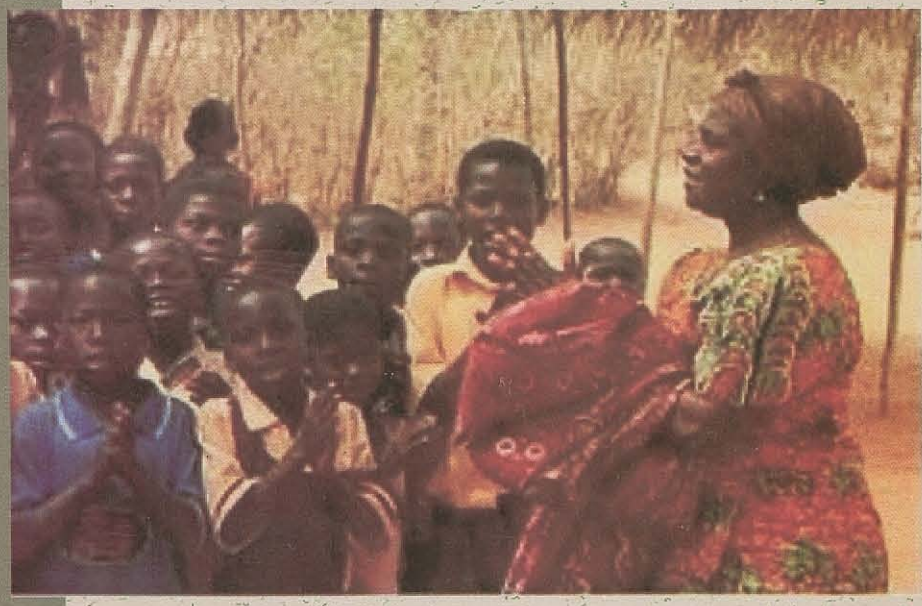
WHERE SHOULD WE STAY ?

Exploring the Options of Caring for Orphans and Vulnerable Children in Ghana



CSPS TECHNICAL REPORT NO. 1/12

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Published by
Centre for Social
Policy Studies(CEPS)
Faculty of Social Studies
University of Ghana, Legon

Designed & Printed by
Sundel Services, Accra

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ABSTRACT

This study provides an insight into care arrangements for orphan and vulnerable children in Ghana. It is an investigatory study using a mixed research method. Data was collected from 2,100 households across 7 regions of Ghana and 36 institutional homes. It is evident that, there are a number of care arrangements available to orphan and vulnerable children in the country which are broadly categorized under institutional, community-based, and family/household care arrangements. Each of these care arrangements also has other sub-types depending on mode of operation. Institutional homes were most prominent followed by fosterage, adoption and house helps. Only one community-based OVC care arrangement was identified. These care arrangements provided all manner of care services to OVC, including education, food, health, socio-emotional and recreational care services; yet, there are obvious situations of lack of capacity and adherence to guidelines and regulations. Issues related to resources for home-based care were pronounced. It is therefore imperative that the situation of orphans and vulnerable children be carefully reconsidered. The capacity of the Department of Social Welfare comes to the fore in the quest to redefined care arrangements for OVC. Nonetheless, the debate on care arrangements for OVC lies in the adoption of a more comprehensive regulatory system with consideration for home-based care arrangements including fosterage and adoption.

ACKNOWLEDGEMENTS

The Centre for Social Policy Studies (CSPS)and the authors of this report are grateful to the Department of Social Welfare for the opportunity to undertake the study on the Situation of Orphan and Vulnerable Children in Ghana. It is the outcome of that study, which has enabled the publication of this Technical Report. We are equally grateful to UNICEF, Ghana for providing the funds for the original study and assisting the team of researchers to finalize the report. Without financial support, this report would not have been possible.

The field work component of this report involved regional and district officers of the Department of Social Welfare, management of public and private orphanages/ children's homes in all the regions and districts covered in this study, household heads or their representatives in the communities selected for this study, as well as children in households and orphanages. To all these people, we extend our sincere gratitude. Our understanding is that, this study will go a long way to shape policy interventions that may positively affect the quality of care given to orphan and vulnerable children in Ghana.

Chapter One

Introduction

Background to the Study

The issues of orphanhood and vulnerability have become critical for millions of children across the world who are experiencing deepening psychological trauma, physical hardship, lack of education, poor healthcare, enormous mental stress and a profound sense of hopelessness (Jackson, 2002:257). Many children have become vulnerable as a result of morbidity and mortality of parents, socioeconomic deprivation of parents, child trafficking, child labour, conflicts, disabilities and other various forms of child abuse making the vulnerable to the hazards of life. Thus, the concepts of vulnerability and orphanhood in relation to children (OVC) have been defined variously but relatedly by different sources.

The UNAIDS Monitoring and Evaluation Reference Group's proxy definition classifies children as orphaned and vulnerable if they have experienced the death of either parent, if either parent is chronically ill, or if an adult (aged 18-59) in the household either died after being chronically ill(Smart, 2003). According to Skinner and Davids (2004), what makes a child vulnerable depends on contexts that centre around three core areas namely, material vulnerability, including access to money, food, clothing, shelter, health care and education; emotional vulnerability, including insufficient care, love, support, space to grieve and containment of emotions; and social vulnerability, including lack of a supportive peer group, of role models to follow, or of guidance in different situations, and risks in the immediate environment. Ghana National Commission on Children (2000) defines a vulnerable child as "*a child below the age of 18 who has been abandoned,*

The Ghana AIDS Commission and United Nations Development Programme (UNDP) jointly sponsored study in 20 districts, involving 1,700 households, and children in orphanages and hospitals showed that only 18 percent of orphans surveyed said they feel safe and secured and only 16 percent have received any form of counseling. For orphans not in school, virtually no counseling was available except in some cases by religious leaders (Ahiadeke et al., 2003: xi).

Hunter and Williamson (2000), cited in Jackson (2002:261), have observed that conditions of OVC, especially AIDS-related ones, largely deny them basic closeness of family life, love, attention and affection. Some of them are pushed into service to care for ill and dying parents, removed from school to help with farm or household work or pressured into sex to help pay for necessities their families can no longer afford. They receive less access to healthcare and often treated harshly or abused by step or foster parents. Thus, some relatives, neighbours, and institutions charged with caring for an OVC rather leave the children more vulnerable to mortality, illness and exploitation. Apt and Blavo (1997) commented on the likelihood of OVC becoming more vulnerable to contracting HIV/AIDS. Making particular reference to street children, the scholars believed that children who are not in school and who lack parental guidance do not receive exposure to reliable information about the disease and how to prevent it. As they live increasingly on the streets they become more vulnerable to exploitation and girls especially become more vulnerable to sexual aggression by older men who may be HIV positive.

The consequences of these for the OVC include malnutrition and seasonal variation in food supply, poor clothing and inadequate shelter, late start of schooling and low level of education, higher infant and child mortality, withdrawal and isolation from other children and larger society, etc. The OVC are noted to undertake more household chores than biological children of their guardians. This means that failure on the part of society to put in place appropriate care arrangements to meet the special needs of OVC creates a huge risk for the children as they grow up, and also for the society in which they live. For example, failure to support them appropriately may expose them to various forms of

orphaned or exposed to extreme physical or moral danger".For the purpose of this study, a working definition for orphan and vulnerable children targeted;

1. Children who have lost one or both parents to AIDS or other causes.
2. Children in residential homes (orphanages, children's homes).
3. Children living in foster care, with adoptive parents, families and other families.
4. Children deserted by his/her parents as in the case of the biological parents' migration.
5. Children infected by HIV/AIDS (including those receiving ART and those not receiving ART).
6. Children affected by HIV/AIDS (parents, siblings, other relatives, friends infected by HIV/AIDS).
7. Children in conflict with the law (in pre-trial detention).
8. Children living in shelters.
9. Children with disabilities.
10. Homeless or street children (beggar's aid).

(Children here refers to all persons below the ages of 18 as adopted in the Ghana 1992 Constitution).

Whatever definition given to orphan and vulnerable children, one thing clear is that they are children of special description, different from the non-vulnerable children in society. This presupposes that OVC have some special needs and concerns slightly different from non-vulnerable children, which must be considered in any form of care and support arrangements that are put in place for them. These concerns include their fundamental human rights and additional care and support, which are urgent requirements to improve their physical and psycho-social conditions. In Malawi, the COPE field notes reported in Webb and Elliott (2000: 54-55) identified the challenges of OVC as food insecurity, reduced access to education, physical and verbal abuse by guardians, lack of healthcare, linked to neglect by the guardians, restricted social interaction, and verbal abuse by other children.

characteristics of institutional arrangement. It is significant to note however that, while community-based care is preferred over institutional care, it is admitted that replacing institutional care with community-based care does not necessarily guarantee better outcomes. In other words, community-based care is necessary but not a sufficient condition (Emerson and Hatton, 1994).

Key constraints to community-based care in the view of the EC expert report (2009) is the continuous co-existence of institutional care and community-based care. The report therefore suggested a holistic system of preventing placements into institutions. What this requires is a sufficiently trained staff with skills in the management of community-based care arrangements with support from families. To this end, the Convention on the Rights of the Child supports the idea that all children have the right to family life or a foster family (if they have no family or if they are at risk in their family). Thus, in the case of OVC, they have the right to be provided with needed support to enable them participate fully in everyday life.

Child Fostering

According to Vandermeersch and Chimere-Dan (2002), child fostering is defined as the delegation of parental roles to persons other than the biological parents. They note that the practicereflects persistent traditional kinship ties. Two dimensions of fosterage are discernible in the literature and these are out-fostering and in-fostering. While out-fostering refers to the giving out of children to be taken care of by others, in-fostering is the receiving of children to be taken care of.

Factors that tend to favour the giving out of children (out-fostering), especially among women, include marital dissolution and unmarried motherhood, migration, where migrant mothers use out-fostering to maintain links with their origin, working motherhood, where out-fostering is used as a strategy for reconciling reproduction and labour force participation, and the number of children in a household (Vandermeersch and Chimere-Dan,2002). On the other hand, factors that promote or favour in-fostering include lack of reproductive success or having no child(ren) or limited number of children

abuse, neglect, exploitation or human rights violations which could adversely affect them for the rest of their lives (Demographic and Health Survey, 2008:13).

The Research Question

Jackson (2002) has noted that failure to provide proper care for children can, among other things, lead to rising crime and homelessness, growing numbers of street children, increasing sex work and worsening exploitation of girls, with a further generation of ill-cared-for children born to these impoverished parents. The question has always been what forms of care and support arrangements best suit the needs of OVC in Ghana? Some literature supports community and household based care, others support institutional based care such as orphanages, outreach ministries or combination of care arrangements, depending on the types of vulnerabilities. Some brief discussion of literature argument on the matter will be appropriate to put the subject in context.

Making a Case for Community-based Care

Institutional care arrangement of Orphan and Vulnerable Children (OVC) involves the housing of children of varied ages and conditions in a residential facility, which tends to segregate the children from the community. According to the European Commission (2009), such institutions are characterized by de-personalization, rigidity of routine, block treatment and social distance. These constitute what has been described as *institutional culture.* The suggestion within the European Commission is for a transition from institutional care for all categories of persons, especially OVC. The main arguments for de-institutionalization are that community based care produces better results in the upbringing of OVC, and their families, as well as better quality of life. Moreover, the material and non-material conditions of children in institutional care tend to be worse than those in alternative care arrangements.

There is also the problem of stigmatization of people in institutional care because they are physically and socially isolated from the wider society. The European Commission expert report further concludes that no matter the amount of money allocated to institutional care, they are unlikely to achieve better results because of the general

having access to resources of their parents and other adults committed to their welfare. While children's access to parents and other relatives depends on their existence and their physical proximity, parents' ability to provide adequate resources of time and money is dependent on their level of productivity and resourcefulness as well as other family commitments imposed on them. Children who live with their parents or other close relatives are likely to be better off than those who do not, especially where they do not have to compete with several other siblings for parental support.

Agreeing with Vandermeersch and Chimere-Dan (2002), Lloyd and Desai (1992) observe that factors that lead to out-fostering include (1) a lack of resources caused by a family crisis such as widowhood, divorce, or separation or a larger economic, political, or environmental crisis, (2) better opportunities elsewhere for children's education and training, and (3) the strengthening of family ties. In their view, factors that lead to in-fostering include (1) the need for labor, (2) the need for financial support, (3) strengthening of family ties, and (4) childlessness. They also note that, there are situations where the decision to foster out may be taken with the children's best interests in mind. But in some other situations, it is the interest of the parents or a large family that dominates.

Thus far, there is basis for emphasizing more on fostering arrangements and community care arrangements rather than institutional care, which is gradually becoming less popular in both developed and developing world. This work explores and documents the various forms of OVC care and support arrangements that are in operation in Ghana, and their capacities to provide meaningful living standards for the children.

Estimated Orphans and Vulnerable Children in Ghana

The Multiple Indicator Cluster Survey (MICS 2006) conducted by the Ghana Statistical Service shows that only 60 percent of children under 18 years in Ghana are living with both biological parents. A significant number of them (15%) are not living with any of their biological parents, and 8 percent of all children have one or both parents dead. Children living with only their mothers constitute 21 percent while a few of them (4%)

or few children of a particular sex, delayed reproduction among young couples, households headed by older females who have passed their reproductive ages and closely spaced childbirth. In such situations, taking in child(ren) is a means of making up for perceived short-coming (Vandermeersch and Chimere-Dan, 2002).

Focusing on the economic motivations for fosterage, Vandermeersch and Chimere-Dan (2002) conclude that, in developing countries, child fostering is a means by which adjustment in labour supply is made and that in countries where there is high rate of population mobility, fostering enables parents to take advantage of job opportunities elsewhere. Moreover, fosterage supplements household labour requirements.

The debate as to the best form of care for children, that is, institutional care or family-centred care, especially vulnerable ones, has been raging for some time. In a report titled *Institutions vs. Foster Homes*, Barth (2002) observes that institutional (or group) care has been noted to be useful within child welfare services system as well as the treatment of children with mental health challenges and the provision of shelter for children who lack immediate family care and also for children who have not been able to be maintained in foster families. He however observes that Group care tends to be more expensive and restrictive and hence should only be used in situations where evidence suggests that its outcomes outweigh those of foster care. Ghana's care reform initiative of the Department of Social Welfare recognizes this and advocates for de-institutionalization of care for orphans and vulnerable children. Barth (2002:25) concludes that "*there is virtually no evidence to indicate that group care enhances the accomplishment of any of the goals of child welfare services: it is not more safe or better at promoting development, it is not more stable, and it does not achieve better long-term outcomes, and it is not more efficient as the cost is far in excess of other forms of care*".

Writing *on Children's Living Arrangements in Developing Countries,* Lloyd and Desai (1992) provides support for fosterage when they observe that under normal circumstances, children depend on adults, particularly their parents for social and economic essential care. That is to say, their welfare needs are normally derived from

Table 1: Estimated Orphan Population in Ghana (2009-2015)

Category	2009	2010	2011	2012	2013	2014	2015
Maternal Orphans							
AIDS	96,259	101,440	104,512	106,070	106,432	105,885	104,723
Non-AIDS	401,568	406,668	411,071	414,743	417,693	420,027	421,821
Total	497,827	508,108	515,583	520,812	524,125	525,912	526,543
Paternal Orphans							
AIDS	93,132	98,586	102,147	104,302	105,383	505,599	505,158
Non-AIDS	692,059	701,882	710,958	719,229	726,647	733,294	739,309
Total	785,191	800,468	813,105	823,531	832,030	838,894	844,467
Double Orphans							
AIDS	58,434	60,605	61,230	60,855	59,772	58,333	56,783
Non-AIDS	88,699	89,964	91,128	92,100	92,832	93,362	93,729
Total	145,053	150,123	153,268	154,864	155,336	155,010	154,240
All AIDS Orphans							
Total	247,825	260,631	267,889	271,227	271,587	669,817	666,664
Total Orphans	**1,428,071**	**1,458,699**	**1,481,956**	**1,499,207**	**1,511,491**	**1,519,816**	**1,525,250**

Source: 2009-2015 National HIV Prevalence and AIDS Estimates Report, 2010

Other Vulnerable Children

Apart from orphans, other vulnerable children in Ghana include children with disabilities, children involved in child labour, trafficked children and street children. Notably, some of the children involved in worst forms of child labour are those trafficked and street children. Although data on disabilities in Ghana are generally limited the National Disability Policy document developed in 2000 estimates that about 10 percent of the country's population are disabled, half of whom are children suffering from various forms of disabilities such as hearing, vision, speech and limb impairments. Byrne (1996:10) cited in MOWAC/UNICEF (2009), notes that childhood disease is responsible for 43 percent of childhood disabilities in the Ashanti Region. UNICEF-Ghana (2000) reports that children with disabilities from poor homes and rural areas are the most at risk of discrimination, lack of care and attention.

live with only their fathers. The MICS statistics are largely supported by the Demographic and Health Survey (DHS) report of 2008, which show that, of the 20,537 children under age 18 in Ghana, about 54 percent of them live with both parents, 19 percent live with their mother only, 5 percent live with their father only, and 14 percent live with neither of their natural parents.

With specific reference to HIV/AIDS related OVC in the country, the 2008 annual report of the National AIDS/STI Control Programme (NACP) estimated 20,808 children to be living with HIV of which 3,978 were new infections (NACP 2008:36, 37). The NACP projections from the HIV sentinel survey data of 2009 put HIV population at 240,802 people comprising 219,600 adults and 21,202 children, with an annual AIDS death of 17,058. The report estimated the number of AIDS orphans as at 2009 at 135,905 and projected HIV prevalence to be stable in 2009. That is 1.7 percent and rise gradually to 1.73 percent in 2012 and then to 1.8 percent in 2015. Notwithstanding the expected stability in prevalence, the number of persons expected to be living with HIV/AIDS is to increase to 265,003 in 2012 and then to 296,491 in 2015 due to factors such as population growth and an increasing number of HIV infected persons that are living on Antiretroviral Therapy.

In the records of MOH/GHS (2004) cited in the National OVC Policy Guidelines (2005:8), the number of AIDS orphans over the next ten years would increase from 132,000 in 2004 to about 225,000 in 2009 and subsequently 291,000 by 2015. The situation can however worsen if the epidemic continues to spread (National OVC Policy Guidelines, 2005:9). The data in Table 1 show projected estimates of orphan population (both AIDS related and non-AIDS related) in Ghana from 2009 to 2015.

risk of contracting HIV (Ahiadeke et al., 2003:15). Meanwhile, UNICEF (2002) suggests that children need families to successfully integrate and thrive in the society, as the family is the best context for a child to successfully develop.

National Response to the Situation of OVC

At the national level, the government of Ghana in January 2005 finalized the national policy guidelines on orphans and other vulnerable children and a national plan of action to address the challenges posed by a growing OVC population. The two pressing goals are to reduce the number of OVCs and ensure that they can enjoy their rights – to food, shelter, healthcare, education and integration into family structures. Achieving these goals however demand better data on the magnitude of the problem, more training for those caring for OVCs, increased resources and increased awareness among families and communities (GAC, MOWAC and MMYE 2005:17). The study indicates that, Ghana's new policy calls for cooperation among a wide range of governmental and non-governmental bodies to fulfill the rights of children made vulnerable by a number of factors beyond HIV/AIDS, such as harmful labour, living on the street and disability.

Traditional and Modern Care Arrangements for OVC

Data from across Africa indicate that where the epidemic is more severe, and or the extended family is weakened, orphaned children are more frequently cared for by grandparents. Of particular concern however is the increasing number of grandparents who now have to take over care of the orphaned children. While some are competent, many are too old to cope, especially with large numbers of children (International HIV/AIDS Alliance, 2004). As indicated by Bray (2003), the pressure of the increasing number of OVC has seen families splitting and reforming in different ways in response to more stressful circumstances. Of great concern is the high number of inadequate carers including those who do not have the skill, do not wish to assume the role or are too old or too young to fulfill the task.

According to Jackson (2002:268), the main carers in most societies are aunts and uncles, but with increasing ill health and deaths among them too, elderly grandmothers and older siblings are increasingly becoming the main carers. In Zambia for instance, more than one-quarter of all children under 15 are already orphaned and an estimated two-thirds of rural households took after one or more orphaned children. A 1996 UNICEF study in four heavily affected communities in Kitwe and Choma Districts in Southern Province of Zambia found that, over 50 percent of surveyed children had lost one or both parents and 71.5 percent of all households were caring for at least one orphan. 98 percent of all orphans were being cared for by a surviving parent, the extended family, or grandparents. UNICEF Zambia (1999) also identified that urban households have fewer orphans because they prefer to send the children to other relatives in rural areas where the cost of living is lower. The irony is that, the burden of care is falling predominantly on the less well-resourced households, not the richer ones, echoing an earlier finding in Kenya (Saoke et al, 1996) cited in Jackson (2002:268).

In Ghana, widows were however found to be the largest single group caring for these orphans and vulnerable children. Since the income of female-headed households is only about half that of male-headed households, poverty was rife and mothers and their daughters were resorting to commercial sex for survival, thereby greatly increasing their

national survey reports relating to orphans and vulnerable children were reviewed. The literature review analysed information drawn from both macro and micro level contextual indicators to show how they relate to orphans and other vulnerable children. The contextual indicators include traditions and culture, legal and policy frameworks, human rights, education system, family structure, NGOs and MDAs. Though the research team recognised the potential value to be gained from gleaning administrative records of ministries, departments and agencies (MDAs), these were not readily available to the team.

Primary Data

As indicated earlier, the design for the study made room for the collection of both quantitative and qualitative data. For the quantitative data standardized questionnaires were administered to respondents through face-to-face or inter-personal interviews. The questionnaire survey was designed for households, institutions and orphaned and vulnerable children.

Household Survey

With the support of district officers of the Department of Social Welfare, community leaders, and the district HIV/AIDS focal persons the researchers identified houses/locations of some orphans and vulnerable children in each selected community for questionnaires to be administered to them and their caregivers. In addition, questionnaires were administered to randomly sampled households in the communities, in which case all members of the households were listed after which defined criteria were used to determine vulnerable children in the households. After the vulnerable ones have been determined they were followed up and specifically designed questionnaire was administered to them to assess their conditions. In situations where the OVC were too young to respond to the questions, the caregivers were made to respond to sections applicable to them while the socio-demographic characteristics of the children like age, sex and HIV status were compiled.

Chapter Two

Research Methods

Introduction

The study adopted survey design comprising both quantitative and qualitative approaches and instruments to systematically and carefully gather and analyse relevant data for the study. Besides, participatory techniques were used to encourage inclusiveness and stakeholder ownership of the outcome of the study. These approaches were used to gather and analyze data on forms of care arrangements for orphans and vulnerable children, as well as livelihood indicators such as shelter, food security and nutrition, education and health etc., which were used to assess conditions of the children. Considering the extreme sensitivity of the subject matter rigorous ethical principles and practices were observed in the entire process of data gathering, processing and presentation/reporting. For the purpose of effective stakeholder participation, arrangements were made for community and institutional leaders to be debriefed on the study as a means of soliciting their cooperation and support for successful execution of the assignment. Thus the study was designed to focus on strengthening collaboration and co-ordination among stakeholders, and to facilitate the development of a common agenda for strategic action through ethically acceptable principles and practices.

Sources of Data

Secondary Data

To provide contextual background to the problem under investigation available secondary literature, study reports, policy/projects/programme documents and relevant

survey data of 2009). Two regions were selected from each of the three zones and three districts were selected from each of the regions. Three communities were further selected from each of the districts for the study. The selection of communities from the districts was done to ensure that, urban, peri-urban (semi-urban) and rural districts were taken care of. District capitals were taken as the urban communities and based on this, peri-urban and rural communities were selected. In the case of the metropolitan and municipal areas, high/middle/low class residential areas were adopted in the selection of the communities. Some municipal areas extended into village communities. In these cases, the village communities selected to be included in the study came from those village extensions.

It is important to mention that Greater Accra region was added as a seventh region for institutional survey and children who were aiding beggars in the begging business on the street. The region's partial inclusion in the study stems from the fact that the region has substantial number of orphanages and children homes sited in it as well as larger population of street children. The selected regions, districts and communities are presented in Table 2.

In-depth interview with key informants was the main qualitative method used.

Institutional Survey

The process of identifying and assessing the conditions of the orphans and vulnerable children, also involved an institutional survey. In each region where the study was conducted the research teamvisited institutions such as orphanages and children's homes, health facilities, NGOs, correctional homes, shelters, and other associations such as the ManyaKrobo Queen Mothers' Association to conduct interviews with the care-givers and administered questionnaire to some of the children. From each institution the information that was gathered included types of care arrangements for the children, types of OVC targeted, services offered, capacity to meet the care and support needs of the children, state of conditions of the children and operational challenges, and way forward regarding the care of orphan and vulnerable children in Ghana.The interviews were meant to give informants considerable liberty to express their knowledge, opinions and experiences on the research problem with the view to unraveling details of the motives and circumstances underlying the care arrangements and conditions of orphans and vulnerable children.

The Sampling Design

A multi-stage sampling technique was used to select the respondents. The stages began with the sampling of regions, followed by districts, then communities and finally the respondents.

Selection of Study Areas

The study was initially conceived for nationwide coverage except that the resources available were not enough to cover all the ten regions in the country. To make the seven selected regions largely representative of the country, they were chosen from the three main Geographical zones (Savanna, Forest and Coastal) in Ghana, which also coincided with regional HIV/AIDS prevalence rates in the country. The predominantly savanna zone (Northern belt) has the lowest prevalence rate, followed by the forest zone (Middle belt) and then predominantly coastal zone or southern belt (MOH/NACP HIV sentinel

Design for Collection of Primary Data

Relevant data collection instruments including questionnaire and in-depth interview guide were developed for the study. The draft of the instruments was presented at stakeholders meeting for them to be discussed to agree on the questions, after which the instruments were pre-tested and modified where necessary, before they were used to collect the data.

The data collection exercise began with brief reconnaissance visits by principal researchers and field supervisors to the selected districts to give the research team the opportunity to make contacts with insiders or local contact persons who could assist with recruitment of participants for the main interviews. Arrangements were also made during the visits with local contact persons to help screen and recruit key participants for the study. The reconnaissance visits also enabled the researchers establish and map out pragmatic and more efficient strategies for the main data collection exercise. It offered them the opportunity to assess the volume of work and the terrain of the districts to enable them plan meaningfully for the actual fieldwork. It was also used to make requests for secondary information or documents that were of relevance to the study to District offices and other relevant Agencies/Bodies.

The main data collection exercise began in all the seven (7) regions concurrently, shortly after the reconnaissance visits. One field supervisor and six (6) interviewers were assigned to each of the regions for data collection simultaneously. This strategy was not only relevant to ensure timely completion of the assignment, but also meant to have enough time for data collection considering the sensitive nature of the topic. In the case of the in-depth interviews some were tape-recorded while others were manually recorded, depending on situations that we encountered on the field.

Ethical Issues

There is no doubt that the study was a very sensitive one which required strict adherence to ethical concerns and principles. Thus, interviewing caregivers and orphans and

Table 2: Selected Regions and Districts for the Study

Zones	Regions	Districts
Savanna/ North	Northern	Tamale Metropolis, Yendi Municipality, Bole District
	Upper West	Wa Municipality, Jirapa Dist., Lambusie Karni Dist.
Forest/ Middle	Ashanti	Kumasi Metropolis, Obuasi Municipality, Asan te Akim North District
	Eastern	New Juaben Municipality, Akwapim South Municipality, Lower Manya Krobo District
Coastal/ Southern	Central	Cape Coast Metropolis, Assin North District, Asikuma - Odoben-Brakwa District
	Western	Sekondi Takoradi Metropolis, Tarkwa Nsuaem Municipality, Wassa Amenfi East District
	Gt. Accra	Accra and Tema Metropolis were selected for institutional study only

Source: OVC Study, 2010

Sample Size for Quantitative Data

Both probability and non-probability sampling techniques were used to reach out to respondents. With regard to the household survey the probability technique was used to randomly sample two thousand and one hundred (2,100) households (300 per region) for the study. The idea was to find out the random distribution of orphans and vulnerable children in the households. The number of OVC identified in the randomly selected household sample has been used to estimate the numbers of OVC in the population. Besides, other respondents were purposively contacted through district officers of the Department of Social Welfare, community leaders, and the district HIV/AIDS focal persons who are involved in the activities of orphans and vulnerable children, and HIV/AIDS, orphanages etc. Snowball sampling technique was also applied to reach some respondents in the communities.

Due to the stigma attached to, and discrimination faced by persons identified to have HIV/AIDS, and the sensitive nature of issues relating to orphans and vulnerable children, it was a bit difficult for people to easily mention the cause of death of the parents of the orphans in each community. Since HIV/AIDS is often associated with sexuality and promiscuity, traditionally, people frown upon any open discussion about this matter. In addition, discussions on the death of children's parent(s) involved recalling unpleasant memories, many of them wanted to avoid. However, the interviewers were trained to be tactful in handling possible reluctance from potential respondents and to adopt different strategies to identify and collect data from all the categories of orphans and their care givers.

Besides, people in many communities in the country have become research weary as a result of regular visits to them for data collection. This had the potential of making some feel reluctant to answer questions or to be identified with houses with orphans or AIDS orphans and vulnerable children. This could have made data collection in such areas difficult and therefore time consuming. However, prior knowledge of the challenge enabled the consultants factor it in the training of the interviewers to enable them develop strategies and the tolerance that they needed to cope and collect the quality data that were needed for the study.

Management of data

Management of quantitative data involved editing of questionnaire (both field and office editing), coding, data entry, cleaning of data and generation of relevant outputs for reporting. On the other hand, management of qualitative data basically involved transcribing the tape-recorded information, extracting relevant information from hand written administered in-depth interview instruments, synthesizing and categorizing the responses for the purpose of report writing.

vulnerable children required the researchers to observe local customs and also to maintain a high sense of privacy. The consent of the respondents to participate in the study was strictly observed. Respondents' participation in the study was made absolutely voluntary. They were given the option to participate and withdraw their participation at any time that they wished to withdraw. In each of the study communities the chiefs and opinion leaders were used as points of entry from where the researchers received further instructions regarding how to approach the study in the communities. In addition, the services of some officials of district administration, particularly the HIV/AIDS focal persons and social workers were sought to help diffuse any tension that might otherwise have made data collection difficult. Respondents were assured of confidentiality in terms of disclosing their identities to any other persons, and or using the data for any other purpose apart from the purpose for which they were being collected. All efforts were made to ensure that interviews with PLWHA were carried out in absolute privacy to allow them the freedom that they needed to express themselves. Under no circumstance was any other/third person allowed to sit in the interviews or to interfere with it.

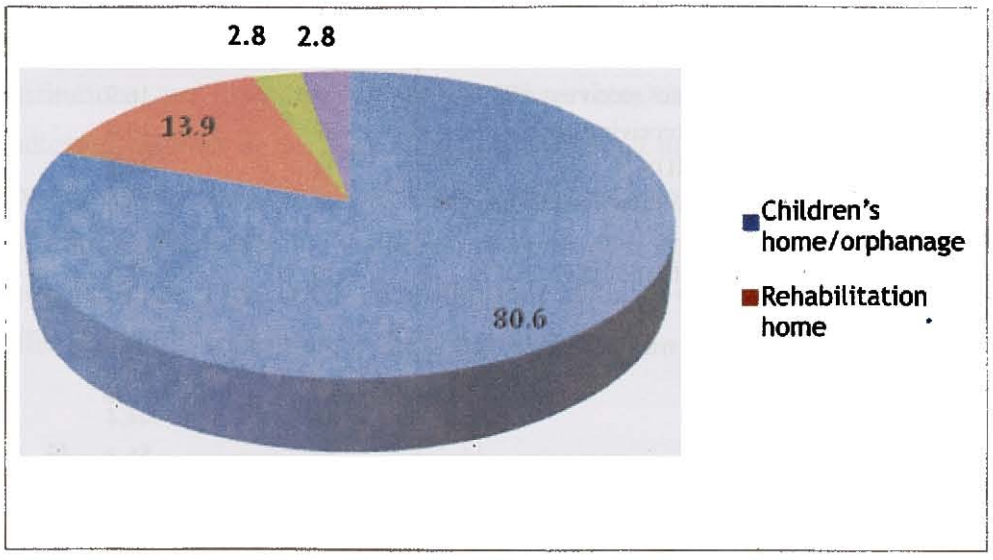
Problems and Limitations

A number of factors threatened effective data collection in the communities, stemming mostly from participants' general sensitivity about stigma and discrimination in the community, as well as unfavourable media attention on both OVC and HIV/AIDS at the time of the study.

One issue that could have worked against the effective data collection for this study was media report about ill-treatment of orphan and vulnerable children in the Osu Children's Home in Accra. As the country's flagship orphanage, this media report travelled far and wide in Ghana, and therefore made many people (including caregivers) in institutions, households among others to be cautious about granting interviews to people. With this knowledge, the consultants deliberately delayed going to the field by a couple of weeks, waiting for public concerns over the media report to die down. It was then that data collection for this study commenced.

captured in the Western Region, while those from the Eastern Region and Upper West Region respectively account for 5.6 percent and 2.8 percent. The institutions have been categorized into four main types of care and support arrangements according to their modes of operation. They are homes and orphanages, outreach ministries, rehabilitation homes/centers and learning centers for OVC. The overwhelming majority of these institutions are Homes and orphanages (80.6%), seeking to create family-like environment for the caring and upbringing of the children. The remaining three types of formal institutional care and support are rehabilitation homes/centers (13.9%), outreach ministries supporting OVC in their natural homes, and learning centers for OVC (see Figure 1).

Figure 1: Types of Formal Institutional Care Arrangements



Source: OVC Study, November, 2010

All the formal institutions captured together have a total of 2,046 OVC in their custody, meaning that on the average each institution is supposed to be caring for and supporting 57 OVC. The data shows that most of the institutions are privately owned, and are either affiliated with religious bodies (27.8%) or not affiliated to religious bodies (44.4%). Less than 30 percent of them are publicly owned, which are also either affiliated with religious bodies (5.6%) or not (22.2%). Some of them (55.6%) have boards to oversee the activities

Chapter Three

Formal Institutional Care Arrangements for Orphan and Vulnerable Children in Ghana

Introduction

This chapter identifies and discusses the various institutional care and support arrangements available to orphan and vulnerable children in Ghana. The analysis of the data from the study shows a number of care arrangements available to orphan and vulnerable children in Ghana. For the purpose of report presentation these care arrangements have been organized under formal and informal institutions. The formal institutions largely focus on statutory arrangements while the informal focuses on household and community based arrangements. This chapter focuses on the former and it utilizes primary data gathered from the field and also draws on available secondary data.

Formal Institutional care and support arrangements

A total of thirty-six (36) formal care institutions were captured in all the districts which the study covered to be providing protection and support for OVC. The dates at which the institutions were established give indications about how long the issue of OVC has been acknowledged and how this acknowledgement has persisted through time. The registration and establishment of the institutions ranged from as far back as 1931 to 2010. More than three-quarters of the institutions covered in the study are in urban (44.4%) and peri-urban (33.33%) areas with a little more than a fifth (22.2%) established in rural areas. A little more than 40 percent of the institutions are located in the Greater Accra region, followed by the Central, Ashanti and Northern regions with 16.7 percent, 13.9 percent and 11.1 percent respectively. A little more than 8.3 percent of the institutions was

The institutions provide a number of similar services to the OVC. As shown in Table, the institutions provide shelter, skills training, formal classroom education, counseling, feeding, clothing and medical care. Although significant numbers of them (more than 80% in all cases) provide all the services mentioned, provision of formal education, feeding and clothing are a little more popular than the rest of the services provided. More than 9 out of ten (94.4%) of the institutions provide these services.

Institutional Care Arrangements

The types of institutional care arrangements for OVC have been presented in Figure 1. From this figure, it is clear that majority (94.5%) of OVC receiving institutional care are in children's homes/orphanages, and rehabilitation homes. As part of their care in institutional homes, the institutions provide a number of care services including education, feeding, clothing and shelter among others. In a survey of some of these institutions, we mentioned a number of services and requested that the institutions indicated whether or not they offer to the children in their care. Three of the services, namely formal class room education, feeding and clothing were offered by most of the institutions. However, when shelter, medical care, counseling and skills training were introduced, the responses of the institutions started to drop. Table 4 presents the services offered by OVC institutions to the children.

Table 4: Services Offered by Institutions (n=36)

Care services for OVC	Yes	%age	No	%age
Formal classroom education	34	94.4	2	5.6
Feeding	34	94.4	2	5.6
Clothing	34	94.4	2	5.6
Shelter	32	88.9	4	11.1
Medical care	31	86.1	5	13.9
Counseling	31	86.1	5	13.9
Skill training (vocational and technical)	24	66.7	12	33.3

Source: OVC Study, November, 2010

of management of the institutions but some (33.3%) do not have management boards. Others (11.1%) do not think their operations require management boards.

The data in Table 3 shows categories of children targeted by formal institutions for admission and care, and the services they provide to the children in their custody. As the table shows almost all the institutions have targeted multiple vulnerable children populations. The most important in their targeting in order of merit are orphans, victims of violence, children with disabilities, children infected and affected by HIV/AIDS, children in child-headed household and children from poor homes.

Table 3: Category of children targeted for admission into the institution and services provided by institutions

Category of Children	**Frequency**	**Percent(x/36)**
Children infected by HIV/AIDS and not receiving ART	6	16.7
Children infected by HIV/AIDS and receiving ART	7	19.4
Children whose parents are sick of AIDS	11	30.6
Children living with children (i.e . children in child-headed households)	11	30.6
Children whose siblings, relatives or friends have HIV or have died of AIDS	12	33.3
Children in conflict with the law (pre trial detention)	7	19.4
Children with disabilities	14	38.9
Child victims of violence	16	44.4
Children whose parent(s) are dead	21	58.3
Street children	4	11.1
Children whose parents are poor	7	19.4
Type of service	**Frequency**	**Percent(x/36)**
Shelter	32	88.9
Skill training (vocational and technical)	24	66.7
Formal classroom education	34	94.4
Counseling	31	86.1
Feeding	34	94.4
Clothing	34	94.4
Medical care	31	86.1

Source: OVC Study, November 2010

For those providing educational care services, we sought to find out who bears the expenses. Here we identified several potential entities and presented to the institutions one after the other to find whether or not they contribute to the payment of educational expenses of the children in those institutions. In doing this, the heads of the institutions, the institutions themselves and friends/non-relatives scored the highest marks (Figure 2)

Health Care Arrangement

Health service is an important care arrangement for OVC. It is an important care arrangement not only for OVC in households but also those in institutions. As such, most OVC institutions in our survey have provisions/actions related to the health care needs of the children. In terms of access to health care services, we asked whether children in OVC institutions have been registered under the national health insurance scheme (NHIS). Of the thirty-six institutions surveyed, 31 of them (86.1%) observed that they have actually registered all the children under their care. This finding is important for the children because, among other things, the children would have access to good healthcare which is essential for their physical, mental and emotional growth and well-being. OVC need to have access to preventive care such as immunization, as well as treatment of illnesses in the institutions they stay.

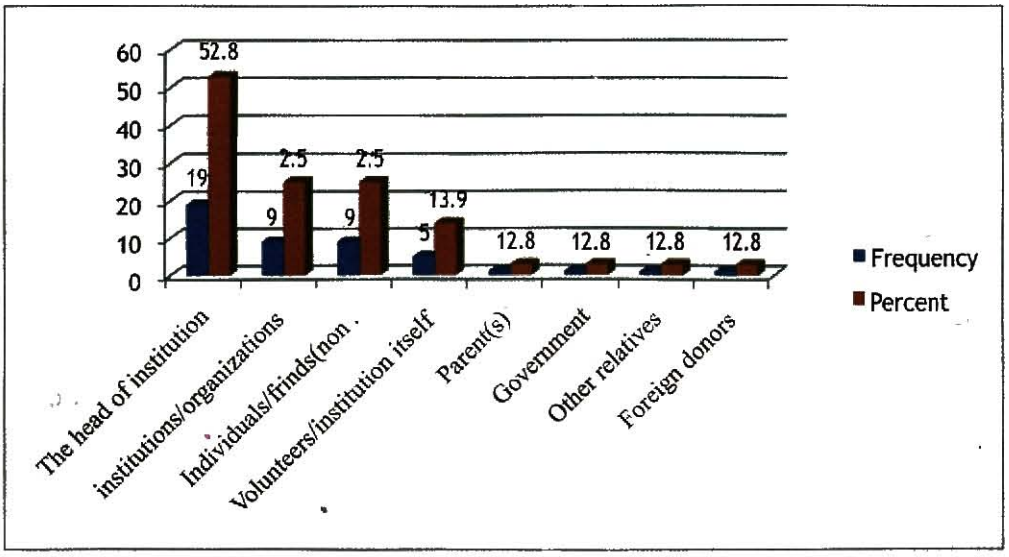
The data show that, of the 36 institutions, 30 of them (83.3%) indicated that when they have children under five years, they offer immunization service to them. Access to health care facility in the communities of the institutions was also assessed. Most of the institutions (86.1%) indicated that there was/were health facility(ies) (health centre, clinic, hospital etc) in the communities where they operate. The same number of institutions observed access to the health facilities was very easy or easy. Overall, 88.9 percent of the institutions are able to get to healthcare facility in less than 30 minutes, and while 41.7% walk to the health facilities, 58.3% get to these facilities by vehicle. In terms of healthcare finance for the OVC in the institutions (Figure 3), there is a mix of responsibilities among heads of the institutions, the institutions themselves, and the national health insurance scheme. The heads of the institutions however bear much of the

Qualitative data from the institutions also throw some light on the kind of care services available in the institutions. These data identify other care services, in particular for the recreational needs of the children. In the sections following from here, we present data on three specific care services in the institutions namely education, health and recreation.

Educational Care Arrangement

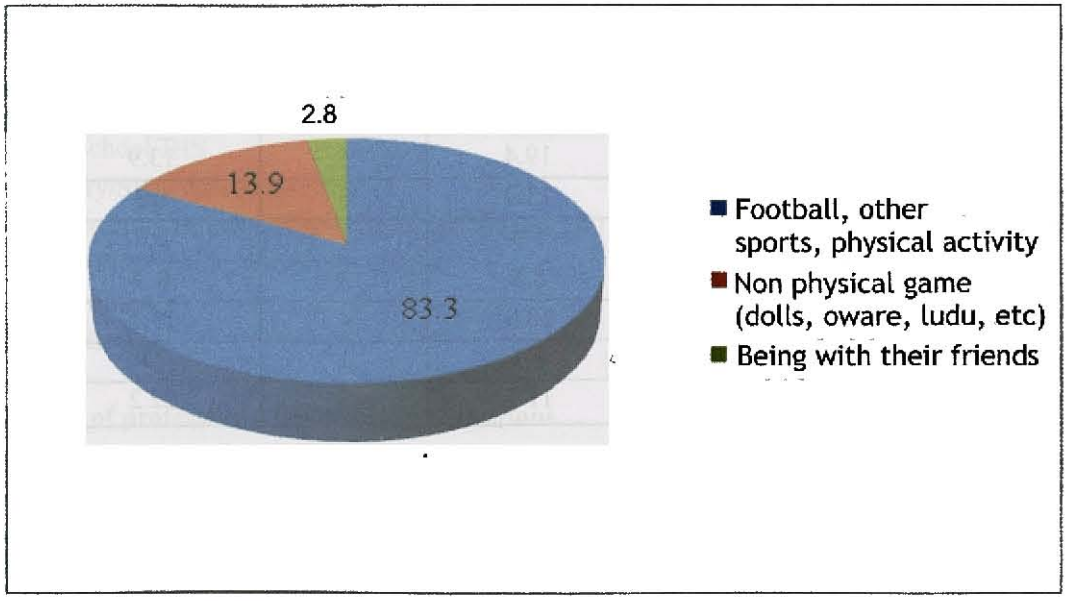
Education is critical to children's social integration and psychosocial well-being. Besides benefiting individual OVC in the future, education benefits whole nations as a major instrument for socio-economic development. Particularly at the basic level (primary and lower secondary), it is a major contributor to the reduction of poverty as it increases labour participation and labour productivity, improves health, and enables people to partake fully in the economy and the development of their societies. With this understanding, we explored the educational care provided by the institutions. Forty-four percent (44%) of the institutions suggested that, all the children under their care attend school and a further forty-seven percent (47%) indicated that some of the children attend school. Only eight percent (8%) of the institutions indicated that children under their care do not attend school.

Figure 2: Who Pays Educational Expenses of Children Who Attend School



Source: OVC Study, November, 2010

Figure 4: What the Children do for Fun



Source: OVC Study, November, 2010

Capacity of Formal Institutions

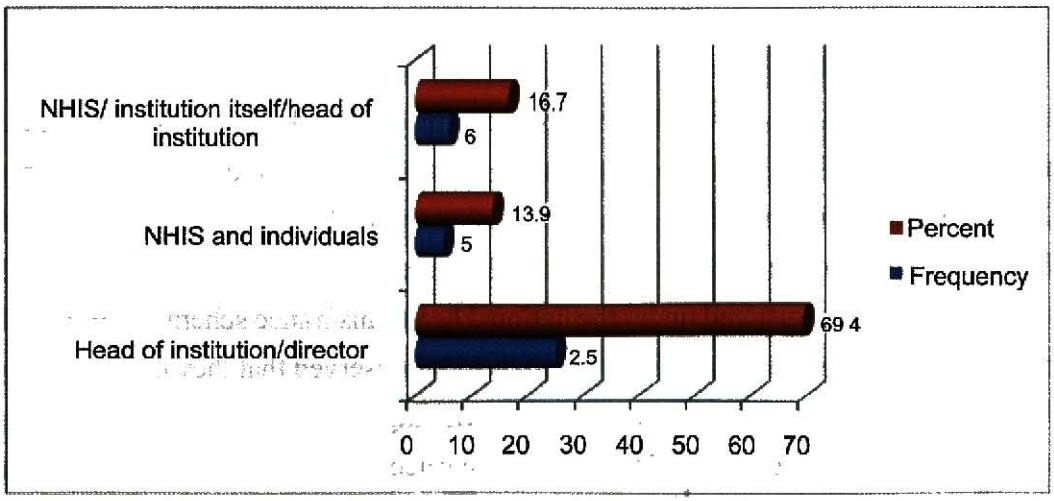
This section focuses on the potential and capabilities of the formal institutions to provide the needed essential protection and support (physical and non-physical) for the children. Considering the fact that these children have special care and support needs, and the fact of being brought up in somewhat artificial environment, it is appropriate to assess the capacities of these institutions to take care of their multifaceted needs. The institutional capacities discussed under this section are human resource, material and counseling services.

Human Resource Capacity

The institutions covered operate with a number of caregivers ranging from one (1) to eight (8), both males and females. However, there is no particular pattern of gender combinations of caregivers in the institutions. Majority of the institutions have a number of caregivers ranging from one to four (Table 5).

health cost of the OVC, finding which shows that, the institutions have some control over the healthcare provisioning for the children.

Figure 3: Who Finances OVC Health Bill



Source: OVC Study, November, 2010

Recreational Care Arrangement

This study shows that, the institutions offer children some in-door and out-door recreational facilities and activities such as football, oware and ludu (Figure 4). These recreational activities offer children the opportunity to mix with other children and also to enjoy themselves. In addition, recreational activities help children discover their talents and potentials as well as sharpen their creativity and individuality. And while ensuring that children are able to strike a balance between home chores time and other activities for the child, recreation also ensures the child has time to play and is able to be a child. Without the institutions providing these facilities as part of their care arrangements, self-actualization of the children in these areas could be impaired. This is because children and teenagers learn, socialize and form sense of self through play/recreational activities with peers.

Table 6: Educational background and professional training of key officials (respondent)

Level of Education	Frequency	Percent(x/36)
Middle school/JHS	4	11.1
Secondary/SHS/Vocational	4	11.1
Post-Secondary (nursing, teacher training college, etc)	5	13.9
Tertiary (Polytechnic, university, etc.)	20	55.6
Pastoral training	2	5.6
Not Applicable	1	2.8
Sources of professional training for institutions	**Frequency**	**Percent(x/36)**
Compassion International (NGO)	7	19.4
Social Welfare / UNICEF	10	27.8
Association of Orphanages and Children's Homes	3	8.3
Pastors' Training Institute / religious bodies	3	8.3
Other organizations	2	5.6
Not Applicable	11	30.6

Source: OVC Study, November 2010

In addition to the formal classroom education, most of the officials (75%) indicated that they had some professional training in relation to the caring for OVC as against 25 percent of them had no such professional training as a way of capacity building for protecting and supporting OVC in their institutions. The Department of Social Welfare and UNICEF are the most popular trainers (27.8%) for the institutions, followed by NGOs (19.4%). Half of the officials presented certificates to show their participation in some professional training in OVC care, while some others (19.4%) showed letters to support the evidence of their participation in such training. A few of them (5.6%) did not have any evidence to support their claim of participation in professional training.

Material Resource Capacity

The study also assessed the extent of supply and availability of adequate material resources to the institutions to support the needs of the OVC in their custodies. The focus

Table 5: Caregivers in Institutions by Sex

Number of caregivers	Female		Male	
	Frequency	Percent(x/36)	Frequency	Percent(x/36)
One (1)	2	5.6	8	22.2
Two (2)	5	13.9	11	30.6
Three (3)	7	19.4	5	13.9
Four (4)	5	13.9	3	8.3
Five (5)	2	5.6	1	2.8
Six (6)	3	8.3	3	8.3
Seven (7)	5	13.9	4	11.1
Eight (8)	3	8.3	1	2.8
Eleven and above	4	11.1	8	22.2

Source: OVC Study, November 2010

Education and Professional Training

The capacities of the institutions have also been assessed in terms of educational background of key officials managing the places and any professional training that they have received in relation to the caring for OVC. Education and professional background is very crucial in the scheme of things, because people taking care of OVC in formal setting must first understand the circumstances of children they are supposed to care for and the most professional approach to manage their circumstances. In this light, data on education and professional qualification of care-givers were gathered from respondents who occupied key positions in the institutions. Indications from Table 6 are that key officials in the institutions largely have appreciable levels of formal classroom education. Most of them (55.6%) have tertiary education and other post-secondary level education (13.9). A few of them have up to secondary and basic level education.

Supply of resources to the institutions is, however, not very regular. A quarter of the institutions receive these support once a year, while 13.9% and 11.1% receive them once in three months and once in a month respectively. In the past six months prior to the interviews with the institutions, clothing (77.8%) and financial support (69.4%) constituted the most common assistance received by the institutions. Food assistance is the third most common support, followed by voluntary services and logistics.

The inadequacy of the material resources for the upkeep of the OVC in the institutions were expressed when the officials were asked to indicate their main concerns and needs of the operation of the places, as shown in Table 8. The most pressing capacity concerns of the institutions are inadequacy of support for the education of OVC (75.0%), inadequate financial support (66.7%), inadequate healthcare (61.1%) and food (50.0%). Similar sentiments were expressed by the officials when they were asked to indicate the challenges and difficulties in taking care of OVC (Table 8).

Table 8: Regularity/Frequency of Support/Assistance

Regularity of Support	**Frequency**	**Percent(x/36)**
Once in a week	3	8.3
Once in a month	4	11.1
Once in three months	5	13.9
Once in six months	3	8.3
Once in a year	9	25.0
Not sure	3	8.3
Twice in a year	1	2.8
Once in 4 months	1	2.8
Once in a while	2	5.6
Not applicable	5	13.9
Support Received for the past 6 months	**Frequency**	**Percent(x/36)**
Financial	25	69.4
Food	22	61.1
Clothing	28	77.8
Logistics	13	36.1
Voluntary service/Home -making	15	41.7

Source:OVC Study, November 2010

has generally been on various sources of support, specific support received, regularity and adequacy of resources received. The data show that the institutions receive various resources in the form of assistance which they use to take care of the OVC. The resources are in the form of food, school fees, medical fees, counseling, technical, clothing and financial services. Financial assistance (55.6%) is the most common resource received, followed by food (38.9%), counseling and technical resources (16.7%), and medical fees (13.9%) in that order of merit. The institutions get the larger part of their material resources from individual philanthropists and friends (80.6%), religious bodies (66.7%), other institutions and organizations (58.3%) and foreign donors (50.0%). Self-supporting (44.4%) is also significant among the institutions (see Table 7 for the resources received by the institutions, and the sources of the resources).

Table 7: Support Received byFormal OVC Care Institution

Nature of the support	**Frequency**	**Percent(x/36)**
Financial assistance	20	55.6
Food assistance	14	38.9
School fees	4	11.1
Medical fees	5	13.9
Counseling/advice/technical operations	6	16.7
Clothing support	2	5.6
Voluntary services	1	2.8
Sources of support for OVC institutions	**Frequency**	**Percent(x/36)**
Supported by owner	16	44.4
Support from other institutions/organizations	21	58.3
Support from individuals/friends	29	80.6
Support from government	8	22.2
Support from some relatives	8	22.2
Support from religious bodies	24	66.7
Support from foreign donors	18	50.0

Source: OVC Study, November 2010

On education specifically, 63.9 percent of the institutions reiterated that they are confronted with the difficulty of providing the educational needs of the OVC in their custody, and they particularly do not get trained teachers to teach the OVC with special needs (those with disabilities). They also do not get enough resource to motivate the officials who take care of the educational needs of the children. In short, the institutions have serious challenges in meeting the cost of education in general and quality education in particular for the children. The situation of education is similar to that of health needs of the OVC. The biggest challenge in providing quality health care for the children relates to their efforts to secure enough financial resources to meet the cost of healthcare. The institutions bemoaned lack of permanent health specialist in their homes to attend to the children as and when necessary and also do not have health facilities such as ambulance to convey the children when they are unwell.

The institutions summarized their material capacities when they were asked to give their general assessments. Apart from those who do not receive any external support at all, the majority of those who receive the support (52.8%) indicated that the resources are not enough for the OVC that they take care of and 8.3 percent said they hardly receive the resources expected from the external source (Table 10).

Table 10: Rating/Assessment of Assistance Received by the Institution

Rating/Assessment	*Frequency*	*Percent(x/3)*
Okay, they are enough	4	11.1
They are not enough	19	52.8
They come, but not needed	1	2.8
They don't come	3	8.3
Not applicable	9	25.0

Source: OVC Study, November 2010

The overwhelming majority of the institutions interviewed (77.8%), considered inadequate financial resources as the most challenging and difficult situation confronting them, followed by general lack of support and interest of the public in the course of taking care of OVC. Besides, they do not get enough food to feed the children (38.9%) and some children do not get the support to access formal education. They also mentioned the demands of the work of taking care of OVC.

Table 9: Main Capacity Concerns/Needs of the Institutions

Capacity Concerns	**Frequency**	**Percent(x/36)**
Inadequate Financial support	24	66.7
Inadequate support for the OVC Education	27	75.0
Healthcare	22	61.1
Shelter	14	38.9
Food	18	50.0
Skill training	12	33.3
Medical support	16	44.4
Socio-emotional support	11	30.6
How to integrate OVC into normal life	1	2.8
Challenges/Difficulties in taking care of OVC	**Frequency**	**Percent(x/36)**
It is hard financially	28	77.8
There is less food for the children	14	38.9
Some children can't go to school	12	33.3
We do not have time to rest	9	25.0
Societal support to us is not encouraging	22	61.1
There is too much pressure	16	44.4

Source: OVC Study, November 2010

Table 11: Guidance and Counseling Services (GCS) Offered by Institutions

Evidence of existence of counseling officer	Frequency	Percent(x/36)
File	5	13.9
Records	5	13.9
None	11	30.6
Not Applicable	15	41.7
Total	36	100.0
Evidence of existence of GCS	**Frequency**	**Percent(x/36)**
File	4	11.1
Minutes	1	2.8
Records	5	13.9
None	11	30.6
Not Applicable	15	41.7
Total	36	100.0
Voluntarily access of GCS	**Frequency**	**Percent(x/36)**
Yes	10	27.8
No	9	25.0
Not applicable	17	47.2
Total	36	100.0
Issues for GCS	**Frequency**	**Percent(x/36)**
Bereavement	3	8.3
Abuse of pupils/students	2	5.6
Parental neglect	1	2.8
Emotional challenges	8	22.2
Academic difficulties	3	8.3
Not Applicable	19	52.8
Total	36	100.0

Source: OVC Study, November 2010

Guidance and Counseling

Considering the conditions of the OVC, one service that is of immense significance in the institutions is counseling. Although the majority of the institutions (55.6%) offer counseling services to the children, a significant number of them (44.4%) do not have formal counseling services. Even in the case of those who offer the services, only a third (33.3%) have office accommodation designated for counseling while the rest have no such office accommodation for that purpose. There is a fewer number of them (41.7%) who have trained guidance and counseling officers than the percentage of the institutions (55.6%) who claim to offer professional counseling services to the OVC.

The evidence to support the professional training of the guidance and counseling officers cast doubt further on whether or not some of those who claim to have trained officers really do have them. That is, only 27.8 percent of the 41.7 percent of the institutions that have trained counseling and guidance officers could provide evidence in the forms of files and other records to show that they indeed have the officers. The evidential proof of the 27.8 percent of the institutions also reflected availability of counseling services, and the OVC accessing the services. The issues on which the children seek counseling vary but the most common issue concerns emotional challenges. Thus 22.2 percent of the few who seek counseling services do seek solutions to emotional problems. Other counseling services deal with academic challenges, bereavement and child abuse (Table 11).

Box 1: The Manya Krobo Queen Mothers Association (MKQMA)

The MKQMA is identified in the Yilo/Manya Krobo area in the Eastern region. As the name suggests, it is made up of queen mothers. The association holds on to the fact that, queen mothers have traditionally been responsible for the welfare of women and children in their respective communities. For this reason, the association works to care for the welfare of women, and more importantly for the discussions here, OVC. They do home visits and help to solve problems women and OVC face. The MKQMA has also been working to build the capacity of the Queens and other opinion leaders. Over 1,035 Orphans have been identified through their home visit programme and these children placed in families and households of the queen mothers for fostering. A Queenmother cares for between one and six orphans, providing them with shelter, food, clothing, health care and education. The rationale is to provide stable home-kind of environment for the children to grow. They are aware of the stigmatization and discrimination that OVC experience and this informed their decision to place the OVC in natural families and care for them the way they do, to help them to be absorbed into the wider community instead of orphanage homes. Aware of the risks of HIV/AIDS, MKQMA home visits also allow the Queenmothers to reach out to community members providing them with knowledge and skills to avoid the risks of HIV/AIDS and STI's while referring the chronically ill to the local hospitals, the St. Martin's or Atua Government Hospital both in the area for care.

Source:http://manyakrobo.blogspot.com/

This care arrangement allows orphaned and vulnerable children to remain in their communities of origin and receive both community and family-based support provided by the communities. By this care arrangement the OVC are brought up and integrated into their natural community environment. The MKQMA is managed by the queenmothers themselves. Each queenmother serves as house-mother for a small number of OVC in a family style.

The OVC under the care of the queenmothers refer to them as 'mothers' and call each other 'brother' or 'sister' and relate to one another as siblings. The association depends on the contribution of benefactors to execute its activities. On the association's website for instance, there is a call to such benefactors to support the association for it to continue to offer care services to OVC.

Chapter Four

Informal Care and Support Arrangements for Orphan and Vulnerable Children in Ghana

Introduction

This chapter is devoted to presentation and discussion of data related to informal care and support arrangements available for OVC in Ghana. The informal care arrangements come in the form of foster care, home-based care and support, and community-based support structures. These care arrangements can also be categorized as kinship care and community care arrangements.

Informal Care and Support Arrangements (Community and Household Based Care)

As indicated earlier, the data on care arrangements for OVC captured in the study are of three categories namely, formal institutional care arrangements, community-based care arrangements and household or family care arrangements for OVC. The first section has looked at the institutional care and their capacities. This section focuses on community-based and household or family care arrangements. One spectacular community-based care arrangement that the researchers came across is the Manya Krobo Queen Mothers Association (MKQMA) which has been described in box 1 below. This is an important, indigenous and traditional way of caring for children in need of care by community members.

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This chapter is devoted to presentation and discussion of data related to informal care and support arrangements available for OVC in Ghana. The informal care arrangements come in the form of foster care, home-based care and support, and community-based support structures. These care arrangements can also be categorized as kinship care and community care arrangements.

Informal Care and Support Arrangements (Community and Household Based Care)

As indicated earlier, the data on care arrangements for OVC captured in the study are of three categories namely, formal institutional care arrangements, community-based care arrangements and household or family care arrangements for OVC. The first section has looked at the institutional care and their capacities. This section focuses on community-based and household or family care arrangements. One spectacular community-based care arrangement that the researchers came across is the Manya Krobo Queen Mothers Association (MKQMA) which has been described in box 1 below. This is an important, indigenous and traditional way of caring for children in need of care by community members.

parents (24.7%), other relatives (6.5%) and other household members (3.8%). At the individual level, there is no different story to tell. Household heads and parents remained the main source for the provision of educational needs for OVC (Table 12).

Table 12: Educational Care Services Offered by Households

	School fees		School uniforms		Books		Feeding		Total	
	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%age
Parent(s)	183	22.8	206	25.6	199	24.8	207	25.7	795	24.7
Other household member	24	3.0	33	4.1	32	4.0	34	4.2	123	3.8
Other relative	47	5.8	52	6.5	53	6.6	58	7.2	210	6.5
Non relative	15	1.9	23	2.9	20	2.5	20	2.5	78	2.4
Self	9	1.1	15	1.9	14	1.7	13	1.6	51	1.6
Household head	206	25.6	222	27.6	229	28.5	233	29.0	890	27.7
Government	77	9.6	--	--	--	--	--	--	77	2.4
NGO	2	.2	13	1.6	16	2.0	--	--	31	1.0
Institutional home	66	8.2	31	3.9	31	3.9	36	4.5	164	5.1
Scholarship	1	.1	--	--	--	--	--	--	1	0.0
Headmaster	4	.5	--	--	--	--	--	--	4	0.1
Don't Know	9	1.1	10	1.2	12	1.5	9	1.1	40	1.2
Not Applicable	161	20.0	199	24.8	198	24.6	194	24.1	752	23.4
Total	804	100.0	804	100.0	804	100.0	804	100.0	3216	100.0

Source: OVC Study, November, 2010

Food Intake as a Measure of Care

Food intake was also considered as part of the care arrangements for OVC. As such, the children were asked to indicate the number of meals they took in a day, and the data show that, most of the children (70.8%) were cared for in the normal child care manner, giving them three meals a day. When asked about the food types most often eaten at home, the children mentioned several food types including maize related foods such as TZ, Kenkey, Banku, porridge, etc; rice related foods such as wakye, jollof, plain rice etc; and cassava-made foods (fufuo/ konkonte, gari etc) and ampesi, both yam and plantain. The import of this is that most OVC in Ghana are probably not treated very different from non-vulnerable children who may find themselves in the same household as far as food intake

Manye Esther with Schoolchildren on a Community Visit

Manye Makutsu with Community Children

Source: http// manyakrobo.blogspot.com

Household Care Arrangements for OVC

In Ghana, the family and community members have traditionally taken care of orphan and vulnerable children and they continue to do so irrespective of a number of transformations that have taken place including an increasing tendency towards nucleation of the Ghanaian family (UNDP-Ghana, 2008; Nukunya, 2000).Within the household and families in the research communities, a number of care arrangements were identified for OVC. They include adoption, fosterage and househelps. In these care arrangements, orphan and vulnerable children were cared for in households/families by both nuclear and extended family members. This means that families or households continue to offer stable environment for OVC. Findings from this study indicate that, the household provides a range of care and support services to OVC. In particular, the children data show that, the households provide educational, food, health, and socio-emotional care for OVC.

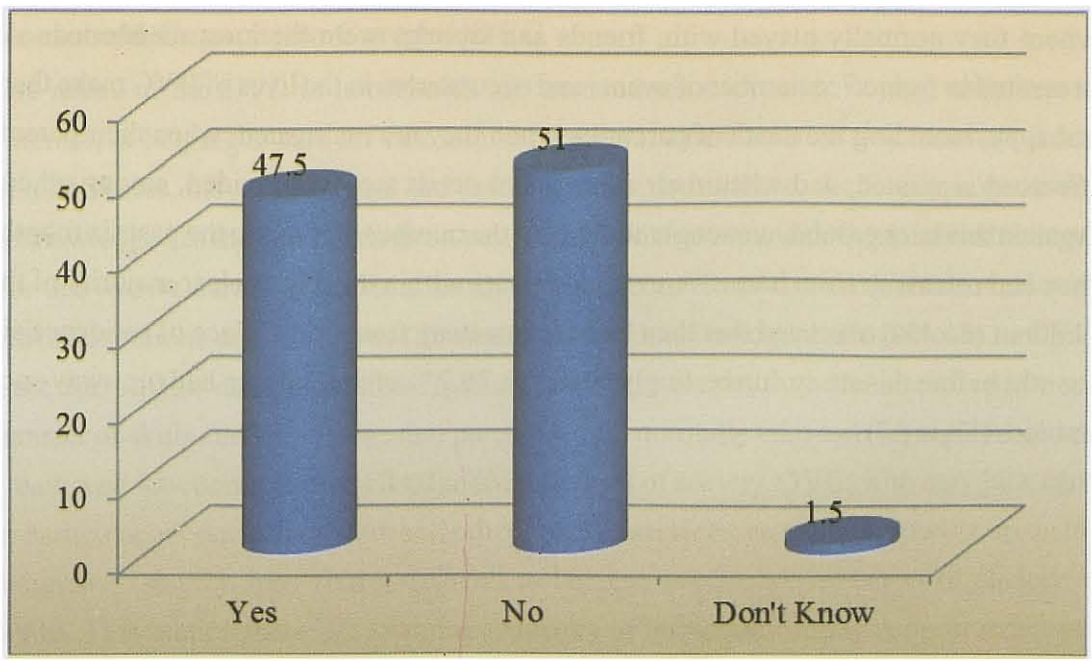
Educational Care

The educational care services provided by households to OVC include school fees, school uniforms, books and feeding at school. When OVC children were asked who provides their educational needs (school fees, school uniforms, books and feeding at school) to them, we found out at both aggregate and individual levels that, most of the children mentioned family/household members. At aggregate level, most of the children (62.7%) mentioned family/household members, namely household head (27.7%),

caregiver(s) often receive less attention when they are sick and may even miss out on health services. This situation makes them even more vulnerable to diseases and infections. To understand the healthcare arrangement for OVC, the children were asked if they had health insurance.

As shown in Figure 6, 47.5% of the children indicated that they had health insurance and a little over half of the children suggesting that they did not have health insurance. This situation could lead to denial of health service when payment of health care service is required and OVC care-givers are unable to make the payment. A few of the children however could not tell whether they had the health insurance or not. For those who did not have health insurance, a number of reasons were given. While some argued that their parents or guardians could not afford, others opined that, they had it in times past but had expired and were yet to renew.

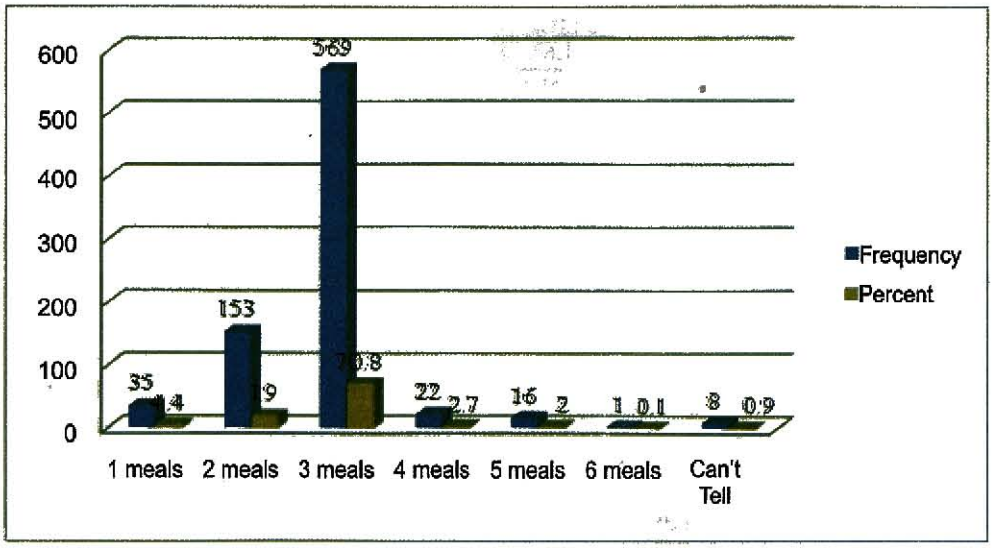
Figure 6: Proportion of Respondents who have registered with NHIS



Source: OVC Study, November, 2010

is concerned. It is more interesting to find that, 4.8% of the children are actually fed more than three times in a day. Adequate food intake suggests, though not conclusive that OVC have access to enough food to meet their nutritional needs in order to live productive and healthy lives. There was however, substantial number of children (23.4%) whose food intake in a day was less than three times, indicating that the available food intake care for them was below expectation. Low and more importantly unbalanced intake of food can lead to malnutrition for all OVC. For vulnerable children, especially those with HIV/AIDS, this may pose growth and development challenges. Scientific facts indicate that, OVC living with HIV/AIDS are more vulnerable to the ill effects of poor nutrition on health.

Figure 5: Number of Meals Children Usually Take in a Day

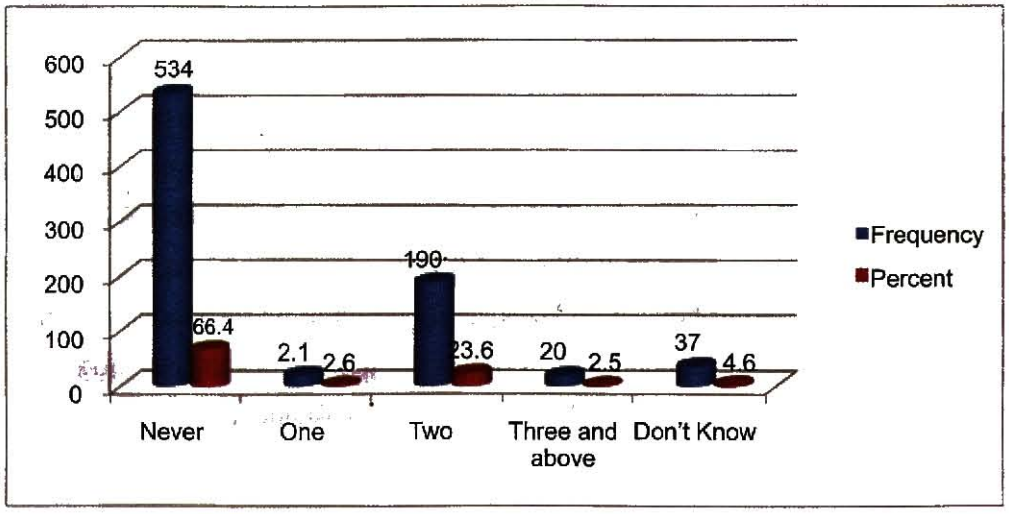


Source: OVC Study, November, 2010

Health Care Arrangements

Health service is an important care arrangement for OVC. Good health refers to physical, mental and emotional well-being of a person. OVC need to have access to preventive care such as immunization, as well as curative or treatment of illnesses. Those who lack adult

Figure 7: Number of Times in the Past Six Months OVC Had Run Away From Home



Source: OVC Study, November, 2010

Household Capacity to Care for OVC

The needs of the OVC in households are tremendous - some are coping with loss of parent(s) or helping to care for sick family members, others are also sick themselves and in many cases, they face stigma and discrimination. In all these, the family is generally acknowledged as the optimal environment for a child to grow and develop into adulthood. For this reason, care for OVC in a family set-up is considered the ideal situation, though other institutions and structures (discussed above) have emerged to offer care to OVC. Care for orphan and vulnerable children is a way to substitute the socialization and transfer of skills and knowledge that parents would normally take care of, with the aim to create well functioning and well-adjusted members of society. OVC, who may lack care, in particular access to education and other types of services, as well as growing up on the margins of society, may find it difficult to become productive members of society as adults. This section therefore examines capacity of household/family support structures to take care of the welfare and needs of OVC.

Socio-Emotional Care Arrangement

Socio-emotional care helps vulnerable children and their caregivers to cope with all manner of challenges. Orphan and vulnerable children often have to face illness, death of parents, extreme poverty, abuse and isolation. The socio-emotional effects of these problems may makeit hard for them to partake in everyday activities as children, including going to school or playing among others. For this reason, socio-emotional care arrangement is needed to help OVC cope with the problems they encounter. This will help them to make sense of their bad experiences, accept and live with strong feelings brought about by difficult situations, and move forward with their lives.

To assess the socio-emotional care arrangement for OVC, we asked the children the person they speak with, when they are sad, worried or have problem, who they normally play with, what worries them/makes them unhappy, and the number of times in the past Six months they had run away from home. Guardians and friends emerged atop of response options for the persons they speak with, when they are sad, worried or have problem. There were quite a significant number of them who kept to themselves. With whom they normally played with, friends and siblings were the most mentioned. As presented in figure 7, a number of events and occurrences in the lives of OVC make them unhappy, including the death of parent(s), when they are maltreated, when their parents divorced/separated, and when their educational needs are not provided, among others. Against this background, we sought to find out the number of times in the past six months they had run away from home for extended hours within the day. A clear majority of the children (66.4%) observed that they had not run away from home/place of residence six months before this study. Interestingly however, 26.2 % of the children had run away once or twice (Figure 7).

Educational Background and Capacity to Care for OVC

One way to assess the capacity of households to care for OVC is to understand the educational levels/attainments of OVC care-givers in the households, in this case the household heads. Though educational attainment in itself is not a good measure for how well a person may be able to care for OVC, it still remains important because of the prospects it provides in terms of job acquisition and the subsequent income that jobs bring to the individuals concerned. Against this background, we examine the educational backgrounds of household heads, their occupation and income levels as well as other relevant variables with the view to understand the capacity of households to care for OVC in Ghana. Majority of the household respondents have low level education: cumulatively, 40% of them have No education, Non-formal education and Pre-primary education; 17.3% and 26.2 percent have primary education and Middle school/junior high school (JHS) education respectively; just about 5% of them have Post-Sec and tertiary education (nursing, teacher training colleges, polytechnic and university).

If formal education in itself is a measure for the capacity of household heads to care for OVC, then the household care situation for OVC in Ghana cannot be said to be anything assuring. But the researchers do not have a definite link on the educational backgrounds of the household heads and how they are able to care for OVC. For this reason, we analyze the occupation (both primary and secondary) of the respondents.

Occupation of Household Heads and Capacity to Care for OVC

It is widely acknowledged that, economic strengthening is a valuable component of OVC care and support because, not only is vulnerability of OVC linked to lack of economic resources, but also it contributes to reduced economic productivity with assets sometimes liquidated to take care of needs. With this view in mind, we found out from the data that, for the primary occupation of respondents, more than a quarter (28.1%) of the respondents were without jobs. In specific, 27.3% were unemployed and the remaining 1.8% being retired. This is a concern, because these respondents were the main caregivers of the OVC in households, and given that they are unemployed/retired, one finds it

Household Size and Capacity to Care for OVC

In examining the number of children that household respondents lived with at the time of the study, we found out that the mean household size computed from the sample was 4.04 with 22.8 of the sample respondents having household sizes ranging from 5 children up to more than ten children (Table 13). Both the mean household size of the sample (4.04) and the 22.8% respondents with between 5-10+ children are higher than the national household statistics. According to the Ghana Living Standard Survey (GLSS5), the mean household size of Ghanaians as at 2008 was 4.0, down from the 5.1 in 2000 population and housing census. Larger household sizes, as found with the respondents, come with more needs and demands (educational, food and nutrition, health, psycho-social and emotional etc) on the households, which also require more financial resources.

Table 13:Household size

Mean~ 4.04	Frequency	Percent
None	217	14.9
One	211	14.5
Two	241	16.6
Three	230	15.8
Four	225	15.5
Five	147	10.1
Six	66	4.5
Seven	45	3.1
Eight	16	1.1
Nine	10	.7
Ten and above	48	3.3
Total	1456	100.0

Source: OVC Study, November 2010

Table 14: Monthly Earnings of Household Heads

Mean~ GHc25.39	Frequency	Percent
Less than GHC100	713	49.0
GHC100-249	204	14.0
GHC250-399	110	7.6
GHC400-549	40	2.7
GHC550-699	11	.8
GHC700-849	1	.1
GHC900+	14	1.0
No response	29	2.0
Don't know	9	.6
Not applicable	325	22.3
Total	1456	100.0

Source: OVC Study, November 2010

Main Capacity Concerns and Support to Households

The study also attempted to assess the main concerns/needs of households to support the needs of the OVC they care for. In all, seven concerns were put up and respondents made to indicate if they were a challenge to them. Evidence from the data shows that the households have a number of concerns/needs in their bid to care for the OVC, with financial concern (60.2%) emerging on top of all other concerns. Educational concern (55.5%), food (41.0%) health care (38.6%) and shelter (29.1%) followed in that order. It also emerged that, the households receive different kinds of support from society as they cater for the needs of OVC. On the kind of support the households receive to take care of the OVC, financial, food, school fees, medical fees and counseling were identified (Table 15). The households get the larger part of their support in the form of finance (15.8%) and food (7.0%). But unlike their institution counterparts discussed above, no technical and clothing support are offered to households even though as evident in Table 15, households also provide *technical* skill training for OVC. Most of the households (72.1%) however do not receive any support from anywhere.

difficult to understand how the needs of OVC could be provided.

Indeed there is even a concern about how these respondents could take care of themselves. The capacity of these unemployed/retired household heads to provide care for the OVC in their care therefore remains an open question. In the analysis of the data, it however emerged that, a cumulative percentage of 68 of the respondents were in active work as farmers (31.6%), as traders/business people (25.1%), and as craftsmen and women or artisans (6.5%). In addition, there were some respondents working as teachers (2.5%) and civil servants (2.5%). It is expected that these household heads, compared to their unemployed/retired counterparts, could be able to provide better care for the OVC.

Monthly Income Earnings of Household Heads and Capacity to Care for OVC

With more than national mean household sizes, majority of the household respondents with low level education, and more than a quarter (28.1%) of the respondents without jobs, we then employ the income earnings of the respondents as a proxy to understand the capacity of the household heads to care for the OVC under their care. The use of income earning here is quite appropriate because it provides better understanding of the financial resources available to the household heads and how best they would be able to meet the needs of the OVC.

Using this income earning variable (Table 14), a mean income earning of GH¢25.39 was attained. In addition, close to half of the respondents indicated that they received less than GH¢100.00 a month, with a further 14% observing that, their monthly income stood between GHC100.00 and GHC249.00. Very few respondents earned monthly income beyond GHC 500.00. The implication for this is that, for many household heads with responsibility to care for OVC (mean household size of 4.04); financial capacity to care for these children is a challenge. For this reason, OVC in these households may be lacking in basic needs – food, clothing, etc., and they may also be denied access to education, health and other services.

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Table 16: Regularity of support//How household support themselves

Regularity of support	Frequency	Percent(x/1456)
Once in a week	32	2.2
Once in two weeks	7	.5
Once in a month	88	6.0
Once in three months	47	3.2
Once in six months	19	1.3
Once in a year	55	3.8
Not applicable	1208	83.0
How household support themselves	**Frequency**	**Percent**
Household head works to support	893	61.3
Other adult household members work to support	395	27.1
Child(ren) in the household work to support	40	2.7
Support from relatives	131	9.0
Support from organizations	5	.3
Support from friends	19	1.3
Support from government	11	.8

Source: OVC Study, November 2010

Gender Dimensions of the Household Capacity to Care for OVC

An interesting aspect of the data on household capacity to care for OVC is in relation to the gender dimension to the capacity to care. The data indicate that, more than twice as many female-headed households reported that they earned monthly income of less than GHC 100.00 compared to male-headed households. Also, female-headed households were significantly more likely to report that they had no education, or they had primary/middle school/JHS education compared to male-headed households. However, when we examined secondary, post-secondary and tertiary education, more male than female household heads had reached those levels. We also observed more female-household heads to be unemployed compared to their male counterparts. Examining the gender issues in relation to household capacity to care, it becomes quite apparent that,

Table 15: Main Concerns and Support to Household for the Care of OVC

Capacity Concerns	Frequency	Percent(x/1456)
Financial support	877	60.2
Educational support	808	55.5
Food	597	41.0
Healthcare	562	38.6
Shelter	424	29.1
Socio-emotional support	134	9.2
Skill training	57	3.9
Kind of support received	**Frequency**	**Percent(x/1456)**
Financial support	230	15.8
Food assistance	102	7.0
School fees	24	1.6
Medical fees	8	.5
Counseling/advice	4	.3
Nothing	1050	72.1

Source: OVC Study, November 2010

The flow of support to the households, just like the institutions, was not very regular (Table 15). For this reason, we asked the household heads to indicate how, in the face of mounting needs and difficulties they were able to support themselves to give the children the needed care. A number of strategies emerged in this direction. Most respondents indicated that, household heads (61.3%) or other adults in the household (27.1%) work to support activities that go on in the households. Support from relatives was also mentioned (Table 15).

Chapter Five

Conclusion and Recommendations

Conclusions

Care arrangement for OVC is a crucial matter as it has implications for the enjoyment of fundamental human rights and the wellbeing of children. Yet, there are clear signs of overlapping and uncoordinated care arrangement coupled with low capacity of institutions and households in providing adequate care for OVC. These observations are discussed below:

Weak Institutional Capacity

Given the available information, it is important to state that the capacity of institutions (orphanages/homes) that manage OVC is weak. Indeed, the institutions sampled have both male and female staff (caregivers) with the number of staff per institution ranging from one to eight. Most of the key staff had obtained tertiary education and other post-secondary level education, and a few have secondary and basic level education. Beside the academic qualification, some of the institutions had had some professional training in connection with caring for OVC, but a significant number of them had had no such professional training. This means that although the personnel in the institutions have some level of capacity to care for the OVC, the human resource capacity is not adequate to deal with the multifaceted needs of the children.

Low level of Material Support for OVCs

From the study, there are obvious situations of low level of material support for

programmatic response to the plights of OVC has to recognize the gender issues underlying care of OVC. The best intervention to address the care and insecurity of orphans and vulnerable children will have to be multifaceted. It would require an appropriate mix of social safety net expenditure and other programmes that strengthen the economic capacity of households that are into this care enterprise.

The Capacity of the Department of Social Welfare and the enforcement of Regulations

Even though the Department of Social Welfare (DSW) hasthe mandate to provide technical support and also license institutions that provide care for children, there are glaring signs of limited capacity of DSW to carry out their mandate. Indeed there are issues of lack of funds, logistics and personnel to effectively monitor the activities of homes and institutions that provide care for OVC.

Recommendations for Policy Direction

Conditions of OVC in Ghana

On the basis of the fact that OVC are found in households, institutional homes, correctional homes, and on the streets, it is important that targeted policy initiatives are directed at OVC found in the various locations. This will ensure that policy initiatives are able to meet the specific needs of such children. For instance, children on the street do not live in normal household conditions and hence their immediate need would not be the same as OVC living in normal household conditions. The disaggregation of policies aimed at addressing the problem of OVC in Ghana would also give clearer direction for policy implementation, monitoring and evaluation. The existing OVC Policy Guidelines should therefore be redesigned to ensure that all categories of OVC are adequately covered.

Majority of the households where OVC are found are low income households, with average household size (approximately 7) above the national average (5), and an average of 4 children in each household. This situation increases the burden of care for OVC living in households. This calls for expansion of the LEAP payments to low income households to cover more households. In doing this, there will be the need to also strengthen the mechanism for selecting beneficiaries for the LEAP transfers. This will ensure that the transfers actually go to those who are truly vulnerable and taking care of OVC.

It is important for the state, through the Ghana Education Service, to ensure the full

institutions involved in caring for OVC. The data clearly show that although the institutions receive support (i.e. financial, food, school fees, medical fees, counseling and technical operations, clothing, logistics and voluntary services) from various sources, the material resource capacity is not the best. These supports mainly come annually and quarterly and almost all the respondents from the institutions bemoaned the inadequacy of the resource for effective upkeep of the OVC in their custody. Some hardly receive any material support from external source.

Guidance and Counseling

Capacity for guidance and counseling services for OVC was also observed to me almost non-existence.About half of the institutions studied did not have any formal arrangements for providing counseling services to the OVC.A significant number of those who claim to have formal arrangements and procedures have no professionally trained personnel for counseling and guidance, neither have they made provision for an office space for the purpose. Not only that, only a few of those who claim to have professionally trained personnel could provide evidence to support the claim, and not all who indicated to be providing the service to the OVC could provide evidence to back their claim. They all boil down to the point that there is very weak capacity for guidance and counseling services for the children in the institutions.

Household Capacity to Manage OVC

Household with OVC were technically and economically constraint to provide the needed care for them.Further to this, it is imperative to note that the household environment provides very strong vulnerable conditions for the children. In the first instance, the household sizes are large, ranging from one to more than ten and this. Larger household size comes with more demand and needs (financial, education, health, food, psycho-social and emotional) on the meager household resources. Again, most household heads in the study lacked the requisite educational qualification which could earn them better incomes to take of the OVC.

services for OVC in the children's own communities.

Stakeholder Capacity to Handle the Issue of OVC

In the short term, there is the need to have competent management boards to oversee the affairs of the institutions, where necessary, and District Social Welfare Department capacity must be strengthened for effective supervision of the running and activities of the OVC institutions and homes in their districts. This stems from the fact that, the distribution of the institutions spans from rural through peri-urban to urban. Again, while some institutions have the management boards some do not have any, and others do not think it is necessary to have an oversight body.

Again, there is the need for regular training in the care for the OVC, resource mobilization and its management for the institution. Efficient and effective management of resources could instill confidence in leadership of the institutions such that philanthropists and donors could be attracted to continuously support the course of the institutions. The institutions must be sensitized and trained on resource mobilization from their operating areas. The mobilization should not be restricted to material resources, but also human and technical support from within their areas of operation.

The counseling services capacity of the institutions appears to be very weak. Looking at the centrality of counseling service to the nature of children in their custody, it is recommended that all the caregivers in the institutions be given some regular training in counseling, in addition of professional counselors to be attached to the institutions and homes. There should be effective monitoring of OVC participation in, and access to NHIS, free education and LEAP programmes.

It is also recommended that the institutions and homes be trained in records taking and management of the children in their custody and their activities. One major challenge that confronted the researchers during the data collection was lack of organized information from the institutions. Most of the data collected from them were from the memories and

implementation of the Free Compulsory Universal Basic Education (FCUBE) and to ensure that all children of school going age actually go to school. This will not only help in the achievement of 100% enrollment of children of school going age, but also ensure that all OVC attended school. At the time of this study, 19% of the OVC captured did not attend school due mainly to financial problems, dropout and death of parent(s). Effort should also be made to extend the implementation of the school feeding programme to include many more public basic schools, especially those in deprived districts. Moreover, the provision of educational materials like textbooks, school uniforms, desks, etc. should focus more on deprived districts and a mechanism found to ensure that identified OVC receive their share of such provisions.

In order to adequately take care of the health needs of OVC in Ghana, it would be necessary to ensure the decoupling of registration of children under the National Health Insurance Scheme from parents. By this, all children would be able to access healthcare even if their parents are not registered under any health insurance scheme. In the case of children who are also HIV+, it is essential to that they are identified and placed on ART.

We propose OVC care policy that focuses on community/families/household care rather than institutional care. This will ensure that OVC are more integrated into their communities/families/society. Directly related to this is the issue of societal attitudes towards OVC. With a policy shift that emphasizes the care of OVC incommunities/families/households, identifying these OVC in the first place would be difficult, and in addition, ensure that, negative attitudes towards them are reduced or eliminated, if possible. In our considered opinion, and based on the empirical data available, families/household care arrangements for OVC including adoption and fosterage, among others are family-based and therefore provide all the support systems embedded in Ghanaian families for the growth of these children. The community-based care of OVC identified in the study - the Manya Krobo Queen Mothers Association – in the Yilo/Manya Krobo area is also recommended as it provides all manner of care services to OVC, including education, food, health, socio-emotional and recreational care

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oral traditions of the operators rather than documented data on the children and activities of the homes and institutions. For the purposes of efficient and effective planning for the institutions, and easy availability of data for other stakeholders, the institutions must be trained in scientific records management practices.

Long term plan for the care of OVC should rather focus on care of OVC in natural families. This could relieve the state and the Department of Social Welfare of many responsibilities, and the children would be brought up in natural environment like any other child in society. In this light, it is recommended that, the concept of outreach ministry, where OVC are supported to be brought up in their natural home environment must be thoroughly explored, facilitated and encouraged by the DSW. Besides, the income earning capacities of households caring for OVC must be enhanced through special income generating projects and skills/technical training for alternative sources of livelihood.

There is also the need for community sensitization for the plight and care of OVC, and the integration of traditional leaders and structures, and religious bodies to support the course of care for the OVC outside institutional homes.

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About CSPS

The Centre for Social Policy Studies (CSPS), University of Ghana was established to provide research and training in social policy issues in Ghana. The Centre has been involved in studies related to social protection, human capital, social mobilisation for development and livelihoods. The Centre is located in the Faculty of Social Studies building, University of Ghana

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