 SOCIO-DEMOGRAPHIC AND ECONOMIC CHARACTERISTICS OF ORPHANS AND CAREGIVERS.

The data indicate that the majority of Asante and Krobo orphans are cared for within households, and a large proportion, 85.3% of caregivers who are females are either widows (surviving parents), aunts, or grandmothers (Table 5.1.2). This is similar to the situation in Uganda where 70% of caregivers are females (GOU, 2002). As observed in this study, about 17% of caregivers are aged above sixty (60) years, and

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are categorised as dependent by definition, a status which has or may have financial implications for the household. Besides, about ten percent of caregivers are less than thirty (30) years old, a group that either lacks sufficient experience in child rearing, or are likely not to be earning enough monetary income. Moreover, only 37.2% of the caregivers are married, implying that over 62% of them are taking care of orphans without any spousal support. These households may, therefore, be battling with limited resources to meet the high demands of caring for orphans.

Among the two ethnic groups studied, both male and female orphans are found with more female orphans (51.7) than male orphans (48.3%). This mirrors the national sex ratio of 97.9 males per 100 female (GDHS, 2008). However in countries like Uganda with huge numbers of AIDS orphans, it is reported that there are more male orphans than female orphans especially among older children. This is because as a solution to orphan status, some orphaned girls marry quite young, others also take on jobs as house helps leading to undercounting of female orphans. In some districts in Uganda there are more orphaned females than orphaned males, this is attributed to civil unrest and wars, where a larger proportion of orphaned boys are abducted and recruited as child soldiers (Ntambireweki, 2001; World Vision, and UNICEF-Uganda, 1999). There are more single orphans (73%) than double orphans, with 8% more paternal orphans orphans than maternal orphans. See table 5.1.1

Studies indicate that the most likely primary caregiver of an African orphan is a surviving parent, grandparent, and any other extended family member when the remaining parent dies or cannot care for the child as is usually the case when the cause

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of death of parent is AIDS (Monk, 2001; UNAIDS, 1999; Nyambedha, Wandibba, and Aagaard-Hansen, 2003a). The results of the study on relationship of caregiver to orphans support this finding. Over one-third of all caregivers in the study districts and metropolis were the surviving parent of the orphan, who in about 78% of the cases was the mother. Other extended family members like grandparents, aunts, uncles and older siblings had assumed the responsibility of being the primary caregivers of the orphans in the absence of the parents, and these formed about 60% of the caregivers in the study areas. As in most African countries, women are the principal caregivers, and in this study formed about 85% of all the caregivers involved. According to the results, singles comprising the widowed, divorcees, the unmarried, and those separated from their spouses are the commonest primary caregivers (63%) of orphans, who may most probably be the heads of their households as well.

Most of the orphans involved in the study (88%) were in-school, although other studies have indicated that orphans or children who live in homes with chronically ill parents or adults often drop out of school (GDHS, 2008). This indicates greater awareness of adult caregivers of the need to educate children as high educational attainment is seen as a means of eradicating or mitigating the effects of severe poverty on households. This may also be due to the effect of the Free Compulsory Universal Basic Education (FCUBE) programme introduced in the country in 1996. Despite the fact that school enrolment of orphans in the study areas is high, the 2008 GDHS indicates that school attendance of Ghanaian orphans is about 14% lower than school attendance of non-orphans. That is "the overall ratio of school attendance of children whose parents are dead to those whose parents are living, and the child resides with at

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least one parent is 0.76" (GDHS, 2008). Orphans are therefore still disadvantaged when it comes to school attendance (World Bank, 1997; (Bicego, Rutstein, and Johnson, 2003; Makame, *et al.*, 2002; Monasch, and Boerma, 2004; Nyambedha, *et al.*, 2003b; Nyamukapa, and Gregson, 2005; Miller, 2008). For the caregivers involved in the study, about 43% of them have never been to school and only 4.2% have tertiary education. These have implications for care of the orphan when it comes to the financial earning potential of these caregivers, and their ability to cater for their dependants' nutritional, health, and educational needs.

The majority of the caregivers are employed in the non-formal sector and are therefore traders, subsistence farmers, artisans or unemployed. These form 96.5% of the caregivers involved in the study, and are not on regular monthly income. Only a small fraction of 3.5% depends on a formal salary. This implies that most of the orphans are cared for by caregivers who live on fluctuating and unstructured incomes that are unreliable, hence, most of the orphans involved in the study may be living in impoverished households, and may face many difficulties. All households that take on orphans will indeed be more insecure financially than they were before, and this situation is usually worse for already poor families prior to their assumption of responsibilities for orphan care. Other studies have also documented the relative impoverishment of households that have been affected by AIDS death (World Bank, 1997; Monasch, and Boerma, 2004; Nyambedha, Wandibba, and Aagaard-Hansen, 2003a; Nyambedha, Wandibba, and Aagaard-Hansen, 2003b; Oleke, Blystand, and Rekdal, 2005; Safman, 2004).

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## 6.2 FEEDING PATTERNS, HEALTH AND NUTRITIONAL STATUS OF ORPHANS

Food and adequate nutrition constitute basic necessity of life and crucial particularly in children. Children, including orphans need some level of adequate and balanced food intake for survival and normal growth. Adults and caregivers of orphans will also be more productive and capable of providing for their families when they take in adequate food. From this study, about 33% of orphans interviewed had less than 3 meals per day which is the recommended daily food intake for children, about 42% had insufficient food intake (Figure 5.2), and also 80% of orphans involved in in-depth interviews felt that food was a primary need, suggestive of some level of food shortage that among orphans and their caregivers. However, food availability, besides eating behaviours, is a critical factor in determining children's body weight, which is a significant indicator of child growth. Although the HIV status [found to be associated with stunting and wasting (Isaranurug, and Chompikul, 2009)] of study orphans was unknown, reports on insufficient intake of food was very strong among participants. It was also indicated by a physician who attends to HIV sero-positive children in the Kumasi Metropolis that AIDS orphans who are on ARV, when they are well fed, pick up very quickly and grow normally like other children free from HIV and AIDS.

Malnutrition and low food intake are fairly common among Sub-Saharan African children in general, however, orphans appear to be confronted with greater risks of malnutrition and other health problems than non-orphans (UNAIDS, 2000; FAO, 1994). This is reflected in the sizeable proportion (36%) of stunted orphans in the study districts and metropolis. Evidence also exists in Tanzania that more orphans

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tend to be stunted (50%) than non-orphans (29 - 39%) depending on household asset base (Einsworth, and Semali, 2000). Childhood malnutrition increases risks for illnesses and decreased physical and cognitive development, most of which cannot be recovered in later life (Martorell *et al.*, 1998; Hall, *et al.*, 2001; Li, *et al.*, 2003; Koichiro, *et al.*, 2005).

The 2008 GDHS indicates that 28% of Ghanaian children less than five years are stunted and 10% of these children are severely stunted. Although the focus of the 2008 GDHS was on children under five years in the general population, this figure is less than the proportion of stunted orphans found in this study (National figures for children above 5 years are not available for comparison). A study in Uganda by Deininger *et al.* (2003) found that orphans' nutritional status was worse than that of non-orphans. However, in a study that assessed nutritional status of orphans and non-orphans by Lindblade *et al.* (2003) in Kenya, the authors found that stunting (height-for-age) Z-scores of orphans were not different from those of non-orphans, but wasting (weight-for-height) scores were lower for orphans.

About 60% of caregivers involved in in-depth interviews who are widows especially among the Asante were ill, and had thus given up active and labour intensive work, hence their income levels had reduced remarkably, and this seems to be linked to the increased malnutrition among Asante orphaned children. This situation according to Bollinger *et al.* (1999) undermines the strength of the widow (mother of the orphan) as well as her general health condition, making her further incapable of providing adequate food to the children under her care. Another factor that may have accounted

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for the poor nutritional state of orphans in the study is the low levels of educational attainment of caregivers, thus, the knowledge on children's needs for balanced and adequate diet may be lacking.

Research has proven that cognitive development as well as adult strength and stature are highly sensitive to nutritional intake and overall health during early childhood (Martorell, 1998; Hauser, 1998; Koichiro, *et al.*, 2005). Desmond *et al.* (2000) have argued further that childhood malnutrition may be the most severe and lasting consequence of orphanhood in Sub-Saharan Africa due to its long term effects, of which improved conditions later in life will not fully reverse. Various studies show the correlation between adult health status indicators, such as height, and adult wages (Koichiro, *et al.*, 2005; Schultz, 1999; Behrman, and Deolalikar, 1988), and because adult height is a reflection of investment in child nutrition, the poor nutritional status of orphans involved in the study revealed by stunting, may have a long term effect on their capacity as adults to compete in the labour market to earn a living.

## 6.3 INHERITANCE CUSTOMS AND THEIR EFFECTS ON CARE OF ORPHANS

The custom of inheritance among the matrilineal Asante and patrilineal Krobo is the transfer of property from an original owner to an heir or heirs after the death of the property owner. In Ghana, only the Akans practice a matrilineal system of inheritance which to the Asante is based on the rationale that it is obvious who the mother of a child is, but the real genetor of a child may be questionable. The matrilineal system of inheritance may also be explained scientifically that a child inherits certain genes from

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the mitochondria of the cytoplasm which are outside the nucleus and hence are inherited by a child only from the mother, without any contribution from the father. This may account for the Asante claim that the child has the same blood as his or her maternal uncle and derives his or her *ntoro* (spirit) from the father. Thus, anecdotal evidence suggests that the Asante do not attach much value to the marriage relationship. A mother can therefore encourage her daughter who is of age to have children without impressing upon her to get married, because a woman views the children of her daughters as her family whilst those of her sons belong to their mothers' families. The cultures of the Asante and Krobo have been described in chapter three.

In both the matrilineal Asante and the patrilineal Krobo customs, however, a man's property is granted to his closest male relatives upon his death. This usually undermines the economic security of widows and orphans despite the promulgation of the intestate succession law of the Provisional National Defence Council (PNDC Law 111) in 1985 which grants widows rights to inherit from their deceased husbands. However, most Ghanaian women lack rights consciousness or are ignorant on legal matters, especially those residing in rural areas of the country (Fenrich *et al.* 2001; Runger, 2006). The studies by Fenrich *et al.* and Runger have indicated that in places where people are aware of the PNDC Law 111 on intestate succession, its application is completely misunderstood, and in some communities in the country like Islamic communities where religious principles govern intestate property distribution, the law does not apply at all.

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As observed in this study, inheritance customs or systems significantly affect care of orphans which is apparent in the proportions of stunted orphans under the two systems of inheritance. The proportion of stunted orphans under matrilineal system of inheritance was about twice that of those under patrilineal system of inheritance (OR = 2.392; P = 0.007; CI = 1.268 – 4.511). One would therefore infer from these results that patrilineal inheritance system makes better provision for orphans than the matrilineal inheritance system. As was emphasized by one caregiver, when the deceased father of the orphan had property, it goes to benefit the orphan. What is difficult about this system of inheritance, he added, is that when the deceased had no property to fall on in taking care of the orphans, the system places extra burden on the inheritor.

Despite this observation from the study, patrilineal Krobo, inheritance was reported to negatively affect the care of orphans especially when the inheritor is unable to maintain the property and orphans are deprived of their inheritance after the death of their fathers. As participants explained in the results chapter, disinheritance leads to economic loss to orphans and their families as it reduces assets and potential income which have implications for the orphans' long term economic security. Where the cause of death of parents is AIDS, the situation is different in the sense that AIDS impoverishes the parents before they die leaving no resources or property for the upkeep of the orphans. Among the Krobo for instance it was learnt that most of the deceased mothers of the AIDS orphans were migrants in Abidjan (Cote d'voire) and had worked to acquire properties like commercial vehicles, wax prints, expensive cooking utensils, and buildings, but had to sell all of these for money to treat their

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ailments (Atobrah, 2005). Thus, most households with AIDS orphans did not inherit any property which would serve as capital or meaningful source of income for the upkeep of the orphans.

This situation is not different for the matrilineal Asante orphans, however, because these orphans do not inherit directly from their fathers, the inherited property belongs to the maternal nieces and nephews of the deceased father, making the plight of Asante orphans worse when their maternal uncles and aunts do not step in to support their sister (widow) in looking after her orphans. Thus, in situations where the deceased father did not offer any property as a gift to the widow and orphans, and the maternal uncles and aunts are also incapable of providing support to the widow (who may be ill if she is infected with HIV), these orphans may live in poverty with its attendant problems.

In patrilineal societies, the decision as to who should take care of newly orphaned children is usually made by men and this may affect orphan care, since women are the main care providers. This was not indicated by the study participants, however, a study among the Langi of Amach in Uganda found that although Langi women are recognized as the primary care providers of orphans, they are excluded from the decision involving who should care for orphans, consequently, some orphans are sometimes placed in the hands of women who are unwilling to care for orphans. Such orphans are therefore perceived by their caregivers as additional and unnecessary burden. This situation puts the orphans at a high risk of deprivation of care, discrimination, and abuse (Oleke, *et al.*, 2007). The authors further linked

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vulnerability of orphans to care by matrikin or patrikin. They found that although patrilineal system of inheritance is regarded as protective of children's rights to inheritance, support, safety, and belonging, orphans with paternal kin caregivers often reported very poor care, greater neglect of their basic needs, and relatively heavier workloads than those cared for by their maternal kin. A Krobo caregiver reported that though paternal kin is supposed to care for orphans, the maternal relatives more willingly support care-giving activities than paternal relatives because maternal relatives tend to be more emotionally attached to the orphans.

Another peculiar finding among the patrilineal Krobo regarding orphan care is the issue of *yobi* (woman's child). As discussed extensively in chapter three, a Krobo man can only wield paternity rights over his child in his matrimonial home, if he fully performs the marriage rights of the child's mother at the time of conception, or after performance of the *po la* rites (see chapter 3). Thus, a child born to an unmarried woman does not belong to his or her father, but to the maternal grandfather, rendering such a child as *yobi* (woman's child). *Yobimi* orphans are not covered under the Krobo traditional patrilineal provision of care. If the fathers of such orphans had paternity rights over them, the care of the orphans falls on the surviving father, or in the case of death of the father or both parents, the care of the orphans becomes the responsibility of the next of kin of the deceased father. This tradition was carefully and strictly observed for fear that the ghost of the deceased would haunt the inheritor if he failed to take good care of the orphans. Consequently, the inheritor would do all he could to care for the orphans as his own biological children.

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In recent times, however, custodians of orphans under both matrilineal and patrilineal systems of inheritance seem not to care much about the orphans in their custody because they tend not to adhere strictly to traditional norms and beliefs. Real economic pressures also make it difficult for custodians to render due responsibilities even toward their own children, let alone an orphan. *Yobima* orphans, in spite of this are worse off than their orphan counterparts since they (*Yobima* orphans) do not have any one on whom they make certain demands except their old grandparents who may be impoverished due to retirement from active work. Such orphans usually live at the mercy of their maternal uncles and aunts or external sympathisers who are not obliged to care for them.

Studies on inheritance patterns in matrilineal and patrilineal societies have identified significant differences in inheritance between women and for that matter widows, of both societies. One such study by Vellenga (1982) claimed that in matrilineal societies, widows inherit from different types of people such as uncle, brother, mother, grandparent, and child. She further claimed that some may even inherit from their husbands and fathers (property given as gift when husband or father is alive), whereas in patrilineal societies, 'the father is by far the most important source of inherited resources, with mothers and husbands far behind' (page 72).

This assertion by extrapolation implies that widows and orphans under matrilineal inheritance system should be better off economically than those under patrilineal system of inheritance. This assertion is at variance with the findings of this study. This may be due to poverty in the widow's family or her HIV sero-status. According to a

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PLWHA caregiver when her husband died and his family threw her and her daughter out of her marital home, her sister offered to stay with her and her daughter. However, as soon as the sister got to know of her HIV status, she not only threw her and the daughter out of her home, but also informed other family members about it, thus, losing all the support she was receiving from her family members.

Differences in the nutritional status between Asante orphans and Krobo orphans may again be attributed partly to increased awareness of AIDS orphans among the Krobo and the interventions that have been put in place to support these orphans. For example the Manya Krobo Queen Mothers Association receives support from the American Embassy and Ghana AIDS Commission to take care of AIDS orphans. The association has put some of the monies received into income generation activities so as to sustain the care of about 1,034 orphans that they support in the communities. Among the Asante however, support for the orphans involved in the study was mainly through the PLWHA support groups, where the direct recipients are ill parents of the orphans who may in turn use almost all the resources received in seeking for treatment of their ailments.

Other factors that may have contributed to the differences in the nutritional status of orphans observed between the two ethnic groups may be caregiver dependent, like educational background, experience in caring for children, household income, love and affection for orphan amidst other social and cultural factors that were found to impact on the care of AIDS orphans. Some of these are discussed later in this chapter.

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## 6.4 IMPACT OF CAREGIVER AGE ON CARE OF ORPHANS

According to Nkosi (2007), there is anecdotal evidence that in Sub-Saharan Africa orphan caregivers are elderly, poor, and do not have adequate support to play their role as caregivers. These coupled with the fact that the elderly ( above 60 years) and the child (less than 18 years), demographically constitute the dependent age groups, often require assistance from others, this study hypothesized that age of caregiver will have effect on the nutritional status (care) of orphans. About 29% and 5% of orphans involved in the study have grandparents and siblings respectively as their primary caregivers (table 5.1.2). This therefore limits the discussion on the care of orphans to those provided by grandparents especially grandmothers since about 32% of caregivers were over 50 years, and 85% of caregivers were females. These figures do not differ so much from the Ugandan study by Hunter (1990) which recorded that 43% of orphan caregivers were over 50 years, and 31% of caregivers were grandparents. This is the pattern that prevails in most Sub-Saharan African countries that are hard hit by AIDS (Oppong, 2004).

The study did not reveal significant association between the various caregiver age groups and nutritional status of orphans with the overall data and the data from Asante ($p>0.05$ in both cases). However, significant association was found between caregiver age and nutritional status of orphans ($p<0.05$) among the Krobo. The regression analysis showed that orphans whose caregivers were in the age range of 41 – 50 years were about eight times more likely to be stunted than those with caregivers among the other age groups. This observation may be due to the fact that care of orphans especially among the Krobo falls heavily on grandparents without much support from

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other family members. The plight of these grandparents particularly grandmothers and orphans has stimulated some interventions and support from traditional and external sources (Atobrah, 2005), but because the age group 41 – 50 years is not regarded as elderly they may not be receiving the needed assistance as orphan caregivers. It could also be that some of these caregivers as well as some of the orphans in their care are infected with HIV or some other chronic diseases. As a result, the caregivers cannot cope with strenuous work to boost their family income, even though they need more money for the upkeep of the orphans as well as for the treatment of their ailments and diseases.

Grandparents have been the second line of defence for orphans and vulnerable children in most traditional African societies (Nyambedha, Wandibba, and Aagaard-Hansen, 2003a; Roe, and Minkla, 1999). Thus, the helping hand given by parents to their children in the upbringing of grandchildren is not a new phenomenon in traditional African societies like Ghana. What is fairly new is the evolvement of grandparents and older siblings as the primary caregivers of orphans due to the devastating impact HIV and AIDS-related deaths (Nyambedha *et al.*, 2003a; Roe, and Minkla, 1999; Barnett, and Blaikie, 1992). These two categories of primary caregivers of orphans have been described by Bicego *et al.* (1999) as requiring care from others, as such care-giving responsibilities on these 'vulnerable' groups may be problematic. In many traditional African settings, social norms required that the elderly receive more help than they give (Nyambhedha *et al.*, 2003a; Makoni, and Ferreira, 2002).

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In societies like ours where state based social welfare systems to care for orphans and vulnerable children are non-existent, the major source of social security at old age are remittances from kin-relations, acquaintances or 'convoys' (Antonucci, and Akiyama, 1987; Hakanson, and LeVine, 1997; Makoni, and Ferreira, 2002). It is thus considered in some traditional African societies that the rewards for successful child-rearing are secure non-restrictive and comfortable life at old age, and labour contributions by adult children to their caring parents (Cattell, 1993). The old woman's role therefore consisted mainly of occasional advisory support on cultural issues, and non-restrictive care-giving activities that were stress-free (Hakanson, and LeVine, 1997). Hence, grandmothers who had at their disposal persons to assist them, and also take up some child-rearing duties in the traditional family setting, were at liberty to pursue their own life interests, and opportunities to indulge their grandchildren (Mboya, 1965; Nyambedha, *et al.*, 2003a).

Thus providing full time orphan care-giving responsibilities implies that the elderly have to carry the burden of old age alone, with no support from their adult children. Grandparent caregivers also have to deal with the burden of nourishing and nurturing their orphaned grandchildren, deal with emotional problems associated with loss of stage appropriate roles, and the death of their own children, and this is usually at a time that they are old, ill, isolated, impoverished, and need assistance (Yamba, 2003; Mukwaya, 1999; Barnett, and Blaikie, 1992). Provision of adequate caregiving actitivies by old grandparents would therefore be difficult. Mann (2002) however noted in Malawi that despite the compromised ability of grandparents to care for their orphaned grandchildren, orphans often ask to be placed in their grandparents' care

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after losing their parents, which according to the author, indicates that orphans place more value on love and respect for grandparents than material provisions.

Sibling caregivers or orphans who are caregivers of other orphans, have been through trying periods of experiencing repeated bereavement and trauma associated with the illness and death of their own parents, and prospective kin adopters. They also have to assume the forced adult roles of family heads, and of providing care for their siblings (Yamba, 2003; Mukwaya, 1999; Barnett, and Blaikie, 1992). Care-giving activities may therefore be too much for them to cope with.

For both elderly and sibling caregivers, being too old or too young, training, supervision, and proper socialization of orphans may be grossly lacking or completely non-existent, because these caregivers may lack the strength, skill or both to appropriately discipline and supervise the orphans, and this may have adverse impact on the future of the orphans cared for by such individuals.

## 6.5 ORPHAN STATUS AND CARE OF ORPHANS

Although the findings of this study did not find statistically significant differences between the nutritional status of paternal orphans and maternal orphans; and no statistically significant differences between the nutritional status of single orphans and double orphans that is, $p>0.05$ in both cases, the qualitative data held that, the situation of the paternal orphan in terms of the care he or she receives is better than the situation of the maternal orphan with various explanations, as recorded in chapter 5. The care situation of double orphans was also perceived to be worse than that of

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single orphans, supported by Hilmilton's rule that the greater the biological relationship of a child to an adult caregiver or head of household, the better their health, educational and nutritional status (Case, Paxson, and Ableidinger, 2003). One can say that the type of orphanhood matters when it comes to care of orphans. In other words, orphan care may be expected to be partly dependent on how close the orphan is biologically to the caregiver with the general view that maternal orphans are at greater health risk after the death of their primary caregiver (Gillespie, 2006; Madhavan, and Townsend, 2007). The death of a father to AIDS in his prime-earning years may leave a lasting blow of economic viability on households, and this may impact on the nutritional status of orphans in those households as observed among the Asante. With the Asante, greater proportion of paternal orphans was stunted (51.8%) than maternal orphans (48.2%). Because these children are AIDS orphans, most of their mothers were ill, compromising their care-giving role and hence affecting the plight of the orphans.

Some researchers have argued that paternal orphans who live in poorer households than non-orphans (Nyamukapa, 2003; Case *et al.*, 2003), may have their relative poverty offset by the sacrifices of a widowed mother whose means though limited, is able to provide emotional and practical support that sustain the paternal orphans, thus cushioning them from educational disadvantage (Nyambedha *et al.*, 2003; Nyamukapa *et al*, 2003; Hosegood, *et al.*, 2003). The Asante as found in the study do not regard a child with one surviving parent as an orphan. This is because the Asante hold the perception that once there is a surviving parent, care of the child should not be a problem, since a parent has the primary responsibility in the care of his or her own

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children. Such children staying with their surviving parent usually have better educational and emotional outcomes. However, both the Asante and Krobo admit that the paternal orphan receives better care than maternal orphans, because the maternal orphan has less chance of living with the surviving father, and is more likely than the paternal orphan to live with distant relatives. This as indicated by Yamano and Jayne (2003) and Nyambedha *et al.* (2003) is because surviving fathers often place maternal orphans in the care of others while they focus on increasing their earnings to support the orphans. However, according to Madhavan and Townsend (2007) this does not replace the absence of a mother. A study by Sharma (2005) in Malawi has also shown that paternal orphans are more likely to drop out of school and work outside the home, because the immediate need to increase financial income for basic consumption after the death of the main income earner (presumably, the father) outweighs investing in the orphan's education which will improve the earning capacity in the future.

In situations where the father heads the households where maternal orphans reside, a step-mother usually cares for the orphans, because the widower usually re-marries, or may have other spouse(s) as indicated by study participants among the ethnic groups studied. These step-mothers often maltreat the orphans in many ways (refer to chapter 5) as they regard the orphans as additional burden. In patrilineal societies, a step-mother may perceive the orphans as competitors with her own children with respect to inheritance, especially when the orphans are older. This breeds contention among children of the same father as well.

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Studies. Bicego, *et al.* (2003), and Nyamukapa, *et al.* (2003) have found that though maternal orphans do not appear to live in poorest households, in many instances they experience more detrimental effects on their school enrolment, educational attainment, and less money spent on their education than paternal orphans. These effects according to Case, *et al.* (2003) and Nyamukapa, *et al.* (2003) are not dependent on household wealth, but lack of care that is manifested in reduced educational attainment of maternal orphans compared to paternal orphans (Bicego, *et al.*, 2003; Nyamukapa, *et al.*, 2003; Case, Hosegood, and Lund, 2003). Some of these researchers argue that in situations where the death of a father is also correlated with children's poor educational outcomes, the cause is more likely to be poverty.

Another reason that has been assigned to paternal orphans being better cared for than maternal orphans is that mothers are more motivated than fathers to support their children, and therefore support paternal orphans better (Nyambedha, *et al.* 2003; Nyamukapa, *et al.* 2003). Ainsworth and Semali (2000) have shown that the death of a mother in Tanzania was associated with an average decline of one standard deviation in child height-for-age, whereas the death of a father was associated with one-third of a standard deviation. The authors therefore stated that the loss of a mother has a more severe impact on orphans irrespective of household assets, whilst the impact of the death of a father is felt only among households that are poor. This situation was reported among both Krobo and Asante orphans and non-orphans, who claimed that they are more emotionally attached to their mothers than their fathers, and hence losing a mother would be more difficult for them than losing a father.

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Studies have also indicated that maternal orphans are more likely to begin sexual activity in early adolescence (before age 16 years) than paternal orphans (Goldberg, 2007) making the maternal orphan more vulnerable to HIV and other sexually transmitted infections as well as teenage pregnancy than the paternal orphan. Furthermore, maternal orphans demonstrate a lower satisfaction with life than paternal orphans (Ohnishi, *et al.*, 2004).

The study indicated that more paternal orphans were stunted (37.8%) than maternal orphans (34.0%), though statistically insignificant. This may be that surviving fathers may have more financial means than mothers, hence, they provide more care than surviving mothers (Ntozi *et al.*, 1999). Also, as reported by study participants especially among the Asante, the husband's relatives deny widows the opportunity to look after orphans. Thus, hardships faced by paternal orphans who live with their mothers are usually linked to poverty (Ntozi *et al.*, 1999).

The loss of both parents may have the most detrimental effects on an orphan. In the study double orphans formed about 27% of all the orphans. Although no statistically significant difference was found between the nutritional status of single orphans and double orphans ($p>0.05$), more single orphans were stunted (36.2%) than double orphans (35.4%). The plight of double orphans have been described by some researchers as being worse than that of single orphans especially in school enrolment and educational attainment (Bicego, *et al.*, 2003). This may be due to the fact that double orphans are most likely to be living with grandparents or child-headed

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households, or may be living with strangers and working as household servants (Nyambedha, *et al.*, 2003).

The impact of the loss of one or both parents on orphan care may however be dependent on the degree of involvement of the deceased parent(s) in the care of the children prior to their death. Thus, the greater the involvement of parents in the care of their children, the more detrimental their absence will be to the children they leave behind and vice versa. For those children who are already vulnerable, the death of their parent may not mean much to them in terms of care.

## 6.6 OTHER SOCIO-CULTURAL FACTORS AND THEIR IMPACT ON ORPHAN CARE

Other cultural and social practices found to affect orphan care among the study groups included the rites of passage (out-dooring of babies, marriage ceremonies and funeral rites), traditional rituals such as festivals and puberty rites traditional norms like inheritance (already discussed above) and puberty rites, and social practices like alcohol and drug abuse, social eating and drinking, fashion, stigma and discrimination, and others already listed (Table 5.18). The effects of these on the part of the caregiver, and on both caregiver and orphan, and how they affect care and well being of orphans as explained by study participants have been recorded in chapter five. Most of these effects had economic, psychological, social life and relationships implications for both the orphan and caregiver. The effects of funeral rites, alcohol and drug abuse, and psychosocial state of orphans are three particular socio-cultural practices that are discussed in relation to orphan care in the following sections.

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### 6.6.1 Funeral Rites and Ceremonies and their Effects on Orphan Care

As found in the study, the extravagance of funeral rites and ceremonies seems to affect the care of orphans in two ways. First, study participants indicated that much money is spent on the dead to the neglect of the needs of orphans and other vulnerable children. Second, the celebration of funerals is so elaborate that time for supervision and guidance of children is compromised, thus, providing opportunity for misdemeanour during the period when death is being celebrated (see chapter five). Both the Asante and Krobo organize funeral rites in the form of ritual observations as the hallmark of the personhood of the individuals both in this world and in the world of the ancestors and spirits. Hence, as noted from field notes the Asante, for instance go through about five phases of funeral rites and ceremonies that are carefully and routinely followed. Study participants revealed that huge sums of money are usually spent, much of which are borrowed with high interest rates and this makes life difficult for orphans and their caregivers. In Asante funeral rites and ceremony, some deceased persons are even preserved in the mortuary for an extensive periods for the family to gather enough resources to enable them organize big funeral functions. These public functions provide the occasion for drunkenness, loss of working hours, and opportunities for immoral behaviours, whose effects on orphan care have been discussed earlier (chapter five).

Some Christian leaders of the Kumasi Metropolis recognized the negative effects of how Asante funerals are organised and celebrated, and, in a pastoral letter signed in 1972 by the hierarchies of the Roman Catholic, Anglican, Methodist, AME Zion, and the Seventh-Day Adventist churches (see appendix IX), expressed grave concerns on

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the conduct of funeral rites in the Kumasi metropolis. The leaders noted that funerals had (i) assumed unnecessary proportions with high and indiscriminate use of alcoholic drinks which precipitated drunkenness, vices, quarrels, and fights; (ii) that neither the bereaved family nor sympathizers who donate money benefit from the expensive funerals. Without casting aspersions on funerals, the ministers were of the "opinion that anything that is done in strict accordance with custom should not be tampered with provided that such a thing is patently at variance with the Christian faith and good morality." They expressed further that "we know how much store the Ghanaian, and especially the Ashanti, lays by the funerals of his forbears, appreciate it, and admire him for that". They therefore contended "that the unbridled use of alcoholic drinks at funerals and the huge expenditures that have come to be inseparably associated with funerals these days, are not customary, and militate against traditional values."

Almost four decades after this letter was circulated in most Asante communities, the problems of Asante funeral rites and ceremonies have gone beyond mere concerns over overwhelming expenditures and alcohol consumption. It has come to the notice of the Asantehene Otumfuo Osei Tutu II the negative impact of the manner in which Asante funerals are organized, and he has thus recently passed a ban on wake-keeping in Asante Kingdom. The effect of this is yet to be realised since the extravagant nature of Asante funerals still persists.

The situation is not too different among the Krobo as indicated by Krobo participants. Modern Asante and Krobo funerals are therefore characterized by expensive preservations of corpses for prolonged periods, hiring of expensive hearses, elaborate

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customary rites, catered food, purchasing of fanciful funeral clothing, performances by musical groups, expensive custom-made caskets, and other related items and activities. The effect of this can only be detrimental to the future and wellbeing of orphans. A story by Kweku Sakyi-Addo on http://news.bbc.co.uk/1/hi/world/africa/2737039.stm (Appendix X) shows how the Ghanaian values the dead more than the living.

### 6.6.2 Alcohol and Drug Abuse

The effects of alcohol abuse were mentioned in all FGDs, and by most informants involved in the study. As indicated by participants of the study, apart from having economic implications on families and households where the head is an alcoholic or drug addict, excessive alcohol use by parents or caregivers also has certain social implications that can affect the future of children. Velleman (1993) has identified seven main aspects of family life that can be marred by alcohol misuse, these are roles, routines, social life, communication, finances, conflicts and rituals.

It can be inferred from the study that problematic alcohol use by caregivers can affect the quality of their care-giving activities. This is because a caregiver who drinks may be inconsistent, emotionally unavailable, and unpredictable which can lead to passive neglect, and cruel care-giving. Children under such caregivers are not supported, nurtured or supervised (Cleaver *et al.*, 1999). Some children are even deprived of their childhood as they take on responsibilities that are beyond their age in the form of taking care of a sibling or a drunk parent or guardian, thus impairing their education and peer relationships, as they are also unable to flow with their friends as much as they should (Velleman, 2002).

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As indicated by some FGD participants among the Asante, children under the care of parents or caregivers who have problem with alcohol or substance misuse go through emotional problems and this affects child-parent attachment throughout their life cycle (Kroll, and Tylor, 2003). Evidence also exists that children of problem drinking parents have higher levels of a range of problems than children of non-problem drinkers, and children of parents with other problems. The factors that could increase the likelihood of children being adversely affected include parental disharmony, violence, both parents drinking problematically, and the drinking taking place within the family home (Eurocare/Coface (1998).

Some studies have also found links between domestic violence and alcohol consumption which is usually perpetrated by men against women (Simmons *et al.*, 2002). The study by Harwin and Forrester (2002) on social work with families in which parents misuse drugs or alcohol found that "alcohol misuse was strongly associated with violence in the home" (pp 5). The impact of domestic violence on children is often manifest in damage to family attachment, aggression or withdrawal, sleep problems, fear and a wish for safety (Mullender, *et al.*, 2002). By implication, a combination of a parent who has a problem with alcohol and who also suffers or perpetrates violence will exacerbate the harm and risk children face. Studies have also shown that some women resort to drinking alcohol to offset the impact of domestic violence on them (Cantrell, 1986; Corbin, *et al.*, 2001; Downs, *et al.*, 1993; Downs and Miller, 1994).

According to Robinson and Hassell (2000), alcohol plays a part in about 25% of known cases of child abuse. Further, some research suggests that children are more

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likely to suffer physical abuse if the father is the drinker, and are more likely to suffer neglect if the mother is the drinker (Cleaver *et al.*, 1999). Thus orphans who live with alcoholic caregivers may be at risk from such violent and abusive behaviour, which may impact heavily on the orphans' behaviour as they grow up.

Velleman (1993) has grouped the resultant impact of alcoholic parents or caregivers on children and for that matter orphans into three, namely, (i) emotional problems; (ii) the school environment; and (iii) anti-social behaviour. Emotional problems consist of a wide range of psychosomatic problems from asthma to bedwetting, negative attitudes to their parents and themselves, high levels of self-blame, withdrawal and depression. Problems associated with the school environment include learning difficulties, reading retardation, loss of concentration, generally poor school performance, aggression and truancy, whilst anti-social behaviour is manifested as increased risk of aggressive behaviour towards others, hyperactivity and other forms of conduct disorder. The researcher stated in addition that such children can have poor development of trust as found in this study (resulting from false accusations to abuse), problems with making and sustaining friendships, being a victim or witnessing conflict or violence, and verbal or physical aggression among others which do not auger well for the wellbeing of children and orphans.

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## 6.7 EDUCATION OF ORPHANS

As recognized in the Convention on the Rights of the Child, education is a basic human right for all children, but one of the most important of the many different needs that orphans have. Children who know how to read and write, and can do basic arithmetic have a solid foundation for continued learning throughout their lifetime. Thus, education is critically important to children's psychosocial wellbeing and social development (London, 2003; Owusu, 2007; Addae-Mensah, 2000; Okyerefo, 2005). Educating children may contribute to the development of children as education creates choices and opportunities for children, gives them a voice in society, decreases poverty diseases, and reduces the vulnerability, especially that of girls to HIV infection (Jukes, Simmons, and Bundy, 2008; Miller, 2008). School participation enhances children's wellbeing, and gives them the opportunity to interact with other children to develop social networks. It also helps children affected by trauma to recover from the impacts of their experiences, regain a sense of normalcy and imparts the necessary skills for them to be successful (Bhargave, 2005; World Bank, UNICEF, and Partnership for Child Development (PCD), 2006; UNICEF, PCD, World Bank, 2009). Schools, according to Miller (2008) can provide children with an environment that is safe, and structured, as well as emotional support of adults from the community.

Apart from benefiting individuals, education plays a vital role in national development, in that it is a major tool for social and economic development. Education contributes to poverty reduction, reduces fertility, improves health, increases labour productivity, reduces social inequality, and enables individuals to

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fully participate in their society's economy, politics, and development (Miller, 2008; Owusu, 2007; Care International, 2007).

A statement issued by Human Rights watch in 2006 indicates the influence of education in breaking the poverty cycle. "Education breaks generational cycle of poverty by enabling children to gain skills and knowledge for better jobs. Education is strongly linked to concrete improvements in health and nutrition, improving children's very chances for survival. Education empowers children to be full and active participants in society, able to exercise their rights and engage in civil and political life in their adult lives. It is well documented that increasing girls' access to education has benefits for development, particularly, maternal and children's health, economic growth sustainable family size and democracy. For example, an additional year of girls' education can reduce infant mortality by 5 – 10 percent. Education is also a powerful protection factor: children who are in school are less likely to come in conflict with the law and much less vulnerable to rampant forms of child exploitation, including child labour, trafficking, and recruitment into armed groups" (paragraph 2).

Despite these identified critical roles that education plays in the life of every human being and national development, 12% of orphans involved in the study were out-of-school. Some caregivers indicated that although primary education tuition is supposed to be free because of FCUBE, examination or printing fee, fee for extra classes, and building fund charges are not free, and it is very difficult for them to pay all these school expenses and others that come up from time to time. Thus, when caregivers are not able to pay for such charges, especially

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examination fee, the orphan drops out of school. For AIDS orphans who live in households with ill individuals, the orphans especially females drop out of school to look after the sick, or younger siblings, others engage in economic activities to assist their caregivers in taking care of the household (Atobrah, 2005; Gilborn, *et al.*, 2001; Yamono, and Jayne, 2005).

Even for those orphans in school, the study found that about 12% of them were in need of school uniforms, 18.4% did not have school scandals, about 60% needed school bags, about 19% did not have books (see table 5.11) and other school gadgets that were essential for schooling. Five (25%) out of the twenty orphans involved in the in-depth interviews indicated that they go to school with empty stomach. This may affect these orphans' capability to learn due to fatigue from walking some distances to school, hunger and weakness. Schooling seems to be the first problem that orphans face after the death of parent(s). Nyambedha, *et al.* (2003) found in their study in Kenya that 84% of households with orphans mentioned schooling problems, such as buying school books, and uniforms as against 48% that reported lack of food as their main problem.

Although school attendance may be critical to academic achievement, the study found that 14% of orphans do not attend school five days in a week, in fact, about 5% of the school going orphans attend school only once a week due to financial or economic reasons (Table 5.11). Such interruptions in academic activities may have serious consequences on the performance and educational attainment of orphans. These orphans may not have enough tutoring to realize the full benefits

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of education. Thus these orphans with little or no education will continue to be vulnerable and poor throughout their entire life, a situation that may negatively affect their descendants creating a vicious cycle of poverty and vulnerability.

The world has recognized the importance of children's education, and has thus, included education as the second Millenium Development Goal (MDG) which is to 'achieve universal primary education' by 2015. This goal is to ensure that children everywhere irrespective of gender have access to education and will be able to complete a full course of primary education (UNDP, 2005). However, it was indicated by the UN Secretary General, Ban Ki-Moon in September 2007, half way to the deadline, Sub-Saharan Africa is unlikely to meet a single goal (BBC News Africa, 2007).

The Government of Ghana has instituted some measures to increase access to primary education in the form of FCUBE, School-Feeding, and Free School Uniforms as well as Capitation Grants for Basic Schools, as a way of affirming the government's commitment to the goals of 'Education for All (EFA). Nevertheless, UNESCO (2007) has recorded that serious barriers to children's education include the direct cost to households which are text books, compulsory uniforms, and school supplies but not just school fees. Other barriers, particularly in the case of the orphan, may include distance to school, over-age, gender inequality, working status, stigma and discrimination in the classroom and Children affected by HIV and AIDS. Also, the government's school-feeding programme, and free school uniforms continue to be in their pilot stages and have

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not reached the majority of children including poor and orphaned children. Poor people, according to Devereux (2002), use incremental income first to satisfy basic needs, before investing in human capital such as education and health care. Thus, school enrolment of orphans has been found to decrease as grade level rises (Sharma, 2005; Case, Paxson, and Ableidinger, 2004).

Consequently, some extended families use school fees as a major reason for not taking on orphaned children (Matsalage, and Powell, 2002). As indicated by some study participants, orphans are the last to be considered for schooling when financial resources are limited. This fact has been confirmed by Case, Paxson, and Ableidinger (2004) when they examined orphanhood on children's education in ten Sub-Saharan African countries and found that although poorer children irrespective of their status as orphans or not are less likely to attend school than other children, orphans are less likely to be enrolled in school than their non-orphan counterparts with whom they live. Current knowledge suggests that when parents die, the amount of resources available for education decreases, thus, orphans are less likely to be in school and more likely to drop out or fall behind, and this limits their abilities and prospects for a better life in future (UNICEF, 2006).

This situation negatively affects the psycho-social development of orphans who are not in school, since school participation has been found to promote the wellbeing of children, by providing them with safe, structured environment, emotional support and security (Bhargave, 2005), these are what the orphans

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found to be out-of-school in this study are missing in addition to bright future economic opportunities.

## 6.9 PSYCHOSOCIAL STATE OF ORPHANS, AND PERCEPTION OF CARE FROM PRIMARY CAREGIVERS

The social and economic impact of HIV and AIDS on children in developing countries according to Foster and Williamson (2000) has taken precedence over the concern about the psychological effects that HIV and AIDS have on children. Thus where basic needs like food, clothing and shelter are not met, agencies addressing the needs of orphaned children are forced to focus on these unmet needs rather than attending to less immediate or obvious psychological needs (Ankrah, 1989; Coombe, 2002; Chase and Wood, 2006; Zhao, *et al*., 2007).

The death of a parent is traumatic for any child, but for the AIDS orphan, many factors contribute to the intensity of bereavement (Siegel and Gorey, 1994; Cluver, Gardner, and Operario, 2007; Wood and Chase, 2006). Various stressors in the experience of illness and death by children affected by HIV and AIDS have been identified by Stein (2003) in addition to stigma. These are: (1) Parenting with a terminal illness; (2) Witnessing an HIV and AIDS death, (3) Psychological impact of death; and (4) multiple losses.

Stein (2003) further explained that when a parent becomes ill, there may be reversal of parent-child roles, with the child assuming care for the household and sick parent, and this is often associated with an elevated sense of isolation on the part of the child.

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Also, when children witness and nurse parents through the debilitating terminal stages of AIDS, it affects all aspects of their lives and can compromise school performance and family relationships (Coombe, 2002). The psychological impact of death of a parent creates fear, a profound sense of insecurity and hopelessness for the orphan and this may additionally complicate the grieving process for orphans. Moreover, children who lose one parent to AIDS may suffer multiple losses because they are at risk of subsequently losing the other parent, younger siblings, and other caregivers or loved ones.

The stress and trauma of orphans are usually elevated as a result of stigma and discrimination, dropping out of school, increased workload, changed friends and social isolation stemming from parental death (Foster, and Williamson, 2000). In an attempt to assess the psychosocial state of the orphans, the results showed that about 2 out of 5 (40%) orphans were unhappy, sad, or depressed most of the time; about 38% reported being too fearful or anxious; about 21% were withdrawn. Some of the orphans rarely stay close to their caregivers or do not stay home at all (12.4%); whilst about 16% of the orphans had problems with sleep (Table 5.14). These results indicate that many of the orphans were not psychosocially sound and this may be the result of the stigma and poverty situation in which they find themselves. Studies in Uganda by Atwine, Cantor-Graae, and Bajunirwe (2005) have reiterated the fact that orphans are about six times more at risk of higher levels of anxiety, and depression than non-orphans. Also, orphans are about five times more at risk of being angry than non-orphans, and that the high levels of psychological distress found in AIDS orphans suggest that material support alone is not sufficient for these children.

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The source of stigma and discrimination may come from the extended family as was indicated by some of the orphans in the study. The in-depth interviews indicated that although the main support for orphans is the extended family, some relatives exploit and abuse them, and fail to meet their basic needs for food, clothing, and education.

A study in Uganda by Segendo, and Nambi (1997) indicated that most of the orphans studied especially those aged 10 – 14 years were depressed and pessimistic about the future. It has also been reported in South Africa that, when socio-demographic factors like age, gender, age at orphanhood, and formal or informal dwelling are controlled, AIDS orphaned children are more likely to report symptoms of depression, have post-traumatic stress, have peer relationship problems, delinquency and conduct problems, show behaviour problems and report suicidal tendencies than both children orphaned by other causes and non-orphans (Cluver, Gardner, and Operario, 2007). The researchers further pointed out that South African children orphaned by AIDS exhibited higher levels of internalising problems and delinquency, but lower levels of conduct problems compared to Western norms. The authors however found no differences in the anxiety levels exhibited by the three groups of children.

Similar findings were revealed by Nyamukapa *et al* (2004) in their measurement of psychosocial effect of orphanhood in a Sub-Saharan African population and, evaluated a new framework for understanding the causes and consequences of psychosocial distress among orphans and other vulnerable children. They used 5, 321 children aged 12 to 17 years in Zimbabwe and, found that Orphans had more psychosocial distress than did non-orphans. For both genders, paternal, maternal, and

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double orphans exhibited more-severe distress than non-orphaned, non-vulnerable children. After controlling for differences in more-proximate determinants, the authors realised that orphanhood remained associated with psychosocial distress.

Stein (2003) has also stated that in addition to orphanhood, poverty must be acknowledged as a primary psychosocial stressor for children affected by AIDS. The effects of poverty as found in this study were expressed through in-depth interviews with orphans in terms of their pressing needs comprising food, clothing, items for school, and shelter. These effects were expressed in terms of material needs, thus, the emotional and psychosocial effects are likely to be ignored. However, it has been established that child developmental outcomes are likely to be influenced profoundly by enduring conditions of deprivation (Mcloyd, 1998; Wood, and Chase, 2006). Therefore poverty, leading to malnutrition and low educational levels has been associated with common mental disorders (Patel, and Kleinman, 2003). The authors however stress that such factors as hopelessness, insecurity, poor physical health, and limited opportunities arising from less education may trigger the risk of mental disorders rather than poverty.

The factors expressed by some of the orphans which may have some psychosocial outcomes for them include stigma and discrimination, hunger, humiliation, anxiety, and loneliness. Wild (2001) however, expresses hope for the orphan, and states that AIDS orphaned children will not be invariably dysfunctional since available support to children and family process variables may play more important role in predicting children's adjustment than parental illness or death. It is therefore critical that

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orphans have access to support networks that are functional, to enable them develop a sense of inclusion to help them cope better with psychosocial problems.

Some researchers have asserted that not all emotional and psychological experiences of orphans yield negative psychosocial outcomes, thus, some orphans display 'resilience' from negative childhood experiences. Resilience is defined by Apfel and Simon in their UNICEF Review Article in 1995 as "the capacity to bounce back from traumatic childhood events and develop into a sane, integrated, and socially responsible adult." Resilient children are resourceful, curious, have the ability to conceptualize, are flexible in emotional experience, can access autobiographical memory (including the ability to remember and invoke images of warm and loving people in their lives), have a goal for which to live, altruism (learned helpfulness), and have a vision of a moral order. Luthar, *et al*, (2000), however, point out that just as the many dimensions of vulnerability in the household may affect psychosocial outcomes, the type of risk or adversity the child or orphan is exposed to, its chronicity, or severity may also be important, and thus, resilient outcomes should therefore be determined in terms of exposure to particular adverse conditions.

The physical and emotional relationships that orphans have with their caregivers may be equally important in determining the psychosocial state and outcome of this vulnerable group of children. In the study, whilst the majority of orphans ( about 81%) perceived the care they receive from their primary caregiver as excellent, very good or good, some (about 19%) perceived the care they receive as either satisfactory or poor. The data portray that more Krobo orphans receive better care than their Asante

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counterparts (Table 5.16). This may account for the differences in the nutritional status of orphans among the two ethnic groups, discussed earlier in this chapter. Eleven out of the twenty orphans (55%) involved in the in-depth interviews indicated that the care provided by their caregivers was either satisfactory or poor and that they felt unloved by their caregivers.

In a study by Ohnishi, Anoemuah, Jagah, Feyisetan (2004) in Sagamu, Ogun State in Nigeria, the authors indicated that orphans and other vulnerable children who demonstrated a higher satisfaction of life were those who had three meals per day, those who felt that their community treated them equally as any other child, and those who had good relationship with their caregivers. These results may throw light on the perception of the study orphans in terms of their level of satisfaction with the care given to them. Some of the orphans whilst admitting that the care provided by their caregivers in terms of provision of basic needs such as food, clothing and school gadget were inadequate, they also felt that their caregivers did not have the financial strength to provide them with all their basic needs. This underscores the importance of monetary input in the care of orphans.

## 6.10 THE CONCEPTUAL FRAMEWORK

The conceptual framework described previously proposed possible interplay of factors that impact orphan care. This section intends to discuss the relationships between these factors based on the findings of the study. As indicated in chapter one, belief system and financial strength of the caregiver represent the common pathway through which all other factors influencing orphan care act. Thus, social, cultural, economic

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and environmental factors that impact on orphan care do so indirectly through the caregiver's beliefs on the care of orphans and his or her financial capability. The findings of the study are consistent with the conceptual framework in the sense that social and cultural practices compete with orphan care for the limited resources available. Thus when the caregiver has positive beliefs on orphan care, priority is placed on it and the orphan(s) under his or her care are well taken care of and vice versa.

As indicated by study participants in both the qualitative and quantitative aspects of the study, strong belief in traditional systems of inheritance played a vital role in the observed findings on inheritance system and care of orphans. For instance, the test of association between inheritance system and orphan care showed a statistically significant association ($p = 0.000$). The qualitative study also showed that caregivers who believed in taking good care of orphans irrespective of inheritance system could do so with sound financial status. Thus, the extent to which orphans are taken care of by a caregiver with positive beliefs on orphan care is largely dependent on the financial capability of the caregiver as indicated by most of the caregivers involved in the study, and where caregivers and other family members with satisfactory financial status refused to take good care of orphans, it was observed that they were influenced by their negative beliefs on orphan care. The findings of the study thus indicate that the conceptual framework is justified.

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# CHAPTER 7

# SUMMARY OF FINDINGS, CONTRIBUTION TO KNOWLEDGE, AND RECOMMENDATIONS

## Introduction

The median HIV prevalence for Ghana is 2.0% (NACP, 2011). This may be relatively lower than those of other African countries. However, the disease as indicated by the NACP is firmly rooted within the general population as well as within certain high risk groups in the country (NACP, 2009). Thus, with an annual AIDS deaths estimated as 17,058 in 2009, the numbers of AIDS orphans are estimated to continue to rise from 128,088 in 2008 to 146,417 by 2012. Caring for these orphans continues to be a challenge for individuals, families and communities as well as the nation. Thus, lack of stable care puts orphans at heightened risk of malnourishment, emotional underdevelopment, illiteracy, poverty, sexual exploitation, and HIV infection. These endanger the wellbeing of orphans as well as the future the society that these children are expected help build and sustain (Howard *et al.* 2006).

The study provided insight into the socio-cultural practices that affect the care of orphans, and for that matter Ghanaian orphans, how these orphans are currently cared for, the needs of AIDS orphans and their caregivers, and how orphans perceive the care they receive from their primary care provider, the extended family, the community, government, NGOs and individuals, using Asante and Krobo orphans as prototype. The qualitative aspect of the study went a step further to review community

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knowledge, attitudes and perceptions of HIV and AIDS, who an orphan is, and how a child must generally be cared for.

This chapter is presented in three sections. Section one summarizes the key findings of the study, section two presents the conclusion of the study, and section three proposes recommendations for future research and for programming.

## 7.1 SUMMARY OF FINDINGS

The key findings of the study are summarised as follows:

### 7.1.1 Community Knowledge, Attitudes and Perceptions of HIV and AIDS

HIV and AIDS awareness and knowledge are generally very good in all study communities. However, there are few misconceptions on the disease causation, spread, prevention and cure (see section 5.14.1). These misconceptions indicate clearly the existence of some knowledge and intervention gaps in eradicating the disease at the community level.

### 7.1.2 Perceived HIV and AIDS-Related Problems

Study participants indicated poverty, increase in the number of orphans with their attendant problems, stigma and discrimination as the main consequences of AIDS in their communities. These affect the care of both the infected and the affected.

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### 7.1.3 General Care of the Child

Study participants believed that children must be cared for until they are independent, up to the age of 25 years. It was also indicated that provision of care is the responsibility of biological parents, and consists of provision of basic needs as well as the socialization of the child to enable him or her fit well into the outside world.

### 7.1.4 Community Definition of Orphan and Who Should Care for Orphans

Whilst the Krobo see an orphan as a child who has lost one or both parents, the Asante see an orphan as a child who has lost both parents. Thus, to the Asante, a child with one parent alive (single orphan) is not an orphan. These different views of who an orphan is may have implications for how orphans are cared for among the two ethnic groups. Both ethnic groups, however, believe that in addition to death, one can view an abandoned child as an orphan. Care of orphans as perceived by study participants falls first and foremost on the family or next of kin of the deceased, with assistance from the community, charity organizations and Government.

### 7.1.5 Nutritional Status of Orphans

Nutritional status, which was used as the proxy for care of orphans in testing the study hypotheses revealed almost four out of ten orphans were stunted.

### 7.1.6 Employment Status of Caregiver and Nutritional Status of Orphans

Caregiver employment status which is the predictor of caregiver's financial strength and his or her ability to provide for the needs of the orphan did not show any

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statistically significant association with the nutritional status of orphans, among both ethnic groups.

### 7.1.7 Inheritance System and Nutritional Status (Care) of orphans

Orphans under matrilineal system of inheritance are about twice more likely to be stunted than those under patrilineal system of inheritance, thus "System of Inheritance" impacts on orphan care with orphans under patrilineal system of inheritance better cared for than those under matrilineal system.

### 7.1.8 Orphan Status and Nutritional Status (Care) of Orphans

Orphan status (paternal/maternal) or (single/double) has no statistically significant effect on orphan care in this study, however evidence from the qualitative study suggests that the plight of the paternal orphan is better than that of the maternal orphan; and that of the single orphan is better compared to the double orphan.

### 7.1.9 Caregiver Age and Nutritional Status (Care) of Orphans

Caregiver age has no effect on orphan care. However, among the Krobo, orphans with caregivers aged 41-50 years are about eight times more likely to be stunted than those cared for by caregivers among the other age groups. Thus, among the Krobo orphans cared for by caregivers aged 41 – 50 years are poorly cared for.

### 7.1.10 Socio-Cultural Factors and Orphan Care

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The cultural practices found to impact on care of AIDS orphans included funeral, marriage, and naming ceremonies; traditional rituals such as puberty rites and festivals; and traditional norms like inheritance, and polygyny.

The social factors, practices and activities found to influence the care of orphans were: Stigma and Discrimination, Alcohol, Tobacco/Drugs, Social Eating/Drinking, Extravagant Living, Fashion, Sports and Games, Films/Video/Drama, Night Clubs/Discos, Traditional Dances, Market Days, Church Worship, and Peer Influence. Most of these socio-cultural factors compete with orphan care for limited time and finance.

### 7.1.11 Rating of Care by Orphans

AIDS orphans perceived care and support offered by extended family, external sources and primary caregivers as poor, irrespective of ethnicity, even though primary care giver scores had an edge over the others. More Krobo orphans are content with how they are cared for than Asante orphans.

### 7.1.12 Level of Care of Orphans

The level of care of children orphaned by AIDS as assessed by feeding patterns, shelter, clothing, education of orphans, working status of orphans, health seeking behaviours of caregivers for orphans when orphans are ill and psycho-social state of orphans, showed that the level of care of the Krobo orphan is better than that of the Asante orphan. Although the majority of orphans had three meals per day, most orphans are in need of food. The majority of orphans are satisfied with their sleeping

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places and the things they sleep on, had at least one pair of footwear, and more than one set of clothing apart from school uniform.

The majority of orphans are in school, attend school regularly, and have their school expenses and items catered for with the exception of school bags. School charges, school gadgets, uniforms and money for food during school hours, are the main reasons for school drop-out and irregular school attendance. Only a few orphans are engaged in paid work.

Health-seeking behaviour of caregivers for orphans is generally poor with only 3 out of 10 orphans in possession of health insurance cards. Although the majority of Krobo caregivers seek for treatment for orphans the same day that orphans complain of illness, a sizeable number of caregivers among both ethnic groups will only send the orphan out for treatment when the health condition of the orphan worsens.

The majority of orphans are psycho-socially sound, however, quite a number are not, indicating preference to be alone most of the time, unhappy or depressed most of the time, anxious or too fearful, and unable to sleep as much as they should.

## 7.2 CONTRIBUTION TO KNOWLEDGE

This study has shed light on the care of children orphaned by AIDS among the Asante and Krobo of Ghana, taking into account, the social and cultural contexts of these two ethnic groups. The impact of AIDS on affected children, and responses from families,

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communities, government, and other supporting agencies are determined by the dynamics of the cultural, economic, psycho-social, and the organizational milieu in which these children find themselves.

It is evident from the study that inheritance system affects orphan care. Though there are no statistically significant differences in the nutritional status of paternal and maternal; and single and double orphans, the plight of the maternal orphan as found in the study is worse than that of the paternal orphan; and that of the single orphan better than that of the double orphan. Caregiver age has no statistically significant association with nutritional status of orphans. Other socio-cultural norms and practices such as funerals, festivals, excessive intake of alcohol, drug abuse, fashion, among others, also impact negatively on the care of orphans by reducing the household income. Even though families and communities try to cushion the impact of AIDS on orphans, they often lack the financial wherewithal to do so adequately thus rendering these orphans vulnerable to many social vices including HIV infection.

Orphan care stakeholders may, therefore, have to adopt appropriate strategies that take into consideration, the cultural, economic, as well as the social factors operating in the environment they work. This would enable them to draw up appropriate local responses to effectively address the needs of orphans and their caregivers, to ensure that these children grow up into responsible adults for the betterment of society.

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## 7.3 RECOMMENDATIONS FOR FUTURE RESEARCH AND POLICY RECOMMENDATIONS

### 7.3.1 Recommendations for Future Research

The present study identified the socio-cultural norms and practices that impact on the care of AIDS-orphaned children among the Asante and Krobo of Ghana, and how these socio-cultural factors affect orphan care. The study also assessed the level of care given to orphans among these two ethnic groups, and provided AIDS orphans with the opportunity to rate the care that they receive from their primary caregivers, extended family members and external sources including the government. The following areas of orphan care in the country may be explored in subsequent research activities.

1. Future research may take into account the HIV status of orphans, to rule out the effect of HIV status on nutritional state of orphans
2. A study on the socio-cultural factors impacting on the care of orphans due to other causes among the two ethnic groups may serve as a basis for comparison between general orphans and AIDS orphans
3. Social, cultural and economic factors that influence the care of AIDS orphans, and general orphans among other ethnic groups in Ghana may throw light on other culture-specific issues that affect orphan care in Ghana

### 7.3.2 Policy Recommendations

1. The study found that although the level of knowledge on HIV and AIDS in study communities was high, there are still some misconceptions about the disease. These misconceptions in relation to the aetiology, transmission, and

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cure of AIDS may be significant enough in deterring people to change relevant behaviours to curb the spread of the disease. It is therefore recommended that specific and targeted interventions are developed to address misconceptions at the community level especially in rural areas of the country.

2. HIV related problems in communities as revealed by the study included poverty, stigma and discrimination, and increased numbers of orphans without adequate care. These indicate that the capacity of the immediate extended family system to effectively absorb AIDS orphans is eroding. It is recommended that policies and interventions are put in place and strengthened to effectively enhance and sustain the capacity of foster families (extended family or unrelated families) to earn income, provide orphans with adequate basic physiological needs, keep orphans in school, and provide them with career skills. Such interventions should also ensure and guarantee the protection of orphans and widows, and their property by enacting and enforcing the appropriate laws to mitigate their vulnerability.
3. The study also found that orphans under matrilineal system of inheritance are poorly cared for than those under patrilineal system of inheritance, as such, it is highly recommended that community-based orphan care policies on interventions should focus more on orphans under the matrilineal system of inheritance in order to bridge the disparity in level of care between the two systems. These interventions should include in addition to those stated in 2 above, education and sensitization of communities on the available laws that protect orphans and widows from losing the entire property of the deceased father and husband to his family, and ensure that the rights of these vulnerable

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groups are protected. Education and sensitization should also include the need for ill parents to organize future care-giving arrangements for their children, and preparation of wills for inheritance especially for the terminally ill.

4. It was also found in the study that the Asante do not regard the single orphan as an orphan that requires extra non-parental support. It is therefore recommended that Asante communities are sensitized to embrace the definition of orphan to include both single and double orphans, so as to ensure that single orphans in need are given the necessary attention as double orphans.
5. The study revealed that some AIDS orphans are psychosocially distressed, thus policies on interventions should include structured, regular and periodic counselling for children orphaned by AIDS to allay their fears and anxiety to promote their psycho-social well-being.
6. Socio-cultural patterns of life, such as funeral rites, puberty rites, festivals, inheritance, naming ceremonies, traditional dancing, among others, as found in the study are institutional and are passed on to generations. Thus, they are strongly cherished and allegiance to some of them is renewed regularly through the performance of rituals and rites. However, some of these patterns are found to negatively affect the care of orphans and children in general. Policies on interventions should therefore seek to make these practices safe and minimise their effect on orphan care.

University of Ghana http://ugspace.ug.edu.gh

## BIBLIOGRAPHY

Abebe, T., and A. Aase (2007). Children, AIDS, and the politics of orphan care in Ethiopia: The extended family revisited. *Social Science and Medicine*, 64 2058-2069

Addae-Mensah, I. (2000). Education in Ghana: A tool for social mobility or social stratification. Accra, Ghana: Institute for Scientific and Technological Information.

Adomako Ampofo, A. (1998b). Framing knowledge, forming behaviour: African women's AIDS-protection strategies. *African Journal of Reproductive Health* 2 (2)

Agyeman, D.K. (1993). Families, neighbours and the AIDS epidemic. Paper presented at a workshop on social dimensions of HIV/AIDS, University of Cape Coast.

Ainsworth, M. and I. Semali (2000). The impact of adult deaths on children's health in north-western Tanzania. Washington DC, USA, World Bank Development Group.

Anarfi, J. (2000). Related literature on sexuality and AIDS in Ghana.

Anarfi, J. (1994). HIV/AIDS in Sub-Saharan Africa: Its demographic and socio-economic implications. *African Population Paper Series*, No. 3. African Population and Environment Institute, Kenya.

Anarfi, J. and M. Pappoe (1999). The dynamics and health implications of emigration of females from the Manya and Yilo Krobo area.

Ankrah, E.M. (1989). AIDS: A research problematic. *Social Science & Medicine*, 293: 265-279.

Ankrah, E.M. (1993). The impact of HIV/AIDS on the family and other significant relationships: The African clan revisited. *AIDS Care*, 5: 5-22

Ansell, N. and Young, L. (2004). "Enabling households to support successful migration of AIDS orphans in southern Africa." *AIDS Care, v. 16, no. 1*, p. 3-10.

Asiimwe,D., R. Kibombo, S. Neena, *et al.* (2003). Focus group discussions on social and cultural factors impacting on HIV/AIDS in Uganda. Final Report. Kampala: Ministry of Finance and Economic Development/UNDP.

Anthropometrics: Qualitative techniques for health equity analysis – Technical Notes # 2

University of Ghana http://ugspace.ug.edu.gh

Antonucci, T. C., and H. Akiyama (1987). An examination of sex differences in social support among older men and women. *Sex Roles*, 17, 737-749.

Atobrah, D. (2005). Care of orphans in Manya Krobo. *Studies in the Culture of Care* 2. Institute of African Studies, University of Ghana, Legon.

Atwine, B., E. Cantor-Graae, and F. Banjunirweb (2005). Psychological distress among AIDS orphans in rural Uganda. *Social Science and Medicine* 61: 555-564.

Awedoba, A.K. (2005). Culture and Development in Africa: With special references from Ghana. Accra: University of Ghana Press.

Barnett, T. and P. Blaikie (1992). AIDS in Africa: Its present and future impact. London: Belhaven Press.

BBC News Africa (2007, September 14). UN boss calls Africa crisis talks. http://news.bbc.co.uk/2/hi/africa/6994789.stm (Accessed on 22/8/2007)

Behrman, J. R., and A. B. Deolalikar (1988). *Health and Nutrition*. In H. B. Chenery and T. N. Srinivasan (Eds.), Handbook of Development Economics, 1:631-711.

Berkley, S. (1992). The AIDS epidemic: personal and social consequences. *Annals of International Medicine* 116:339-341.

Bicego, G; Rutstein, S. and K. Johnson (2003). "Dimensions of the emerging orphan crisis in sub-Saharan Africa." *Social Science & Medicine, v. 56, no. 6*, p. 1235-1247.

Bhargave, A. (2005). AIDS epidemic and the psychological well-being and school participation of Ethiopian orphans. *Psychology, Health & Medicine*, 10(3), 263-275.

Bhargava, A. and B. Bigombe (2003). Public policies and the orphans of AIDS in Africa. *BMJ*. 326(7403):1387–1389

Bledsoe, C.H., Ewbank and U.E. Isiugu-Abanihe (1988). The effect of child fostering on feeding practices and access to health services in rural Sierra Leone. *Social Science and Medicine* 27:627-636.

Bicego, G., S. Rutstein, K. Johnson (2003). Dimensions of the emerging orphan crisis in sub-Saharan Africa. *Soc Sci Med.*; 56(6):1235–47.

University of Ghana http://ugspace.ug.edu.gh

Bigombe, B., and M. Gilbert (2001). Major trends affecting families in Sub-Saharan Africa.

Bollinger, L., J. Stover, and B. Kibirige (1999). The economic impact of AIDS in Uganda (A POLICY Project Paper). Washington DC: USAID.

Bowlby, J. (1969/1982). *Attachment and Loss*. Vol. 1. Attachment. New York: Basic Books.

Bowlby, J. (1973). *Attachment and Loss*. Vol. 2. Separation: Anxiety and Anger. New York: Basic Books.

Caldwell, C.J. *et al.*, (1993). "African families and AIDS: context, reactions and potential interventions". In Orubuyole *et al.*, eds., Sexual networking and AIDS in Sub- Saharan Africa: Behavioural research and the social context. Australian National University, Canberra.

Cantrell, L.A. (1986). Alcohol and family violence. Cheyenne, Wyoming Department of Health and Social Services

Care International (2007). Care Education http://www.careinternational.org.uk./education+8301.twlCare (Accessed on 18/10/2007)

Case, A., C. Paxton and J. Ableidinger (2003). The education of African orphans. Princeton, N.J., USA, Centre for Health and Well-being Research in Development, Princeton University.

Case, A., C. Paxton and J. Ableidinger (2004). Orphans in Africa: Parental death, poverty, and school enrolment. *Demography*, 41:483-508.

Case, A., V. Hosegood, & F. Lund (2003). The reach of the South African child support grant: Evidence from Kwazulu Natal. Draft, September.

Cattell, M. G. (1993). Caring for the Elderly in Sub-Saharan Africa. *Ageing International*, 20(2), 13-19.

Cattell, M.G. (1989). Old age in rural Kenya: Gender, the life course and social change. Unpublished doctoral thesis, Bryn Manur College

CDC: Revision of the CDC surveillance case definition for acquired immune deficiency syndrome. *NMWR* 36(supplement):3, 1988.

Chigwedere, A. (1996). The abandoned adolescent. The Mutapa Publishing House. Marondera."Community Based Support of Orphans and Vulnerable Children: *A manual for frontline workers in Africa.*" 2004. The Kindernothilfe e. V. Germany.

University of Ghana http://ugspace.ug.edu.gh

Christiansen, C. (2003). 'Reflections on the changing patterns of care for orphans.' *Codesria Bulletin*, No. 2, 3, & 4: 94-98.

Cleaver, H., I. Unell, and J. Aldgate (1999). Children's needs - parenting capacity: The impact of parental mental illness, problem alcohol and drug use, and domestic violence on children's development. London. The Stationary Office.

Cluver, L., F. Gardner, and D. Operario (2007). Psychological distress amongst AIDS-orphaned children in urban South Africa. *Journal of Child Psychology and Psychiatry*, 48: 755–763. doi: 10.1111/j.1469-7610.2007.01757.x

Coombe, C. (2002). Editorial: HIV/AIDS in Education. *Perspectives in Education* (20), vii-x

Corbin, W. R., J.A Bernat, K.S. Calhoun, L.D. McNair, and K.L. Seals (2001). The role of alcohol expectancies and alcohol consumption among sexually victimized and non-victimized college women. *Journal of Interpersonal Violence, no. 16(4)*, pp297-311.

Crampin, A.C., S. Floyd, J.R. Glynn, N. Madise, A. Nyondo, M.M. Khondowe, *et al.* (2003). The long-term impact of HIV and orphanhooh on mortality and physical well-being of children in rural Malawi . *AIDS*. 17(3):389–397

Dean, M. (1992). AIDS and Murdoch Press. *Lancet* 339 1286.

Duesberg, P. H. (1998). AIDS Epidemiology: Inconsistencies with HIV ad with Infectious Disease. *Proc Natl Acad Sc* 86: 755-64.

Deininger, K., M. Garcia, and K. Subbarao (2003). AIDS induced orphanhood as a dynamic shock: Magnitude, impact and programme interventions in Africa. *World Bank Development*, 31: 1201-1220.

DeSilva, M., M. Cakwe, B. Nkosi, A. Parikh, T. Quinlan, S. Tshabangu-Soko, and J. Simon (2007). Vulnerability of orphan versus non-orphan caregivers in Kwazulu Natal. (AIDS Impact Conference Presentation, July 4), South Africa.

Desmond, C., K. Michael, and J. Gow (2000). The hidden battle: HIV/AIDS in the family and community. Paper of the Health Eonomics and HIV/AIDS Research Division, University of Natal. Durban, South Africa.

Devereux, S. (2002). Can Social Safety Nets Reduce Poverty? *Development Policy Review* 20 (5), 657-675

University of Ghana http://ugspace.ug.edu.gh

Dodoo, F.N. and A. Adomako-Ampofo (2001). AIDS-related knowledge and behaviour among married Kenyan men: A behavioral paradox? *Journal of Health and Human ServicesAdministration*, 24(2).

Downs, W.R., B.A. Miller, and D.E. Panek, (1993). Differential Patterns of partner-to-woman violence: a comparison of samples of community, alcohol-abusing, and battered women, *Journal of Family Violence*, no. 8(2), 113-135.

Downs, W.R., B.A. Miller, and D.E. Panek, (1994). Differential Patterns of partner-to-woman violence: a longitudinal examination. Paper presented at the Annual Meeting of the Research Society on Alcoholism, Maui, Hawaii.

Dzokoto, A. *et al*. (2002). Background to reproductive tract infections in Ghana. In Manuscript.

Ember, R., and m.Ember (1981). Cultural Anthropology, 3rd Edition, Englewood Cliffs: Prentice Hall.

Engle, P., and H. Ricciuti (1995). Psychological aspects of food and nutrition. *Food and Nutrition Bulletin*, 16:356-77

Eurocare/Coface (1998) Alcohol problems in the family: A report to the European Union. St Ives, Cambridgeshire, *Eurocare*.

Fausi, A. S. (1998). The HIV: Infectivity and mechanisms of pathogenesis. *Science* 239: 617-22.

Fenrich, J., Higgins, T. E. (2001). 'Promise unfulfilled: Law, culture and women's inheritance rights in Ghana' *Fordham International Law Journal*, 25: 259-341.

Fieldhouse, P. (1986). Food and Nutrition- Culture and Customs, s.l: Croom Helm Ltd. Australia

Food and Agriculture Organization of the United Nations. (1994, February). Uganda – The socio-economic impact of HIV/AIDS on rural families with emphasis on youth. Rome: Author.

Fortes, M. (1950). 'Kinship and marriage among the Ashanti' In Radcliff-Brown & Forde, eds. African Systems of Kinship and Marriage. London: Oxford University Press.

Foster, G. (2000). The capacity of the extended family safety net for orphans in Africa. In *Psychology, Health and Medicine*. Vol. 5, issue 1.

Foster, G., and J. Williamson (2000). A review of current literature of the impact of HIV/AIDS on children in Sub-Saharan Africa. *AIDS* 14 (suppl. 3): S275-S284

University of Ghana http://ugspace.ug.edu.gh

Fox, R. (1994). AIDS: The third wave. *Lancet.* Vol. 343 No. 889 pp186.

Fuller, J. S. and K. Schaller-Ayers (1990). Health assessment: A nursing approach. J. B. Lippincott Company, Philadelphia.

Gaber, M. and F.R.A. Dean (1955). Psychological factors in the actiology of kwashiorkor. *Bulletin of World Health Organization* 12:471-475.

Ghana AIDS Commission/UNDP (May 2003). A study of the status of AIDS orphans and vulnerable children in Ghana: Towards the formulation of national policy.

Ghana AIDS Commission/Ministry of Women and Children Affairs/Ministry of Manpower, Youth and Employment (2005). National policy guidelines on orphans and other children made vulnerable by HIV/AIDS.

Gibson, R. S. (1993). Nutritional assessment: A laboratory manual. Oxford University Press, New York.

Gilborn, et al. (2001). Making a difference for children affected by AIDS: Baseline findings from operations research in Uganda. The Population Council Inc., New York.

Gillespie, S. (2006). Child vulnerability and AIDS: Case studies from Southern Africa. Food Policy Research Institute.

GNCC (2000). Ghana's Children: The child's perspective. Report.

Godwin, P. (1997). Socio-economic implications of the epidemic. UNDP Regional Project on HIV Development, New Delhi.

Goldberg, R. (2007). Orphan status and age at sexual debut in Kisimu, Kenya. Department of Sociology, Brown University.

Goody, J. (1973). Polygyny, economy and the role of women. In: "The character of kinship". Edited by Goody. pp. 175-190. Cambridge, Cambridge University Press.

GOU/UAC (2002). Situation analysis of orphans in Uganda.

Gregson, S., G.P. Garnet and R.M. Anderson (1994). Is HIV-1 likely to become a leading cause of adult mortality in Sub-Saharan Africa? *Journal of Acquired Immune Deficiency Syndrome* 7:839-852

GSS/GHS (September 2009). Ghana Demographic and Health Survey, 2008.

University of Ghana http://ugspace.ug.edu.gh

Hakanson, N.H. and R.A. LeVine (1997). Gender and life-course strategies among the Gusii. In T.S. Weisner, C. Bradley, K.L. Kilbride (Eds.), *African Families and the Crisis of Social Change* (pp 253-267). Bergin and Garvey: London.

Hall, A., L.N. Khanh, T.H. Son, N.Q. Dung, R.G. Lansdown, D.T. Dar, N.T. Hanh, H. Moestue, H.H. Kho, & D.A. Bundy (2001). An association between chronic under nutrition and educational test scores in Vietnamese children. *Eur. J. Clin. Nutr.* 55:801-804.

Hampton, J. (March, 1991). Meeting AIDS with compassion, AIDS care and prevention in Agomanya, Ghana. *Strategies of Hope 4, Action AID.*

Harwin, J. and D. Forrester (2002). Parental substance misuse and child welfare: a study of social work with families in which parents misuse drugs and alcohol. First stage report for the Nuffield Foundation (unpublished)

Hauser, R. M. (1998). In Support of the Nutrition Theory. In the rising curve: Long-term gains in IQ and related measures. Washington DC: American Psychological Association. Cited in Hamoudi and Sachs (1999) pp 207-218.

Health and Nutrition Breakthroughs (1999). pp. 1-3, 26-28.

Heymsfield, S. B. and K. Kasper (1987). Anthropometric measurements of adult hospitalized patients. *J Parenteral and Enteral Nutr* 11:36S-41S.

Hirsch, M.S., F. Brun-Vezinet, B. Clotet, *et al.* (2003). Antiretroviral drug resistance testing in adults infected with HIV type 1: 2003 recommendation of an International AIDS Society- USA Panel. *Clinical Infections Diseases* 37: 113-128

Hogg, R.S., B. Yip, K.J. Chan, *et al.* (2001). Rates of disease progression by baseline CD4 cell count and viral load after initiating triple drug therapy. *JAMA* 286(20): 2568-77

Hosegood, V., K. Herbst, & I. Timaeus (2003). The impact of adult AIDS deaths on households and children's living arrangements in rural South Africa. Paper prepared for Scientific Meeting on the Empirical Evidence for the Demographic and Socio-Economic Impacts of AIDS. Durban.

Howard, B.H., C.V. Philips, N. Matinhure, K.J. Goodman, S.A. McCurdy, and C.A. Johnson (2006). Barriers and incentives to orphan care in a time of AIDS and economic crisis: A cross-sectional survey of caregivers in rural Zimbabwe. *BMC Public Health*, 6:27doi:10.1186/1471-2458-6-27.

Huber, H. (1963). "The Krobo, traditional, social and religious life of a West African people". The Anthropos Institute. St. Augustine near Bonn.

University of Ghana http://ugspace.ug.edu.gh

Huber, H. (1993). "The Krobo, traditional, social and religious life of a West African people", (2nd edition). University Press, Fribourg, Switzerland.

Human Rights Watch (2006). Children's rights: Education. http://hrw.org/children/education.htm (Accessed, 15/12/2006)

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. *Social Science and Medicine* 31, 6:681-690.

Hunter, S. and J. Williamson (2002). Children on the brink. Executive summary: Updated estimates and recommendations for interventions. Washington: USAID, 2000.

Hunter, S., J. Williamson (1998b). Responding to the needs of children orphaned by HIV/AIDS. Discussion paper on HIV/AIDS care and support. No. 7. Health and Technical Services (HTS) Project for USAID. June.

Isaranurug, S. and J. Chompikul (2009). Emotional development and nutritional status of HIV/AIDS orphaned children aged 6 – 12 Years Old in Thailand. *Maternal and Child Health Journal*, 13(1): 138-43.

Jeejeebhoy, K. N. (2000). Nutritional assessment. *Nutrition* vol. 16, No. 7/8.

Jelliffe, D. B. (1966). The assessment of the nutritional status of the community. First edition. WHO. pp. 62-77.

Jukes, M., S. Simmons, and D. Bundy (2008). Education and vulnerability: the role of schools in protecting young women and girls from HIV in southern Africa. *AIDS*. Suppl 4:S41-56

Kanawati, A. A. (1976). Assessment of nutritional status in the community. In: MacLaren, D. S. (1976). Nutrition in the Community. John Wiley and Sons, New York.

Kilbride, P.L., and J.C. Kilbride (1990). Changing family life in East Africa: Women and children at risk. Pennsylvania State University Press.

Kludze, A. K. (1983). Property law and rural development in Ghana. *Rural Africana* 17:57-67.

Koichiro, W., R. Flores, J. Fujiwara, and L.T.H. Tran (2005). Early childhood development interventions in cognitive development of young children in rural Vietnam. *Nutr.* 135: 1918-1925. August.

University of Ghana http://ugspace.ug.edu.gh

Kroll, B. and A. Taylor (2003) Parental substance misuse and child welfare. London Jessica Kingsley Publishers.

Lartey, A. *et al.* 2000. Predicators of Growth from 1 to 18 Months Among Breastfed Ghanaian Infants. *Eur J Clin Nutr.*

Levy, A.R., D. James, K.M. Johnson, *et al.* (2006). The direct costs of HIV/AIDS care. *Lancet Infect Dis. 6:171-7.*

Li, H., H.X. Barnhart, A.D. Stein, and R. Martorell (2003). Effects of early childhood supplementation on the educational achievement of women. *Pediatrics*: 112:1156-1152.

Lifson, A.R. (1994). Preventing HIV: Have we lost our way? *Lancet*, Vol. 343, No. 9809 pp 1306

Lindblade, K., F. Odiambo, D. H. Rosen, and K. M. DeCock (2003). Health and Nutritional Status of Orphans <6 Years Old Cared for by Relatives in Western Kenya. *Tropical Medicine and International Health*, 8:67-72.

LINKAGES (1999). Facts for feeding. Breastfeed babies for the first 6 months of life. Washington D.C: Academy for Educational Development.

London, N. A. (2003). Pathways to educational transformation and development: Policies, plans, lessons. Toronto: Canadian Scholars' Press.

Luthar, S.S., D. Cicchetti, and B. Becker (2000). The construct of resilience: A critical evaluation and guidelines for future work. *Child Development*, 71(3): 542-562

MacLaren, D.S. (1976). Nutritional Assessment. In: Maclaren D. S. and Burman, D. (1976). Textbook of Paediatric Nutrition. Churchill Livingston, Edindurgh. pp. 91-102.

Mahan, L. K. and I. M. Arlin (1992). Food, nutrition and diet therapy. 8th Edition. W. B. Saunders Company. pp. 644-7.

Makame, V.C. S. Ani, and Grantham-McGregor (2002). Psychological well-being of orphans in Dar El Salaam, Tanzania. *Acta Paediatr.*:91(4):459–65.

Makoni, S., and M. Ferreira (2002). Old age and close relationships in Africa: Snapshots and emerging perspectives. In J. G. Miller and X. Chen (Eds.), Aging and close relationships. *International Society for the Study of Behavioural Development Newsletter*, 1(41), 11-14

Mann, J. (1992). "AIDS in the world". Cambridge MA: Harvard University Press.

Mann J. *et al.* (1994). Health and human rights. *Health and Human Rights* 1, 1:6-23. HIV/AIDS in Malawi. Save the Children Alliance, CPSC Project.

University of Ghana http://ugspace.ug.edu.gh

Mararike, C.G. (1997). The socio-cultural context of the AIDS epidemic in Zimbabwe. Unpublished paper.

Martorell, R. (1998). Nutrition and the worldwide rise in IQ scores. In the Rising Curve: Long-term Gains in IQ and Related Measures. Washington DC: American Psychological Association. Cited in Hamoudi and Sachs (1999) pp 183-206.

Martorell, R., L. K. Khan, and D. G. Schroeder (1993). Reversibility of stunting: epidemiological findings in children from developing countries. In J. C. Waterlow & Beat Schurch (Eds.), Causes and mechanisms of linear growth retardation. (Proceedings of an I/D/E/C/G Workshop, 15-18 January 1993.) London: International Dietary Energy Consultancy Group.

Maslow, A.H. (1970). Motivation and personality. 2nd Ed. New York. Harper and Row Publishers Inc.

Masmas T.N., H. Jensen, D. da Silva, L. Hoj, A. Sandstrom, and P. Aaby (2004). The social situation of motherless children in rural and urban areas of Guinea-Bissau. *Soc Sci Med.* 59(6):1231–9.

Matsalage, N. and G. Powell (2002). Mass orphanhood in the era of HIV/AIDS. *British Medical Journal*, 185-186

Mboya, P. (1965). "Luo customs and beliefs". Kendu Bay: African Herald Publishing House.

McCubbin, H.H., and J.M. Patterson (1982). Family adaptation to crisis. In H.I. McCubbin, A.E. Cauble, and J.M. Patterson (Eds.), Family Stress, Coping, and Social Support. Springfield IL: Thomas.

Mcloyd, V. (1998). Socio-economic disadvantage and child development. *American Psychologist* 53: 185-204

McCorkindale, C., K. P. Sucher, and A. M. Coulston (1990). Nutritional status of HIV-infected patients during the early disease stage. *J Am Diet Assoc* vol.90 No 9 pp. 1236.

MESW/UNICEF (2010). National plan of action for orphans and vulnerable children, Ghana. June 2010 - 2012

Miller, C. H. (2008). Educational access for orphans and vulnerable children in Woliso, Ethiopia. Alaska Pacific University. April, 15.

University of Ghana http://ugspace.ug.edu.gh

Monasch, R., J.T. Boerma (2004). Orphanhood and childcare patterns in Sub-Saharan Africa: An analysis of national surveys from 40 countries. *AIDS*.: 18 (2):55–65.

MONDIACULT (1998), Stockhom.

Monk, N. (2001). Underestimating the Magnitude of a Mature Crisis: Dynamics of Orphaning and Fostering in Rural Uganda. Orphan Alert: International Perspectives on Children Left Behind by HIV/AIDS. New York.

Mukwaya, J. (1999). The AIDS Emergency. 'The Progress of Nations': New York: UNICEF.

Mullender, A., G. Hague, U. Imam, L. Kelly, E. Malos, and L. Regan. (2002) Children's perspectives on domestic violence. London, Sage.

Muller, O. and N. Abass (1990). The impact of AIDS mortality on children's education in Kampala (Uganda). *AIDS Care* 2.1:77-80.

MoH/NACP (March 1999). HIV/AIDS in Ghana: Background, projections, impacts and interventions.

MoH/NACP ( 2001). HIV/AIDS in Ghana: Background, projections, impacts and interventions. Accra, Ghana

NACP/DFID/WHO/GHS/GAC (February, 2008). National HIV prevalence and AIDS estimates report, 2007 – 2012

NACP/GAC (September, 2004). HIV/AIDS in Ghana: Current situation, projections, impacts, interventions. 4th Edition

NACP/GHS (January 2005). HIV/AIDS in Ghana: Current situation, projections, impacts and interventions. *NACP Bulletin; Quarterly Technical Bulletin on HIV/AIDS-STIs in Ghana*. Special Edition.

NACP/GHS (March 2005). 2004 HIV Sentinel Survey Report. Accra, Ghana.

NACP/GHS (April 2009). 2008 HIV Sentinel Survey Report. Accra, Ghana.

NACP/GHS/MoH (March,2011). 2010 HIV Sentinel Survey Report.

Ntata, P.T.R. (1998). "Best Practice in Orphan Care". A report submitted to UNICEF, Zomba.

University of Ghana http://ugspace.ug.edu.gh

Ntambirweki, P. (2001). Assessment of the orphan situation in Bundibugyo district. Report. Uganda Women's Efforts to Save Orphans (UWESCO) and United Nations Children's Fund.

Ntozi, P.M. and J. Mukiza-Gapere (1995). Care for AIDS orphans in Uganda: Findings from focus group discussions. *Health Transition Review*. Supplement to Volume 5, 245-252.

Ntozi, F., F.E. Ahimbisibwe, J. O'dwee, N. Ayiga, and F. Okurut (1999). Orphan care: The role of the extended family in northern Uganda. *Health Trans Rev*. 8:225-236.

Nyambedha, *et al*. (2001) "Policy implications of the inadequate support systems for orphans in Western Kenya". *In Health Policy*. Vol. 58. Elsevier Science. Ireland Ltd.

Nyambedha E.O. S.Wandibba, J. Aagaard-Hansen (2003a). Retirement lost-the new role of the elderly as caretakers for orphans in Western Kenya. *J Cross Cult Gerontol.*; 18(1):33–52.

Nyambedha, E. K., S. Wandibba, and J. Aagaard-Hansen (2003b). Changing patterns of orphan care due to the HIV epidemic in western Kenya. *Soc Sci Med*. 57(2):301–11

Nyamukapa, C. and S. Gregson (2005). Extended families and women's roles in safeguarding orphans' education in AIDS-afflicted rural Zimbabwe. *Social Science and Medicine*. 60: 2155-2167.

Nyamukapa, C. A., S. Gregson, B. Lopman, S. Saito, H. J. Watts, R. Monasch, and M.C.H. Jukes (2008). HIV-associated orphanhood and children's psychosocial distress: Theoretical framework tested with data from Zimbabwe. *American Journal of Public Health* Vol 98, No. 1: 133-141.

O' Shaugnessy, J. (1990). "The phenomenon of Political Marketing". New York: Saint Martin's Press.

Oleke, C., A. Blystad, and O.B. Rekdal (2005). "When the obvious brother is not there": Political and cultural contexts of the orphan Challenge in northern Uganda. *Social Science & Medicine* 61: 2628-2638c

Oleke, C., A. Blystad, and O.B. Rekdal, K.M. Moland (2007). Experiences of orphan care in Amach, Uganda. Assessing policy implications. *Journal of Social Aspects of HIV/AIDS*. 4(1): 532-543.

Ollenu, N. A. (1966). The law of testate and intestate succession in Ghana. London: Sweet and Maxwell.

University of Ghana http://ugspace.ug.edu.gh

Ollenu, N. A. and G. R. Woodman (1985). Principles of customary land law in Ghana. 2nd Edition. Birmingham: CAL Press.

Ohnishi, O.M, A.B. Anoemuah, J.T. Jagah, and F.D. Feyisetan (2004). Psycho-ocial characteristics of AIDS orphans and vulnerable children in Sagamu, Ogun State, Nigeria. *Int Conf AIDS*. Jul. 11-16: 15: abstract no. WePeD6558.

Okyerefo, M. P. K. (2005). Pursuing effective pre-university education in Ghana: Theory and praxis. *Legon Journal of Sociology*. 2(1). 36-41

Opoku, K. A. (1982). The World's View of the Akan. *Tarikh* 7. No 2:61-73.

Oppong, C. (2004). "Gender, family strategies and responsibilities of grandparents in Sub-Saharan Africa". Occasional Research Papers Series 2000, IAS, Legon, Accra.

Osei K. (2002). A handbook on Asante culture. Cita Press Ltd. Kumasi.

Owusu, M. A. S. (2007). The mis-education of the Ghanaian: A critique of the Ghanaian education system. In D. E. K. Amenumey (Ed.). *Challenges of education in Ghana in the 21st century* (pp. 91-101). Accra, Ghana: Woeli Publishing Services.

PANOS (1990). *The 3rd Epidemic: Repercussions of the Fear of AIDS*. London: Panos Institute.

Patel, V. and A. Kleinman (2003). Poverty and common mental disorders in developing countries. *Bulletin of the World Health Organization*. 81: 609-615

Payne, W.A., and D.B. Hahn (1998). Understanding your health. Fifth edition

McGraw-Hill Companies, Inc, pp. 402-408

Pelton, J, and R. Forehand (2005). Orphans of the AIDS epidemic: an examination of clinical level problems of children. *J Am Acad Child Adolesc Psychiatry*. 44(6):585–91

Piwoz, E. G., and E. A. Preble (2000). HIV/AIDS and nutrition. A review of the literature and recommendations for nutritional care and support in Sub-Saharan Africa. pp. 1-4, 27-31, 47.

Poehlmann, J. (2003). An attachment perspective on grandparents raising their very young grandchildren: Implications for intervention and research. *Infant Mental Health Journal*, 24(2), 149-173.

University of Ghana http://ugspace.ug.edu.gh

Rattray, R. S. (1927). Religion and Art in Ashanti. London: Oxford University Press.

Richter, L., G. Foster, and L. Sherr (2006a). Where the heart is: meeting the psychological needs of very young children in the context of HIV/AIDS. The Hague, The Netherlands: Bernard van Leer Foundation.

Runanga, A.O. and P. Aggleton (1998). Migration, the family and the transformation of a sexual culture. *Sexualities* 1:63- 81.

Robinson, W. and J. Hassell (2000). Alcohol problems and the family: From stigma to solution. London, ARP and NSPCC.

Roe, K. M., and M. Minkla (1999). Grandparents raising children: Challenges and responses. *Generations*, 22(4), 25-34.

Runger, M. (8-11 March, 2006). 'Governance, land rights and access to land in Ghana – A development perspective on gender equity'.

Safman, R.M. (2004). Assessing the impact of orphanhood on Thai children affected by AIDS and their caregivers. *AIDS Care.*; 16(1):11–19.

Sarker, M., C. Neckermann, and O.Muller (2005). Assessing the health status of young AIDS and other orphans in Kampala, Uganda. *Trop Med Int Health.*10(3): 210–5.

Scheehler, M. T. *et al.* (1993). HIV-1 and the etiology of AIDS. *Lancet* vol 341 No 8846 pp 658-59.

Schultz, T. P. (1999). Health and schooling investments in Africa. *Journal of Economic Perspectives*, 13(3), 67-88.

Scrimshaw, N. S. (1997). Synergism of nutrition, infection and immunity: An overview. *Am J Clin Nutr* 66: 464S-477S.

Segendo, J. and J. Nambi (1994). The psycho-social effect of orphanhood: A study of orphans in Rakai district. *Health Transition Review*, 7(Supplement), 105-124.

Serwadda, D., *et al.* (1992). HIV risk factors in three geographic strata of rural Rakai District, Uganda. *AIDS* 6:983-989.

Sharma, M. (2005). Orphans in Malawi: Prevalence, outcomes, and targeting of services. Washington, DC, USA, International Food Policy Research Institute.

Siegel, K. and K. Gorey (1994). Childhood bereavement due to parental death from AIDS. *Developmental and Behavioural Paediatrics*, 15 (3): 66-70.

University of Ghana http://ugspace.ug.edu.gh

Simmons, J., *et al* (2002) Crime in England and Wales. London. Home Office Research, Development and Statistics Directorate

Smart, R. (2003). Policies for orphans and vulnerable children: A framework for Moving Ahead. POLICY.

Stein, J. (2003). Sorrow Makes Children of us all: A literature review on the psycho-social impact of HIV/AIDS on children. *CSSR Working Paper No. 47*, University of Cape Town, Centre for Social Science Research.*Adoption Quarterly*, 2, 55-85.

Stovall, K.C., and M. Dozier (1998). Infants in foster care: An attachment theory perspective.

Swadener, B.B. (2000)."At risk" or "at promise": From deficit constructions of the "other childhood" to possibilities for authentic alliances with children and families. In D.C. Soto (ed). The Politics of Early Childhood Education. pp.117-134 New York: Peter Lang.

Tylor, E.B. (1924).Primitive culture. Gloucester, M.A: Smith (first published in 1871)

UNAIDS. An Exceptional Response to AIDS.

UNAIDS. (2010). AIDS epidemic update: 2009

UNAIDS (2005). Report on the global AIDS epidemic.

UNAIDS (1999). The children left behind: UNICEF and UNAIDS issue new report on AIDS orphans. December 1. Press Release, Geneva.

UNAIDS (2000). Report on the global HIV/AIDS epidemic (The Durban Report, December). Geneva.

UNAIDS/UNICEF (2002). Children on the brink: A joint report on orphan estimates and program strategies. July.

UNAIDS/WHO (1998). Guidelines for using HIV testing technologies in surveillance. UNAIDS/WHO Working Group on HIV/AIDS/STI Surveillance

UNDP (2005). Millenium Development Goals. http://www.undp.org/mdg/basics.shtml. (Accessed on 5/11/2010)

UNESCO (2002). HIV/AIDS Prevention and Care in Mozambique: A Socio-Cultural Approach.

University of Ghana http://ugspace.ug.edu.gh

UNESCO (2007). Primary Education. http://portal.unesco.org/education/en/ev.php-URL_ID=30859&URL_DO=DO_TOPIC&URL_SECTION=201.html. (Accessed on 18/01/2011)

UNICEF (2005). The state of the world's children: Children under threat. New York. http://www.unicef.org/publications/index_24432.html. (Accessed on 18/01/2011)

UNICEF (2006). Africa's children and vulnerable generations: Children affected by AIDS. New York, UNICEF.

UNICEF, PCD, World Bank (2009). Promoting quality education for orphans and vulnerable children: A sourcebook of programme experiences from eastern and southern Africa

USAID (2000). Children on the brink: Executive summary: updated estimates and recommendations for interventions. Washington.

USAID/UNAIDS/UNICEF (2004). Children on the brink

Van Eterik, P. (1995). Factors influencing quality of care: Care, caregiving, and caregivers. *Food and Nutrition Bulletin*, vol 14. No. 4. http://www.unu.edu/unupress/food/8F164e/8164E0f.htm (Accessed on 14/10/2008)

Velleman, R. (1993). Alcohol and the family. London. Institute of Alcohol Studies.

Velleman, R. (2002). The Children of problem drinking parents: An executive summary. *Executive Summary Series;* Centre for Research on Drug and Health Behaviour, Executive Summary 70, 1 -5.

Vallenga, D. D. (1986). 'Matriliny, patriliny, and class formation among women Cocoa farmers in two rural areas of Ghana'. C. Robertson and I. Berger (Eds.), *Women and Class in Africa*. London: Holmes and Meier Publishers, Inc.: 62-77.

Weisner, T.S. (1997). Support for children and the African family crisis: In *African Families and the Crisis of Social Change*. Weisner,T.S.; C. Bradley, and P.L. Kilbride (eds.). pp. 20-44. Westport. Conn: Bergin and Garvey.

Whitney, E. N., C. B. Cataldo, and S. R. Rolfes (1991). Understanding normal and clinical nutrition. Third Ed. West Publishing Company. pp.938.

WHO (1993). HIV prevention and care. Teaching Modules for Nurses and Midwives. WHO/GPA/CNP/TCMD/93.3

University of Ghana http://ugspace.ug.edu.gh

WHO (1995). Field guide on rapid nutritional assessment in emergencies. (WHO) Regional Office for Eastern Mediterranean. pp.16

WHO Working Group (1986). Use and interpretation of anthropometric indicators of nutritional status. Bulletin of the World Health Organization, 61 (6): 929-41. WHO (1986) WHO Geneva.

Wild, L. (2001). The psychological adjustment of children orphaned by AIDS. *Southern African Journal of Child and Adolescent Mental Health*, 13 (1): 3-22.

Wild, L. (2003). The psychological adjustment of children orphaned by AIDS. Cape Town: University of Cape Town, Department of Psychiatry, unpublished.

Williamson, J. (2000). Finding a way forward. Washington D.C.: USAID. Displaced Children and Orphans. War Victims Fund.

Wiseman C.C. (2002). Social exclusion and inclusion: Challenges to orphan care in Malawi. *Nordic Journal of African Studies* 11 (1) 93-113.

World Bank (1997). Confronting AIDS: Public priorities in a global epidemic. Washington, DC.

World Bank, UNICEF, PCD (2006). Ensuring education access to orphans and vulnerable children: A Planner's Handbook. 2nd Edition.

World Vision-Uganda & United Nations Children's Fund-Uganda, 1999. Shattered innocence, http://www.worldvision.org/worldvision/pr.nsf/stable/nb18_31 (Accessed on 18/10/2010)

Yamano, J. and T.S. Jayne (2003). Measuring the effects of prime-age adult mortality in Kenya. Policy Brief: Temegeo Working Paper 5.

Yamba, B. (2003). "Children of the storm". News from Nordic African Institute 1/2003.

Yamba, B. (2003). AIDS orphans of Africa: Victims or vestiges of hope. Uppasala: The Nordic African Institute.

Zhao, G., Li, X., Fang, X., *et al.* (2007). Care arrangement, grief, and psychological problem among children orphaned by AIDS in China. *AIDS Care*, 19(9): 1075-1082

Zimmerman, B. (2005). "Orphan living situations in Malawi: A comparison of orphanages and foster homes."

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# APPENDIX I

## SOCIO-CULTURAL DETERMINANTS OF CARE OF AIDS-ORPHANED CHILDREN AMONG THE ASHANTI AND KROBO OF GHANA

**Questionnaires for Orphans 8 – 17 years Old**

IDENTIFICATION

*Complete the following information for all households with AIDS orphans approached*

Region:.....

District:.....

Town/Village:.....

Number of persons in household:.....

Name of Orphan:.....*(Record first name only)*

Name of Caregiver:..... *( Record first name only)*

| INTERVIEWER VISITS | 1 | 2 | 3 |
|---|---|---|---|
| Date | | | |
| Interviewer's Name | | | |
| Interviewer's Remark | | | |
| Interviewer's Signature | | | |
| Time | | | |

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BACKGROUND INFORMATION ON ORPHAN

1) Age .....(*write age in complete years*)

2) Sex:..... 1. Male 2. Female

3) Schooling Status:..... 1. In-School 2. Out of School

4) Class/ level ..... (*Specify*)

5) Ethnicity: ..... 1. Krobo 2. Akuapim 3. Ashanti 4. Other ..... (specify)

6) How are you related to your Caregiver .....1. Maternal aunt/uncle 2. paternal aunt/uncle 3. Maternal grandmother/grandfather Paternal grandmother/ grandfather 4. Sibling 5. Mother 6. Father 7. Other .....(Specify)

7) Religion..... (specify)

**BASIC NEEDS OF ORPHAN**

**Shelter**

***(Now ask the following questions)***

1) How many rooms does your household occupy/use? (exclude bathrooms and toilets).....(Specify)

2) Where do you sleep? 1. Bedroom 2. Hall 3. Kitchen 4. Veranda 5. Other..... (Specify)

3) How many people sleep with you in the same room? 1. one 2. two 3. three 4. four 5. five 6. Other..... (Specify)

4) On what do you sleep? 1. Mattress 2. Mat 3. Blanket 4. Cloth 5. Floor 6. Other..... (Specify)

**Food**

1) In the past month, how many meals did you sit down to eat in a day? 1. 1 meal per day 2. 2 meals per day 3. 3 meals per day 4. Other

2) In the past month, how often did you consume meat? Would you say 1. Every day 2. A few times per week (2-6 times per week) 3. Once a week, few times per month 4. Never 5. N/A, household does not eat meat 6. Other

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3) How often in the past month did you go without getting enough (quantity) food to eat? Would you say 1. Everyday 2. A few times per week (2-6 times per week) 3. A few times per month 4. Once 5. Never

4) Why didn't you get enough to eat?..... (*Record all reasons mentioned*)

**Clothing**

1) Do you have more than one set of clothes? 1. Yes 2. No

2) If no, Why?..... (*List reasons*)

3) Do you have a pair of Shoes? 1. Yes 2. No

4) If no, Why? ..... (*List reasons*)

**EDUCATION**

1) Are you currently attending school? 1. Yes 2. No

2) If no, why are you not attending school? 1. School fee 2. Ill/handicapped 3. Chores 4.Too far 5. Other ..... (Specify)

3) If yes, are your school fees paid up to date? 1. Yes 2. No 3. Don't know

4) If yes, how many times do you go to school in a week? 1. 5 times 2. 4 times 3. 3 times 4. 2 times 5. once

5) If you do not go to school everyday, what is the cause of your absenteeism from school? .....

6) Do you have the following school items?

| | 1 = Yes | 2 = No | 3 = Don't know |
|---|---|---|---|
| i. | Books | | |
| ii. | School Uniform(s) | | |
| iii. | School Scandals | | |
| iv. | School Bag | | |
| v. | Any other (Specify) | | |

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## WORK STATUS OF ORPHAN

1) During the past week, did you do any kind of work for someone who is not a member of your household? 1. Yes 2. No

2) If yes, was it a paid work? 1. Paid 2. Unpaid

3) If you worked for someone who is not a member of your household, about how many hours did you do the work?.....(*Record number of hours*)

4) Why do you work for pay? ..... (*List Reasons*)

5) During the past week, did you do any household chores such as farming, caring for the aged, childcare or other housework? 1. Yes 2. No 3. Don't know

6) If yes, about how many hours did you spend doing these chores? ..... (*Record number of hours*)

## HEALTH STATUS AND HEALTH CARE FOR ORPHAN

1) Would you say your health is very good, good, fair or poor? ..... 1. Very good 2. Good 3. Fair 4. Poor

2) How many times did you visit a health center or health practitioner in the past month due to a health problem? ..... (*Record number of times*)

3) How many times have you been hospitalized in the past year? ..... (*Record number of times*)

4) Do you have a health insurance card? .... 1. Yes 2. No 3. Don't know

5) If no, why don't you have an insurance card? ..... (*Record reasons*)

6) Do you need any health services you are not receiving? 1. Yes 2. No 3. Don't know

7) What type of health services do you need? ..... ( *Record all mentioned*)

8) When you are ill, how early is treatment sought for you? 1. same day
2. two/three days later when I don't get better 3. When I'm very ill
4. Treatment not sought at all

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9) What will hinder your from seeking health care for you when you are sick?.....(*Record all mentioned*)

## EXTERNAL SUPPORT

***The next few questions are about help you or your caregiver might have received in the past 6 months. I am interested in whether you or your caregiver received money, food or clothing or other types of help such as help with education or educational expenses, transportation, medical care, childcare or some other type of help.***

### Extended family support

1) In the past 6 months, did you or [caregiver's name] receive clothing, medical care, food, help with transportation or educational expenses, childcare or some other type of help from extended family? 1. Yes 2. No 3. Don't know

2) If yes, what type of help did you or [caregiver's name] receive from the extended family? 1. Food 2. Clothing 3. Education or educational expenses 4. Monetary 5. Childcare 6. Counseling/Emotional 7. Medical care/Medicines 8. Transportation 9. Other..... (*Record all mentioned*) 10. Don't know

### Support from friends/neighbours

1) In the past 6 months, did you or [caregiver's name] receive clothing, medical care, food, help with transportation or educational expenses, childcare or some other type of help from friends/neibours? 1. Yes 2. No 3. Don't know

2) If yes, what type of help did you or [caregiver's name] receive from friends/neighbours? 1. Food 2. Clothing 3. Education or educational expenses 4. Monetary 5. Childcare 6. Counseling/Emotional 7. Medical care/Medicines 8. Transportation 9. Other.....(*Record all mentioned*) 10. Don't know

### Support from church

1) In the past 6 months, did you or [caregiver's name] receive clothing, medical care, food, help with transportation or educational expenses, childcare or some other type of help from church? 1. Yes 2. No 3. Don't know

2) If yes, what type of help did you or [caregiver's name] receive from church? 1. Food 2. Clothing 3. Education or educational expenses 4. Monetary 5. Childcare 6. Counseling/Emotional 7. Medical care/Medicines 8.

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Transportation 9. Other ..... *(Record all mentioned)* 10. Don't know

**Support from community organizations**

1) In the past 6 months, did you or [caregiver's name] receive clothing, medical care, food, help with transportation or educational expenses, childcare or some other type of help from community organizations? 1. Yes 2. No 3. Don't know

2) If yes, what type of help did you or [caregiver's name] receive from community organizations? 1. Food 2. Clothing 3. Education or educational expenses 4. Monetary 5. Childcare 6. Counseling/Emotional 7. Medical care/Medicines 8.Transportation 9. Other .....*(Record all mentioned)* 10. Don't know

**Other sources of support**

1) Did you or [caregiver's name] receive help from anyone else? 1. Yes 2. No 3. Don't know

2) If yes, what type of help did you receive? 1. Food 2. Clothing 3. Education or educational expenses 4. Monetary 5. Childcare 6. Counseling/Emotional 7. Medical care/Medicines 8. Transportation 9. Other .....*(Record all mentioned)* 10. Don't know

**PSYCHO-SOCIAL CARE**

1) How often do you stay close to [caregiver's name] when you are home? 1. Very often 2. Quite often 3. Rarely 4. Don't stay close to caregiver

2) Are you withdrawn/ prefer to be alone? 1. Yes 2. No

3) Are you unhappy, sad, depressed most of the time? 1. Yes 2. No

4) Are you too fearful or anxious? 1. Yes 2. No *(Observe as well)*
5) Do you have trouble sleeping? 1. Yes 2. No

**INHERTANCE PATTERNS AND SYSTEMS/SOCIAL FACTORS**

1) What is the system of inheritance of your family? 1. Matrilineal 2. Patrilineal 3. Don't know

2) Did you inherit any property from your parent(s)? 1. Yes 2. No 3. Don't know

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3) If yes, what type of property did you inherit? 1. Land 2. House 3. Money
4. Material property (eg. Kitchen utensils, furniture, etc) (*Record all mentioned*)

4) Is/are the inherited property in your possession? 1. Yes 2. No

5) If no, in whose possession is the property? (*Record all responses*)

6) How are you related to this person if this person is not your primary caregiver? (*Record responses*)

7) Does this person support you in any way? 1. Yes 2. No 3. Don't know

8) If yes, what kind of support do you receive from this person? (*Record responses*)

9) How often do you receive this support? 1. Daily 2. Weekly 3. Monthly 4. Quarterly 5. Twice a year 6. Yearly 7. Not regular 8. Other..... (*Specify*)

**CARE RATING**

1) How would you rate the care you receive from your primary caregiver?
1. Excellent 2. Very good 3. Good 4. Satisfactory 5. Poor

2) How would you rate the support you receive from your extended family?
1. Excellent 2. Very good 3. Good 4. Satisfactory 5. Poor

3) How would you rate the support you receive from external sources?
1. Excellent 2. Very good 3. Good 4. Satisfactory 5. Poor

In your opinion, what should be done to improve the care you are currently receiving? (*Record all responses*)

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## ANTHROPOMETRIC/GROWTH MEASUREMENTS OF ORPHAN

Date of measurement Day.....Month.....Year.....

Date of birth of [child's name] Day..... Month..... Year.....

Sex of [child's name] 1. Male 2. Female

Height /Length (*Record child's height/length to the nearest .1cm*) .....cm

Height measurement 1. Measured 2. [child's name] not present 3. Refused

Weight (*Record child's weight to the nearest .5kg*) ..... kg

Weight measurement 1. Measured 2. [child's name] not present 3. Refused

Upper Mid-arm circumference (*Record child's upper mid-arm circumference to the nearest .1cm*) ..... cm

Upper mid-arm circumference measurement 1. Measured 2. [child's name] not present 3. Refused

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APPENDIX II

SOCIO-CULTURAL DETERMINANTS OF CARE OF AIDS-ORPHANED CHILDREN AMONG THE ASHANTI AND KROBO OF GHANA

**Questionnaires for Primary Caregivers of Orphans**

IDENTIFICATION

*Complete the following information for all households with AIDS orphans approached*

Region:.....

District:.....

Town/Village:.....

Number of persons in household:.....

Name of Caregiver:.....(*Record first name only*)

Name of Orphan:..... ( *Record first name only*)

| INTERVIEWER VISITS | 1 | 2 | 3 |
|---|---|---|---|
| Date | | | |
| Interviewer's Name | | | |
| Interviewer's Remark | | | |
| Interviewer's Signature | | | |
| Time | | | |

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BACKGROUND INFORMATION ON CAREGIVER

1) Age of Caregiver: .....(*write age in complete years*) 1. Child 2. Adult

2) Sex: ..... 1. Male 2.Female

3) Occupation of Caregiver:.....

4) Marital Status of Caregiver..... 1. Married 2. Never Married 3.Divorced 4. Separated 5. Widowed

5) Educational Background of Caregiver..... 1. No formal education 2. Primary 3. Junior High 4.Senior High 5. Tertiary

6) Relationship of Caregiver to [child's name].....1. Maternal aunt/uncle 2. paternal aunt/uncle 3. Maternal grandmother/grandfather Paternal grandmother/ grandfather 4. Sibling 5. Mother 6. Father 7. Other ..... (Specify)

7) Ethnicity: ..... 1. Krobo 2. Akuapim 3. Ashanti 4. Other ..... (specify)

8) Religion..... (specify)

BACKGROUND INFORMATION ON ORPHAN

8) Age of Orphan .....(*write age in complete years*)

9) Sex:..... 1. Male 2. Female

10) Schooling Status:..... 1. In-School 2. Out of School 3. Never attended school

11) If orphan is in school, what class/ level is he/she? (*Specify*)

12) Is [child's name] a single or double orphan?.....1. Single 2. Double

13) If [child's name] is a single orphan, which of the parents is deceased? .....1. Mother 2. Father

14) How many years has child been orphaned? .....(*indicate full years*)

15) Do you know the cause of death of child's mother? ... 1. yes 2. No

16) If yes, what was the cause of death of child's mother? ..... (*Specify*)

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17) Do you know the cause of death of Child's father? ..... 1. Yes 2. No

18) If yes, what was the cause of death of child's father?..... (*Specify*)

19) Does [child's name] have any siblings less than 18 years of age who are not living with you? 1. Yes 2. No 3. Don't know

20) How many of [child's name] siblings less than 18 years of age live somewhere else? (*Record number*) Don't know

21) Where are [child's name] siblings living? 1. With other family members 2. With friends, community members 3. School 4. Orphange 5. On the street 6. In own home 7. Other..... 8. Don't know

**BASIC NEEDS OF ORPHAN**

**Shelter**

**(*Please observe the following with regards to main materials of house*)**

5) Main materials of FLOOR 1. Concrete 2. Mud 3. Tile 4. Other.....(*Specify*)

6) Main materials of WALLS 1,Brick 2. Mud 3. Tin 4. Cement 5.Grass/Thatch
6. Wood 7. Other..... (*Specify*)

7) Main materials of ROOF 1. Iron/metal sheets/asbestos 2.Grass thatched 3. Flattened tins 4. Tile/Shingles 5. Wood 6. Other ..... (*Specify*)

***(Now ask the following questions)***

8) How many rooms does your household occupy/use? (exclude bathrooms and toilets).....(Specify)

9) Where does [child's name] sleep? 1. Bedroom 2. Hall 3. Kitchen 4. Veranda 5. Other..... (Specify)

10) How many people sleep with [child's name] in the same room? 1. one 2. two 3. three 4. four 5. five 6. Other..... (Specify)

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11) On what does [child's name] sleep? 1. Mattress 2. Mat 3. Blanket 4. Cloth 5. Floor
6. Other..... (Specify)

**Food**

5) In the past month, how many meals did [child's name] eat per day? 1. 1 meal per day 2. 2 meals per day 3. 3 meals per day 4. less than 3 meals per day 5. Other

6) In the past month, how often did [child's name] consume meat? Would you say 1. Every day 2. A few times per week (2-6 times per week) 3. Once a week, few times per month 4. Never 5. N/A, household does not eat meat 6. Other

7) How often in the past month did [child's name] go without getting enough (quantity) food to eat? Would you say 1. Everyday 2. A few times per week (2-6 times per week) 3. A few times per month 4. Once 5. Never

8) Why didn't [child's name] get enough to eat?..... (*Record all reasons mentioned*)

**Clothing**

5) Does [child's name] have more than one set of clothes? 1. Yes 2. No

6) If no, Why?..... (*List reasons*)

7) Does [child's name] have a pair of Shoes? 1. Yes 2. No

8) If no, Why? ..... (*List reasons*)

**EDUCATION**

7) Is [child's name] currently attending school? 1. Yes 2. No

8) If no, why isn't he/she attending school? 1. School fee 2. Ill/handicapped 3. Chores 4.Too far 5. Other ..... (Specify)

9) If yes, are school fees paid up to date? 1. Yes 2. No 3. Don't know

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10) If yes, how many times does [child's name] go to school in a week? 1. 5 times 2. 4 times 3. 3 times 4. 2 times 5. once

11) If [child's name] does not go to school everyday, what is the cause of his/her absenteeism from school? ..... (*List all*)

12) Does [child's name] have the following school items?

1 = Yes 2 = No 3 = Don't know

vi. Books
vii. School Uniform(s)
viii. School Scandals
ix. School Bag
x. Any other (Specify)

**WORK STATUS OF ORPHAN**

1) During the past week, did [child's name] do any kind of work for someone who is not a member of your household? 1. Yes 2. No

2) If yes, was it a paid work? 1. Paid 2. Unpaid

3) If [child's name] worked for someone who is not a member of your household, about how many hours did he/she do the work?.....(*Record number of hours*)

4) Why does [child's name] work for pay? ..... (*List Reasons*)

5) During the past week, did [child's name] do any household chores such as farming, caring for the aged, childcare or other housework? 1. Yes 2. No 3. Don't know

6) If yes, about how many hours did he/she spend doing these chores? ..... (*Record number of hours*)

**HEALTH STATUS AND HEALTH CARE FOR ORPHAN**

10) Would you say [child's name] health is very good, good, fair or poor? .....
1. Very good 2. Good 3. Fair 4. Poor

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11) How many times has [child's name] visited a health center or health practitioner in the past month due to a health problem? ..... (*Record number of times*)

12) How many times has [child's name] been hospitalized in the past year? ..... (*Record number of times*)

13) Does [child's name] have a health insurance card? .... 1. Yes 2. No 3. Don't know

14) If no, why doesn't he/she have a health insurance care? (*Record all responses*)

15) Does [child's name] need any health services he/she is not receiving? 1. Yes 2. No 3. Don't know

16) What type of health services does [child's name] need? ..... ( *Record all mentioned*)

Now I would like to ask you about caring for [child's name] when sick

1) Sometimes children have severe illnesses and should be taken to a health facility. What symptoms would cause you to take [child's name] to a health facility right away? - Sick child becomes sicker , - Child develops fever, - Child has fast breathing, - Child has difficult breathing, - Child has blood in stool, - Child cannot eat, - Child is drinking poorly. – Other, - Other, - Don't know (***Prompt for more signs and symptoms until caregiver cannot recall any additional symptoms. Record all symptoms, but do not prompt with any suggestion***)

2) The last time you sought treatment from someone outside the home for [child's name] illness, where did you go? 1. Hospital 2. Health center 3. Dispensary/pharmacy 4. Community health worker 5. MCH clinic 6. CHPS compound 7. Mobile/outreach clinic 8. Private physician 9. Traditional healer 10. Friend/Relative (*Record only one response*)

3) How far away is the place you sought treatment for [child's name]?.....km. (N/A for mobile services)

4) How did you get there?..... 1. Walk/bicycle 2. Public transportation 3. Own vehicle/someone's vehicle 4. Other..... 5. N/A for mobile services
5) 6. Don't know

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6) The last time you needed medicine for the sick child, where did you go? 1. Hospital 2. Health center 3. Dispensary/pharmacy 4. Community health worker 5. MCH clinic 6. CHPS compound 7. Mobile/outreach clinic 8. Private physician 9. Traditional healer 10. Friend/Relative 11. Other 12. Don't know

7) What will hinder you from seeking health care for [child's name] when he/she is sick?.....*(Record all mentioned)*

**EXTERNAL SUPPORT**

***The next few questions are about help you or the orphan might have received in the past 6 months. I am interested in whether you or the orphan received money, food or clothing or other types of help such as help with education or educational expenses, transportation, medical care, childcare or some other type of help.***

**Extended family support**

3) In the past 6 months, did you or [child's name] receive clothing, medical care, food, help with transportation or educational expenses, childcare or some other type of help from extended family? 1. Yes 2. No 3. Don't know

4) If yes, what type of help did you or [child's name] receive from the extended family? 1. Food 2. Clothing 3. Education or educational expenses 4. Monetary 5. Childcare 6. Counseling/Emotional 7. Medical care/Medicines 8. Transportation 9. Other..... *(Record all mentioned)* 10. Don't know

**Support from friends/neighbours**

3) In the past 6 months, did you or [child's name] receive clothing, medical care, food, help with transportation or educational expenses, childcare or some other type of help from friends/neibours? 1. Yes 2. No 3. Don't know

4) If yes, what type of help did you or [child's name] receive from friends/neighbours? 1. Food 2. Clothing 3. Education or educational expenses 4. Monetary 5. Childcare 6. Counseling/Emotional 7. Medical care/Medicines 8. Transportation 9. Other .....*(Record all mentioned)* 10. Don't know

**Support from church**

3) In the past 6 months, did you or [child's name] receive clothing, medical care, food, help with transportation or educational expenses, childcare or some other type of help from church? 1. Yes 2. No 3. Don't know

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4) If yes, what type of help did you or [child's name] receive from church? 1. Food
2. Clothing 3. Education or educational expenses 4. Monetary 5. Childcare
6. Counseling/Emotional 7. Medical care/Medicines 8. Transportation
9. Other ..... (*Record all mentioned*) 10. Don't know

**Support from community organizations**

3) In the past 6 months, did you or [child's name] receive clothing, medical care, food, help with transportation or educational expenses, childcare or some other type of help from community organizations? 1. Yes 2. No 3. Don't know

4) If yes, what type of help did you or [child's name] receive from community organizations? 1. Food 2. Clothing 3. Education or educational expenses 4. Monetary 5. Childcare 6. Counseling/Emotional 7. Medical care/Medicines 8.Transportation 9. Other .....(*Record all mentioned*) 10. Don't know

**Other sources of support**

3) Did you or [child's name] receive help from anyone else? 1. Yes 2. No 3. Don't know

4) If yes, what type of help did you receive? 1. Food 2. Clothing 3. Education or educational expenses 4. Monetary 5. Childcare 6. Counseling/Emotional 7. Medical care/Medicines 8. Transportation 9. Other .....(*Record all mentioned*) 10. Don't know

**PSYCHO-SOCIAL CARE**

6) How often do you stay close to [child's name] when you are home? 1. Very often 2. Quite often 3. Rarely 4. Don't stay close to orphan

7) Is [child's name] withdrawn/ prefers to be alone? 1. Yes 2. No

8) Is [child's name] unhappy, sad, depressed most of the time? 1. Yes 2. No

9) Is [child's name] too fearful or anxious? 1. Yes 2. No

10) Does [child's name] have trouble sleeping? 1. Yes 2. No

11) Compared to other children of [child's name] age, do you find orphan difficult to manage or control? 1. Yes 2. No

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## INHERTANCE PATTERNS AND SYSTEMS/SOCIAL FACTORS

10) What is the system of inheritance of your family? 1. Matrilineal 2. Patrilineal 3. Don't know

11) Did you inherit any property from the dead parent(s) of [child's name]? 1. Yes 2. No 3. Don't know

12) If yes, what type of property did you inherit? 1. Land 2. House 3. Money
4. Material property (eg. Kitchen utensils, furniture, etc) (*Record all mentioned*)

13) Are you caring for [child's name] because you inherited property from his/her deceased parent(s)? 1. Yes 2. No

14) If no, what is the main reason for taking on the responsibility of taking care of [child's name]? (*Record all responses*)

15) Are you taking care of [child's name] because tradition/culture in your area/family demands that you do so? 1. Yes 2. No 3. Don't know

16) Are your care-giving activities influenced by 'something' 1. Yes 2. No 3. Don't know

17) If yes, what motivate your care-giving activities? (*List all motivating factors*)

## PROBLEMS ASSOCIATED WITH CARE-GIVING ACTIVITES

1) Do you have any problems taking care of [child's name]? 1. Yes 2. No 3. Don't know

2) If yes, what problems do you have in taking care of [child's name]? (*List all mentioned*)

## ANTICIPATION OF STRESS

1) Do you have any worries now about your responsibilities as a caregiver/guardian?
1. Yes 2. No

2) If yes, what worries you the most? (*List all mentioned*)

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## ANTHROPOMETRIC/GROWTH MEASUREMENTS OF ORPHAN

Date of measurement Day.....Month.....Year.....

Date of birth of [child's name] Day..... Month..... Year.....

Sex of [child's name] 1. Male 2. Female

Height /Length (*Record child's height/length to the nearest .1cm*) .....cm

Height measurement 1. Measured 2. [child's name] not present 3. Refused

Weight (*Record child's weight to the nearest .5kg*) ..... kg

Weight measurement 1. Measured 2. [child's name] not present 3. Refused

Upper Mid-arm circumference (*Record child's upper mid-arm circumference to the nearest .1cm*) ..... cm

Upper mid-arm circumference measurement 1. Measured 2. [child's name] not present 3. Refused

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APPENDIX III

**SOCIO-CULTURAL DETERMINANTS OF CARE OF AIDS-ORPHANED CHILDREN AMONG THE ASANTE AND KROBO OF GHANA**

IN-DEPTH INTERVIEW GUIDE FOR ORPHANS

Name:
Age:
Educational Background:
Class:

1. How orphan is related to caregiver?
2. Which parent is deceased?
3. Number of orphans being cared for by caregiver
4. Why caregiver took on care-giving responsibility
5. Deceased parent(s)' property/Type of property
6. Care-taker of property and use of property
7. Provision of basic needs (sources)
8. Health problems of orphans/ Type of health problems
9. Health-seeking behaviour of caregiver
10. Schooling/Items for schooling
11. Problems affecting schooling
12. Place of abode/Problems with shelter
13. Other forms of support (emotional/psychosocial)
14. Stigma and discrimination issues
15. Problems and challenges of orphan
16. Assessment of care by orphan
17. Additional things orphan wants to be done for him/her
18. Aspirations of orphan

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APPENDIX IV

**SOCIO-CULTURAL DETERMINANTS OF CARE OF AIDS-ORPHANED CHILDREN AMONG THE ASHANTI AND KROBO OF GHANA**

IN-DEPTH INTERVIEW GUIDE: CAREGIVERS OF ORPHANS

1. Identification number/ Name of orphan caregiver (*first name only*)
2. Age of caregiver
3. Educational background of caregiver
4. Occupation of caregiver
5. How is orphan related to caregiver
6. Number of orphans being cared for by caregiver, their ages and sex
7. Number of caregiver's own children
8. Which parent is deceased
9. What happened when the deceased parent fell ill? (type of illness, place and cost of treatment
10. Disclosure of cause of parental illness
11. Why caregiver took on the responsibility of care for orphan
12. What influences care-giving activities (List of motivating factors)
13. Any cultural or moral reason for accepting care-giving responsibility
14. Inheritance system, how it influences care of orphan
15. a. Deceased parent(s)'s property b. Type of property
16. Caretaker of property and use of property
17. Provision of food, clothing, and other basic needs of orphan, sources
18. Health problems of orphans
19. Types of health problem

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20. Health-seeking behaviour of caregiver (present or future oriented)
21. Forms of treatment of and cost involved in treatment of health problems
22. Schooling of orphans and cost involved
23. Problems affecting orphan's education (e.g. school fees, stationery, uniforms, shoes, etc.)
24. Place of abode of orphan, problems with shelter
25. Other forms of support (from family or community members, religious groups, NGOs, government institutions, etc.)
26. Issues of stigma and discrimination
27. Problems and challenges of orphans
28. Problems and challenges of caregivers
29. Aspirations of orphans
30. Aspirations of caregivers

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APPENDIX V

## SOCIO-CULTURAL DETERMINANTS OF CARE OF AIDS-ORPHANED CHILDREN AMONG THE ASHANTI AND KROBO OF GHANA

KEY INFORMANTS INTERVIEW GUIDE FOR ORGANIZATIONS/MDAs

Name of Organization: Date of Interview:

Region: District:

Position of Interviewee in Organization: Age of Interviewee:

No. of years of work with organization: Sex of Interviewee:

1. Knowledge, attitudes, and perceptions on HIV/AIDS
2. HIV and AIDS related problems
3. Estimate number of AIDS orphans in area of operation (Region/District)
4. Type of orphans and their numbers (Paternal/Maternal/Double)
5. Age and sex distribution of AIDS orphans
6. Number of orphans being supported by organization
7. Types of orphans being supported
8. Age and sex distribution of orphans being supported
9. Reasons for support
10. Type of support
11. Criteria for selection of orphans for support
12. Direct recipient of support (eg. Orphan, caregiver)
13. Ages of caregivers
14. Relationship of caregiver to orphans

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15. Community influence on support activities of organization (How)
16. Cultural/traditional/social practices in area of operation (List them)
17. Influence of these practices on care of orphans (How each affect orphan care)
18. Situation of AIDS orphans [(Basic needs- food, clothing, shelter), Education, Health]
19. Stigma and discrimination issues
20. Needs of orphans
21. Needs of caregivers
22. Facilities for orphans (Governmental, Non-governmental/Private)
23. Assessment of care of orphans
24. Suggestions for improvement of orphan care

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APPPENDIX VI

**SOCIO-CULTURAL DETERMINANTS OF CARE OF AIDS-ORPHANED CHILDREN AMONG THE ASHANTI AND KROBO OF GHANA**

FOCUS GROUP DISCUSSION GUIDE FOR GROUPS OF MEN, WOMEN, YOUNG PEOPLE, ORPHANS AND CAREGIVERS AT COMMUNITY LEVELS

Group: Date:

Region: District:

Community: No. of people in group:

Ages of persons: No. of females:

Educational Level (Range): No. of males:

1. Knowledge, attitudes, and perceptions on HIV/AIDS
2. HIV and AIDS related problems
3. How children are cared for generally in the area
4. Who an orphan is
5. Causes of orphanhood
6. How orphan care differs from care of non-orphans
7. How orphans should be cared for
8. Care of orphans: whose responsibility?
9. Cultural/traditional/social practices in the area
10. How each of these affects orphan care
11. Which practices should be modified to improve orphan care
12. How?
13. Prevailing inheritance system of the area

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14. How system of inheritance affect care of orphans
15. Differences in the treatment of maternal orphans and paternal orphans
16. Problems of orphans
17. Problems of orphan care
18. Stigma and Discrimination Issues
19. Facilities available for orphans
20. Merits and demerits of these facilities
21. Needs of orphans
22. Aspirations of orphans
23. Needs of caregivers
24. Aspirations of caregivers
25. Suggestions to improve orphan care

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# APPENDIX VII – LETTERS OF INTRODUCTION

SCHOOL OF PUBLIC HEALTH
COLLEGE OF HEALTH SCIENCES
UNIVERSITY OF GHANA

Department of Social and Behavioural Sciences

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028910 9013
Fax/Phone: +233-21-517501
Cable: UNIVGhana
E-mail: gsph@ugsph.edu.gh

P O Box LG 13
Legon-Accra
GHANA

My Ref. No.
Your Ref. No.

1st September, 2008

The Deputy Director
Ashanti Regional Health Directorate
Kumasi

Dear Sir/Madam,

INTRODUCING MRS. I H.Y YARNEY

The above-named is a doctoral student in the Department of Social and Behavioural Sciences of the School of Public Health, University of Ghana. Mrs Yarney is conducting a research titled 'Socio-Cultural Determinants of Care of AIDS orphaned Children among the Ashanti and Krobo of Ghana', a dissertation towards a PhD. Degree in Public Health.

I would be most grateful if you could provide her with all the necessary assistance (material, logistics, etc.) she would require to enable her complete the study successfully.

It is worth mentioning that the findings of the study would be disseminated among all stakeholders including you. It is also envisaged that the study findings could contribute to the improvement of care of orphans in the country.

I thank you in anticipation of your cooperation.

Yours faithfully,

Matilda Pappoe, MPH, PhD.
(Head of Department)

University of Ghana http://ugspace.ug.edu.gh


# SCHOOL OF PUBLIC HEALTH
## COLLEGE OF HEALTH SCIENCES
## UNIVERSITY OF GHANA

**Department of Social and Behavioural Sciences**

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**E-mail: gsph@ugsph.edu.gh**

**P O Box LG 13**
**Legon-Accra**
**GHANA**


**My Ref. No.**
**Your Ref. No.**

1st September, 2008

The Metropolitan Director of Health Services
Kumasi Metropolitan Health Directorate
Ashanti Region
Kumasi

Dear Sir/Madam,

**INTRODUCING MRS. LILY YARNEY**

The above-named is a doctoral student in the Department of Social and Behavioural Sciences of the School of Public Health, University of Ghana. Mrs Yarney is conducting a research titled "Socio-Cultural Determinants of Care of AIDS orphaned Children among the Ashanti and Krobo of Ghana", a dissertation towards a PhD. Degree in Public Health.

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**(Head of Department)**

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## COLLEGE OF HEALTH SCIENCES
## UNIVERSITY OF GHANA

**Department of Social and Behavioural Sciences**

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P O Box LG 13
Legon-Accra
GHANA


My Ref. No.
Your Ref. No.

1st September, 2008

The District Director of Health Services
Sekyere East District Health Directorate
Sekyere East District

Dear Sir/Madam,

**INTRODUCING MRS. LILY YARNEY**

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P O Box LG 13
Legon-Accra
GHANA

My Ref. No.
Your Ref. No.

1st September, 2008

The District Director of Health Services
Manya Krobo District Health Directorate
Manya Krobo District

Dear Sir/Madam,

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P O Box LG 13
Legon-Accra
GHANA

My Ref. No.
Your Ref. No.

1st September, 2008

The District Director of Health Services
Yilo Krobo District Health Directorate
Yilo Krobo District

Dear Sir/Madam,

INTRODUCING MRS. LILY YARNEY

The above-named is a doctoral student in the Department of Social and Behavioural Sciences of the School of Public Health, University of Ghana. Mrs Yarney is conducting a research titled "Socio-Cultural Determinants of Care of AIDS orphaned Children among the Ashanti and Krobo of Ghana", a dissertation towards a PhD. Degree in Public Health.

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Matilda Pappoe, MPH, PhD.
(Head of Department)

University of Ghana http://ugspace.ug.edu.gh

## APPENDIX VIII – CONSENT FORMS

### PARENT/CAREGIVER CONSENT FORM FOR ORPHANS (AGE 5 – 11 YEARS)

INFORMED CONSENT

Hello, my name is ....., and I am a student from the School of Public Health, University of Ghana, Legon. I am conducting a study on the Socio-Cultural Determinants of Care of Children Orphaned by AIDS among the Ashanti and Krobo of Ghana. This study is intended for academic purpose and also to provide information that would help the government, individuals and other organizations to plan and implement programmes that would improve the care and living conditions of orphans and their households. Participating in this study involves no risk of any form to you or your family.

I would like to ask (NAME) to participate in the study. (His/her) participation is entirely voluntary. If (NAME) decides to take part, (he/she) has the right not to answer any particular question and may stop at any time if (he/she) does not want to continue.

The interview usually takes about 45 minutes to complete. All information collected from this study will be strictly confidential. I will not share any information that (NAME) provides in the interview with anyone. No information which could identify you or your household would ever be released.

If you agree that (NAME) can participate in the study, please sign or write your initials here to indicate that you understand the information above and that your consent is given voluntarily.

I can sign below instead, if you do not feel comfortable signing. However, it is important that you understand the information I read to you, and that you give your consent voluntarily.

Parent/Caregiver..... Date.....

**IF A PERSON AGREES BUT IS UNWILLING TO SIGN/INITIAL OR UNABLE TO READ OR SIGN/INITIAL:**

I [the interviewer] will sign here indicating that the information was read to you, that you agree that (NAME) can participate in the study, and that your consent is given voluntarily.

Signature of interviewer..... Date.....

PARENT/CAREGIVER AGREES THAT MINOR CAN BE INTERVIEWED..... (1)

PARENT/CAREGIVER DOES NOT MINOR CAN BE INTERVIEWED..... (2)

APPROACH ELIGIBLE MINOR FOR INFORMED CONSENT

END

Contact Address: Lily Yarney, Box KB 369, Accra. Tel: 0208137326/021281069

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## CONSENT FORM FOR ELIGIBLE ORPHAN 12 – 17 YEARS

INFORMED CONSENT

Hello, my name is ....., and I am a student from the School of Public Health, University of Ghana, Legon. I am conducting a study on the Socio-Cultural Determinants of Care of Children Orphaned by AIDS among the Ashanti and Krobo of Ghana. This study is intended for academic purpose and also to provide information that would help the government, individuals and other organizations to plan and implement programmes that would improve the living conditions of orphans and their households. Participating in this study involves no risk of any form to you or your family.

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I can sign below instead, if you do not feel comfortable signing. However, it is important that you understand the information I read to you, and that you give your consent voluntarily.

Respondent..... Date.....

**IF A PERSON AGREES BUT IS UNWILLING TO SIGN/INITIAL OR UNABLE TO READ OR SIGN/INITIAL:**

I [the interviewer] will sign here indicating that the information was read to you, that you agree to participate in the study, and that your consent is given voluntarily.

Signature of interviewer..... Date.....

RESPONDENT AGREES TO BE INTERVIEWED..... (1)

RESPONDENT DOES NOT AGREE TO BE INTERVIEWED..... (2)

PROCEED WITH INTERVIEW

END

Contact Address: Lily Yarney, Box KB 369, Accra. Tel: 0208137326/021281069

University of Ghana http://ugspace.ug.edu.gh

## PARENT/CAREGIVER CONSENT FORM

INFORMED CONSENT

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I can sign below instead, if you do not feel comfortable signing. However, it is important that you understand the information I read to you, and that you give your consent voluntarily.

Respondent..... Date.....

**IF A PERSON AGREES BUT IS UNWILLING TO SIGN/INITIAL OR UNABLE TO READ OR SIGN/INITIAL:**

I [the interviewer] will sign here indicating that the information was read to you, that you agree to participate in the study, and that your consent is given voluntarily.

Signature of interviewer..... Date.....

RESPONDENT AGREES TO BE INTERVIEWED..... (1)

RESPONDENT DOES NOT AGREE TO BE INTERVIEWED..... (2)

PROCEED WITH INTERVIEW

END

Contacs: Lily Yarney, Box KB 369, Accra. Tel: 0208137326/021281069

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## APPENDIX IX

## PASTORAL LETTER ISSUED BY THE HEADS OF THE MAIN CHRISTIAN CHURCHES IN KUMASI TO THEIR FAITHFUL AND CONGREGATIONS ON FUNERAL EXPENSES

To be read in all churches in Kumasi
on Pentecost Sunday, May 21, 1972

Dear Beloved in Christ,

We the undersigned heads of the main Christian Churches in Kumasi presenting a united front, in a Ministers' Fraternity, have thought it our duty as leaders, in accordance with the true tenets of Christianity, to draw the attention of our beloved members to a social and anti-Christian evil that has crept into our society and is gaining firm ground particularly in Kumasi, and to warn all against it. Admittedly, this is not the first time that the problem is being unraveled and tackled on the Christian level, but the fact that previous efforts to deal with it have failed, strengthens our belief that it must be fought with determination.

1. We need hardly mention that, of late, the use of alcoholic drinks at funerals has assumed alarming proportions.

2. This has produced two devastating effects:

(a) Funeral expenses have shot up and are mounting with passing days. The tragedy of the situation is that neither the donor nor the bereaved benefit from the expensive funerals. While the former, forced to donate an amount of money commensurate with the type and quantity of alcoholic drink offered him, loses economically, the bereaved too inevitably find themselves at the same losing and when the accounts of the funeral are made. We become saddled with debts and sometimes cannot perform our Christian duty of looking after ourselves and our families.

(b)Drunkenness, with its attendant vices of insulting others, quarrels, and fights very often becomes a feature at funerals, which should rather

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be characterized by an atmosphere of calm and dignity, and respect for the deceased.

We are of the conviction that if we are to keep our dignity as human beings, children of God, whom he has bought with the blood of His own son, and if we are to keep our honor as Ghanaians, then these two evils must be eliminated.

3. therefore we direct that with effect from Sunday, May 21, 1972:

(a) No member of our churches may offer or accept alcoholic beverages at funerals.

(b) No member of our churches may normally give a donation which is more that forty pesewas (¢0. 40) except in the case of chiefs who may give up to one cedi (¢1.00).

(c) No member of our churches may demand donations which are in excess of the amounts stated in number (3b) above.

4. We are not unaware that strict adherence to these regulations will, initially at least, be difficult. All the same, we are sure that you will exhibit your usual sense of good judgment to perceive the blessings that will flow from keeping them, and co-operate with us in this our earnest attempt to solve these disturbing problems.

5. By these regulations, we by no means intend to cast aspersions whatever on the institution of funeral itself, for we are all too aware of it and the highly Christian it helps to pin-point by emphasizing the imperishable nature of our souls, and the need to be a source or consolation to one another in times of distress.

6. For this reason, we are of the opinion that anything that is done in strict accordance with custom should not be tempered with provided that such a thing is not patently at variance with the Christian faith and good morality.

7. For we know how much store the Ghanaian, and especially the Ashanti, lays by the funerals of his forbears, appreciate it, and admire him for that. However, we contend that the unbridled use of alcoholic drinks at funerals and the huge expenditures that have come to be inseparably associated with funerals these days, are not customary, and militate against traditional values.

8. As Christians, we are ordered by the master to be the light of the world. Here is one area of darkness in which our light must shine brightly so that those who are

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outside our folds, to whom also this letter is addressed, if only indirectly, may soon realize the wisdom in the foregoing injunctions and keep them.

9. By copy of this letter we are informing Otumfuo the Asantehene, the custodian of custom in this land and the President of the National House of Chiefs of our action and soliciting his blessing.

10. May we conclude with an exhortation to courage, humility, love, and above all prayer, so that we may succeed in this long-overdue battle with the forces of evil, the confusion of the devil, for our own salvation, and to the greatest glory of God.

We are,

Yours devotedly in the Lord,

Signed: RT. Rev. Peter Sarpong
(Catholic Church)

RT. Rev. J. B. Arthur
(Anglican Church)

Rev. F.W.K. Akuffo
(Presbyterian Church)

Rev. C.A. Apatu
(Methodist Church)

Rev. j. W. Enchill
(A.M. E. Zion Church)

Major R. Agbenorto
(Salvation Army Church)

Pastor A. Agyei
(S.D.A. Church).

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APPENDIX X

# Ghanaian doctor fined for funeral trick


**By Kwaku Sakyi-Addo**
BBC, Accra
http://news.bbc.co.uk/1/hi/world/africa/2737039.stm

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About three years ago, a Ghanaian doctor in the south-east of the country came to public notice when he tricked a family into believing their relative had died, in order to get them to pay the hospital bill.

The doctor has now been sanctioned by the Ghana Medical Association for unethical conduct.

The state-owned Ghanaian Times reported that Dr Adolph Takyi, who runs the Akpe na Mawu, or Thanks Be to God Clinic at Ho, in the Volta Region, has paid a fine of $120.

Three years ago, Dr Takyi was having a difficult time getting a patient, Cujoe Gokah and his family, to pay his hospital bill of nearly $60.

But the family showed up with the money, when the doctor sent a message that Gokah had died.

**Alive again**

Whilst waiting to be shown the corpse, Gokah emerged alive, leaving the family pleased but confused, until the doctor explained what he had done.

Still, the incident attracted crowds who wanted to see the man who had been resurrected.

Dr Takyi allegedly charged curiosity seekers to get a glimpse of Gokah.

Despite Dr Takyi's sanction, the incident does raise questions about Ghanaian attitudes, where families insist they cannot afford the cost of medical care, but will willingly spend huge sums of money on funerals.

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**Party on**

These days, it has become increasingly difficult to tell the difference between a wedding party and a funeral.

There's a lot to eat and drink; families order special textiles or T-shirts with the image of the deceased embossed on it.

There is live big band music, and mourners, if you can still call them that, dance and romp and make merry all day and night.

The practice has led some churches and traditional leaders to place limitations on funeral expenditure in parts of the country.

It has also led people to conclude that in Ghana if you see mourners actually crying, it is not only because a relative they love has died, but because of what it costs to bury them.

The cost of living may be high, but the cost of dying is even worse.