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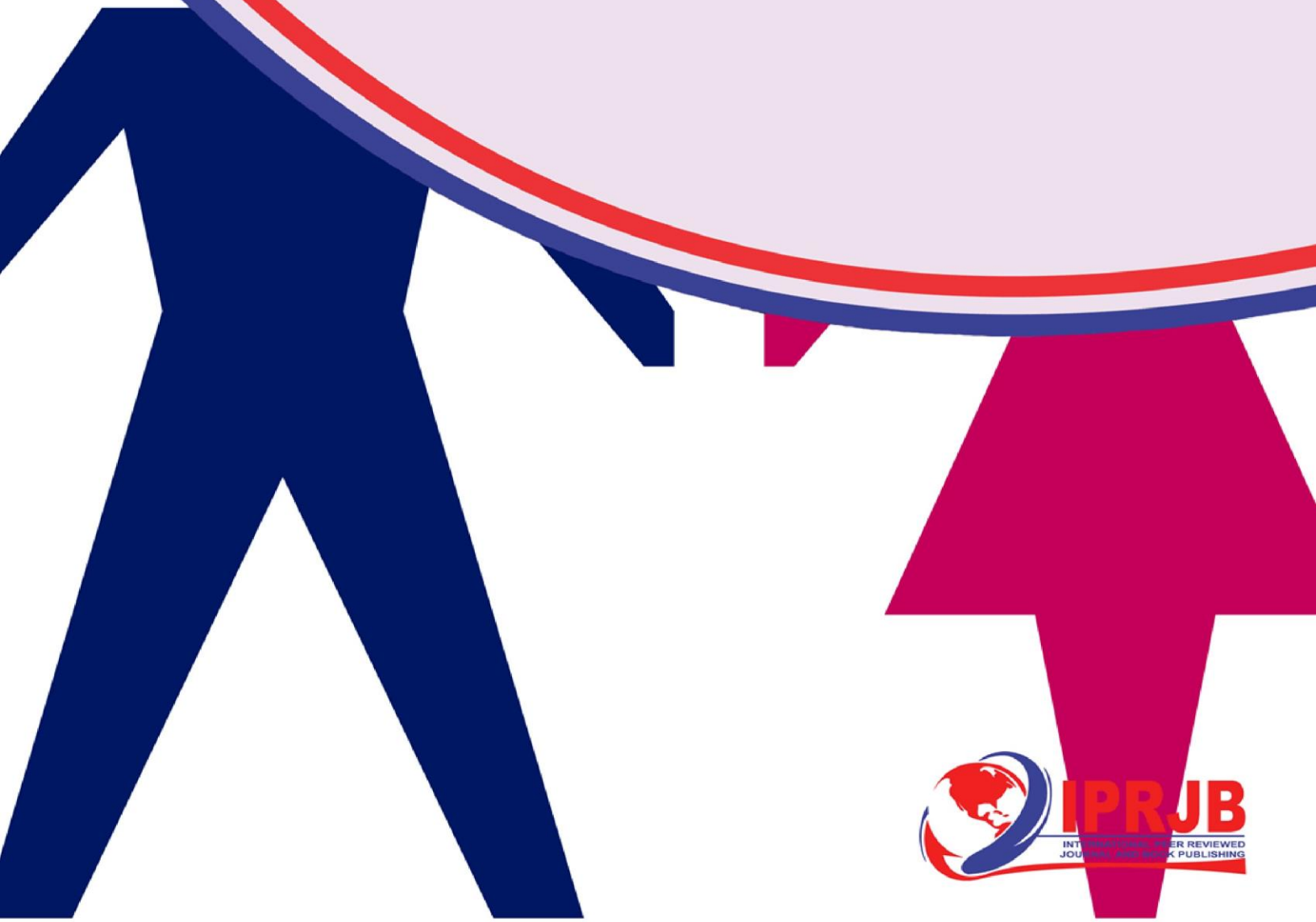
Dorcas Nthenya Kibachio and Dr. Pius Mutuku Mutie



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EFFECTIVENESS OF THE VARIOUS OVC CARE AND SUPPORT PROGRAMMES ON THE IMPROVEMENT OF QUALITY OF LIFE OF OVC IN EMBU COUNTY

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Abstract

Purpose: To find out the effectiveness of the various OVC care and support programs on the improvement of quality of life of Orphans and Vulnerable children in Embu County.

Methods: This study adopted a descriptive research design. The study aimed at interviewing the 3 managers in NGO programs dealing with orphans, 7 chairpersons from CBO, FBO or a SHG supporting orphans, 5 additional group members and 20 caregivers, holding 2 focus group discussions and 4 case studies. The study used both qualitative and quantitative research methods. The responses to every question in the filled questionnaires from the respondents were edited, tabulated, analyzed and computed to percentages by use of a Statistical Package for Social Sciences (SPSS) version 20.0. Descriptive statistics such as mode, mean, percentages, standard deviations and correlation coefficients were computed and information presented in form of tables and frequency distributions.

Results: The study noted the importance of the contribution of NGOs to orphan care, but these NGOs have financial constraints and cannot adequately cover or expand to other areas. These organizations already exist at the community level and if their funding is increased there would be no need for government to establish new structures and employ new staff. The study also highlighted another important factor in the care of OVC. In Embu, there was strong community involvement in the care of OVC, with individuals and community organizations, including the commercial sector, contributing to the care of OVC.

Unique contribution to theory, practice and policy: The study recommends that Government should use this model to sensitize other communities to take care of orphans in their localities. This would contribute to making OVC care sustainable.

Key words: *Effectiveness, care, support programs, orphans.*

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1.0 INTRODUCTION 1.1Background of the study

In 2003 the UN estimated the total number of orphans to be over 43 million that is 12.3% of all children in the region. This is an increase of over 1/3 since 1990. The highest concentrations of orphans are in countries that have a high HIV prevalence level or recently have been involved in armed conflict. Even though children lose their parents for many different reasons, the issue of HIV/AIDS is hard to avoid when talking about orphans and vulnerable children. It is the leading killer worldwide of people between 1549 years old and orphan hood is the most visible and measurable impact this disease have on children‟s lives. The numbers of orphans in the world would be declining if it were not for HIV/AIDS (UNICEF, 2004) and by 2008 UNICEF estimates the number of children orphaned by AIDS in Sub-Saharan Africa to reach 15.7 million, nearly twice as many as by 2001. The UN states that "the worst is yet to come", as young adults now living with HIV eventually develop AIDS and die, they will leave behind large number of orphans (UNICEF, 2008; UNICEF, 2003). The number of orphans generally increases with age, hence older orphans greatly outnumber younger ones (UNICEF, 2004). These children suffer long before they lose their parents. They may miss out on their education as they may be taken out of school to care for their sick parents. This is especially a problem for girls as they are often the first ones to be given the responsibility of caring for the sick. Studies show that in addition to be deprived of their education, these children often live in households with less food security and have a higher risk of suffer from anxiety and depression. Orphaned children may also be forced to relocate and in this process lose their social networks and the community they are familiar with (UNICEF, 2008). There is no doubt that the children orphaned by AIDS and the problems they face needs attention and solutions. However, this focus on children orphaned by AIDS has put the sufferings of orphans of other reasons in the shadow (Foster, 2005), as donor and aid campaigns have often been directed at solely helping children orphaned by AIDS. This study does not make any distinctions between orphans and vulnerable children of AIDS and orphans and vulnerable children of other reasons.

The vast majority of children orphaned in Sub-Saharan Africa are cared for by the extended family system, a coping mechanism that have cared for orphans and vulnerable children, aged people and disadvantaged family members for generations. However, the extended family system is overburdened by poverty, as households who take in orphans are likely to become poorer, and due to the huge number of orphans in need have care. Studies show that the biological ties to the caregivers are an important factor in how the orphans are treated. Children taken in by their extended families risk living in households that are already overburdened and where they are really not welcome (Foster, 2005). This increases the children‟s risk of being neglected, abused or exploited. Ahiadeke (2003) also points to the discrimination and stigmatization that follows orphans and vulnerable children, especially orphans of AIDS, as another reason for rejection by the extended families. All this combined leaves many children to fend for themselves and they often end

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up as street children as they migrate to urban areas in order to survive. The problems and dangers street children are at risk of facing are many, such as malnutrition, sexually transmitted diseases (such as HIV/AIDS), drug and alcohol abuse, prostitution, sexual abuse and violence (Ahiadeke, 2003).

According to the financial year 2008/09 Country Profile, Kenya"s national HIV prevalence among adults (ages 15-49) was 4.9 percent, adults and children (ages 0-49) living with HIV at the end of 2007 was 1.1 million, AIDS deaths (adults and children) in 2007 was 73,000, and AIDS orphans at the end of 2007 was 1.1 million (UNAIDS, Report on the Global AIDS Epidemic, 2008). According to a report by International Children and HIV/AIDS symposium, 2008, the number of OVC in Kenya has increased from 1.8 million in 2004 to 2.4 million in 2006 Through the U.S. President"s Emergency Plan for AIDS Relief (PEPFAR) grant to various Non-Governmental organizations in the country, 533,700 Orphans and Vulnerable Children (OVC) were served by an OVC program. It is important to look at aspects of Quality of Life (QoL) of this group of children because this time in their life is a determinant of how their adult life will be. A problematic and difficult childhood will most likely result in a troubled adulthood. Children who do not get the care and safety that only primary caregivers can provide are more vulnerable to health risks, violence, exploitation and discrimination (UNICEF, 2004). The importance of Quality of Life studies cannot be overestimated. Virtually every government and development sector would be interested in the impact of its initiatives on people"s standard of living and essentially their Quality of Life. Results of such studies can be used to enable people, as far as possible, achieve their goals and choose their ideal lifestyle.

1.2 Statement of the problem

A child who loses one or both parents to AIDS might also be infected with HIV. Orphans often find themselves battling the very disease that took their parents. Orphans are also at greater risk of malnourishment and stunted growth. Young orphans, healthy or not, are often forced into adult roles long before they should be. An eldest child who loses parents to HIV/AIDS might carry the heavy responsibility of caring for brothers and sisters. The loss of one or both parents has serious consequences for a child"s access to basic necessities such as shelter, food, clothing, health and education (Greig & MacKay, 2007). Many Orphans find they need to contribute financially to the household, in some cases driving them to the streets to work, beg or seek food. AIDS orphans often leave school to attend to ill family members, work or to look after young siblings. Many children already function as heads of households and as caregivers and need to be supported as part of the solution.

Despite the fact that children orphaned by AIDS are the most vulnerable group affected by AIDS, they have received little attention, both in terms of sectoral plans and practical programs. This is partly due to the lack of knowledge of their actual numbers, and as a consequence their living conditions and needs have not been focused on. Research with children has for a long time not been the focus of attention in geography or any other social

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science. Children have mainly been a part of research projects where the focus has been on more "important" themes, such as education and family. These traditional ways of doing research have been criticized for doing research on children, rather than with children. The focus has also been on adult interests and the research built on adults assumptions (Hood et al. 1996; Valentine, 1999). Hence, children have not been given a real opportunity for their voices to be heard (Oakley, 1994; Christensen & James, 2008).

This is now changing with the emergence of the new social studies of childhood where children are seen as competent social actors, as beings in their own right (Christensen & James, 2008, James et al, 1998, Qvortrup et al, 1994). Children are in this line of thought no less able or competent than adults (Holloway & Valentine, 2000). They are the experts of their own lives and it is necessary find meaningful ways of communicating with them (Christensen & James, 2008). It analyses aspects of the children's quality of life based on a basic needs approach, supplemented by a subjective well-being approach. One of the basic assumptions of this study is that aspects of the children"s quality of life vary according to the material and social structures and supplies of the homes where the orphans and venerable children live.

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

According to Nyambedha (2006), providing care and support for OVC is one of the biggest challenges Kenya faces today, as the growing numbers overwhelm available resources. AIDS, fuelled by high poverty levels, is one of the main contributors to OVC incidence in Kenya. Understanding the magnitude of the problem and socio-demographic characteristics of OVC can provide the foundation for building programs of appropriate design, size and scope. Adult HIV prevalence in Kenya is estimated by UNAIDS to be between 7.1% and 8.5%; and 150,000 to 180,000 children are estimated to have the virus. The most recent modeling of sentinel surveillance data indicates that HIV prevalence stood at 5.1% among adults at the end of 2006 compared with 10% in 1997/98. Gitobu (2012) studied implications of cash transfer programmes for social relations:

Kenya"s Cash transfer for orphans and vulnerable children. The study found that the programme has resulted in social capital gains within beneficiary communities; it has also had perverse effects that have simultaneously engendered threats to social cohesion. The negative outcomes are largely seen to emanate from programme processes, particularly the

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small percentage of households targeted. Ultimately the study highlights the necessity for directing focus towards a comprehensive social protection system with a universal orientation to maximise benefits of transfer programmes. Meanwhile, there is need to expand the evaluative space to take cognizance of the range of impacts engendered by such programmes, including relational outcomes.

Muyanga (2014) studied factors influencing the implementation of social transfer programmes in Kenya: a case of orphans and vulnerable children cash transfer in Nginda location, Embu west district. However, it was found out that resource allocation posed a major challenge to the implementing agency as resources allocated did not match the size and growth of the programme. The amount of money transferred to caregivers should be reviewed regularly depending on market prices of goods and services and that transfer benefit should not be standard for all household but should be pegged on individual household needs and the number of children a caregiver is taking care of. From the local studies little has been done on effectiveness of the various OVC care and support programmes on the improvement of quality of life of OVC in Embu County.

1.3 Objective of the study

To assess the effectiveness of the various OVC care and support programmes on the improvement of quality of life of Orphans and Vulnerable Children in Embu County.

2.0 LITERATURE REVIEW 2.1 Children and Childhood

The Convention on the Rights of the Child (CRC) defines a child as "every human being under the age of eighteen years, unless under the law applicable to the child, majority is attained earlier". The CRC was presented by the UN in 1989 and even though a Human Rights Convention already existed there was a growing understanding that children as a group are in need of special attention and protection. The Convention on the Rights of the Child (CRC) incorporates the full range of human rights such as civil and political rights as well as economic, social and cultural rights of all children. The CRC outlines in 41 articles the human rights to be respected and protected for every child under the age of 18 years and requires that these rights are implemented in the light of the convection"s four guiding principles; non-discrimination, best interests of the child, survival and development, and participation of the child (Kälin, Muller, & Wyttenback, 2004).

Child Rights Provisions in the Kenya Children"s Act Part II Section 3 and 4 of the Children"s Act states that: The government shall take steps to the maximum of its resources with a view to achieving progressively the full realization of the rights of the child. Section 4(1) further states that: Every child shall have an inherent right to life and it shall be the responsibility of the government and the family to ensure the survival and development of the child. Section 5 of the Children"s Act addresses the issue of nondiscrimination and states that: No child shall be subjected to discrimination on the ground of origin, sex, religion of birth, social, political, economic or other status like disability. The new

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sociology of childhood claims that the concept of childhood is a social construction which varies across cultures and societies. Hence, its meaning and contents varies across time and space (James & Prout, 1997). In the Western societies childhood has become more or less synonymous with the first eighteen years of human life. This age-set criterion and the contents of childhood vary with what expectations and responsibilities a specific culture or society puts on a child.

Childhood is not just a word to describe certain years of the human life. UNICEF (2005), claims that the concept of childhood also "refers to the state and condition of a child"s life: to the quality of those years", (UNICEF, 2004). Poverty is a factor that can affect children"s childhood in a profound way. Children that live in poverty and that are denied access to basic needs like proper food, shelter; sanitation facilities and education are denied their childhood. Poverty can force children into early adulthood. Where a child's contribution to the family household is absolutely necessary for survival, the child can be forced to "grow up" much faster than its peers. Poverty can create social differences of childhood within a society, where children from better off families are given the opportunity to "be a child" longer than their peers from poorer families.

2.2 Caring for Orphans

Traditionally in Africa, orphans have always been absorbed within the extended family structure and raised as children of those families. But now extended families are struggling to cope, according to (Nyirenda, 1996) this is largely because of the overwhelming number of deaths due to HIV/AIDS, economic changes which have led active young people to leave, and the fact that many middle-aged people have died, leaving the old and the young to care for children. Most households caring for orphans and vulnerable children, including child-headed households, receive little or no support from their families, communities or the state, largely because resources are so limited. Community support is usually confined to one-off donations or handouts rather than routine, long-term care and support. Households that are already marginalized and urban households without extended family networks often receive the least support.

Orphaned children experience changes in their lives; some are moved from town to the rural area and vice versa, others remain in their rural homes and move in with their relatives, while others remain in their actual home and the eldest child becomes the caregiver (Heidi & Heidi, 2001). This can be very difficult for children who are grieving. Some may have to leave school because there is no money for fees and uniform. Losing a parent to AIDS can bring stigma to children, they lose self esteem; can lead to poor results in school, bad behavior or depression. Some children are stigmatized for being HIV-positive or being thought to be because of their parents" illness. Other children can be very cruel to a child that they think is different. Guardians often report that orphans are very quiet and sad. Some families take on orphans and mistreat them. The children may have to do all the heavy work and may be abused or neglected by members of the family.

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2.3 The Basic Needs Approach (BNA)

Needs are necessities that are lacking in people‟s lives. Meeting needs are the requirement for human survival and for people to be able to live decent lives. Needs are often divided into fundamental or basic needs and wants. Wants are not essential for human survival, but can have implications for people‟s quality of life (Næss, 2009). The
BNA emerged in the mid 1970‟s with the realization of the failure of the mainstream development approaches‟ ability to solve various problems in the developing world. “It has become increasingly evident, particularly from the experience of the developing countries, that rapid growth at the national level does not automatically reduce poverty or inequality or provide sufficient productive employment

The BNA attempts to define the absolute minimum standards for a decent and acceptable life. The main idea is that everyone should have the same chance of living a decent life and the ultimate goal is to eradicate mass deprivation (Streeten, 1981). However, the objective of the basic needs approach have not been the issue of controversy, but the content of the term basic needs have been, and still is heavily debated; What constitutes basic needs and what makes them different from other needs? The BNA assumes that some factors are more prominent, or more basic, than others. The basic needs are the preconditions for a minimally decent life. In other words, people have to have access to enough food, good health and enough education as to be able to enjoy other aspects of life (Stewart, 1996). This is however no easy and straightforward definition. The term basic needs is difficult to define as human needs vary across both time and space. Human needs vary between individuals, among societies and across generations. What people perceive as needs is very much determined by their expectations and aspirations. What were previously considered luxury items might now be necessities. What people perceive to be a minimally decent life is culturally and historically specific.

The most minimalist BNA, basic goods, have a rather limited list of factors that are perceived as necessary for a decent life; nutrition, health and some level of educational attainment. The justification for using these three factors is threefold; first, they are most likely to reach universal agreement as the most essential human needs. Second, they can be seen as preconditions for the enjoyment of other aspects of a full life. Third, they are relatively easy to identify and measure, as there exists international indicators on life expectancy, child malnutrition and educational attainment to be used as proxy measures (Philips, 2006; Stewart, 1996). Other and slightly broader lists of what to include under the term basic needs exists and include adequate nutrition, health, shelter, water and sanitation, education and “other essentials.

In low-income countries these needs contribute to the quality of life even though culture and the level of comparison and personal preferences influence such assessments. In developing countries like Kenya where the majority of people struggle every day to have their needs for survival met, it is relatively easy to identify and classify what constitute

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their basic needs. It is also worth noting that any opportunity for personal fulfillment is reliant upon the choices available and the knowledge of these. When people do not even have their most basic needs for survival met, it is futile to talk about self-fulfillment needs. In this study the focus is both on basic needs (food, shelter, clothing, education and health), but also on safety and social needs. The basic needs approach offers an opportunity to set some relatively clear and specific terms for measuring the quality of life.

2.4 Theoretical Perspective

The study was based on the theory of structuration developed by Anthony Giddens. Understanding the underlying structures in a society and what impact the actions of the agents have on these, is important when trying to understand fundamental problems in a society. The theory of structuration as developed by Anthony Giddens (1995) emphasizes the concepts of "structure" and "agency" and how these work to recreate and reshape each other. The main idea of Giddens" theory is the duality between "agency" and "structure"; structures shape practices and actions and these can again create and recreate social structures (Gatrell, 2002).

The theory of structuration is relevant to the problem under consideration because it is essential in understanding how the material and social structures and supplies that surround the children in the study areas affect aspects of their quality of life. The theory of structuration also gives room to see the children as competent social actors that act as individuals rather that a homogeneous group. The children are not passive objects under the structural constraints that surround their lives (Giddens, 1995). Resources provided by the homes intended to benefit all the children equally, can be redistributed due to hidden hierarchies among the children and create differences in aspects of their quality of life.

3.0 RESEARCH METHODOLOGY

This study adopted a descriptive research design. The study aimed at interviewing the 3 managers in NGO programs dealing with orphans, 7 chairpersons from CBO, FBO or a SHG supporting orphans, 5 additional group members and 20caregivers, holding 2 focus group discussions and 4 case studies. The study used both qualitative and quantitative research methods. The responses to every question in the filled questionnaires from the respondents were edited, tabulated, analyzed and computed to percentages by use of a Statistical Package for Social Sciences (SPSS) version 20.0. Descriptive statistics such as mode, mean, percentages, standard deviations and correlation coefficients were computed and information presented in form of tables and frequency distributions

4.0 DATA ANALYSIS, PRESENTATION AND INTERPRETATION.

4.1 OVC opinion about the types of support they have received

Majority the OVCs 27.6% indicated that the care and support they had received was fair, 5.3% indicated that it was inadequate while 1.8% indicated that it was very bad.

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4.2 Membership to a care group

All the caregivers indicated that they were members of different OVCs care groups. They further cited that about 13.3% groups had between 2 to 10 members while 86.7% indicated the members were between 21 to 30 members. The sizes of groups were found to be manageable.

4.3 Benefits from being a member care group

The care givers were asked to indicate the benefits accrued by being a member of OVCs support groups. Majority of them (64.0%) indicated that they have gotten psychosocial support, 26.0% cited group business while 10.0% indicated that they have access IGA grants.

4.4 Influence of education support

Due to education support received from OVC programs, 48.0% of OVC have been able to attend classes continuously, 73.7% have improved their performance, 8.6% are not being chased from school and 1.5% was able to return to school after dropping out.

4.5 Influence of food and nutritional support

The influence of food and nutritional support on ability to access balance diet 2-3 time a day was found to be (40.4%) which caused majority of OVC to feel more healthier while others indicated the food supply was continuous.

4.6 Influence of shelter and care support

Of the OVCs who had accessed shelter support, 31.3% felt that the house does not leak during rainy season, 16.2% indicated that they now have a private room, especially the boys who were grown up and felt that they needed to move from the main house, while 21.2% felt that they now have enough space in their house.

4.7 Influence of psychosocial support

Of the OVC who had accessed psychosocial support, 72.7% of them felt loved, appreciated and taken care of, 12.6% don‟t feel discriminated while 21.2% now interact freely and openly with other children.

4.8 Influence of health care support

Of the OVCs who had accessed health care support, 33.8% indicated that they don‟t get sick often while 60.6% felt that now know where to get health services when they require them. The table below summarizes the findings.

4.9 Influence of legal protection support

Of the OVCs who had accessed protection support, 40.9% were impacted on knowledge of where to get assistance, 44.9% have acquired knowledge on their rights and 25.8% are not abused any more.

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4.10 Influence of economic strengthening support

As a result of care givers involvement in IGA, 23.7% can now earn some income while 22.7% can provide better for their family. To supplement house hold income, majority of the care givers indicated that they were involved in business which are micro in nature and generate very little income to sustain the family needs. However, this business helped OVCs in buying clothes, food, paying school fees, books and medication. This business includes e.g. selling sugarcane to passersby, selling fruits, grocery etc. Due to age and health status of some of the care givers, they could not be involved in any form of business.

Table 1: Influence of economic strengthening support

	Variables	Items	Percentage
a	OVC opinion about the types of support they have received:	Very bad	14.8%
		Inadequate	29.3%
		fair	37.6%
		Very good	18.3%
b	Membership to a care group	2 to 10	13.3%
		21 to 30	86.7%
c	Benefits from being a member care group	Gotten psychosocial support	64.0%
		Group business	26.0%
		access IGA grants	10.0%
	Influence of Educational support received (Attend school continuously)	Has benefited	48.0%
	Perform better in exams	Has benefited	73.7%
	Not chased from school nowadays	Has benefited	8.6%
	Returned to school (incase child had dropped out of school)	Has benefited	1.5%
	Eat 2-3 (balanced diet) times a day	Has benefited	40.4%

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Feeling healthier than before	Has benefited	51.5%
Have continuous supply of food	Has benefited	22.7%
Influence of Shelter and Care support received. (Have a house that doesn‟t leak water & wind (from roof, walls)	Has benefited	31.3%
Have a private room of my own	Has benefited	16.2%
Have enough space in our house	Has benefited	21.2%
Influence of Psychosocial Support received (Feel loved, appreciated, taken care of	Has benefited	72.7
Don‟t feel discriminated (from adults and children)	Has benefited	12.6
Interact freely and openly with other children	Has benefited	21.2
Influence of Health Care support received (Reduced incidences of sickness)	Has benefited	33.8
Acquired knowledge of where to get health services when required.	Has benefited	60.6
Influence of Protection support received (Acquired knowledge of where to get assistance)	Has benefited	40.9
Acquired knowledge on rights	Has benefited	44.9
Ability not to be abused any more or less abused	Has benefited	25.8
Influence of economic strengthening support received (Earn some income)	Has benefited	23.7
Provide better for the family	Has benefited	22.7

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Case Study: Pherisina Muthoni

My name is Pherisina Muthoni, I am 53 years old. I am a caregiver from Kibugu location, Embu district. I‟m a member of Makena Care group which cares for OV C. I take care of three children, 2 boys and one girl. They are my grand children, I started taking care of them 5 years ago when my son and his wife died of "that disease" (AIDS). They fell ill for a long period, my son died first then his wife died four months later. Since they were staying in Embu town I had to take in their children. I am old now and not strong enough to go and fend for these children, so I joined a group of other women in the village who have such children in their homes. We get money through merry-goround and also the church helps us with food and school uniform. I have a small farm so during the planting season, some younger women from our village come and help me to till and plant. The farm gives us cereals which we are able to use for food and sell some to pay part of my grand children‟s school fees. In 2009 an organization by the name World Concern came to our village and trained us on how to care and support orphans, this training helped me a lot because it gave me new information about orphans that I dint know before now am able to understand my grand children better. World concern gave my each of my group members‟ one sheep. My sheep has helped her with manure which I use on my small kitchen garden where I have planted onions, kales, spinach, and French beans. I also have a nursery tree bed in my shamba, where each group member contributes two trees per month to the group so we can sell them to the forest department who come round our village to but trees, the money is used in group IGAs which go a long way in helping us the group members. My sheep has given birth to kids and now I have 3 more sheep from the one I was given. When I sell the produce from my shamba, I get money to feed my children, buy cloths and pay school fees. I am is currently harvesting and selling French beans. Farming has proved to be beneficial to me. With the support world concern gave me I intend to put more efforts in faming because there is a seasonal river that flows through Shamba and I can tap some water and do irrigation farming.

Her biggest challenge is lack of enough capital, because farming requires a lot of manure, fertilizer and pesticides. The support I received from World Concern, my group members and my neighbors has strengthened me and my grand children, we are able to work together and make ends meet in the family.

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The above case is an indication of the plight of elderly caregivers. They are obliged to take in their grand children after their parents die. Some of the elderly caregivers are old and weak such that they are not able to fend for the young children in their care. They are struggling without support to meet their children‟s basic needs for food, clothing, education, housing and medical care. When these needs are not met, their opportunities diminish and the vicious cycle of poverty sets in. However with the help of the community members and other organization, the caregivers are strengthened economically through supporting agricultural production hence preventing malnutrition, promoting informal rotating savings and credit associations and provision of small grants for income – generating activities. Community members and trained volunteers who visit and help the caregivers provide psychosocial care. Most OVC are traumatized and stressed by the loss of a parent, early intervention is vital and they should be given an opportunity to express their feelings. Caregivers also have psychosocial needs too which should be met to enable them provide the best possible care and support to orphans and affected children.

5.0 SUMMARY, CONCLUSION AND RECOMMENDATION 5.1 Summary

The study noted the importance of the contribution of NGOs to orphan care, but these NGOs have financial constraints and cannot adequately cover or expand to other areas. Constraints include shortages of manpower, transport and finances. They are also unable to cover some aspects of their core mandate. Since government cannot sufficiently provide services for OVC across the length and breadth of the country it is important to support these NGOs. These organisations already exist at the community level and if their funding is increased there would be no need for government to establish new structures and employ new staff.

5.2 Conclusion

In Embu there was strong community involvement in the care of OVC, with individuals and community organisations, including the commercial sector, contributing to the care of OVC. Government should use this model to sensitize other communities to take care of orphans in their localities. This would contribute to making OVC care sustainable.

5.3 Recommendations for NGOs

1. Develop programmes that focus on strengthening the capacities of families and caregivers rather than targeting vulnerable children only.
2. Develop programmes with approaches to providing care for orphans that are socially and culturally acceptable as well as appropriate to the needs of the children.
3. Document best practices in OVC programming and duplicate them where applicable to achieve a more lasting impact.
4. Work with local leaders and community groups to identify ways to increase access to health care for the most poor and vulnerable children and households.

5. Ensure that caregivers especially grandparents and older children, know how to access the services they provide.
6. Identify and train community volunteers who can identify and enroll the right children in the OVC programmes.
7. Conduct participatory monitoring with all partners so as to identify the impact of their interventions and improve their services and carry on best practices.
8. Get help from community leaders in involving men, especially grandfathers, older boys and widows who are acting as caregivers in caring and supporting OVC under their care.
9. Promote small-scale, community-based agriculture and food processing to improve household food security, as it offers increased food, employment and income.
10. Empower local communities to solve their own food and nutrition problems, by strengthening agricultural extension services.
11. Have programmes that take into account all the needs of the child in a holistic manner and avoid specialization in services. This ensures that all children"s needs are met.
12. Identify, strengthen and use existing community structures to implement OVC projects and help children remain in the community.
13. Identify areas requiring special skills and provide basic training; for example health care, income generation e.t.c
14. Work with communities to identify resources and services available to them and jointly plan how to use them.
15. Come up with OVC programmes together with the community that do not require ongoing external support or equipment that is expensive or difficult to repair.

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