Universidade do Minho
Instituto de Ciências Sociais

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HIV/AIDS Generation Nexus: Gender and Provision of Safety net for Orphans and Vulnerable Children (OVC)

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HIV/AIDS Generation Nexus: Gender and Provision of Safety net for Orphans and Vulnerable Children (OVC)

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Trabalho efectuado sob a orientação dos
Professora Doutora Paula Cristina Almeida Remoaldo
Professor Doutor Samuel Agyei-Mensah

Julho de 2012

DEDICATÓRIA

I decided long ago,
Never to walk in anyone's shadows,
If I fail,
If I succeed,
At least I'll live as I believe,
No matter what they take from me,
They can't take away my dignity.

Education is our passport to the future, *for tomorrow belongs* to the *people who prepare for it* today

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RESUMO

Os objetivos principais deste estudo foram avaliar a situação das crianças órfãs e vulneráveis (OVC) em Manya Krobo, o território que apresenta a maior prevalência de HIV no Gana, e a viabilidade do trabalho desenvolvido pela rede existente das Queen Mothers. Embora alguns pesquisadores tenham estudado aspectos desta rede, esta é a primeira tentativa de caracterizar de forma holística o papel central das mulheres como elemento de mediação na construção de relações entre as gerações. Usando o conceito de empowerment e a triangulação entre agência, relação e estruturas, que se refletem nas relações e na construção da capacitação envolvendo as Queen Mothers, cuidadores e OVC é sublinhada a sua relevância para a integração social das OVC. Para estudar os papéis dos diferentes intervenientes foram usados métodos quantitativos e qualitativos. Os resultados indicaram que os cuidados às OVC são essencialmente do foro feminino, culturalmente adequados e proporcionam capacidade de liderança às mesmas. Os resultados revelaram ainda que este projecto tem contribuído para romper a cultura do silêncio em torno do HIV/SIDA e para a destigmatização da doença no território estudado, ajudando as crianças afectadas a levar uma vida normal, bem como, a obterem assistência.

Todavia, os resultados indicaram lacunas relevantes em relação à eficácia e eficiência do projecto, devido à existência de cuidadores idosos, debilitados, com ausência de competências em gestão de projectos, e pouca consciência dos desafios modernos da parentalidade. Estes elementos constituem um grande risco para o resultado do projeto a longo prazo. Embora não tenha sido possível provar que as mudanças positivas na vida das OVC e o empoderamento das mesmas são atribuíveis principalmente ao trabalho desenvolvido pelas Queen Mothers, não pode ser provado que o trabalho não tem sido relevante. As barreiras existentes devem ser superadas para permitir obter todo o potencial, se o projeto é para continuar a existir como uma rede de segurança e uma ligação geracional.

ABSTRACT

The purpose of this study was to examine the situation of orphans and vulnerable children (OVC) in Manya Krobo, an area with the highest HIV prevalence in Ghana and the viability of a safety net module operated by the Queen Mothers. Though some researchers had studied aspects of this system, this is the first attempt to holistically characterise the central role of traditional female rulers as the mediating factor in building relationships between generations. Using the concept of empowerment, the triangulation of agency, relation and structures as reflected in the connections and capacity-building processes involving the Queen Mothers, caregivers and the OVC was argued out stressing its relevance to social integration and building one's self-esteem. A blend of quantitative and qualitative methods were used to conduct study among the OVC, caregivers and the Queen Mothers to determine their roles and their relevance, efficacy and efficiency to the overall success of the project. The results indicated that it is relevant, care is feminised, and it is culturally appropriate and provides transformational leadership. The analysis revealed that this project contributed to breaking the culture of silence around HIV/AIDS and de-stigmatized the disease in the traditional area which is helping those affected to enjoy normal life as well as getting assistance. The results indicated many gaps in efficacy and efficiency such as weak and elderly caregivers, lack of exit strategy, lack of project management skills, weak managerial system and financial position, and overall lack of awareness of the range of modern day parental challenges which pose great risk to the long term outcome of the project. Although one cannot prove that the favourable trend changes in the lives of OVC and conservative level of empowerment of PLWHA and OVC are attributable solely or even mainly to the initiative of the Queen Mothers, it cannot be proved that it has made no contribution either. These barriers enlisted must be overcome to derive the full potential if the project was to continue to serve as a safety net and a generation nexus.

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LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
AU	African Union
BCC	Behaviour change communication
BCG	Bacillus calmette-guérin
BECE	Basic Education Certificate Examination
CBI	Community-based intervention
CBO	Community-based organisation
CDD-Ghana	Centre for Democratic Development Ghana
CD4	Cluster of Differentiation antigen 4
CHRAJ	Commission on Human Rights and Administrative Justice
CRS	Catholic Relief Services
DFID	Department for International Development (UK)
DHMT	District Health Management Team
DMHIS	District Mutual Health Insurance Schemes
DNA	Deoxyribonucleic acid
DOVVSU	Domestic Violence and Victim Support Unit
DPT	Diphtheria, pertussis and tetanus
DSW	Department of Social Welfare
EEZ	Exclusive Economic Zone
EQUIP	Educational quality improvement programme
FCUBE	Free compulsory universal basic education
FGD	Focus group discussion
FGM	Female genital mutilation
FHI	Family health international
FSW	Female sex workers
GARFUND	Ghana AIDS Response Fund
GDHS	Ghana Demographic and Health Survey
GDP	Gross domestic product
GES	Ghana Education Service
GHS	Ghana Health Service
GLSS	Ghana Living Standard Survey
GMA	Ghana Medical Association
GMMS	Ghana Maternal Mortality Survey
GPRS	Growth and poverty reduction strategy
GSS	Ghana Statistical Service
HBC	Home-based care
HDI	Human Development Index
HIV	Human immunodeficiency virus
HOPE	HIV/AIDS OVC and PLHIV Care, Support and Economic Enhancement Programme
IDA	International Development Association (World Bank)
IDI	In-depth interview
IEG	Independent Evaluation group (World Bank)
JHS	Junior High School
MDG	Millennium Development Goal

MKQMA	Manya Krobo Queen Mothers Association
MMDAs	Metropolitan/Municipal/District Assemblies
MMR	Maternal Mortality Ratio
MOWAC	Ministry of Women and Children's Affairs
MSM	Men who have sex with men
PHRL	Public Health Reference Laboratory
PMTCT	Prevention of mother-to-child transmission
NACP	National AIDS/STIs Control Programme
NDC	National Democratic Congress
NDPC	National Development Planning Commission
NGO	Non-governmental organisation
NHIA	National Health Insurance Act
NHIS	National Health Insurance Scheme
NPA	National Plan of Action
NPP	New Patriotic Party
NREG	Natural resources and environmental governance
NSPS	National social protection strategy
OAU	Organisation of African Unity
OIC	Opportunities Industrialization Centre (Ghana)
OICI	Opportunities Industrialization Center International
OVC	Orphans and vulnerable children
PHRL	Public Health Reference Laboratory
PLHIV	People Living with HIV/AIDS
PLWHA	People Living with HIV and AIDS
PTSD	Post Traumatic Stress Disorder
RNA	Ribonucleic Acid
SCOPE	Strengthening Community Participation for the empowerment of OVC
SHARPER	Strengthening HIV/AIDS partnership with evidence-based results
SHS	Senior High School
SPSS	Statistical Package for Social Science
SSA	Sub-Saharan Africa
TVET	Technical and Vocational Education and Training
USAID	Unite States Agency for International Development
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNCLOS	United Nations Convention on the Law of the Sea
UNCRC	United Nations Convention on the Rights of the Child
UNDESA	United Nations Department of Economic and Social Affairs
UNDP	United Nations Development Programme
UN ECOSOC	United Nations Economic and Social Council
UNFPA	UN Population Fund (once United Nations Fund for Population Activities)
UNICEF	United Nations Children's Fund
UU-UNO	Unitarian Universalist United Nations Office
UWG	United Way Ghana
VCT	Voluntary counselling and testing
WASSCE	West Africa Senior Secondary Certificate Examination
WHO	World Health Organisation

INTRODUCTION

Ever since the first report of Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) diagnosis in Ghana in 1986, there has been a significant shift in the HIV/AIDS programme. From the 1990s, the programme has broadened from the almost exclusive focus on HIV awareness creation and prevention, to include a comprehensive programme on prevention, care and support. According to Antwi and Oppong (2006), the objective was to help families take care of their sick relatives. The activities included infection prevention, administering drugs and providing for spiritual needs of the patients.

Arguably the most neglected crisis spawned by HIV/AIDS pandemic is children affected by HIV as either orphans or vulnerable children (OVC). OVC are being left uncared for and are increasingly becoming disconnected from the care and support intervention opportunities offered by the known social support institutions (Bellamy, 2003). In 2007, an estimated 12 million children in sub-Saharan Africa had lost one or both parents to AIDS and that 8% of children in Ghana had been orphaned by HIV/AIDS between 2003 and 2007 (United Nations, 2009). Using a definition of age 0-17 years as of 2012, it was estimated that at least there are 1,156,320 orphans in Ghana for children who have lost one or both parents due to all causes. It is also estimated that children who have lost one or both parents to AIDS number 168,907 with 36,470 being double AIDS orphans and 101,323 as paternal AIDS orphans. It however projects that the number of AIDS orphans peaked in 2009 at 178,303 and that there would be a decline in the trend of the number of AIDS orphans to 137,578 by 2015 as more PLWHAs survive on ART (NACP, Ghana Health Service, and Ministry of Health, 2011). Regrettably, many more are vulnerable to the same circumstances orphans face even though they may still, for the time being, have at least one of their parents alive.

Accordingly, there is a need for a "nexus" or a connecting point where such people affected by HIV can be helped to refocus and reconnect to a ‘mental and social well-being’ so as to enjoy the highest attainable standard of health and associated opportunities.

The preamble to the World Health Organisation Constitution (WHO, 1946) adopted in July 1946 characterises health as a state of complete physical, mental, and social well-

being and not merely the absence of disease or infirmity. The Buenos Aires Declaration on Primary Health Care in 2007 reaffirmed that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition” (Sorel, 2007: 2). There are many aspirations and envisions contained in the definition. The utmost is that people are the first consideration whether the issue is economic development or socio-cultural as it impacts every aspect of the next generation. When citizens are caring, civil, healthy and productive, the society becomes prosperous, energetic, supportive and liveable. Human investments cannot be completely separated from society’s other important initiatives such as the building of roads, the provision of potable water and the enhancement of educational facilities. However, to achieve a balance, there must be careful and deliberate nurturing, support and encouragement. All citizens irrespective of their background should be provided with the means to achieve their full potential to enable them to identify and realise their aspirations, satisfy needs their, and change or cope with the environment. Hence human investments must be addressed in a way that highlights their importance to the long-term health of the society.

The term orphan and vulnerable child (OVC) is defined as a child under the age of 18 years and belongs to one or more of these categories:

-parents or guardians are incapable of caring for them;

-physically challenged;

-staying alone or with poor grandparents;

-lives in a poor sibling-headed household;

-has no fixed place of abode;

-lacks access to healthcare, education, food, clothing, psychological care;

-no shelter to protect from the elements;

-exposed to sexual or physical abuse, including child labour (UNDP, 2007).

Minimal research works such those by Atobrah (2004), Deters (2008), Lund and Agyei-Mensah (2008), Manful and Badu-Nyarko (2011) among others have looked at the issue of promoting care and support for HIV/AIDS orphans and vulnerable children in Ghana. Even then, they did not scrutinise the living conditions, the empowerment and sustainability of any local initiative. Until recently, little attention was paid to numbers of

orphaned children, either globally or nationally (Ainsworth and Over, 1992; UNICEF, UNAIDS and USAID, 2004; Todres, 2007; Deters, 2008; UNICEF and UNAIDS, 2010). Ghana subscribes to the 2004 “three ones principles”. This calls for one agreed AIDS action framework, one national AIDS coordinating authority, one agreed country-level monitoring and evaluation system. This is attested by the establishment of the Ghana AIDS Commission, a supra-ministerial body with multi-sectoral representation. The development and implementation of the national HIV and AIDS strategic framework in 2001 and orphans and vulnerable children national action plan in 2010 sought to help people affected HIV/AIDS including the OVC. Orphan studies are likely to assume greater prominence when the number of children affected by HIV/AIDS is accurately and consistently quantified. This is likely to examine the implications of community-based support in their upbringing.

Providing care and support for OVC is one of the biggest challenges Ghana faces today, as the growing numbers overwhelm available resources. The aim of this review of literature is to update available evidence on priority OVC topics that lack an adequate evidence base, in order to inform programming and research activities. The reviews so far looked at scale, scope, and impact of AIDS ophanhood and AIDS-caused vulnerability as well as the traditional means of care and support. In Ghana, efforts had over the years focused on five main thematic fields. These are the spread of HIV/AIDS in Ghana, trends in knowledge about HIV/AIDS, sexual behaviour, knowledge and use of condoms, and attitude of adolescents as well as some level of care and support for those affected.

The aim of the current study is to investigate and propose an alternative care and support for OVC. The objectives of the study are to investigate and characterise the demographic profiles of caregivers as well as the social conditions of OVC and caregivers in the study area. Also to investigate and describe the knowledge, beliefs, attitudes and practices with respect to HIV/AIDS among the OVC and their caregivers. Then to evaluate Ghana AIDS Commission’s goal to empower women and vulnerable groups to reduce vulnerability and provide care and support for OVC and other persons affected by AIDS. To assess the effectiveness of a community-organised foster care regarding providing shelter, food, health, and psychosocial support for OVC; and to

establish factors necessary for creating enabling environment to sustain and replicate such a scheme.

The present study examined the attempt by Manya Krobo traditional women leaders called Queen Mothers where the study was conducted and their community members or caregivers to take on the role of providing care for OVC. The aims included the characterisation of the conditions of the Queen Mothers, the caregivers and OVC, the capacity of their project to sustain itself and the implications for the future.

The notion of a stakeholder society for the dispersion of wealth and opportunity, and the creation of an enabling welfare society is the underlying framework for the study. Much of the Manya Krobo Queen Mothers' work involves empowerment which is the process whereby the capabilities of both the caregivers and OVC are strengthened to enable and sustain an expanded, comprehensive response to the HIV/AIDS epidemic. It entails establishing and strengthening networks and linkages, implementing awareness, training and developing human resources. It involves identifying people to be trained, providing guidelines, delivering training that is responsive to their needs, and providing appropriate learning environments, ensuring supervision and mentoring for continued skills transfer. These arrays of objectives and programmes are schematically depicted in Figure 1.2 on chapter one as comprising Agency, Structure and Relations.

i. - Research Problem

Although Ghana is the only country in sub-Saharan Africa that has reached the hunger reduction target of both the World Food Summit and the Millennium Development Goals [MDGs] (FAO, 2008), the same cannot be said of the goal to 'halt and begin to reverse the spread of HIV/AIDS' (UN Millennium Declaration, 2000). Ghana was also the first country to ratify the United Nations Convention on the Rights of the Child (UNCRC) in 1990. Subsequently, Ghana initiated steps to harmonise national laws including the passage of the Children's Act in 1998 (Act 560) as an attempt to affirm its moral and legal obligation towards the survival, development and protection of Ghanaian children. In 2005 and 2007, the National Policy Guidelines on Orphans and other Children made Vulnerable by HIV/AIDS and National Social Protection Strategy (NSPS) respectively were developed to provide safety nets for the vulnerable and excluded groups including

children. Furthermore, a 3-year framework covering 2010-2012 period called National Plan of Action (NPA) for OVC is in operation. The OVC NPA framework is to provide care and support to vulnerable children in care institutions. It sets out time bound goals and objectives and outlines key activities and indicators for measuring progress towards addressing vulnerabilities faced by children in Ghana (Ministry of Employment and Social Welfare and UNICEF, 2010).

Notwithstanding the implementation of the NPA OVC, Ghana acknowledges the increasing need for an overarching social protection framework in which an integrated range of support services and policies focus on community-based family support and livelihoods promotion. Ghana's response to their rising OVC situation includes both the official shift towards deinstitutionalization and towards developing community based approaches (Deters, 2008). In this regard, the legal framework outlines measures to put an end to institutionalisation and provide for OVC in a manner that best reflects the rights of children and to promote a policy where OVC are supported to continue to live with their families within their communities. A community here is geographically [by location] or socially [people with common social attributes and interests] (Maclean, 2006) or HIV-risk [behaviours] (WHO, 2001). Some "communities," such as those of children living and/or exposed to HIV/AIDS vulnerabilities are geographic, social, and behaviours as they share the same location and social conditions. Extended families are caring for 90% of all orphans because many of the most severely affected countries in sub-Saharan Africa have no national policies to cope with the situation. Affected extended families however, are already overstressed and often overwhelmed, and face ever-greater burdens as the number of children without parents spirals upward (Bellamy, 2003). Children and young people in an HIV/AIDS -affected household begin to suffer even before a carer passes away. Household income plummets and many children are forced to drop out of school to care for a sick parent or to earn money (Bellamy, 2003). Ghana's OVC situation, although not as severe as other African nations, has grown due to the HIV and AIDS epidemic and changing migration patterns from rural to urban environments. Other influences include social and economic factors which have caused a growing number of children to require care and support outside of their immediate or extended family home, creating a population of vulnerable children

(Deters, 2008). Taking into account all these facts, we want to answer to the following question, which will be our research question:

How does the environment (cultural milieu) define women's response to the evolving concept of care and support for OVC?

ii. - Main Objective

The main objective of the study was to determine the social, economic, psychosocial conditions and experiences as well as the prospects of OVC and Caregivers and the Manya Krobo Queen Mothers response to the OVC challenge.

iii. - Specific Objectives

The specific objectives of the research were:

1. To investigate and characterise the socio-demographic profiles of caregivers in the study area;
2. To establish the social conditions of OVC and caregivers in the study area;
3. To investigate and describe the knowledge, beliefs, attitudes and practices with respect to HIV/AIDS among the OVC and their caregivers;
4. To evaluate Ghana AIDS Commission's goal to empower women and vulnerable groups to reduce vulnerability and provide care and support for OVC and other persons affected by AIDS;
5. To assess the effectiveness of a community-organised foster care regarding providing shelter, food, health, and psychosocial support for OVC;
6. And to establish factors necessary for creating enabling environment to sustaining and replicating such a scheme.

iv. - Hypotheses of Research

On the basis of the ideas of various writers, we associate the apparent danger to the rights of AIDS orphans and vulnerable children most especially their rights to health, survival, education, psychosocial needs, and freedom principally to:

H1- Intra-household neglect in terms of high malnutrition and reduced access to attention and care;

H2- Low access to health services and high burden of disease; and

H3- Alienation and exploitative survival strategies such as high school drop-out rate and engaging in work detrimental to proper growth due to lack of care and protection.

Therefore, in our view, the basic research task boils down to determining the empirical veracity of these hypotheses within the context of provision of safety net by the community and society at large in Ghana.

v. - Research Methods

We surveyed OVC caregivers organised under the umbrella of the Manya Krobo Queen Mothers Association (MKQMA) to support the OVC using a combination of qualitative and quantitative methods. The study data collection therefore consisted of interviews, observations, interactions and personal experience within an authentic setting. It involved gathering information about the epidemic, its consequences, household and community coping responses, and relevant policies and programmes. MKQMA supported caregivers and OVC beneficiaries responded to structured questionnaires, and participated in key informant interviews and focus group discussions. A more thorough and detailed description of the research project design and methods are captured in Chapter 3.

We also conducted a thorough review of the OVC literature, both published and unpublished.

The study concluded with an analysis of the information gathered, identifying geographic and programmatic priorities. It included making specific and sound recommendations for action and to promote shared understanding among interested parties. Such stakeholders could include government ministries, non-governmental organisations (NGOs), international aid organisations, religious bodies, the public and private sectors, and community groups. All have a stake and play a role in addressing and responding to the needs of children and families destabilised by the brunt of HIV/AIDS on their lives.

vi. - Factors influencing the choice of study area

Manya Krobo area in the Eastern region of southeast Ghana (the study area – Figure 1.4) has an HIV prevalence several-fold higher compare to other regions of Ghana (Sauvé et al., 2002). No geographical region in Ghana has been so much affected by the HIV/AIDS pandemic as it is in Manya Krobo area (Lund and Agyei-Mensah, 2008). HIV prevalence in the area since the inception of Surveillance Report in 1992 and 2010 averaged 9.4% compared with a national figure of just 2.6%.

Similarly, prevalence in the Eastern region and *Manya Krobo* area in particular is very high and a cause for concern. Out of the cumulative figure of 9,420 AIDS cases reported in the Eastern region in 2003, *Manya Krobo* alone accounted for 2,941 (31.2%). In the 2010 HIV Sentinel Survey report, Agomanya, the site representing Manya Krobo area had prevalence of 7.8 which is way above five per cent, the threshold at which the pandemic is considered to have gained epidemic proportion (Ghana Health Service, 2010). This however is much lower than the 18.0 and other double figures recorded at the onset. Indeed the continuous albeit unsteady decline observed in prevalence figures is a source of hope that efforts to contain the epidemic in the area are yielding some positive results.

Farmers who lost their lands on the creation in the 1960s of Lake Volta, the world's second largest artificial lake, often migrated while women work as iterant traders sometimes engaging in transactional sex even in neighbouring countries.

Further, the establishment in 2002 of first Voluntary Counselling and Testing (VCT) centres, prevention of mother-to-child transmission (PMTCT) activities and clinical care services at Atua Government and St. Martins de Porres Catholic Hospitals in the area put it ahead in the fight against the pandemic. An initiative to integrate antiretroviral therapy (ART) into comprehensive care for people living with HIV/AIDS (PLWHA) in 2004 involved home-based care, referral networks and linkages to such existing services as spiritual and social support, and support for OVC (Family Health International, 2006).

In his research on Spatial and Cultural Ramifications of HIV/AIDS in Manya Krobo area, Gyabaah (2005), concluded that the extended family support is still functional in a unique form. This is contrary to claim by Drew et al. (1998) that support from extended family for members HIV/AIDS is dying off in Africa. The fact is that in Manya Krobo area the system is sustained by the traditional rulers and a number of civil society groups.

They teamed up to create a safety net project to help HIV/AIDS orphans and vulnerable children (OVC). An umbrella body of female traditional rulers in the area known as Manya Queenmothers Association plays the role of mothers to OVC by employing the African extended family concept. On the demise of a positive parent(s), capable relations are identified and tasked to foster the offspring. Where no capable relation of the OVC is found to support and care for him/her, the Queen Mother of the community concerned takes responsibility by adding the child to her own family. They afford the same support and care they give their own biological children to the OVC. The OVC are urged to refer to the queens as 'Manye' or 'Yayo' literally meaning 'mother' to erase any feeling of alienation. Our research explores the social and cultural context of this community-based OVC support initiative and to establish the perimeters for the possibilities of enhancing and expanding such initiatives in other areas.

vii. - User value/Significance

The significance of this study is to support and contribute to the achievements of the Millennium Development Goals (MDGs) that must be met by 2015. The research sought and discussed the brunt of HIV/AIDS on OVC regarding MDGs target six and overall human development. The findings and conclusion will assist in the formation of future programmes on care and support for those affected by HIV/AIDS most especially OVC. It is also our hope to help in the achievement of the MDG goal six to combat HIV/AIDS, malaria and other diseases specifically the desire to halt by 2015 and begin to reverse the spread of HIV/AIDS.

viii. - The structure of the study

Our thesis is divided in two main parts. The first part entitled "The methodology and the conceptual framework" comprises chapters one and two.

This part deals with the methodology which involved a description of the research techniques used mainly centred on how to systematically organise field work, data collection and analysis in furtherance of the research. There is also a write up on the study area intended to give brief information on the background characterisation of Ghana and Manya Krobo District.

Within this part is the conceptual framework and thorough review of the literature from both published and unpublished sources pertaining to HIV/AIDS and OVC situation. We made a review of the main literature in the problematic area of HIV/AIDS generation nexus and about the OVC problem with respect to provision of safety net. We addressed issues such as why focus on social protection for HIV/AIDS orphans, what others had done in the area of the social and health care for OVC, the role of traditional women rulers and other civil society groups in social interventions and the gaps still remaining and drawing on the conclusions adapted the social integration, capacity building and empowerment concepts. The framework consists of individual people building relationships through joint efforts, coalitions, and mutual support in order to claim and expand agency, alter inequitable structures to realise rights and livelihood security.

The second component comprised the empirical research, social and health care for OVC, and the role of traditional women rulers and other civil society groups. This part of the thesis focused on data collection, analytical tools employed as well as summary, findings, conclusions, and recommendations adduced.

We firstly, considered how to access or acquire field data by following the methods prescribed or decided on. This stage involved designing, testing, deploying, and operating research instruments selected. Field data is the most relevant and useful information for validating the research goals by sorting and classification of data. We surveyed the Manya Krobo Queen Mothers Association OVC project providing services to OVC using a combination of qualitative and quantitative methods. Three appointments were held with the Project Director and Paramount Queen Mother prior to the pre-test in January and February 2011. Necessary changes were effected on questions after pre-test. A debriefing workshop was organized for all participants. Project staff caregivers and OVC responded to a structured questionnaire, and participated in key informant interviews and focus group discussions. We also conducted a thorough review of the OVC literature, both published and unpublished. This brief and a more detailed country report are available from the authors. This was followed with the discussion of the results involving a sifting and consideration of possibilities. The discussion section gave interpretation to and assertion of what the

data collected actually meant. This helped to clarify the information and facilitated its understanding.

Furthermore, a whole chapter was dedicated to examining the role of relevant prevailing social protection and intervention mechanisms beside the role of traditional women rulers. This section particularly discussed traditional support, care and social protection networks regarding OVC. We also looked at the role of funding and sources of such funds and its implications for sustainability of care and support. The aim is to look at how to internally generate alternative and innovative ideas to the overdependence on external sources of funding for support to households and children made vulnerable by HIV and AIDS.

The final section of the study concerned the summary, findings, conclusion and the implications of the results. What does this study add to the body of knowledge and policy implications of the findings of the study?

Lastly, a portion of the study was dedicated to cataloguing the bibliography which is a database of complete references cited in the study as well as appendix of relevant materials used.

PART:

THE CONCEPTUAL FRAMEWORK AND THE METHODOLOGY

CHAPTER ONE

LITERATURE REVIEW/CONCEPTUAL FRAMEWORK - WHAT OTHERS SAY OF THE OVC PROBLEM

1.1 - Introduction

The 44tth president of the United States of America, Barack Obama aptly captured the interconnectivity the world has become. In a speech in Ghana, Obama stated that “the 21st century will be shaped by what happens not just in Rome or Moscow or Washington, but by what happens in Accra, as well. This is the simple truth of a time when the boundaries between people are overwhelmed by our connections” (The White House, 2009: 1). This buttresses a global village view where no one is immune from society’s malaise. There is no gainsaying of new interdependence paradigm that permeates every facet of society from the household, family, community, nations, across ages and between genders. However a supposed shared world in time and space is plagued by differentials in access to resources resulting in vulnerability to exclusion from life’s opportunities to a large section of society.

The HIV pandemic has many faces including orphanhood. Projections of orphans expected, caring mechanisms and service structures to support them do not offer much hope (Skinner, et al., 2006) although successfully addressing HIV risk and vulnerability will be key to achieving virtually all of the MDGs (UNAIDS, 2008). The long-term repercussions are many, varied and unknown (Williamson, Cox and Johnston, 2004; President’s Emergency Plan for AIDS Relief, 2006).

This chapter provides a review of work relating to conflicts regarding definitions and concepts of a child, orphanhood, vulnerability; approaches to geography and health, community mechanisms to provide safety net and its sustainability or otherwise. Importantly, the role of gender in interventions to safeguard the future of OVC and conceptual framework underpinning the study are highlighted.

In Africa, the extended family and community provide the most important social safety nets, and the threat by HIV to disconnect these systems greatly increases an orphan’s long-term vulnerability. Poorly prepared to integrate into community life, and with little knowledge of potential risks and how to protect themselves, these young people may

feel hopeless and depressed and become involved in harmful activities (UNAIDS, UNICEF and USAID, 2004). This chapter scrutinises this insurance system on how it works, its sustainability, benefits to OVC and more crucially, seek to contribute to enhancing this mechanism of social connectedness.

1.2 - Health and Geography

We all acknowledge and sometimes identify the differences in diseases experience by different people living at different parts of the world such as high versus low elevation. It is easily understood that those at living low elevations near for instance waterways would be more prone to malaria than those at higher elevations or in drier, less humid areas. Though arguably we might not fully fathom the reasons for these variations, the study of this spatial distribution of disease is the beginnings of medical geography.

Geography is often thought of as the generation and interpretation of maps that describe the physical world but the physical description of boundaries has a great deal to do with how we view communities and how we construct society (Giddens, 1984; Ricketts, 2002). According to Gatrell (2002), our “health” and our “geographies” are inextricably linked. Health or Medical Geography concerns about spatial variations in its subject matter and the nature of the relationship between health and place (Yantzi and Skinner, 2009).

There have been two traditional branches in the health geography: disease ecology and health care delivery. Disease ecology involves the study of infectious diseases such as HIV/AIDS, malaria, and infant diarrhoea. The study of health care delivery focuses on consumption of care regarding spatial patterns of health care provision and patient behaviour as well as accessibility (Rosenberg and Wilson, 2005; Remoaldo, et al., 2010). Medical Geography uses the concepts and techniques of the discipline of geography to investigate health-related topics. Subjects are viewed in holistic terms within a variety of cultural systems and a diverse biosphere. At the present time, the most important step is probably the development of Health Geography at the Universities, as a discipline of basic geographical studies. This is important both to the development of health geographic research and to the affirmation of this research at a social level. For instance the last quarter of a century has seen pioneering Health Geography research activities by a number of scholars on the Iberian Peninsula leading

to the establishment of Health Geography as a discipline at some Universities. They include the works of Remoaldo (1999); Gonzaléz (2005), Nossa (2005) and Nogueira (2007).

The form and approach to studying Medical Geography is a subject of great debate. Mohan (1989) argued that local variations in health status and health care provision are certainly important, but the principal concerns of Medical Geography as currently practiced are limiting. Medical Geography requires radical surgery if it is truly to come to grips with such issues. Kearns (1993: 141) also suggested that in the marriage of humanistic geography and contemporary models of health, we have an incipient "post-medical" geography of health. He made a distinction between what he labeled as 'traditional' and 'contemporary' areas of work within the health geography framework.

According to Kearns the 'traditional' strands accept disease as a naturally occurring, culture-free, and 'real' entity, where the problems posed by questions of accurate measurement and distribution are assumed to be technical and solvable. An important branch within this tradition is Disease Mapping as a cartographic identification of casual relationships of disease beginning with the John Snow Map in 1854 (Remoaldo, et al., 2010). The researchers asserted that until the mid 1980s, Health Geography concerned itself with empirical development rather than conceptual and theoretic works as focused before (Paul, 1985; Phillips, 1985).

It is instructive to indicate that the background of tendency to stick to latitude-centred medicine (Raphael, 2008) as a recognition of the special relationship between geography and health. This means one may not properly and fully understand or appreciate the morbidity patterns observable in any part of the world without taking account of geographical conditions operative in that area. Hence the categorisation of special branches of health studies such as tropical medicine and arctic diseases have evolved. The geography of maternal and child mortalities, which is referred to as `silent epidemic´, seems to correspond fairly closely to the geography of several communicable diseases almost exclusively occurring in the tropics (Hill and Amouzou, 2006; WHO, 2006a). Furthermore, Braga, et al. (2004) emphasised the time and space variation of the incidence of certain diseases and established its relationship to spatial patterns. The implication is that many disease conditions can be blamed on climate, latitude and harmful environmental factors.

In contrast, the ‘contemporary’ strands adopt a stance which argues, in various ways, that notions of health, disease, and illness are problematic. It adds environmental concerns as a third theme. Environment and health is a relatively new focus that draws on geography's long tradition in environmental hazards research together with health geography (Kearns, 1993). Topics within this new tradition include environmental risk assessment, as well as the physical and psychosocial health impacts of environmental contamination including the spatial distributions of meteorological, biological and cultural phenomena associated with disease, as well as the social, political and economic barriers to positive change.

In recent years a growing interest in place effects on peoples’ health has emerged, often at the neighbourhood and community level (Sampson, Raudenbush and Earls, 1997; Jencks and Mayer, 1990). This work is particularly important with respect to older people because, more than any other group, they rely on local social support and facilities. Certain research explores the impact of social ‘composition’ on health; that being the characteristics of people in given areas including affluence, class, and family composition. Other research explores the impact of social ‘context’ of health; that being the resources available to people locally such as primary care facilities, various local shops, and services (Leventhal and Brooks-Gunn, 2003; Turner and Popkin, 2010).

Writing on Social Geographies, Pain, et al. (2001) identified five key themes or levels at which culture interfaces with space. These are the society denoting the ties people have with others, and space which reflects and constructs social activity as well as a means of resistance and celebration. Different meanings assigned to a place and their relation to power, social relations, identities, and evolution in social policy all contribute to defining well-being or otherwise at different spatial scales. Thus it has as a central concern the relations between people, people’s identities, the spatial variation of these, and the role of space in their construction. We all live somewhere on the earth’s surface and at the same time have health. There is no question about the real intimate connections between place and well-being as where you live affects your risk of disease or ill-health.

Even more recently, the World Bank has identified conflict as a place vulnerability factor now known for disrupting health care via physical destruction, sexual violence and their

propensity to proliferate diseases like HIV and communicable infections. The Bank thus places considerable emphasis on it (Woods, 2006).

This view has been criticised as simplistic, incomplete, and condemned as contributing to fatalistic and non-interventional attitude (WHO, 2006b). This is due to the divergent structures and approach adopted by a number of researchers. Furthermore, delay in development of concepts and theoretic frameworks account for this. This in itself is borne out of late introduction of the discipline in a number of higher institutions of learning (Remoaldo, et al., 2010). They backed this view by arguing that in spite of early empirical research on Health Geography in the Iberian Peninsula for instance, witnessed the growth of the research both on concepts and at higher level of learning only in the 1980s. The reason in this case was the adoption of "*Géographie de la santé*" (Health Geography) whose evolution was quite irregular characterised by short periods of scientific dynamism and then followed by decades of inactivity. The lack of conciseness and consistency in the evolution and development of concepts and theoretic works have to large extent affected the effect of geography in highlighting in more pronounced way the place-health agenda.

HIV/AIDS was first described about gay men in the USA in 1983 and classified by the World Health Organisation (2008) as a global pandemic hence it is a condition that has spread across the world. As pandemic, it quickly gained notoriety for discrimination and stigmatisation on the international scene partially due to the misconceptions of its origin and mode of transmission which was and still is erroneously attributed to immorality. Consequently, in the late 1980s and throughout the 1990s and even till date, many researchers have attempted to set the record straight on this aspect of the disease. One of such bold many studies on the AIDS pandemic was pioneered by a leading geographer and specialist in diffusion theory, Peter Gould called 'the Slow Plague: A Geography of the AIDS Pandemic' in 1993. He dealt with the spatial diffusion of the disease. Gould's work gave a geographical account of the origins, spread and likely future consequences of the HIV viruses, based on worldwide research. It showed how the virus jumps from city to city, creating regional epicentres from which it spreads into surrounding areas. Four case studies at different geographic scales demonstrate the devastating effects of the disease and brought out poignantly the relationships between poverty, drugs and HIV infection. He argued that research into AIDS was being

hampered by fundamental misconceptions of the nature of the disease. These misconceptions were either conscious or unconscious beliefs that those affected are, and will continue to be, confined to specific minority groups and to parts of the Third World.

As Gould correctly predicted, these misconceptions of the slow plague was bound to impact negatively on those who will be most at risk, now and in the immediate future. One group of such victims is AIDS orphans and vulnerable children. The definition of orphanhood is significant in relation to child development. Estimating orphan population is not a clear-cut due to varying definitions of parental status and age range chosen. Definitions based on either only paternal or maternal and or both parents as well as specific to AIDS or all causes tend to either underestimate or boost orphan numbers. Similarly, age definitions range from as low as below 14 years to as high as time of marriage have been applied (Tarantola and Gruskin, 1998; Foster and Williamson, 2000). The wider definition is more useful for programming purposes since it is inappropriate at community level to determine eligibility for assistance based on specific cause of parental death or age of orphan. Even the adoption of broader definitions may yet still underestimate the orphan problem as some children either care for sick parents or are fostered by relatives hence never get assisted (Foster and Williamson, 2000; Atobrah, 2004). Large and growing numbers of millions of children worldwide are being orphaned or made vulnerable by HIV/AIDS and with the numbers projected to increase. Studies indicate that millions of children have lost their mothers to AIDS, and millions more are caring for their sick mothers (Foster and Williamson, 2000; Save the Children, 2006). Research is needed to identify the implications of different age and parental-status definitions in terms of willingness to respond, resource allocation decisions, programmes selected and their implementation (Tarantola and Gruskin, 1998; Foster and Williamson, 2000). To the extent that development takes place, old hazards are reduced and new ones arise. These changing circumstances require a shift in strategy. Health Geography seeks to identify spatio-temporal development of provision of health care.. It can therefore expose disparities thereby highlighting the need to trigger the process through which the general system of society particularly social and health services are made accessible to all. Such as intervention programmes can be directed

at specific population groups most at risk by improving medical care, training and regulating specific health and environmental conditions.

The havoc the AIDS pandemic is wrecking on many innocent victims by the virtue of the death of the breadwinner was not given any serious considerations for quite a while. These vulnerable children face the added burden of AIDS-related stigma and discrimination, which often contributes to them missing school and lacking access to basic healthcare. Stigma, discrimination and stress do not just affect the people infected by the disease but extend to their families, relations and associates as well as affecting the level of support and care received. As a result, choice and usage terms associated with HIV/AIDS are quite sensitive. For instance Meintjes and Giese (2006) highlight the fact that the term AIDS orphan has been abandoned in OVC literature due to the fact that it promotes an undesirable stigma and stress by labelling children as well as misrepresented the orphan situation.

Thus in recent years, analysis of the psychosocial conditions of the people affected by the disease, the support and care being giving them is gaining prominence among stakeholders including researchers. Resources must be channelled into improving the lives of mothers living with HIV and protecting the welfare and development of their children. Indeed it is imperative to set out the help that is needed, propose strategies and recommendations to help extended families and communities to give mothers and children the support they need (Save the Children, 2006).

The support for the infected and affected is increasingly being recognised as the responsibility of all and the district and community levels are more sustainable sources and points of coordination of OVC programmes in Ghana. The District Response Initiative is the 'grassroots' strategy adopted to combat HIV/AIDS in Ghana in 2002. The aim is scaling up initiative to improve care and support of those infected and affected by HIV/AIDS by strengthening the capacity for care and support in communities and all relevant sectors at the district level. It further seeks to reduce denial, stigma and discrimination of those infected and affected by HIV/AIDS. It initially covered 40 districts and sub metros in 6 regions of the country. Among its components is scaling-up of interventions including strengthening of decentralised institutions to provide counselling and improve prevention, care and support of those affected and infected with HIV. Simwanza (2005) in a study concluded that the care and support project has served as

an entry point to further strengthen the continuum of responding to HIV/AIDS. However, the capacities at district level to do continuous diagnosis of the different dimensions of HIV/AIDS needs to be further developed up to the unit committees within the structure.

1.2.1 - Understanding HIV and AIDS

You have probably heard a lot of confusing talk about the disease known as AIDS. AIDS is a scary pandemic the world has ever faced. HIV has already killed more people than all the wars and natural disasters such as famines, floods, and earthquakes in history. Fourteen thousand people get infected with HIV every day; that is one person every time you breathe. Some 120 people get infected in just ten minutes. Over 34 million people across the world are infected with HIV (UNAIDS, 2011). In a year alone, over three million people die from AIDS that is like 2747 airbus full of passengers crashing every day for one year or like the entire population of the 137th ranked populous country in the world, Albania being wiped out in one year. The AIDS epidemic is really ripping families apart; it is one of the most effective ways to destroy a family. The HIV pandemic has undergone four main phases of evolution namely emergence, dissemination, escalation and stabilisation. So what exactly is it? AIDS is a disease that represents the final stages of infection with incurable virus known as the human immunodeficiency virus or HIV. HIV and AIDS are not one and the same. Those with AIDS are infected with HIV but people with HIV do not necessarily have AIDS. A person has AIDS when their T-cell or CD4 count falls below a maximum scale of 200 as opposed to the 500 to 1,500 in a healthy person (WHO, 2003). To understand how AIDS works, it helps to have a grasp of HIV.

The immune system protects our body by fighting off infections. Much of this fight is carried out by the T-cells often called the CD4 cells. Now a deadly intruder such as HIV enters the immune system and re-programmes the CD4 cells until there are so few good T-cells left in the body that it cannot fight off infections and cancer. Then it infected cells get other cells replicate to repeat the process over and over. HIV immobilises our immune system from functioning as expected (Lehne, 2007). Simply put, HIV attacks and destroys cells in the immune system much as an invading army might destroy a high wall that protects a city. With a weakened immune system, a person becomes less able to fight off infections. This is human immunodeficiency virus or HIV. The key is

immune. Human is a reference to the person, immune is a resistance to a disease and deficiency is lacking or failure. Therefore it is a human failure to resist disease. Before HIV can attack, it has to get in. So where does HIV live? HIV lives in bodily fluids like semen, vaginal secretions, blood, and breast milk. It is relatively a difficult virus to transmit and requires very specific situations towards the transmission, very intimate relationships. It is largely a sexually transmitted disease worldwide. You can also get it from needle or syringe sharing, blades/razors, childbirth, breastfeeding and blood transfusion. It is very important to explain that it does not infect to casual contact, hugging, and light kissing, or spread through door handles or toilet seats. Eating in the same utensils with a person infected with HIV poses no risk. A person who carries HIV can pass it to another through any of these fluids usually the exception and of course breast feeding or sharing of drug paraphernalia. Rarely a person will contract HIV through blood transfusions and while it is highly unlikely for people to acquire HIV through saliva, it is possible to pass it through oral sex.

Regardless of how the virus is introduced to the body, HIV replicates and spreads in the same manner. Its first task is to locate a CD4 cell—a type of helper T lymphocyte. Once the virus is transferred, it attaches to its new host body's CD4 cells or T-cell which are integral part of the immune system. Inside the T-cell, HIV literally changes to become part of the body's DNA or genetic code. An enzyme called reverse transcriptase transcribes the viral RNA into DNA. Then this DNA can be incorporated into the CD4 cell's DNA. Therefore, the virus' genetic material is replicated along with the CD4 cell's DNA. This enables the virus to multiply itself (Lehne, 2007). At this point the body will be forced to produce the virus. Because HIV lives in the immune system, every time a foreign invader triggers this system to work, HIV is activated too. This means that when good T-cells fight for example the flu virus, new HIV particles are formed. Many people do not develop symptoms after they first get infected with HIV. However up to nine in ten people during the first days and weeks after they contract HIV, he or she may experience flu-like symptoms such as a fever, headache, fatigue, and enlarged lymph nodes in the neck. These symptoms generally disappear on their own without treatment within a few weeks. After that, the person feels normal and has no symptoms. But as the body is forced to create new HIV cells, the virus continues to multiply actively and infects and kills the cells of the immune system. The immune system eventually gets

weaker, a progression that can take from a few months to more than ten years. This is known as the asymptomatic phase. Even though the person has no symptoms, he or she is contagious and can pass HIV to others through the routes listed earlier.

Eventually, untreated HIV leads to acquired immune deficiency syndrome or AIDS. The name is appropriate. Acquired means to obtain or receive an infection, immune means resistance to disease, deficiency is a lacking or failure and syndrome is a group of problems that comprise a disease or a disease reflecting a particular set of symptoms. So AIDS is an obtained failure to resist a disease.

Studies are being conducted on numerous theories about the origins and transmission of HIV, and while many theories have been proposed and researched, a number of facts including HIV strains are now undisputed. There are two species of the virus, HIV-1 and HIV-2. HIV type I supposedly came from a simian immunodeficiency virus (SIV) found in chimpanzees and HIV type II supposedly originated from the sooty mangabey monkey. The overwhelming majority of infections around the globe (approximately 90%) are strains of HIV type I, while HIV type II remains primarily confined to West Africa. HIV type I has been classified into three groups namely “M” for “major”, “O” for “outlier” and “N for “new”. The bulk of infections are HIV-1 M. A person’s diagnosis changes from HIV to AIDS when either their CD4 cells falls below 200 counts. AIDS is generally diagnosed by blood or saliva test that measures the CD4 cells in a person’s body. If T-cell count drops below 200, the immune system is seriously damaged and unable to fight infections properly. An extremely low CD4 count means that a person’s immune system is no longer healthier enough to fight off intruding viruses and bacteria. AIDS is diagnosed. Another way of affirming the progression from HIV to AIDS is if they develop an infection that takes advantage of the weakened immune system called opportunistic infections. It reflects the weakness in the immune system. A diagnosis of AIDS occurs if a person gets one of twenty-six opportunistic infections which are conditions common in advanced HIV patients but are rarely found in people with intact immune systems. The following symptoms are some of the conditions people with AIDS commonly experience. They include rapid weight loss, dry cough, recurring fever or profuse night sweats, profound and unexplained fatigue as well as swollen lymph glands in the armpits, groin or neck. The others are diarrhoea that lasts for more than a week, white spots or unusual blemishes on the tongue, in the mouth, or in the throat, and pneumonia. The

rest are red, brown, pink, or purplish botches on or under the skin or inside the mouth, nose or eyelids, and memory loss, depression and other neurological disorders (UCSF Medical Center, 2011).

The infections that happen with AIDS are called opportunistic infections because they take advantage of the opportunity to infect a weakened host. The infections include (but are not limited to) pneumonia which causes wheezing, brain infection with toxoplasmosis which can cause trouble thinking or symptoms that mimic a stroke, and widespread diseases with certain fungi like histoplasmosis, which can cause fever, cough, anaemia, and other problems (UCSF Medical Center, 2011). A weakened immune system can also lead to other unusual conditions such as lymphoma in the brain (a form of cancer of the lymphoid tissue) which can cause fever and trouble thinking, and a cancer of the soft tissues called Kaposi's sarcoma, which causes brown, reddish, or purple spots that develop on the skin or in the mouth.

Several opportunistic conditions that confirm an AIDS diagnosis stem from an invading bacterium like tuberculosis and recurrent bacterial pneumonia. Pneumocystis carinii pneumonia is a potentially deadly inflammation of the lungs that is one of the most common infections occurring in people with HIV worldwide (WHO, 2007). Tuberculosis is the leading opportunistic infection in nations where access to medications is low. Although HIV itself is a virus, another virus can enter the body and cause an opportunistic infection. One example is cytomegalovirus or CMV, herpes virus that healthy adults fight easily. In people with HIV however, the virus causes damages to the body most notably the eyes. If untreated, CMV can lead to blindness. Other complications that lead to AIDS diagnosis include wasting syndrome, whereby a person loses at least ten percent of their body weight and AIDS dementia complex where nerve damage causes diminished mental functioning. These conditions and others mean that HIV has progressed to AIDS.

If a person has one or more of any of these signs and symptoms, it does not necessarily mean that a person has HIV or developed AIDS. Many common diseases can cause one or more of these symptoms. For example a person with a fever or a sore throat is probably just experiencing common illnesses such as cold or influenza. There is therefore no point to panic. However if a person has any of these symptoms and think even there is the slightest chance that you might ever have been exposed to HIV, it is

advisable to seek professional opinion or asked to be tested. On the other hand, the absence of any of these symptoms also does not prove that one does not have HIV infection. Thus one cannot make any assumptions. It is only a test that settles any lingering questions of HIV or not. Most people who die of AIDS do so from one of these infections.

Since the beginning of the AIDS pandemic in the 1980s, more than 60 million people have been infected with HIV that causes AIDS (UNAIDS, 2011). While this is disheartening, many modern medications can keep AIDS infections from progressing in definitively. HIV can be controlled for many years with cocktails of drugs, but there is as yet no cure. The introduction of highly active antiretroviral therapy (HAART) has caused a number of AIDS-related deaths to decrease significantly. More people than ever are living with the AIDS virus but this is largely due to better access to drugs that keep HIV patients alive and well for many years (UNAIDS, 2011). The number of people dying of the disease fell to 1.8 million in 2010, down from a peak of 2.2 million in the mid-2000s. The year 2011 marked a watershed for the AIDS response with unprecedented progress in science, political leadership and results. UNAIDS has described this period as "a game-changing year" in the global AIDS fight during which has been so much science, so much leadership and such results in one year. Nearly 50% of people who are eligible for antiretroviral therapy now have access to lifesaving treatment. According to UNAIDS and WHO estimates, 47% (6.6 million) of the estimated 14.2 million people eligible for treatment in low- and middle-income countries were accessing lifesaving antiretroviral therapy in 2010, an increase of 1.35 million since 2009. This is largely due the result of substantial scale up, even during the financial crisis, highlighting country driven commitments; an impetus that new investment framework will help countries save more lives and money. According to UNAIDS and WHO, a series of scientific studies have shown that getting timely treatment to those with HIV can substantially cut the number of people who become newly infected with the virus. The big point is the number of new infections that is where the war against the epidemic is won. Declines in new HIV infections are also being spurred by changes in sexual behaviour, particularly in young people, as people reduce their numbers of sexual partners, increase condom use and are waiting longer before becoming sexually active (UNAIDS, 2011).

HIV and AIDS is a critical public health issue for a number of reasons. Public Health is the science of protecting and improving the health of communities through education, promotion of healthy lifestyles, and research for disease and injury prevention. Public health is concerned with protecting the health of entire populations. These populations can be as small as a local neighbourhood, or as big as an entire country. The classification of the disease as *pandemic* in itself is a cause for public health. A pandemic is an unexpected outbreak of a new contagious disease that spreads from person to person across multiple borders such that almost no one has natural immunity. Most significantly, it affects both the productive and reproductive segments of the population. This has not just a public health problem but social as well. The epidemic has far reaching consequences to all social sectors and to development itself. It can decimate the workforce, create large numbers of orphans, exacerbate poverty and inequality, and put tremendous pressure on health and social services. Annual basic care and treatment for a person with AIDS, even without antiretroviral drugs (ARV), can cost as much as 2-3 times per capita gross domestic product in the poorest countries. There is one infection per breath, 4,900 deaths per day and 34 million people living with HIV/AIDS is a bold statement (UNAIDS, 2010). At the end of 2010, an estimated 34 million (31.6 million – 35.2 million) people globally living with HIV, 2.7 million (2.4 million – 2.9 million) new HIV infections in 2010, and 1.8 million (1.6 million – 1.9 million) people died of AIDS-related illnesses in 2010 (UNAIDS, 2011). To achieve universal access to HIV prevention, treatment, care and support by 2015 requires a scaling up of funding to US$ 22-24 billion in 2015, in line with the targets in the 2011 United Nations Political Declaration on HIV/AIDS. If full implementation of the new framework is achieved in the next four years, global resource needs would peak in 2015 and decline gradually thereafter; making the AIDS response an excellent investment opportunity where returns will offset the upfront cost in less than one generation.

Some limitations known to be associated with AIDS medications are the obstacles preventing ART distribution and use that are both provider and patient-related. Provider-related obstacles include limited availability of drugs, total cost, lack of healthcare staff and facilities, lack of organisation, and government regulations. Patient-related obstacles include cost, transportation, geographic proximity to healthcare facilities, side

effects and hunger, pill burden, hospital-related factors, cultural beliefs, social stigma, lack of adequate counselling, and drug resistance (Paquette, 2010).

1.2.2 - HIV/AIDS and vulnerable children

Thirty years after doctors in the USA described the first case of AIDS, there has been huge progress in our understanding and attempts at combating the pandemic globally. However, closer analysis of the statistical evidence demonstrates a disproportionate extent to the epidemic across the globe. Since the first case in 1981, more than thirty million people have died from it and 33.3 million more people living with the disease (UNAIDS, 2010). The gains made so far are real but very fragile. Out of the estimated 15 million people living with HIV in low-and middle-income countries who need treatment, 5.2 million have access which translates into fewer AIDS-related deaths. Thus experience with the disease is diverse. This diversity adds further dimension to the discourse as it demonstrates how individual life prospects of those affected by HIV/AIDS, fluctuate geographically. More people in Sub-Saharan Africa die from AIDS-related illness than of any other cause. Botswana has one of the highest adult (25-49 years old) prevalence rates of 34.4 percent. Therefore, chances of survival are more likely to be influenced by factors that are beyond personal control. Some of these extraneous factors include but not limited to gender inequality, poverty, access to education, availability and or affordability of healthcare services and national political stability. Consequently in such a precarious climate, this perhaps clarifies possible reasons why, for many, both personal and family health remains at great risk (Patterson, 2006).

Accordingly, AIDS is one of the main contributors to OVC incidence globally as no single nation is exempted from this canker. Understanding the magnitude of the problem and socio-demographic characteristics of OVC can provide the foundation for building programmes of appropriate design, size and scope. The number of AIDS orphans is soaring at an unprecedented rate. By 2003, 14 million children under age 15 had lost one or both parents to HIV/AIDS. By 2010, an estimated 106 million children under age 15 were projected to have lost one or both parents, with 25 million of this group orphaned due to HIV/AIDS. The extended family of uncles and cousins was a social safety net for orphans, yet it is unravelling under the strain of AIDS although there

spots of hope (Lee, 2006; Lund and Agyei-Mensah, 2008). As the middle generation dies, grandmothers are left holding the baby and bringing together children from different parts of the extended family. The impact on children's lives is both complex and multi-faceted.

According to the latest data by UNAIDS (2010) from 182 countries, it is estimated that more than 16 million children under 18 have been orphaned by AIDS. It is estimated that by 2015, the number of orphaned children will still be overwhelmingly high (UNAIDS, 2008). In addition, a large number of children have been, and continue to be, made vulnerable due to the impact of the AIDS pandemic, although they are not orphans. These vulnerable children include children living with sick parents and children who were primarily dependent on a breadwinner who has died. Others are children who are in precarious care as a result of being dependent on old, frail or disabled care-givers. Lastly, we have children in households that assume additional responsibility by taking in orphaned children. Hence as the pandemic unfolds and takes its toll on the young adults, it is leaving one or more generations of children to be raised by their grandparents. Some others also are forced to live households with high dependency ratios, or child-headed households. However it is very difficult to obtain the exact figures on the numbers of vulnerable children (Rusakaniko, et al., 2006). A former United Nations' special envoy for HIV/AIDS in Africa, Stephen Lewis aptly described the precarious condition of the AIDS orphans: "it's been clear, inescapably clear that as the pandemic evolves children orphaned by AIDS are becoming the single most intractable and painful legacy. There are no equivalent precedents. Nothing in historical experience has prepared us for two generations of children rendered desperate, lonely, sad and bewildered by sheer circumstance. And it leads to bizarre permutations" (Lewis, 2006: 170).

The World Health Organisation (2004) guide to HIV/AIDS care and support for people living with and households affected by HIV/AIDS outlines a wide range of services as including psychological, social, legal and clinical ones. Care and support programmes must therefore be developed to respond to these needs and demands. Complicating the situation, these needs reflect an environment in both industrialised and resource-constrained settings in which discrimination, stigma, fear, neglect and impoverishment surround HIV/AIDS to various degrees in the community, workplaces and health care

settings. To address these needs, HIV/AIDS care and support programmes should have the objectives of ensuring equitable access to diagnosis, health care, pharmaceuticals and comprehensive supportive services. Other objectives are reducing morbidity and mortality from HIV/AIDS and related complications, promoting opportunities for preventing HIV transmission within the delivery of care and support services, and improving the quality of life of both adults and children living with HIV/AIDS and their families.

Although children's concerns have always been present within the great spectrum of need associated with HIV, they have to some extent been overshadowed by the very scale of the epidemic in the adult population (UNICEF and UNAIDS, 2010). The international focus on children affected by HIV/AIDS pandemic has been on the four 'Ps' or the *Unite for Children, Unite against AIDS* priority areas. The four 'Ps' comprises preventing mother-to-child transmission, providing paediatric care and treatment, preventing infection among adolescents and young people, and protecting and supporting children affected by HIV and AIDS (UNICEF and UNAIDS, 2010). While children in general have benefited enormously from the substantial progress the AIDS response has made, there are millions of women and children who have been passed over because of inequities rooted in gender, economic status, geographical location, education level and social status.

It is quite clear that therefore that orphans may grow up without basic material resources and may lack the love and support that emotionally-invested caregivers usually provide; they may be discriminated against because of the presumed sero-status of their parents; and they may be forced to discontinue their education because of money or the need to take care of their siblings. From the social perspective, the consequences of large number of children being raised without parents will prove costly, both in direct costs for relief, indirect costs associated with increased ill health and or social pathology, as well as opportunity costs associated with lost years of education and work preparedness. Luckily, the UNAIDS guesstimates that around 400, 000 new HIV infections in children are estimated to have been averted since 1995 due to increased access to effective antiretroviral regimens in low- and middle income countries by 2010, almost half (48%) of all pregnant women living with HIV were able to

access effective regimens to prevent their child from becoming infected with the virus (UNAIDS, 2011).

1.2.3 - Sub-Saharan Africa and the burden of orphanhood

Sub-Saharan Africa is still by far the worst hit area (epicentre of HIV/AIDS), accounting for 68 percent of all those living with HIV in 2010 despite its population accounting for only 12 percent of the global total. Around 70 percent of new HIV infections in 2010, and almost half of all AIDS-related deaths, were in sub-Saharan Africa (UNAIDS, 2011). There are an estimated 22.4 million people living with the disease in sub-Saharan Africa. Every two out of three people living with HIV/AIDS is found in sub-Saharan Africa. Three-fourth of every AIDS-related death occurs in this region. Around 14.8 million children in sub-Saharan Africa have been orphaned by AIDS. There are an estimated 160,000 orphans in Ghana (UNAIDS, 2010). The region suffers annual gross domestic product loss of 2% to 4% due to the effects of the pandemic. Though the magnitude of the situation is alarming, there seems to be a beacon of hope as 3.9 million Africans on ART. Twenty-two sub-Saharan African countries cut new HIV infections by greater than 25% in 2009.

Examples of the effects of the pandemic from six countries in the region for the period 2009 would highlight the seriousness. There are variations in infections, number of people affected and access to care across the continent. Ghana and Rwanda each has a population of 23.4 and 10.3 million people, prevalence rates of 1.9% and 2.9%, total 260,000 and 170,000 PLWHAs apiece while pregnant women covered by antiretroviral drugs for prevention of mother-to-child treatment (PMTCT) were 27% and 65% (President's Emergency Plan for AIDS Relief, 2006; NCDP/UNDP, 2010; UNAIDS, 2010). The problem in Zambia and Lesotho is serious. They have populations is 13.3 and 2.1 million, 15.2% and 23.2% prevalence rates, 980,000 and 290,000 people living with HIV/AIDS while 69% and 71% of pregnant women with infection are provided with PMTCT drugs respectively. The cases for South Africa and Swaziland are even more alarming. They have populations is 50.5 and 1.2 million peoples, 29.4% and 26.1% prevalence rates, 5.7 million and 180,000 people living with HIV/AIDS while 57% and 88% of pregnant women with infection are provided with PMTCT drugs respectively (UNAIDS, 2010).

This social approach to studying the conditions of living of OVC has not been used before till date by geographers or other social scientists in Ghana. Geography can play an important role in shaping intervention strategies and policy programmes. In some countries which are badly affected by the epidemic a large percentage of all children, for example 16% of children in Zimbabwe and 12% in Botswana and Swaziland, are orphaned due to AIDS (UNAIDS, 2010). According to a recent report by UNICEF and UNAIDS (2010), the number of orphans in some sub-Saharan African countries exceeds one million, and, in some countries, children who have been orphaned by AIDS comprise half or more of all orphans nationally. Prior to this, Mishra and Bignami-Van Assche (2008) had analysed status of OVC in eight sub-Saharan African countries with relatively high HIV prevalence using Demographic and Health Surveys (DHS) and AIDS Indicator Surveys (AIS) data. The countries involved are Cameroon, Cote d'Ivoire, Kenya, Lesotho, Malawi, Tanzania, Uganda and Zimbabwe. The study highlighted the heavy burden and the multi-dimensional nature of the OVC problem in sub-Saharan Africa. The main trust of their finding was that the levels of external care and support for OVC remain unacceptably low. It said not only few primary caregivers of children make arrangements for succession planning but also that most OVC and their families are not receiving the necessary care and support. The researchers implied that a large and growing population of OVC and their families were yet to be reached with support to shoulder the burden of care and suggested a need for vigorous efforts in that vein. There is certain notion that the effect of AIDS on the African population depends on who the individuals are, their place in society, and the resources that they, their households, communities and societies have available (Barnett and Whiteside, 2002). This is particularly applicable for African women and children. Arguably, due to widespread cultural gender inequality, women in Africa are often forced to bear the brunt of HIV/AIDS (Patterson, 2006). This burden is illustrated in the rising cases of women being the main care givers (Atobrah, 2004; Lund and Agyei-Mensah, 2008).

This notion might explain the seeming contradictions in findings by a number of studies that did not find adverse effects of parental loss on lives of OVC. They rather found that over the last three decades, there has been growing interest and investment in the protection, care and support of children affected by AIDS (Ainsworth and Filmer, 2002;

Nyamukapa and Gregson, 2005; Parikh et al., 2007; Mishra and Bignami-Van Assche, 2008; UNAIDS, 2010).

Advocacy and investment on behalf of children have had an impact. Before 2005 in many sub-Saharan African countries, children who had lost both parents to AIDS were much less likely to be in school than children whose parents were alive. Today, in most places they are almost equally likely to be in school (UNICEF and UNAIDS, 2010). According to Mishra and Bignami-Van Assche (2008) there is some evidence to suggest that the epidemic has caused rapid recent increases in the prevalence of orphanhood. Prevailing childcare patterns have dealt with large numbers of orphans in the past, and to date there is no consistent evidence that this system is not absorbing the increase in orphans on a large scale. Yet, there is some evidence that orphans as a group are especially vulnerable, as they live in households with less favourable demographic characteristics and have lower school attendance.

The relationship between mental illness and HIV/AIDS is complex and bidirectional. A significant amount of research has been performed in high-income countries but less is known about HIV and mental health in sub-Saharan Africa. A review of literature for 104 quantitative research studies published after 2005 in sub-Saharan Africa on mental health and HIV identify research needs and priorities (Breuer, et al., 2011). The finding includes the fact that the major topics covered were mental-health-related HIV-risk behaviour, HIV in psychiatric populations, and mental illness in HIV-positive populations. The study also reported that prevalence levels of mental illness among people living with HIV or AIDS (PLHIV) was high, with all but one study noting a prevalence of 19% or higher. Neuro-cognitive changes in adults with HIV were also prevalent, with reported deficits of up to 99% in symptomatic PLHIV and 33% in non-symptomatic PLHIV. It found that research on HIV in relation to mental health is increasing; however, there is a need for good-quality prospective studies to investigate the bidirectional effects of mental illness and HIV on each other (Breuer, et al., 2011).

Southern African countries which by far are seriously affected by the pandemic, conducted longitudinal studies in a number of member countries aimed at developing appropriate models for the support of AIDS orphans. In 2002, the Human Sciences Research Council was commissioned by the WK Kellogg Foundation to develop and implement a five-year intervention project focusing on orphans and vulnerable children

(OVC) in southern Africa. In collaboration with several partner organisations, the project focused on how children, families and communities in Botswana, South Africa and Zimbabwe are coping with the impact of HIV/AIDS. The aim of the project was to develop models of best practise so as to enhance and improve support structures for OVC in the southern African region as a whole.

Foster and Williamson (2000) reviews published studies on orphans in Africa where many are still being cared for by members of their extended family. The study further describes indicators by which weakened or saturated extended family safety nets can be identified. The researcher claims that measures of the weakening of the safety net include the paternal: maternal caregiver ratio, the uncle/aunt: grandparent caregiver ratio, the prevalence of child-headed households, sibling dispersal and migration. Increasing numbers of children are slipping through the extended family safety net, leading to child-headed households, street children and child labour. Such children have increased likelihood of physical, social, economic and psychological morbidity and vulnerability including risk of HIV infection. It recommends an understanding of how the extended family safety net mechanisms work so that initiatives support rather than undermine traditional orphan care.

In exploring how children affected AIDS in Kenya cope with their difficult circumstances through an interaction with their social environment, Skovdal (2009) uses an iterative process to develop a social psychology of coping. The researcher finds that the ability of a child to cope is shaped by the on-going negotiation between individual and community which shapes a person's identity and access to local support networks and resources to tackle adversity. It also depends on the quality of the community they live in and its ability to share resources and the children's different abilities to negotiate community support. This social psychological conceptualisation of coping opens up new levels of analysis for research and intervention, which take account of the need to identify and bolster the social psychological resources evident within communities that can facilitate or hinder support. There is concern that orphans may be at particular risk of HIV infection due to earlier age of sexual onset and higher likelihood of sexual exploitation or abuse. Researchers utilized empirical data to explore the relationship between orphan status and sexual risk behaviour among South African adolescents. The analysis found both male and female orphans significantly more likely to have engaged

in sex as compared to non-orphans (Thurman, et al, 2011). The programmatic implications of these findings for the care and protection of orphans include higher caregiver monitoring and HIV prevention interventions targeting improvements in family level psychosocial support.

The reports, recommendations and policies generated from these and other studies helped with intervention efforts across the continent. Various intervention agencies such as government ministries, NGOs, CBOs, FBOs and the community at large, are making tremendous efforts in caring for OVC. However, the efforts of these agencies are either inadequate, inappropriate and or hampered by lack of both capacity and resources. According to UNAIDS governments in some of the hardest hit countries want to act on the science, seize the moment and reverse the AIDS epidemic but are limited by limited funding as many international donor countries struggle with slow economic growth and high debt. At the end of 2010 around US$ 15 billion was available for the AIDS response in low- and middle-income countries. Donor funding has been reduced by 10% from US$ 7.6 billion in 2009 to US$ 6.9 billion in 2010. In a difficult economic climate the future of AIDS resourcing depends on smart investments. The sub-Saharan African AIDS fight has to become even more focus on high impact interventions to deliver progress in the places worst hit. It calls for the need to maintain investment, but in a smarter way which will then deliver a serious decline in the epidemic (UNAIDS, 2011).

1.2.4 - Care and Support for OVC in Ghana

The key features of HIV/AIDS in Ghana since the epidemic was detected in a visiting German couple in March 1986 (Yankah, 2004) have been comparatively a low prevalence rate compared to other states in West, Eastern and Southern Africa (Amoa, 2005; Goodell, 2009). Goodell controversially argues that the situation in Ghana is not due to an excellent response by the Ghanaian government, but rather due to a lack of formalised migration and transportation, a low prevalence of concurrent sexual relationships and high levels of male circumcision. Male circumcision is the surgical removal of some or all of the foreskin (or prepuce) from the penis. Langerhans cells, an important component of human immunity, are not present in the human prepuce. Moreover, the warm, protected area of the prepuce can incubate organism growth and

thus facilitate viral transmission (Moses, 2000). One recent report (UNAIDS, 2011) found that an increase in uptake of male circumcision contributes to averting 2000 new HIV infections among men in Kenya's Nyanza province. Estimates in the report highlight that circumcising 20 million more men would avert around 3.4 million new HIV infections by 2015 (UNAIDS, 2011). Circumcision is widely practised in Ghana for religious, social, and health purposes. According to the Ghana Demographic and Health Survey in 2008, 92 percent of males 15 to 59 years old were circumcised. Parents take steps to circumcise their baby boys because an uncircumcised boy (*koteboto*) in the Ghanaian setting is teased like hell. Being *koteboto* means you have to be at many public places of convenience (KVIP), boarding school bathhouses among others when these places are least patronised (Frimpon, 2010). Additionally, he warns that unless there is an increase funding to HIV/AIDS prevention and treatment to maintain current prevalence levels, Ghana remains a very vulnerable state due to low civil engagement, gender relations, and bureaucratic government programming (Goodell, 2009).

The problem with male circumcision and risk of HIV infection is the conduct of the procedure particularly those perform by traditional expert circumciser locally refer to as a *wanzam.* The wanzam is an itinerant usually Muslim man who specialises in the craft of circumcising young boys who have come of age. They move from village to village plying their trade to whom it may concern (Frimpon, 2010). The risk of infection associated with this practice was brought to the fore on November 20, 2011 in a news report by www.myjoyonline.com headlined '*wanzam* 'cuts off' baby's penis'. It indicated that a certified 70-year old wanzam only named as Abdullah has been arrested by the police for literally cutting off a 4-month old baby's penis at Maamobi in Accra, Ghana due to poor vision and excessive movements and gyrations*.* Frimpon (2010) describes the *wanzam* sitting room surgery procedure illustrating why it is risky for HIV infection.

"The wanzam first properly secured the patient about to be circumcised. It is imperative that the boy is well secured because excessive movements and gyrations could result in a bad accident. Patients are known to bleed to death if an artery is accidentally severed during the surgery. The word anesthesia is unheard of in the rural African medical lexicon, and screams of boys that were undergoing this kind of surgery were common place. Ideally, two adults hold the extremities of the legs with the genitalia dangling between the legs. A couple of adults take care of the upper torso. The wanzam then

pulls the loose end of the penis and slices it off with one simple stroke. A wanzam's knife is reputed to be the sharpest in the world, and the dexterity of the wanzams with knives is the stuff of legends. After slicing this off, he removes some veinlike growths at the top base, and this is where the shrieking is at its zenith. The whole process lasts less than five minutes. The more skillful wanzams get the surgery done in two minutes or less.

There were no mothers there, not because of the boys' nudity but the women used to cry as the boys cried, so the wanzams deemed it appropriate that they were stayed home. Since nothing is supposed to touch the wound, no underwear is worn during this recuperation period. A little sling is used to suspend it so it doesn't drop and touch the thighs; basically a newly circumcised boy walks gingerly around with his hand in the form of a protective arc in his cloth shielding this member. To avoid this comedy, some simply disappear from view until everything is over" (Frimpon, 2010: 137).

Some 46 cases were recorded in 1986 and by 2004; nearly 90% of infections were within the age group 15-49 years with 63% being women and girls while six cities have prevalence rates above 5%. The latest prevalence in Ghana as of 2010 is 2.0 and HIV is spread primarily through heterosexual sex (NACP and GHS, 2011). The beginning of the epidemic was characterised by high prevalence in females of a 5:1 ratio to males (Goodell, 2009).

According to Amoa (2005), the national response directed by Ministry of Health initially was managed as a disease which largely focused on prevention rather than as a developmental issue. Faria (2008) claims this approach was shaped by an international politics of funding for HIV/AIDS. An American geographer analysing the Ghanaian HIV/AIDS situation, she asserts that this agenda privileges prevention through behaviour change over integrated prevention-treatment effort. In her view, the pretext is that prevention is a more cost-effective option in resource-poor setting Ghana. From the initial response, the next phase was the establishment of National Advisory Commission on AIDS in 1985, National AIDS/STIs Control Programme (NACP) in 1987. As the disease later assumed a complex nature of an epidemic, the control body metamorphosed into Ghana AIDS Commission (GAC) in 2000. The GAC adopted a multi-sectoral approach programme (MAP) and developed a National Strategic Framework to guide the National Response. The National Response focuses on

prevention of new transmission, support and care for PLWHAs, creating an enabling environment, decentralised implementation structures, and research (Amoa, 2005). By 2005, ninety regional and district focal persons trained on monitoring and evaluation.

Although Ghana has been able to maintain low HIV/AIDS prevalence rates, Goodell (2009) maintains that challenges of structural adjustment and gender inequality expose vulnerability. This vile threat may be after all not seen invalid when one examines the pockets of explosion in the epidemiology of HIV infection in Ghana. The patterns of infection show variations both spatially and temporally in prevalence rate, incidence, gender and age (NACP and GHS, 2011). One such geographical region that has highest HIV prevalence rates is Manya Krobo traditional area (our study area). Indeed, when sentinel surveillance of HIV began in the country in 1992, the sentinel site at Agomanya in the district reported the highest HIV prevalence of 18.0%. Even though the rate has gone down since 1992, Agomanya still reports the highest HIV prevalence in the country (Anarfi, 1990; Agyei-Mensah, 2001; Sauvé, et al., 2002; Tuakli-Ghartey, 2003; Atobrah, 2004; Brown, 2005; Lund and Agyei-Mensah, 2008). According to Sauvé, et al. (2002) two distinct patterns of HIV distribution were identified in this area. Among the Krobos, the most important ethnic group, HIV was common among all age groups, reached a plateau (21.9%) in the 30- to 34-year-old group and was associated strongly with having lived in Côte d'Ivoire and with having received only primary school education. Among the other ethnic groups, prevalence decreased with age. The high HIV prevalence documented in this part of Ghana seems to be, to some extent, a consequence of a number of factors well explained and documented. Some include the consequence of the construction of the Akosombo Dam in the 1990s that submerged a third of the farms, poverty, migration, local transmission and diffusion (Anarfi, 1990; Agyei-Mensah 2001; Sauvé, et al., 2002). Recently, however, and as problems relating to OVC have escalated, new institutional mechanisms have been put in place, such as non-governmental organisations (NGOs), community-based organizations (CBOs), public services, and orphanages (Lund and Agyei-Mensah, 2008).

UNAIDS estimates that at least there are 1.1 million orphans of age 0-17 years in Ghana as of 2009 for children who have lost one or both parents due to all causes. It also estimates that children who have lost one or both parents to AIDS averaged 160,000 with a low estimate of 120,000 and a high estimate of 210,000. Many more are

vulnerable to the same circumstances orphans face even though they may still, for the time being, have at least one of their parents alive (UNAIDS, 2010).

Children are a vulnerable population, depending on adults for their needs and physical support. Vulnerability is both a useful and complex concept. The concept originated in the medical sciences, where the word “vulnerability” was first used for people who were susceptible to contracting illnesses and diseases. The concept is now used extensively to describe the situation of children experiencing diverse difficulties in various societal contexts (Manful and Badu-Nyarko, 2011). A collaborative vulnerability analysis carried under auspices of Republic of Ghana and UNDP Group’s Common Country Assessment (2004) reported that children’s vulnerabilities were not universal, but varied based on their developmental stages. Most children zero to five years old are infected with HIV through mother to child transmission, increasing infant mortality rates in areas where HIV is most prevalent. Poor nutrition and exclusion from preschool were also identified as significant issues. Ghana and UNDP (2004) concluded that the zero to five age group’s survival largely depends on the primary caregiver. According to the report, vulnerability levels depend on the quality of care available to the child (UNDP and Ghana, 2004). Exploitation and abuse were identified as the primary vulnerabilities of 6 to 12 year olds (Ghana and UNDP, 2004). These vulnerabilities lead to child labour, denial of schooling, poor health, and inadequate material support. Children, especially girls 13 to 18 years old, are at risk of becoming loose. Such behaviour may lead to unplanned pregnancies and places boys and girls at higher risk of acquiring HIV. If a girl becomes pregnant and acquires HIV, her infant is made vulnerable to infection, and the cycle continues (Ghana and UNDP, 2004). The multiple vulnerabilities that children face throughout their development are best understood when placed on a continuum from more to less vulnerability.

In 2005 and 2007, the National Policy Guidelines on Orphans and other Children made Vulnerable by HIV/AIDS and National Social Protection Strategy (NSPS) respectively were developed to provide safety nets for the vulnerable and excluded groups including children. Furthermore, a 3-year framework covering 2010-2012 period called National Plan of Action (NPA) for OVC is in operation. The OVC NPA framework is to provide care and support to vulnerable children in care institutions (UNICEF, 2010). From 8 NGOs in 2002, the number rose to 22 in 2004 were supported with financial assistance

for giving care and support to 3,000 OVC by GAC. Care and support includes food, school fees, counselling and nutritional supplementation to OVC. The challenge is how to sustain this initiative for which checks at the study area indicate is no longer functional (Amoa, 2005). Ankomah (1998) noted that condom use by women is problematic because in sexual exchange for economic gain, women find it difficult to refuse sex or demand condom use with men who offer them payment. The attitudes of adolescents were found to be similar to the general population except the concern for premarital sex. It is important to examine trends in knowledge and sexual behaviour in young people to understand current status and define areas that require future intervention (the MEASURE Project and the Ghana AIDS Commission, 2003).

Although Ghana began a pilot project to offer antiretroviral therapy (ART) to PLWHAs in 2003 (Amoa, 2005; Family Health International, 2006), there is no CD4 count reference intervals in healthy adult population as a baseline. The depletion of CD4 T-lymphocyte population in the blood helps to predict the disease progression in AIDS. Therefore the estimation of CD4 T-lymphocyte plays an important role in monitoring HIV progression and response to ART after accounting for variations in environment, ethnicity, genetic differences, dietary patterns, age and gender. Immunologists at Noguchi Memorial Institute for Medical Research, Ghana conducted Normal CD4+ T lymphocyte levels in HIV seronegative individuals in the Manya and Yilo Krobo communities in the Eastern Region of Ghana. The goal of this study was to determine the normal levels of CD4+ T lymphocytes in healthy individuals who were HIV seronegative (Ampofo, et al., 2006). The mean CD4 count of these individuals was 1067 cells/microl with women demonstrating higher baseline CD4 counts than men. This study found a WHO comparable HIV seronegative baseline CD4 count as well as gender-based differences in the CD4 count and CD4/CD8 ratio. Ampofo, et al. (2006) believes the establishment of the adult baseline for the country provides important demographic data. It indicates the appropriateness of current global treatment guidelines with regards to CD4 levels in Ghana.

Nutrition plays important role in the health and lives of people affected by HIV/AIDS. The association is clearly established as the disease is commonly referred to as "slim disease" because as it progresses, food intake and metabolism are altered, leading to visible body weight loss. Some studies by food scientists and nutritionists shed light on

coping strategies of sero-positive people. It is estimated that malnutrition robs at least 2-3 percent of GDP growth in Sub-Saharan Africa due to losses from increased health care costs in addition to losses from poor cognitive function and the losses it causes on schooling and learning ability. An exploratory investigation of dietary intake and weight in sero-positive individuals in Accra, Ghana found cost as a barrier in purchasing adequate amounts of food. The main foods contributing most to daily energy intake were fried fish, white rice, kenkey, white bread, and fufu (Wiig and Smith, 2007; Garcia, et al., 2008). However, a more recent comparative study in Manya and Yilo Krobo on dietary intakes of Ghanaian lactating women in relation to HIV status, Addo, et al. (2011) did not identify any differences in energy and nutrient intakes of HIV-infected women as compared with women who were uninfected or had not been tested for the virus. Diet was assessed with three 24-h recalls (one market day, one weekend day, and one non-market weekday). These results suggest the need to integrate multi-dimensional interventions that address economic and mental health constraints which may limit caregivers' ability to meet the dietary needs of OVC. In fighting the HIV/AIDS in Ghana especially regarding OVC, policy makers as well as caregivers must consider using a culturally appropriate method and meals to overcome barriers especially financial to achieving optimal dietary interventions to enhance OVC health and proper growth.

One of the biggest challenges of care efforts for OVC is how to handle their traumatized psychological state of mind. The main implication of such disorder is the increased risk of emotional and behavioural disturbance in these children. A quantitative psychological study was conducted to examine the impact of parental HIV/AIDS status and death on the mental health of children in Ghana. Doku (2009) found that orphaned children and children living with parents infected with HIV/AIDS are at heightened risk for psychological disorders. It also found signs of conduct, peer and emotional problems. The paper suggests that efforts to at urgently addressing the short and long term psychological care needs of both orphaned children and children living with parents infected with HIV/AIDS.

Education is the bedrock on which individuals especially children hold the key to escaping the vicious cycle of poverty, disease and ignorance. Early childhood, from birth through school entry, was largely invisible as a policy concern. Children, in the

eyes of most communities, were "appendages" of their parents or simply embedded in the larger family structure. The child did not emerge as a separate social entity until school age. Analysis of national data from 47 Sub-Saharan African countries including Ghana confirms the strong contribution of early childhood factors to success in primary school. Average primary completion rates are associated with pre-primary enrolment and with health and nutrition status early in life. Regrettably Ghana had only 40% of children enrolling in preschool in 2004 (UNESCO, 2006; Garcia, et al., 2008). Ghana's early childhood development sector has made a lot of progress, though it is still young and requires an expansion of services to allow for greater access to all. In addition, it will require more time and energy spent on improving the quality. Ghana has shown such dedication and if the rate of progress continues, the early childhood development centres, nurseries and crèches will become the essential centres of support for OVC (Deters, 2008).

The OVC situation in Ghana is comparatively less severe although is growing due to HIV/AIDS epidemic, changing rural-urban migration patterns and other socio-economic factors (Deters, 2008). The growing OVC numbers requires official care and support and has caused the country to rethink an official shift in approaches. The attitude is a shift towards developing both institutional/residential care and community-based interventions within their immediate or extended family home (Deters, 2008; Ministry of Employment and Social Welfare and UNICEF, 2010).

Children entering Ghana's public residential care have varying reasons for admission and characteristics. However, little is known about the different groups of children in residential care. An empirical research to understand the children in care and guide the implementation of appropriate interventions that meet the needs and improve the situations of different children groups in residential care was done at the Osu Children's Home, a large public residential care home in Ghana. Manful and Badu-Nyarko (2011) found that AIDS orphans were underrepresented in the home, contrary to what is reported in the dominant literature. Gender difference was not an issue in the home, since there were almost equal numbers of boys and girls. The absence of proper understanding of children's characteristics in residential care seems to be a barrier to identifying the interventions necessary for dealing with the true causes of children's vulnerabilities in the society. The study concludes that knowing the true characteristics

of children in public care will inform what type of interventions are appropriate for each population group, thus working to improve their residential care experiences.

A community-based intervention consists of a partnership approach that equitably involves community members, civil society groups, and experts to contribute their collective expertise with shared responsibility and ownership. The aim is to enhance understanding of the OVC phenomenon and integrate the knowledge gained with interventions to improve the health and well-being of OVC in the community. Many communities have spontaneously responded to the growing burden of young children affected by HIV/AIDS drawing on their own local child care traditions. With an adult HIV prevalence rate that is between 250 and 400 per cent higher than the national median, Manya Krobo communities in Ghana face extraordinary challenges in HIV/AIDS control and impact mitigation.

In 1965, construction of the Akosombo Dam on Lake Volta was completed. Lake Volta is the largest manmade lake in the world and extends from Akosombo Dam in southeastern Ghana to the town of Yapei, 520 kilometres to the north. The lake generates electricity, provides inland transportation, and serves as a resource for irrigation and fish farming. The construction of the Akosombo Dam flooded acres of land, which consequently displaced many farmers and people from their homes. Indeed, over 80,000 people were relocated to fifty-two townships. Resettlement resulted in economic displacement and local poverty and forced people to migrate to places like Côte d'Ivoire in order to seek work. Many female migrants engaged in commercial sex work in Côte d'Ivoire. HIV was likely introduced in the communities when women returned home for short visits or festive occasions, or when economic conditions improved in the area (Anarfi, 1990; Agyei-Mensah, 2001; Sauvé, et al., 2002; Brown, 2005). This trend diffused into the communities and left in its trail several victims including children some of whom were themselves infected as well. Like most African societies, institutionalised social welfare schemes for such deprived children and their caregivers are almost nonexistent even in the face of dwindling family resources and the breakdown of warm care and support (safety net) from the kinship system (Atobrah, 2004).

In the traditional African context, a parent was anybody who performed the role of parents – anybody who had taken over that responsibility. This tradition helped to

ensure that societal values and culture were respected, upheld and enforced. The on-the-job training many parents formerly received from extended family members or from religious and cultural traditions is largely unavailable to contemporary parents (Evans, et al., 2004). Yet some traditions remain. As Tuakli-Ghartey (2003) notes, Queen Mothers and male chiefs or kings are regarded as community leaders in Ghana, with Queen Mothers responsible for community children whose parents die or are too ill to care for them. They as custodians of traditions and cultural values intervened in this unfolding tragic drama as change agents or catalysts. After witnessing countless families struggle with the devastating impacts of the perplexing syndrome, Manye Nartekie, Manye Mamle Oklyeou, and Manye Makutsu, and other Queen Mothers from Lower Manya Krobo, approached the District Health Management Team for guidance and assistance (Brown, 2005; Steegstra, 2009). Thus was the birth of the Manya Krobo Queen Mothers Association Orphans and Vulnerable Children Safety net programme as a community response to the epidemic. Community-driven interventions at the household level that aim to strengthen capacities of affected families and communities appear to be the most cost-effective (Richter, et al., 2004). Responses must occur on all levels linking local actions with those at the national and global scales and should aim to make a difference over the long term. The potential is great for donors and implementing agencies to provide support to strengthen and increase the scope of this home-grown effort and to reach more children with better care (Garcia, et al., 2008).

Brown (2005) describes the economic and living conditions in Manya Krobo as poor. Poverty is widespread across the Manya Krobo area with high levels of hunger, malnutrition, and poor and inadequate housing and proper sanitation facilities. There is a high rate of unemployment among inhabitants, and much of the economic activity that takes place is subsistence-based. Brown (2005) further notes that while Lower Manya Krobo serves as the economic centre, Upper Manya Krobo consists mainly of small rural and scattered communities and villages. The transportation infrastructure in both Lower and Upper Manya Krobo consists of poor and deteriorating roads. While a paved single-lane road connects Upper and Lower Manya Krobo, community and village roads are extremely poor and difficult to access (Brown, 2005).

The traditional safety net in the Manya Krobo District largely hinges on the operations of the Queen Mothers' Association (Lund and Agyei-Mensah, 2008). The Krobo people

have strong and enduring traditional belief systems and practices (Brown, 2005). Brown identifies that MKQMA is actively assisting in the building of AIDS competence, which is understood as the notion that communities can become empowered to create and implement successful AIDS programmes for prevention and support. MKQMA has recognised the social consequences of the disease, which includes the loss of income for those affected and have thus created income-generating schemes for women in their communities, which include production of jewellery, cloth, soap, crops and training as seamstresses. There is a strong sense of community solidarity and commitment to one's neighbours and family. In building competency, Queenmothers have actively engaged in social marketing campaigns aimed at educating the public; identified harmful social and customary practices; created income schemes for affected women; provided support for those living with and affected by HIV/AIDS and; actively solicited resources from external agencies and programmes (Brown, 2005).

In comparison to prevention strategies and clinical trials of therapy, there have been very few studies of care and support programmes. Mensah (2011) assessed HIV/AIDS Orphans and Vulnerable Children and PLHIV Care, Support and Economic Enhancement Programme (HOPE) in Ghana. The overall aim was to carry out an evaluation of the 'HOPE' programme of community-based interventions (CBIs) in Ghana. Some of the challenges Mensah (2011) identified include apprehension of dissolution of the support groups when the programme ends. This is because they were not adequately involved in the decision making. Beneficiaries identified participation and cooperation as key prerequisites for sustainability but they also identified important weaknesses in 'HOPE' with respect to these criteria. To compound these weaknesses, most reported that they preferred doing something else rather than the skills offered them. The HOPE evaluation study apparently just examines activities of NGOs and PLHWAs rather than OVC and caregivers. From the literature on HIV/AIDS in Manya Krobo so far, Anarfi (1990), Agyei-Mensah, (2001) and Sauvé, et al. (2002) focus on the epidemiology and interpretation of the causes of the HIV/AIDS epidemic in Manya Krobo. Also Addo, et al. (2011) shows interest in the role of food intakes on PLHWAs while Ampofo, et al. (2006) seeks to establish CD4+ count baseline for Manya Krobo. Atobrah (2004) studies implications of the disease for OVC within the traditional and cultural context of the Krobo people while Brown's (2005) study provides a detailed

overview of the history and background of Manya Krobo, Krobo society, its system of traditional leadership, and the HIV/AIDS epidemic that currently threatens its people. Others for example Tuakli-Ghartey (2003); Amoa (2005) and Family Health International (2006) concentrate on issues linked to their own programmes but executed through MKQMA. These are the spread of HIV/AIDS in Ghana, trends in knowledge about HIV/AIDS, sexual behaviour, knowledge and use of condoms, and attitude of adolescents and generally care largely for PLHWAs. Among others Lund and Agyei-Mensah (2008) examines the significance of the traditional safety net to provide security and help to orphans and vulnerable children (OVC).

Providing care and support for OVC is one of the biggest challenges Ghana faces today, as the growing numbers overwhelm available resources. The aim of this review of literature is to update available evidence on priority OVC topics that lack an adequate evidence base, in order to inform programming and research activities. The reviews so far looked at scale, scope, and impact of AIDS ophanhood and AIDS-caused vulnerability as well as the traditional means of care and support. In Ghana, efforts had over the years focused on five main thematic fields. These are the spread of HIV/AIDS in Ghana, trends in knowledge about HIV/AIDS, sexual behaviour, knowledge and use of condoms, and attitude of adolescents as well as some level of care and support for those affected.

The aim of the current study is to investigate and propose an alternative care and support for OVC. The objectives of the study are to investigate and characterise the demographic profiles of caregivers as well as the social conditions of OVC and caregivers in the study area. Also to investigate and describe the knowledge, beliefs, attitudes and practices with respect to HIV/AIDS among the OVC and their caregivers. Then to evaluate Ghana AIDS Commission's goal to empower women and vulnerable groups to reduce vulnerability and provide care and support for OVC and other persons affected by AIDS. To assess the effectiveness of a community-organised foster care regarding providing shelter, food, health, and psychosocial support for OVC; and to establish factors necessary for creating enabling environment to sustain and replicate such a scheme.

1.3 - Social Exclusion

Social exclusion like all other social phenomena is beset with the problem of converging on a single acceptable definition. The concept is about how removed an individual is from the happenings in society due to inability to participate fully in all facets of life. That is to say people don't live randomly in neighbourhoods, they are incredibly economically segregated (Krieger, 2001). One definition that fits into the current study is one by Walker and Walker (1997: 8), as “the dynamic process of being shut out from any of the social, economic, political and cultural systems which determine the social integration of a person in society”. Its remit is wide including but not limited to the following: truancy, school exclusions, rough sleeping, drugs, unemployment, community breakdown, bad schools, lack of access to services for poor areas and poor individuals. The key to the identification of a substantial difference in health status or access between geographically defined populations or population segments is the degree to which the boundaries separate or include the population which is negatively affected or the degree to which the nature of the area itself affects health and health care. The wide disparity in access to health care services between rural and urban areas has been explored by health services researchers for decades (American College of Physicians, 1995; Schur and Franco, 1999).

Butler and Watt (2007) viewed social exclusion from two key points by tracing the philosophical origins and contextual definitions of the concept. They highlighted the concept’s ambiguities and theoretical paradigms shifts from poverty and rights induced redistributionist discourse, moral arguments for the excluded, to social integrationist approach. Focusing on areas of consensus, they defined it as “complex web of groups who find themselves economically marginalized, socially disadvantaged and politically powerless in contemporary society” (Butler and Watt, 2007: 111). The definition by Council of the European Union (2004) recognises other factors which are not in themselves directly or exclusively associated with lack of material resources of individuals. The Council viewed the concept as a “process whereby certain individuals are pushed to the edge of society and prevented from participating fully by virtue of their poverty, or lack of basic competencies and lifelong learning opportunities, or as a result of discrimination. This distances them from job, income and education opportunities as

well as social and community networks and activities. They have little access to power and decision-making bodies and thus often feel powerless and unable to take control over the decisions that affect their day to day lives" (Council of the European Union, 2004: 9). This definition is more relevant to this study as orphans and vulnerable are nearly always having little or no access to power and decisions which shape their well-being, empowerment and unveiling their potentials.

Since children absorb and learn knowledge especially cultural traits for survival from older generations, any phenomenon that disrupts the process becomes a major hindrance to their proper integration and development into the community. HIV/AIDS does not only infect individuals but also affects whole families and community by first attacking the centre of gravity within families and thereby disadvantage their dependants who then become vulnerable to environmental shocks. This phenomenon gradually erodes the mental and economic capacities of the affected person to equally and fairly compete in the hostile world where resources allocation and acquisition is determined by demand and supply factors. Thus one's inability to either meet demand or supply leads to a situation of exclusion. And like a vicious cycle, once the exclusion spiral is initiated, the process of moving downhill knows no end unless decisive external or rarely divine intervention sets in to intercede. Such is the power exclusion that eventually brings about social differences.

1.4 - Inequalities and Vulnerability

Geographic disparities in health have been noted throughout history; indeed "place" was long considered more a determinant of health than vectors or micro-organisms (Ricketts, 2002). Geography enables us to find a way of describing, understanding and explaining patterns of social and spatial interaction. It emphasises the welfare issues which affect people's lives, and often involves moral and political positions which oppose social inequality and oppression. Human ecology theory gives a more general definition of the interaction of the physical environment and health as including social structures and economic processes in a field sometimes termed "social epidemiology" (Berkman and Kawachi, 2000, Pain, et al., 2001, Butler and Watt, 2007). Indeed among experts, there is no agreement about how to best define a geographical area in terms of socioeconomic position or about which area-based measures of socioeconomic position

are most informative, especially across multiple kinds of health outcomes (Krieger, 2001).

Ideally, all human being should live in a minimum condition that will ensure proper development and most essentially healthy environment. Sadly, reality is sharply in contrast to the desirable ideals especially for many children and women in many parts of the world due to several predisposing factors. The nature and effects of inequality is best explained in the contemporary affluent social environment by the spatial relations paradigm which says ‘you are where you live’ (Savage, et al., 2004; Butler and Watt, 2007). Thus exposure to risks or vulnerabilities is largely influenced by certain environmental shocks that retard proper well-being. Vulnerability has been defined as "a high probability of a negative outcome", or an expected welfare loss above a socially accepted norm, which results from risky/uncertain events, and the lack of appropriate risk management instruments.

There is a difference between poverty and vulnerability as pointed out by Walker and Walker (1997) and Dercon (2005) where poverty is seen as the ‘”lack of material resources, especially income, necessary to participate in the society”, while vulnerability is defined as ex-ante poverty, forward-looking and warning about potential future poverty. While most of the estimated 37.8 million people living with HIV/AIDS in the world are adults, the pandemic’s devastating effects on families and communities reach down to the most vulnerable being the children (UNAIDS, UNICEF and USAID, 2004). These figures are meaningless without attachment to any geo-referenced coordinates. Statistical evidence helps us to appreciate the scale of inequality. However, it also does not by itself allow us to understand its social nature and impact. In order to understand such social processes, other social scientific studies based on qualitative research methods must be referred to (Butler and Watt, 2007). This helps to highlight the inequalities and vulnerabilities both intra and inter spatial phenomenon being investigated or under study.

The World Bank has developed a special OVC Toolkit on how to support Orphans and Other Vulnerable Children in Sub-Saharan Africa. The Bank sees vulnerability to mean "a high probability of a negative outcome", or an expected welfare loss above a socially accepted norm, which results from risky/uncertain events, and the lack of appropriate risk management instruments (World Bank and World Bank Institute, 2005). This is

consistent with the definition used in the Bank's social protection framework for social risk management (Holzmann and Jorgensen, 2001). The Bank revealed that vulnerability is shaped by risk and stress characteristics such as magnitude, frequency, duration, and scope, to which individuals, households and communities are exposed. Therefore, the degree and type of vulnerability vary overtime and between countries and are highly contextual. This implies that vulnerability is a relative state - a multifaceted continuum between resilience and absolute helplessness.

Compared to adults, all children are vulnerable by nature, but some children are more critically vulnerable than others. Child vulnerability is a downward spiral where each shock leads to a new level of vulnerability, and each new level opens up for a host of new risks. In other words, the probability of a child experiencing a negative outcome rises with each shock. At the bottom of this spiral we find children who live outside of family care or in situations of severe family abuse and neglect (World Bank and World Bank Institute, 2005).

1.5 - Orphan or Vulnerable child

HIV/AIDS is recognised worldwide as a threat to children and their families. AIDS is the leading cause of death worldwide for people ages 15 to 49. Millions of children have been orphaned or made vulnerable by HIV/AIDS (UNAIDS, UNICEF and USAID, 2004). The numbers for HIV/AIDS are staggering despite the reported overall decrease in the number of new infections, largely because people infected with the virus are surviving longer. At the end of 2007 there were an estimated 22 of the 33million people living with HIV in sub-Saharan Africa. AIDS is now the leading cause of death in sub-Saharan Africa – killing an estimated 1.3 million people in 2007 alone. In the same year another 1.7 million became infected with HIV (UNAIDS, 2008; NDPC and UNDP. 2010).

The impact of AIDS is extremely severe and wide-ranging and will have devastating consequences in the decades to come for virtually every sector of society ranging from households and farms, to growth of whole economies. Life expectancies have fallen below 40 years in some African countries, whereas they would have been above 60 years without AIDS. Most AIDS deaths occur among young adults, and these deaths have a devastating effect on families, communities and economies. The epidemic is wiping out development gains, fuelling the spread of other diseases (including

tuberculosis), even threatening to undermine national security, and orphaning millions of children in highly-affected societies (United Nations, 2004). The level of exposure to vulnerability by these orphans is a matter of serious concern to both policy makers and researchers. Sadly, not so much attention has been paid to this group like those given to awareness, advocacy, preventive measures, behaviour change communication, treatment for people living with HIV/AIDS for obvious reasons. Beegle, De Weerdt and Dercon (2008) adduced evidence that orphanhood matters in the long-run for health and education outcomes by expressing welfare in terms of consumption expenditure and concluded that there is a gap of 8.5 percent compared to similar children whose mother survived till at least their 15th birthday.

The concepts of gender, orphan and vulnerable child (OVC) are social constructs that vary from one culture to another. In addition, these terms take on different definitions that can be at odds with one another depending on whether they were developed for the purpose of gathering and presenting quantitative data or for developing and implementing policies and programmes. It is important to make this distinction and establish a firewall between definitions developed for one purpose versus the other. Problems occur in the field when definitions established for quantitative purposes are picked up and used for program targeting or eligibility criteria in policy and programme implementation (Williamson, Cox, and Johnston, 2004). Schenk, et al. (2008) highlighted the need to carefully consider the meaning of “vulnerability” when targeting programmes to support children affected by HIV and AIDS. In their view, local community input is vital to inform context-specific criteria for distributing programme resources but also stressed that while eligibility criteria should be context-specific yet should be flexible to evolving community realities. This brings to the fore the need to consider the ‘geography’ of the specific programme area so as to prepare a criteria that meets their needs. Schenk, et al. (2008) recommended that settings where levels of HIV, related vulnerability are high, it may be more efficient to target at the level of communities rather than assess individual households.

It is in this light that the World Bank OVC Toolkit definition becomes useful. This was developed especially for Sub-Saharan Africa and thus more appropriate for this research. The World Bank OVC Toolkit (World Bank and World Bank Institute, 2005) defined orphan or vulnerable child as a concept generally referring to orphans and other

groups of children who are more exposed to risks than their peers. It further emphasis that “in an operational context, we can say that they are the children who are most likely to fall through the cracks of regular programmes, or, using social protection terminology: OVC are groups of children that experience negative outcomes, such as the loss of their education, morbidity, and malnutrition, at higher rates than do their peers”. It suggested that to be protected from negative outcomes and/or allowed participation, OVC need to be given special attention to remove the barriers that stand in the way of their equal participation in projects designed to benefit all children, or through special project components and targeting strategies tailored to their needs.

Orphanages, children’s villages, or other group residential facilities may seem a logical response to growing orphan populations. In fact, this approach can impede the development of national solutions for orphans and other vulnerable children. Such institutions may be appealing because they can provide food, clothing, and education, but they generally fail to meet young people’s emotional and psychological needs. This failure, and its long-term ramifications, support the conclusion of a study in Zimbabwe that countries – and children – are better served by programmes that keep children with the community, surrounded by leaders and peers they know and love, are ultimately less costly, both in terms of finance and the emotional cost to the child (Powell, et al., 1994).

World Bank (2005) has categorised OVC in Africa into six main groups namely:

1) Street Children;
2) Children in the Worst Forms of Child Labour;
3) Children Affected by Armed Conflict;
4) Children Affected by HIV/AIDS;
5) Children Living with Disability;
6) Local OVC Groups.

It stresses that the categories are neither exhaustive nor exclusive. Many critically vulnerable children fall into many of the categories. For instance, street children can also be orphans or disabled. Children affected by armed conflict can be all of the above. Street children are "children of the street", and "children on the street", children in the Worst Forms of Child Labour includes all forms of slavery or practices similar to slavery, use, procuring or offering of a child for prostitution or illicit activities as well as harmful

work. Children Affected by Armed Conflict are children who can become orphaned, disabled, traumatized, or end up unaccompanied or with disabled or traumatized parents and siblings as a result of acts of war or current or former child soldiers, messengers, spies, support staff and sex slaves. Children living-with-disability is a term that refers to "a physical, intellectual or sensory impairment, medical conditions or mental illness, whether long or short-term, which leads to the loss or limitation of opportunities to take part in the life of the community on an equal level with others" (UN General Assembly, 1993: 5). There are also special local OVC groups whom must be taken into consideration. These should be identified both at a national level and in communication with the beneficiary communities.

According to the World Bank categorisation (World Bank and World Bank Institute, 2005), there are four main categories of children affected by HIV/AIDS.

Firstly, children who live with parents infected with HIV/AIDS. They may experience neglect as a result of parental illness, suffer social stigma, be responsible for caring for sick parents and younger siblings, have experienced abandonment by one parent who leaves to escape the other's illness, or simply live with great insecurity and anxiety as they wait for their parents to become sick(er) and eventually die. Property grabbing sometimes happens even while the parents are alive, but too ill to defend themselves.

Second definition is children who are orphaned by HIV/AIDS. This includes maternal, paternal or double orphans. It is important to note that children living with a step parent or a co-wife can be particularly vulnerable in their own household, even if one of the parents is still alive.

Third category is children who are infected with HIV/AIDS. Infected children generally live with one or both parents, but they can also be orphaned or rejected (most common for infants and youth) and end up in institutional care or in the streets. Infected children often experience social stigma that may result in their being refused access to school or other services. In addition, they have special health care needs that must be addressed.

The last group is children who live away from home because of HIV/AIDS. Some children have left their homes because of the way the disease has affected their primary caretakers.

1.6 - Operational definitions

In the context of this research, the following definitions were applied.

1.6.1 - Child

A person aged 18 years and below (UNICEF, 2001; Rusakaniko, et al., 2006). This definition of child is a subject matter of ongoing debate. In many parts of Africa, a child is not considered adult until he/she leaves home to marry, which could be over the age of 18 years. Hence, some 'persons' are excluded from the category of children and thus as OVC. This anomaly may underestimate the orphan situation in some countries (Atobrah, 2004; Lund and Agyei-Mensah, 2008). In absence of convergence, we adapt and operationalise the above definition for this study albeit the contentious aptness.

1.6.2 - Orphan

A child aged 18 years and below who has lost either one or both parents (UNICEF, 2001). The definition adapts similar approach regarding as that of a child given earlier.

1.6.3 - Vulnerable Child

A child who is living under difficult circumstances which include children in poor households, with sick parents, children in child-headed households, children who head households, children dependent on old, frail or disabled caregivers, and children in households that assume additional dependency by taking in orphaned children. This is another concept that at the moment has no clear working definition or a conclusive agreement yet. There are multiple definitions as every organisation combines several characteristics in their definition of vulnerability. Research shows for example that the number of OVC in Kenya is not known partly because of lack of a common country definition of OVC, especially the term "vulnerable" (Kenya Country Brief, 2009). Of note is that there is no direct relationship between orphanhood and vulnerability. One can be an orphan but not vulnerable, or one can be vulnerable and not necessarily be an orphan (Rusakaniko, et al., 2006).

1.6.4 - Household

This term refers to a group of persons who stay or who usually reside together and share food from the same pot, whether or not they are related by blood (Rusakaniko, et al., 2006).

1.6.5 - Child-headed Household

A household in which a person aged 18 years and below is responsible for making day-to-day decisions for a group who stay or who usually reside together and share food from the same pot, whether or not they are related by blood (Rusakaniko, et al., 2006).

1.6.6 - Caregiver/Caretaker

A person who regularly and voluntarily assists a household whose members are related to him/her in terms of doing household chores, advice, giving spiritual, psychosocial and material support (Rusakaniko, et al., 2006). The words caregiver and caretaker are used interchangeably in this study. The Ghana Children's Act uses the phrase *foster-parent.* A foster parent is a person who is not the parent of a child but is willing to undertake the care and maintenance of the child. By Ghanaian law, any person above the age of twenty-one years of high moral character and proven integrity may be a foster-parent to a child. Any person who is legally liable to maintain a child or contribute towards the maintenance of the child is under a duty to supply the necessaries of health, life, education and reasonable shelter for the child.

1.6.7 - OVC

OVC is defined as a child who is more vulnerable because of any or all of the following factors that result from HIV/AIDS: is HIV, positive; lives without adequate adult support; lives outside of family care; or is marginalised, stigmatised, or discriminated against (President's Emergency Plan for AIDS Relief, 2006; Kenya Country Brief, 2009).

It is instructive to also take cognizance of the Ghana Children's Act of 1998 which provides an expanded all inclusive definition. While it only mentioned orphans without specifically using the word vulnerable, it nonetheless defined contexts which can be construed to mean vulnerability. It referred to such situations as constituting a *child in*

need of care and protection. These precarious contexts can be broadly categorised into orphanhood, desertion (including destitution, streetism, homelessness and no visible means of subsistence), shirking parental/guardian responsibilities, exposure to social ills and physical danger (including moral corruption, criminal conduct, hazardous conditions and trafficking), abuse, any harm and being an offender.

The original definition from quoted sources classified a child as 0-17 years but since our operational definition already identifies a child as 18 years and below, we apply our operational concept of a child. Furthermore, for practical reasons as argued out by Atobrah (2004) and because children develop at varying rates as they age, the community's age-appropriate concept of a child and vulnerability will be considered. However, since the study focuses on those with increased vulnerabilities from HIV/AIDS, greater attention will be paid to HIV/AIDS OVC.

1.6.8 – Incidence

The number of people developing AIDS over a specified period, for example in 2009 there were 22,541 newly diagnosed cases of AIDS in Ghana (NACP and GHS, 2010).

1.6.9 – Prevalence

The number of people with HIV infection (condition or characteristic of AIDS) at a specified time, for example in 2009, 1.9% of the adult population aged 15 to 49 years attending antenatal clinic tested HIV positive. It is about HIV is distributed by gender, age, socio-economic class, ethnicity, etc.

1.7 - Gender, Care and Caregiving

With the emergence of HIV/AIDS and its consequent high death tolls on the productive sector, child social inequalities have increased within countries, within communities, and even within households due to increased vulnerability. Addressing the needs of orphans and vulnerable children (OVC) and mitigating negative outcomes of the growing OVC population worldwide is a high priority for national governments and international stakeholders that recognise this as an issue with social, economic, and human rights dimensions (Kenya Country Brief, 2009). As has been defined earlier in this text, vulnerable children are those who face a higher risk than their local peers of

experiencing shocks. When compared to other children, an OVC bears a substantive risk of suffering emotional or mental harm. Thus, a child is vulnerable when he/she is affected or infected by HIV or is either neglected, abandoned, from a poor home, or even in a child labour situation (World Bank and World Bank Institute, 2005; Lund and Agyei-Mensah, 2008). The World Bank's Social Risk Management framework (World Bank and World Bank Institute, 2005) has outlined the following areas of OVC needs that make them require special attention:

- Infant, child and adolescent mortality;
- Low immunisation, low access to health services, high malnutrition, high burden of disease;
- Low school enrolment rates, high repetition high rates, poor school performance and / or drop out rates;
- Intra-household neglect vis-à-vis other children in the household in terms of reduced access to attention, food, and care;
- Family and community abuse and maltreatment such as harassment and violence; and
- Economic and sexual exploitation due to lack of care and protection.

Although a growing number of researchers recognise that children are resilient and have agency (Boyden and Mann, 2000; Cook and Du Toit, 2005; Dawes and Donald, 2005; Sheahan, 2006), children living in the wake of HIV/AIDS are limited in their agency. The 'ideal' image of childhood, "one where children have love, time and a safe place to play, nurturing, schooling" (Cook, Ali and Munthali, 2000: 30) and connections to their cultural traditions is not the case for many children.

The growing number of orphans and the high number of adult deaths have caused a shock to the traditional child protection mechanisms in many areas, and social capital is weakening as family and community systems disintegrate (World Bank and World Bank Institute, 2005). Traditional absorption mechanisms for children have become strained. For instance while many orphans and vulnerable children need direct communication with adults about parental illness and death, adults themselves are often unable to identify and manage children's distress constructively and positively (Wood, et al., 2006).

Some researchers argue that such apocalyptic predictions are unfounded and ill-considered and there is no evidence from countries where numbers of HIV/AIDS orphans are already high to suggest that their presence is precipitating societal breakdown (Bray, 2003; Abebe and Aase, 2007; Lund and Agyei-Mensah, 2008). Such misrepresentations of course do not exist in a vacuum but might be borne out of the problems faced by children and their families due to the multiple layers of social, economic and psychological disadvantage that affect individual children, families and communities. According Bray, the problem with such conclusions is that insufficient consideration is given to the multifaceted supports necessary to cope with the extremely difficult circumstances caused by the HIV/AIDS epidemic and its long-term impacts.

A typical example is found in the 2006 annual report of the Manya Krobo District Assembly, the study area. The report specifically identified six problematic areas associated with the vulnerable and excluded in the District. These were high illiteracy rate among the vulnerable, low awareness in gender main streaming, high incidence of child labour and child delinquency (especially on market days), large number of single parenting women in difficulty, inadequate facilities and resources for training the vulnerable and excluded and difficulty integrating the trained disabled back into the community as productive members. While it may look strange that the district with highest HIV prevalence in Ghana does not even make mention of the disease as a problem associated with the vulnerable, the next paragraph paradoxically indicates people living with AIDS and orphans as beneficiaries of its efforts and support to alleviate the challenges of the vulnerable and excluded. However, a careful reading and analysis of the wording of the subsequent sentences reveal in greater detail the less importance the authorities in the district attach to the AIDS OVC situation confronting them. Indeed the use of words like ‘efforts and support’ in the report are mere charade for the formal relationship that is expected to exist between the district and its civil society partners. These lapses in reporting maybe however over exaggerated if consideration is given to local and traditional multifaceted support systems that exist in cultures where institutional support either never existed or only exist on paper. For instance in the same report, two paragraphs following reveal that the bulk of care and support for OVC in the District is provided by Non-Governmental Organisations (NGOs) and community Based Organisations (CBOs). This could also reflect and support the

assertion that social capital for OVC is weakening (World Bank and World Bank Institute, 2005).

Some researchers postulate that for the first time in African history the acclaimed extended traditional clan system of care and support for the vulnerable and excluded is breaking down under the weight of HIV/AIDS. This is indeed worrying, particularly as Africa has gone through warfare, colonialism and post-colonialism without experiencing any such breakdown (Webb, 1994; Hunter and Williamson, 2001; Johnson and Dorrington, 2001; UNICEF, 2001; UNAIDS, UNICEF and USAID, 2004).

Providing care and support for OVC is one of the biggest challenges today as the growing numbers overwhelm available resources. AIDS, fuelled by high poverty levels, is one of the main contributors to OVC incidence. Understanding the magnitude of the problem and socio-demographic characteristics of OVC can provide the foundation for building programmes of appropriate design, size and scope. Dawes and Donald (2005: 9) argue that "an understanding of children's lived contexts is central to the design of effective interventions because it can take into account both the universal aspects of development and local cultural practices." The task of meeting the emotional, psychological, social and physical needs becomes even most herculean in the Ghanaian context where local knowledge and practices vary. It thus calls for design and adoption of more appropriate and effective interventions to suit each setting in question. Indigenous cultural practices here refer to the norms, taboos and rituals that are upheld within various groups or communities (van Heijden and Swartz, 2010). And this is where the inclusion and contribution of the third sector comes to the fore.

The third sector is diverse, incorporating a range of informal and formal organisations of varying sizes and capacities. In the area of health, many condition-specific organisations now exist, alongside organisations with a broader health and welfare-related scope. The term 'third sector' has increasingly been used to describe, and capture the diversity of the voluntary and community sector (Salamon and Anheier, 1997; Lyons, 2001). The third sector often with gender focus or more appropriately feminist bias works within and across the diverse fields of queer and feminist theories to generate political alternatives to the subjugation of people across multiple nodes of difference and the myriad hierarchies of power that materialise in relation to them (Wright, 2010). The non-profit groups perhaps achieve better results as their sole

objectives are often ascribed to the spirit of volunteerism denoting donating their time, effort and talent to causes of narrow fields of social and community needs and thereby improve the quality of community life. The full potentials of some of these NGOs and CBOs are not however tapped and realised due to inadequate resources, stringent conditions and terms (Fosu, 2008).

In the 1980s, gender and development approach (GAD) emerged as a result of women in development (WID) and its shortcomings, concentrating on the unequal relations between men and women due to “uneven playing fields”. Gender refers to the social attributes and opportunities associated with being male and female and the relationships between women and men and girls and boys, as well as the relations between women and those between men. These attributes, opportunities and relationships are socially constructed and are learned through socialisation processes. They are context/time-specific and changeable. Gender determines what is expected, allowed and valued in a women or a man in a given context. In most societies there are differences and inequalities between women and men in responsibilities assigned, activities undertaken, access to and control over resources, as well as decision-making opportunities. Gender is a part of the broader socio-cultural context. Other important criteria for socio-cultural analysis include class, race, poverty level, ethnic group and age (Osagi, 2001).

The term gender as an analytical tool arose from an increasing awareness of inequalities due to institutional structures. It focuses not only on women as an isolated and homogeneous group, but on the roles and needs of both men and women. Given that women are usually in disadvantaged position as compared to men, promotion of gender equality implies an explicit attention to women’s needs, interests and perspectives. The objective then is the advancement of neutralising the biological differences between women and men. However, due to conservatism entrenched in local traditions and practices, any politics by and in support of those who subvert normative gendered and sexual subjectivities will require ‘geographical imagination(s)’ that bridge approaches across the social sciences and humanities (Elder and Nast, 2007; Wright, 2010). Thus is where context/time-specific and changeable GAD approach fits in and has over time brought on board the evolution of a number of concepts such as empowerment and mainstreaming which aim to assuage the fears of

myriad hierarchies of power (Osagi, 2001; Wright, 2010). Gender empowerment is seen as the process of gaining control over self, over ideology and the resources, which determine power. It implies people comprising both women and men taking control over their lives by setting their own agendas, gaining skills (or having their own skills and knowledge recognised), increasing their self-confidence, solving problems, and developing self-reliance. It is both a process and an outcome and means an expansion in women's ability to make strategic life choices in a context where this ability was previously denied to them (also see more details on conceptual framework).

Gender mainstreaming has been defined by the UN ECOSOC agreed conclusions (1997), as *a* strategy for making women's, as well as men's, concerns and experiences an integral dimension in the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and social spheres so that women and men benefit equally and inequality is not perpetuated. The ultimate goal is to achieve gender equality.

According to Ghana Demographic and Health Survey 2008 (GDHS), "in Ghana, gender issues are basic to confronting the HIV and AIDS epidemic. Many interventions have been developed and implemented to address gender equity so that men and women have full access to information and services that can help reduce vulnerability to infection and or mitigate effects of HIV and AIDS" [Ghana Statistical Service (GSS), 2011; Ghana Health Service (GHS), 2010; 237, Ghana AIDS Commission (GAC), 2009].

Children in Manya Krobo and indeed Ghana as a whole face many challenges during childhood. As a child's age increases, the likelihood of the child living with both parents decreases. Lack of parental care and support due to HIV/AIDS exposes children to increasing vulnerability, such as food insecurity and chronic malnutrition, lack of protection/shelter, lack of access to education and physical and sexual abuse. These children also face the increased burden of caring for ill parents and of stigma and discrimination. This vulnerability can, in turn, increase children's risk for contracting HIV/AIDS. The Ghana AIDS Commission and some NGOs provide support and assistance to OVC in Ghana. However, this support is inadequate and the burden still falls on the immediate family and the extended family system. According to a national survey on services for OVC in 2005 by the Ministry of Local Government and Rural

Development, there were an estimated 208,628 OVC in 96 out of the 110 districts in Ghana at the time (i.e. number of existing districts before 28 and 42 more were created in 2007 and 2011). The survey found that 133,779 or 64.1 percent of OVC were receiving various forms of support, while the remaining 74,849 or 35.9 percent have not been reached by any services (Republic of Ghana, 2005). The Ghana Statistical Service (2004) estimated that about 27% of all OVC have been orphaned through HIV/AIDS.

In the Manya Krobo District (see Figure 2.7 in chapter two) , efforts as far as the vulnerable and excluded are concerned, have been in the areas of support for the disabled, people living with HIV/AIDS and orphans who have been helped to be placed in foster family care (Manya Krobo District Assembly Report, 2006). The foster family mentioned herein according to Lund and Agyei-Mensah (2008), mainly refers to the Queen Mothers of Manya Krobo traditional area (traditional women leaders) who provide care and support for OVC in the District. The term Queens as Mothers is used metaphorically to depict how these Queen Mothers serve as Mothers to the HIV/AIDS OVC. The question that readily arises is why the Queen Mothers serve as foster family? So much has been written about them, their roles and perhaps they are so nobly unique beyond compares. Common to all Queen Mothers is that they are recognised as leaders for other women within the community. Queen Mothers in different communities in Ghana have had a variety of roles, ranging from ancestral heads equal to a chief, to respected persons within the community charged with the responsibility of performing various rituals and rites. Though Ghanaian law grants traditional leaders authority to codify customary laws, Queen Mothers in Ghana in reality do not participate in the local, regional, and national assemblies of traditional leaders, only male chiefs participate in these bodies. By denying Queen Mothers equality in governance and exclusion from traditional bodies, Ghanaian women's concerns and rights are not adequately advocated for, represented, nor protected (Teyegaga, 1985; Huber, 1993; Von Struensee, 2004; Stoeltje, 2004; Fayorsey and Amolo, 2005). Another reason for placing OVC in Queen Mothers foster care maybe the belief and philosophy professed by James Allen in his book as a man thinketh so he is that “man is a growth by law and not a creation by artifice. A noble and God-like character is not a thing of favour or chance, but is the natural result of continued effort in right thinking, the effect of long-

cherished association with God-like thoughts" (Allen, 2001: 5). The Queen Mothers have unquestionable character desirable for bringing up OVC and naturally as women can have the tender love and care for children.

Despite extolling the virtues of this culturally-sensitive OVC foster care arrangement as creating a local response to crisis and vulnerability, its future looks gloomy because it is not ideal (Lund and Agyei-Mensah, 2008). The researchers identified challenges with its operation, kinds of solutions it provides and its prospects. The scheme operates to cover both development and health-related OVC but it is economically dependent on external donors making its operations vulnerable to uncertainties in terms of coverage and maintenance. There is no state support and direction. Secondly, it provides immediate short-term well-being and care which lacks capacity to provide enough individual attention, care and love to all OVC. Its effectiveness and sustainability is at risk of balancing on the brink of its carrying capacity.

A number of issues arise as a result of lack of state support and clear cut guidelines on quality standards. Such standards of care should aimed at accurately documenting the magnitude and characterisation of the OVC population in terms of numbers, age, gender, geographical location, and care placement whether numbers in residential or family care. These issues include lack of consistency in measuring standards of care, balancing global standards to specificity, understanding and addressing gender dimensions in the context of domestic workers, caregivers, transitional shelters, and addressing the absorptive capacity of families.

In the absence of standards of care, it becomes imperative that this study determines the ratio of school attendance between OVC and non-orphans evaluate Ghana AIDS Commission's claim of empowering women and OVC to reduce vulnerability as well as provision of care and support, and assess gender roles in the OVC problem. This hopefully will help create a society where all OVC live to their full potential and their rights and aspirations are fulfilled.

1.8 - Prevention, protection, care and support for children affected by HIV and AIDS

Whether a person is positive or negative doesn't really have to determine where they get

to in life. At the end of the day, all should be given the same amount of time every year-24 hours, 365 days. At the end of the day, whether one is positive or negative, all still need each other. Ideally, this perspective should ring true for the millions of youth living with HIV. They need support from each other, their families, and their communities. However, that support and youth-friendly services-including HIV counselling and testing, care, and treatment-can be hard to find where resources are scarce. A statement by the United Nation's International Children's Fund (UNICEF) to commemorate World AIDS Day 2010 encapsulates the state of affairs of young people infected with and having to live the rest of their lives HIV positive. According to UNICEF Chief of HIV/AIDS, Jimmy Kolker tens of thousands of children who were born HIV positive because of mother-to-child transmissions are reaching their teens, and there's a whole new set of issues. These include their need for medical and emotional support as they move from paediatric to adult care and navigate the normal hurdles of growing up (UNICEF, 2010).

Basically, there are four thematic interests or priorities with respect to young people infected with HIV. These are prevention of mother-to-child transmission of HIV, paediatric treatment, prevention among adolescents and young people, and protection for orphans and vulnerable children. Significant progress has been made in achieving universal access to HIV treatment, care, prevention and support in some countries (WHO, UNICEF and UNAIDS, 2010).

One vital way of facilitating the attainment of these laudable goals is ensuring communication rights. There is the need to intensify efforts to advance communication rights that help prevent the stigmatisation of people living with HIV and AIDS. Greater progress is possible if universal access to care and prevention are understood as a fundamental human right. According to the World AIDS Campaign (WAC), the choice of 'universal access and human rights' theme for 2009 and 2010 offers opportunities to have a comprehensive approach that ties directly to universal access (Burke, 2009). Linking universal access to human rights helps bring the HIV diagnosis and treatment issues into existing fora and before world leaders who are already committed to pursuing a human rights agenda. A rights-based approach gives more credence to the international agreements related to human rights and their precedence in international law (Burke, 2009). Communication rights are essential to promoting universal access to HIV and AIDS treatment, care, prevention and support. Communication rights empower

people living with and affected by the virus to express their needs, to make their voices heard, and to take charge of their own lives. New knowledge and support from the Christian Council of Ghana on the right to a life free of discrimination aided Regina to successfully challenge a landlord's threat to evict her from a rental home because of her sero-positive status. Information on the legal supports in place made it possible for Regina to stay until the end of her tenancy agreement (World Association of Christian Communication, 2010).

Creating awareness about such laws is a first step towards providing people living with and affected by HIV and AIDS with the knowledge necessary to make informed decisions about their lives. Such decisions bear directly on their possibilities to access treatment, care, prevention and support. The willingness and desire by all to find more intentional approaches to advance communication rights challenge stigmatisation and discrimination and save lives.

1.9 - Social Support

Social exclusion, inequality, vulnerability and other shocks place individuals particularly children at a disadvantaged position in relation to their peers in the society. In view of the dire and negative consequences of such a challenge, the society has a major role to ensuring that it supports all its members through interventions with the ultimate goal of levelling up.

Social support is a concept that is generally understood in an intuitive sense, as the help from other people in a difficult life situation. One of the first definitions was put forward by Cobb (1976). He defined social support as the individual belief that one is cared for and loved, esteemed and valued, and belongs to a network of communication and mutual obligations (Cobb, 1976). In defining social support a distinction can be made between the quality of support perceived (satisfaction) and provided social support. Most studies are based on the measurement of subjectively perceived support, whereas others aim at measuring social support in a more objective sense. One could also distinguish between the support received, and the expectations when in need, and between event specific support and general support. The definition in terms of a subjective feeling of support raises the question whether social support reflects a personality trait, rather than the actual social environment (Sarason, et al., 1986; Pierce,

et al., 1997). Most researchers will agree that the person as well as the situation affects perceived social support, and that the concept deals with the interaction between individual and social variables. Social support is receiving help from other people when in need of help (Dalgard, 2009).

Lack of social support is shown to increase the risk of both mental and somatic disorders, and seems to be especially important in stressful life situations. Poor social support is also associated with enhanced mortality. Social support may affect health through different pathways: health behavioural, psychological and physiological pathways. Geographically, social support varies across space and time as well as between men, women and children. This is often determined by individual and environmental factors. The position of a person within the social structure, which is determined by factors such as marital status, family size and age, will influence the probability of them receiving social support. The occurrence of social support depends on the opportunities that a person creates to interact with other people. The structure of the community determines the extent to which people live in a social context conducive to social support.

Following the distinction between perceived and provided social support; a varying number of groups deemed to constitute types and sources of social support have been identified. House (1981) described four main categories of social support: emotional, appraisal, informational and instrumental.

Emotional support generally comes from family and close friends and is the most commonly recognised form of social support. It includes empathy, concern, caring, love and trust.

Appraisal support involves transmission of information in the form of affirmation, feedback and social comparison. This information is often evaluative and can come from family, friends, co-workers, or community sources.

Informational support includes advice, suggestions, or directives that assist the person to respond to personal or situational demands.

Instrumental support is the most concrete direct form of social support, encompassing help in the form of money, time, in-kind assistance, and other explicit interventions on the person’s behalf.

1.10 - The concept of social integration in the era of HIV/AIDS

There is a quite large body of evidence indicating that social relationships are important determinants of health (Commission on the Social Determinants of Health, 2008; Raphael, 2008). Social scientists over the years have being exploring the links between a sense of inclusion or otherwise and their implications for purpose and meaning in life to humankind. Integration studies have sought to demonstrate the positive impact of interaction on isolated groups of society. Actively engaging in social roles helps people build self-esteem, physical wellness and a sense of commitment to the community around them.

One such acclaimed study was posited by a French Sociologist, Emile Durkheim (1858–1917). He contributed significantly to the study of social constructs and the purposes they serve with his Theory of Social Integration (Durkheim, 1951). Social integration theory shows that a lack of positive social interaction and acceptance has negative consequences from an individual, family, community and societal perspective. Actively engaging in social roles helps people build self-esteem, physical wellness and a sense of commitment to the community around them.

Social integration theory explores the effects of belonging to a social group or society. Three social constructs are highlighted in the study of integration domestic society, religious society and political society. Durkheim theorised that a lack of affiliation with each of these societal groups is dangerous to an individual's mental well-being. The significance of social integration is that it is the means through which people interact, connect and validate each other within a community. The theory proposes that people experience mental, emotional and physical benefits when they believe they are a contributing, accepted part of a collective. Without that sense of connection, they can experience depression, isolation and physical illness that could limit them from experiencing productive and happy lives (Durkheim, 1951).

His studies were concentrated in political social groups, domestic social groups and religious social groups. Durkheim identified three key levels of integration, namely, domestic, political and religious integrations (Durkheim, 1951).

On Domestic Integration, Durkheim believed that a person’s level of integration could be measured by marriage, the size of one’s family and sexual contacts (Durkheim, 1951).

Political Integration according to Durkheim is indicated by events such as war and major political upheavals which increase social integration thus lowering accounts of depression and suicidal thought. The "us-against-them" mentality that overflows during times of war causes people to bond closely with others on the same side of the conflict. Having a common enemy brings people together turning individuals into a society (Durkheim, 1951).

And lastly, Durkheim explored the bonds that exist between members of a religious sect. What Durkheim found was that those who could boast of some sort of religious affiliation were less likely to become depressed and suicidal. He believed that the most important thing religion brings to society is a sense of purpose, without which humankind is more prone to self-destruction due to a lack of meaning in life. Religion provides bonding experiences as well as a common goal and shared belief system (Durkheim, 1951).

Durkheim concluded that a lack of social integration leads to what he saw as a dangerous state of mind. He named this state of mind "excessive individualism". His theory was that social bonds and attachments along with an established place within a group are the things that keep people grounded in emotional reality. According to Durkheim (1951), without social integration, the suicide rate will skyrocket. Thoughts of worthlessness are prevalent among individuals who feel isolated from others. According to social integration theory, people need to be part of a society.

This theory established the basis for making very strong correlation between interactions on the one hand, and the quality of life and physical health on the other. Social scientists from Columbia and Harvard Universities conducted a quality of life study among patients with severe mental illness (Ware, et al., 2008). Applying social integration theories to demonstrate the emotional and mental value of interaction and citizenship for disabled individuals in the community, the study supported the belief that both interaction and citizenship are reasonable expectations in patient care. Citing successful employment programs that place disabled individuals into competitive jobs, the study demonstrated the potential capacity of social integration in effective long-term treatment and sense of wellness among patients.

According to Durkheim, improper social integration was linked to the health risks of prolonged isolation, including mental or physical illness and suicide. Cohen, et al.

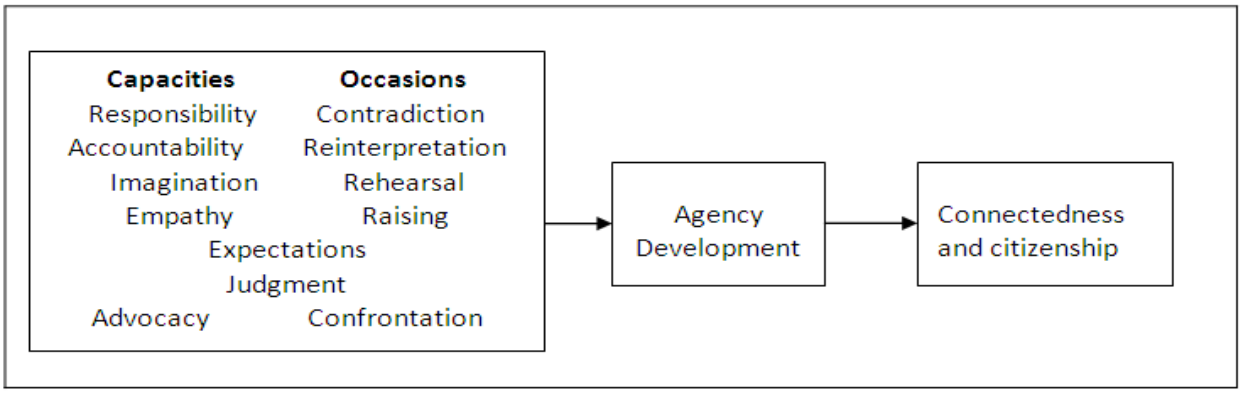
(2000) investigated the link between social networks and public health by looking at network diversity and susceptibility to an infection by two strains of the common cold. The scientists found that rates of illness decreased as an individual's social network increased. Individual perception of their roles in society (such as parent, spouse, or friend) generated positive emotional and mental states. Positive self-perception was linked to the production of hormones associated with immune function. The study also suggested multiple social roles could also impact individual exposure to positive health models and influence.

Ware, et al. (2008) drew upon theoretical orientations developed by Durkheim contemporary social network theorists to develop attachment theory in relation to psychiatric capability development. Their intent was to construct a working theory of capacity development for social integration that applies to persons who had been psychiatrically disabled. The capabilities approach offers several advantages as a conceptual framework. It assumes diversity and treats growth rather than chronicity as a way of thinking about life possibilities following shocks. Growth is the contingent outcome of dialectic between the individual and the social context. The development process is thus one in which occasions for growth follow and build upon one another in order of increasing difficulty. Success and failure, trial and error, are expected parts of the process. Finally, the capabilities approach leads to a framing of quality of life following vulnerability challenges that prioritise capacity for reflective action over satisfaction and functioning. The working theory posits a spiral-like growth process through which once-disabled persons increase social integration through capacity development.

The study also sought to determine the capacities that needed for connectedness and citizenship. Researchers Ware, et al. (2008) writing on ‘a theory of Social integration as quality of life’ suggested the following capacities, their meanings and usefulness in reintegration process.

Responsibility is the ability to act in ways that reflect consideration and respect for others. Accountability is being answerable to others for the consequences of one’s actions in the context of a given set of social or moral standards. Imagination is the ability to form ideas and images in the mind and know they are mental creations. Figure 1.1 illustrates the theory which reflects the capabilities approach.

Figure 1.1 - Capacities and occasions for the development of agency and social integration



Source: Ware, et al., 2008: 31.

Judgment is the ability to form sound opinions and sensible decisions in the absence of complete information. Advocacy is the ability to argue articulately for a position orally or in writing. The relative salience of social, emotional, cognitive, and moral dimensions varies across capacities. Empathy, for example, is prominently social and emotional. Cognitive and emotional dimensions are especially salient in advocacy. In responsibility and accountability, social and moral dimensions come most quickly to the fore. A major advantage of the capacity construct and the larger capabilities approach is that they highlight the moral dimension of agency, thus allowing moral experience, or 'what really matters' to be introduced into the discourses on social integration (Klienman, 2006).

One relevant question that needed to be addressed was what does occasions for building capacities look like? To address this question, five types of occasions were identified. Occasions are defined as structured mechanisms of change leading to capacity development. Here, mechanisms of change are embedded in micro exchanges between mental health providers and users of care. In each type of occasion, change is directed at building capacity for connectedness or citizenship. The five types of occasions represented—contradiction, reinterpretation, rehearsal, raising expectations, and confrontation—are those most salient (Ware, et al. (2008).

Contradiction refers to a seemingly contradictory juxtaposition of callousness and concern that trigger a shift in both perspective and behaviour for a vulnerable person.

Reinterpretation is occasioned by encounters with new meanings of a familiar idea and rehearsal means enactment considered essential to capacity. Hence a third capacity-building mechanism is rehearsal. By rehearsal, we mean executing a developing

capacity in a learning environment, with the expectation of feedback. Rehearsal may usefully be contrasted with practice. As a capacity-building mechanism, rehearsing creates experience. Raising expectations involves mechanisms that ensure increased sociability brought about through a subtle raising of expectations. The last mechanism is termed "confrontation" meaning deliberate challenges to actions that fail to meet accepted standards. Confronting unacceptable actions on the part of individuals with severe mental illness sets an expectation of accountability. It assumes that capacity reinforces connectedness and communicates how one can act to affect others implying that in social interactions, something real is at stake.

In the final analysis, the researchers were able to establish the ingredients for a theory of capacity building for social integration. Having laid out the building blocks of the theory—capacity, occasion, mechanism—it now comes to the task of assembling them into a proposition, as follows: Vulnerable individuals bring pre-existing capacities to the development process. Existing capacities expand, and new ones take root, through exposure to occasions for growth. Occasions present challenges and may be simple or complex, that is, made up either of single interactions or of orchestrated sequences arranged in order of increasing difficulty. As challenges are mastered via mechanisms—contradiction, reinterpretation, confrontation—competency is affirmed. A sense of possibility emerges, and with it, aspiration. Together, aspiration and a sense of possibility fuel engagement with new, more challenging occasions. Capacity builds and expands into agency in an iterative, open-ended process.

Occasions for capacity development share a number of characteristics. They assume that capacity development is possible and will take place. Practitioners act accordingly by setting expectations for performance and insisting that the expectations be met. They also allow for the possibility of failure and, when it occurs, find constructive ways of responding. Constructive responses examine failure and place it in perspective but also allow the consequences to unfold. Genuine actions and events are characterized by the fact that something significant is at stake.

The development process is expected to be neither uniform across capacities nor steady in pace. Slippage, stalling, and temporary reversals will occur. Unexpected obstacles will crop up. Challenges will be declined. An adequate theory must account for such contingencies, as the representation we offer attempts to do.

1.11 - Conceptual Framework

Empowering adolescents particularly the vulnerable and disadvantaged can be a very challenging and arduous task. It can however serve as a preventive intervention for many of the challenges that confront them. OVC like all young people in their adolescence face biological, intellectual, emotional and social changes that accompany this phase of growing up and can have a telling effect on the future of OVC hence handling them should be well planned.

The term empowerment (Figure 1.2) has different meanings in different socio-cultural and political contexts, and does not translate easily into all languages. Empowerment concept is explained and defined by various disciplines including social work, psychology, education, community psychology and nursing. In addition, empowerment concept is lately used in different phenomenon (Rodwell, 1996). Linguistically, the word 'to empower' as the verb of the noun empowerment was defined by the Oxford Dictionary as to make (someone) stronger and more confident, especially in controlling their life and claiming their rights: *movements to empower the poor* (Oxford University Press, 2011). Empowerment is the process of increasing the capacity of individuals or groups to make choices and to transform those choices into desired actions and outcomes. Central to this process are actions which both build individual and collective assets (World Bank, 2002). This document addressed questions about moving the empowerment agenda forward and outlined four key elements that must underlie institutional reform: access to information, accountability, local organisational capacity, and inclusion and participation. This definition identified empowerment as the expansion of assets and capabilities of poor people to participate in, negotiate with, influence, control, and hold accountable institutions that affect their lives.

In essence empowerment speaks to self determined change. It implies bringing together the supply and demand sides of development – changing the environment within which poor people live and helping them build and capitalise on their own attributes. Empowerment is a cross-cutting issue. From education and health care to governance and economic policy, activities which seek to empower poor people are expected to increase development opportunities, enhance development outcomes and improve people's quality of life.

Youth empowerment specifically is defined as an attitudinal, structural, and cultural process whereby young people gain the ability, authority, and agency to make decisions and implement change in their own lives and the lives of other people, including youth and adults (Vavrus and Fletcher, 2006). The Commonwealth of Nations particularly encourages youth mainstreaming as public policy concept to address youth issues across various sectors and line ministries such as health, finance, economic development, housing, justice, foreign affairs, education, and agriculture (Pan-Commonwealth Office, 2007).

Activities involved therein may focus on youth-led media, youth rights, youth councils, youth activism, youth involvement in community decision-making (Sazama and Young, 2006) and other methods. Notable out of the various definitions is in its focus on choice and three critical elements are identified agency, structure and relations (Martinez and Wu, 2009).

Agency (power within/to), is operationalise in reference to resources (power to/over), and made visible in its resulting beneficial/valued achievements. And finally, agency is exercised, in this conception of empowerment, in opposition to a prior condition of subordination in important (strategic) arenas of life. The individual person is central in society. People are deeply knowledgeable and can step back and assess the context in which they act, and they can even talk about the large-scale structures that might act as constraints to freedom of action. Nobody is powerless; nobody is all-powerful (Martinez and Wu, 2009).

Structures according to Martinez and Wu (2009) regard trends agents (that is individuals) that produce and reproduce as routines, conventions, relationships and taken-for-granted behaviour. Over time these become givens and people enact them largely without thinking why or how thereby resulting in social structure. These social structures imply unspoken rules that are deeply implicated in the reproduction of social relations; these are rules that often lie hidden behind formalistic rules such as law, bureaucracy, politesse, language, etc. Structures accomplish three crucially important social goals:

1. they establish agreed-upon significations (meanings);
2. they establish accepted forms of domination (who has power over who);
3. and they establish agreed criteria for legitimising the social order.

Finally, the last part of the concept is relations which are the social relationships through which people negotiate their needs and rights with other social actors. Both agency and structure are mediated through relationships between and among social actors while at the same time, forms and patterns of relationships are deeply influenced (frequently in hidden ways) by agency and structure. Empowerment, in part, consists in individual people building relationships, joint efforts, coalitions, and mutual support, in order to claim and expand agency, alter inequitable structures, and so realise rights and livelihood security (Martinez and Wu, 2009).

Empowerment aims to provide a solid platform and building blocks with which vulnerable individuals can each construct more independent and secure future for themselves. From the perspective of the caregiver, empowerment focuses on enhancing the conditions of especially those in less fortunate circumstances.

One pathway to empower OVC is to let them be truly accountable with relationships. The ideal way to view OVC empowerment is through the lens of the vulnerable children themselves playing active roles to achieve their full and equal potential. Every concept designed to help them should be explicitly defined and ideas about how it can be measured clearly stated. Concepts seeking to equip the OVC must strive to balance practical individual achievements with strategic, collective, long-term work to challenge biased social rules and institutions.

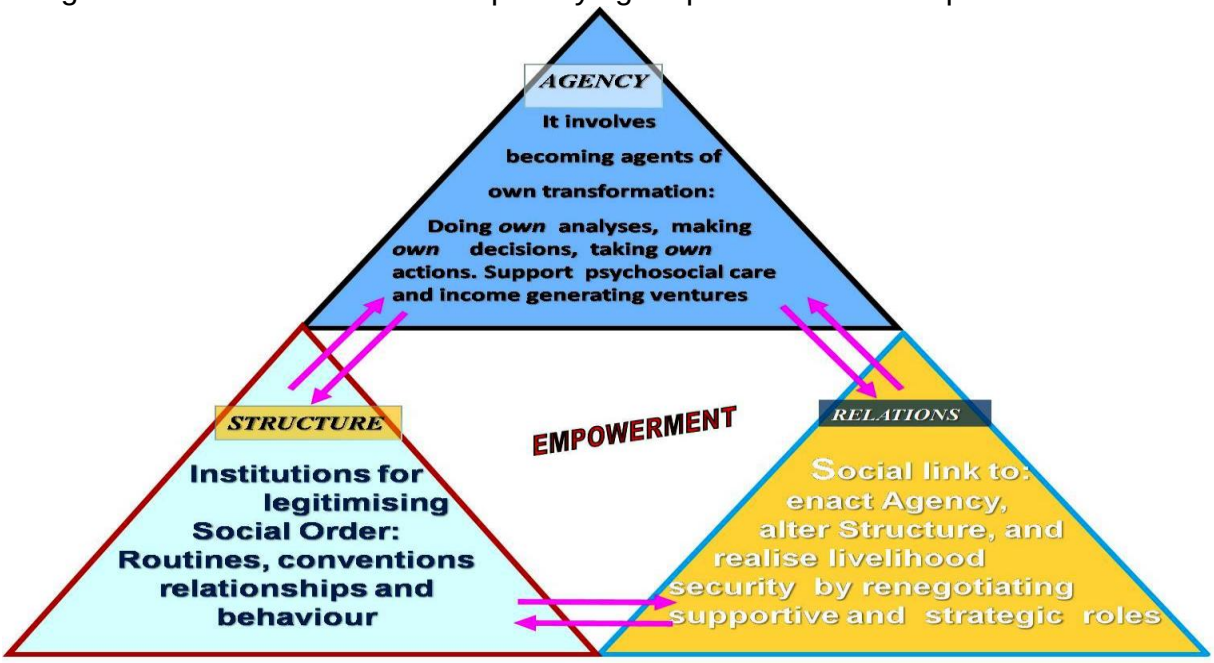
The interplay of these three factors form the sum total of changes needed for an OVC to realise their full and proper development. This allows all concerned to understand, be challenged and engaged. So in using the Empowerment Framework, there must be an assessment through a mix of dimensions that cut across these three domains of agency, structure and relations.

A relevant combination usually explores each dimension through a mix of indicators outlined that reflect changes in agency, structure and relations. In other words, what is the ideal situation for a child to grow and become a normal responsible adult? What does it mean for every child to be safe, healthy, in a loving home, and receiving solid foundation in education, sanitation, nutrition and economic security? What does it take to achieve these goals? What does it look like to have all of these aspects of the community functioning for the OVC?

What plans, programmes and resources are needed to develop, tap, and act to give them better future? Agency refers to the OVC´s own aspirations and capabilities. Structure represents the environment that surrounds and conditions OVC´s choices, while relations define the power relations through which OVC negotiates their path.

In terms of agency, the OVC looks confident. It regards the aspirations, resources, actions and achievements of the vulnerable themselves; carrying out their own analyses, making their own decisions, and taking their own actions. Every person as agency can analyse, decide and act. Agency is a continuum, from less to more. Empowerment involves a journey through which the vulnerable ones increase their agency. Given the context, the OVC may be aware of their plights but has fewer opportunities than their peers to advance. However, these attributes do not occur in a vacuum. Similarly, caregivers may require the necessary retooling in areas of psychosocial care and financial support in order to take good care of the OVC. Figure 1.2 illustrates these three key domains of empowerment in various settings.

Figure 1.2 - A Schematic model portraying empowerment Conceptual Framework



Source: Author's own concept based on design by Martinez and Wu (2009: 12).

The psychosocial care training may take the form of counsellors visiting and giving tips on the special needs and this become particularly needful in a single parenting setting. Deeply intertwined with agency are structures and relations. In terms of structures,

cultural values and social norms may afford the OVC equal opportunities for education that allow them to gain information about their options and influence development. Official policies may be in place that allows the OVC equal opportunities to self expression.

Beyond these structures, however, relationships also influence the OVC's life. The dynamics of their relationship will weigh heavily on their proper growth and development as well as their ability to negotiate for options or interests.

Each of these domains namely agency, structures and relations are deeply intertwined to form a picture of empowerment. Furthermore, these aspects of agency, structures and relations cut across the various spheres within which the OVC grows up.

1.12 - Contextual application of empowerment

To empower OVC and caregivers means to activate the confidence and capabilities of these previously marginalised people so that they can exert greater control over their lives, mobilise resources to meet their needs, and work to achieve social justice (Scheyvens, 2009). This simply implies that OVC and caregivers have a prominent voice in the debates that matter in their sphere of influence; be it political, economic, or social. OVC and caregivers empowerment means creating the environment that enables OVC and caregivers too to "dream"; and having dreamt, it is about lending a hand to enable them achieve those dreams. OVC and caregivers empowerment means breaking taboos. It is about questioning ancient rules that say that disadvantaged groups must be docile in the society and pick up the crumbs that fall off the table. It is about removing and not just unlocking the "doors" inside communities and within nations that lead to the inner sanctums where decisions are made.

The notion of a stakeholder society for the dispersion of wealth and opportunity, and the creation of an enabling welfare society is the underlying framework for the study. The realisation of this goal depends on effective building of local capacities. In her book 'at the interface of development studies and child research: rethinking the participating child', Lund (2007) emphasises the need to build capacities as a way of empowerment. She questions the extent to which child participation alone is able to empower self and communities. Lund argues that while child research concentrates on the role of the child to participate as a way to empower self and local communities, recent development

discourse focuses on building capacities and strategising to achieve social and economic improvement at different scales. Citing case examples from different Asian and African countries, she illustrates how in disempowered and poor contexts the discourse of participation may be inadequate, even irrelevant, to gain in-depth understanding of what takes place on the ground and how children participate. She demonstrates that participation may be embedded in local, cultural contexts, but also how participation may be embedded in external structural forces related to globalisation and geopolitics. The participation of children may be passive or active, and it may reflect children's vulnerability and how they, through their participation, may even be exposed to direct violation and fear. These forces will have to be deconstructed and acted upon and participation can be fully utilised as an enabling and capacitating force (Lund, 2007).

Much of the Manya Krobo Queen Mothers' work involves empowerment which is the process whereby the capabilities of both the caregivers and OVC are strengthened to enable and sustain an expanded, comprehensive response to the HIV/AIDS epidemic. It entails establishing and strengthening networks and linkages, implementing awareness, training and developing human resources. It involves identifying people to be trained, providing guidelines, delivering training that is responsive to their needs, and providing appropriate learning environments, ensuring supervision and mentoring for continued skills transfer. These arrays of objectives and programmes are schematically depicted in Figure 1.2 as comprising agency, structure and relations.

The process of gaining control over self, over ideology and the resources inherently presupposes the existence of gender-gap (ASPBAE/FAO, 1993). This leads us to the realm of gender and it requires concerted efforts to bridge so as to harness the full potentials of all citizens. Gender refers the socially constructed and culturally determined characteristics associated with women and men, the assumptions made about their skills and abilities based on these characteristics and the conditions in which they live and work as men and women. Gender is about the relations that exist between women and men, and how these are represented, communicated, transmitted and maintained. It includes sexual and social relations based on sexuality, and relations of power and control. These are learned through socialisation processes. They are

context/ time-specific and changeable. It determines what is expected, allowed and valued in a woman or a man in a given context (Itzin and Newman, 1995).

By context-specific I am referring to the socio-cultural milieu. In Ghana, tradition and culture is held with a tint of divine or mystic reverence. There is a popular saying that 'we don't throw away tradition and culture'. This saying has hypnotised the old folks particularly in the rural areas of Ghana from embracing new ideas. It is true that tradition and culture might be relevant somewhere in time continuum. As society grows however, and science and technology advance, the way things were done in the past we call tradition and culture would not be relevant today. It is interesting to note that when people find it difficult to give solution to problems that confront them, they seek subterfuge under custom and tradition. This mentality is a great barrier to social and scientific advancement in our society.

1.13 - Conclusion

Although scholarly interest in the HIV/AIDS pandemic has gained overwhelming attention since the emergence of the disease in the 1980s, empirical research specifically focused on care and support for OVC does not seem to have proliferated especially in the study area. One fact that both researchers and policy makers alike seem too often to agree on but has been sidetracked is that tens of thousands of children who have been infected and affected by HIV/AIDS are yearning for help for that we conducted this research to ascertain the true situation of the Ghanaian OVC and what kinds of interventions might needed. This is because OVC needs keep changing in a whole new set of issues temporally and spatially. These include their need for medical and emotional support as they move from child care to adult care and navigate the normal hurdles of growing up (UNICEF, 2010). Although recognising some progress especially by the Queen Mothers aimed at lessening the suffering of OVC in the study area, Lund and Agyei-Mensah (2008) obviously believed the traditional community safety net operations which are economically dependent on external donors and immediate short-term well-being and care solutions is at risk of balancing on the brink of its carrying capacity.

The concept of social integration and empowerment might be more aptly invoked to meet the social response of the reality of the OVC challenge. Approaching care and

caregiving for OVC from a gendered perspective raises questions about how the caring work performed by women is undervalued and often invisible in society. Care and caregiving activities that were once the responsibility of skilled professionals now are the responsibility of volunteers and family members in the home and community, the majority of whom are female (Yantzi and Skinner, 2009).

CHAPTER TWO

CHARACTERISATION OF THE STUDY AREA

2.1 – Introduction

This chapter focuses on socio-cultural locale of the study area and offers detailed description of the research location, Manya Krobo, Ghana. To offer a better understanding and appreciation of the physical, it is proper to provide some basic information. In Geography of Health, we seek to analyse and offer an explanation for health development over space and time. This implies that the phenomenon called health, whether in terms of the availability of care provision or accessibility in the physical and affordable senses, knowledge of the terrain cannot be ignored. This is because the physical and socio-cultural terrains provide the basis for the existence or otherwise of provision of health consumption. It is for example the main determinant for the decision to train health professionals in either tropical medicine or temperate health care regimen.

Though the enquiry concerns the provision of safety net for OVC, it is in the existence of intricate and complex relationships between the socio-cultural and physical environments that we discover the true reasons and meanings for observed phenomena. It affects both the physical health and cultural conditions of the underprivileged children. In recognition of the importance of the position of geography and the investigation, some level of data on Ghana and specially Manya Krobo traditional area has been provided. It covers the physical environment, the cultural environment, the historical antecedent and current state of the study. In order to give a clear picture to Portuguese readers, where this study is being undertaken and examined, a painstaking research was conducted to establish the historical links between Ghana and Portugal.

2.2 - Background to the study area

The attraction to carry out this study in the Manya Krobo traditional area is borne out of a number of interests. The most obvious that come to mind is the consistently high HIV prevalence in the area. There must be a reason accounting for this phenomenon. For

this many explanations have been offered (Anarfi, 1990; Agyei-Mensah, 2001; Sauvé, et al., 2002) among others. The seemingly existence of contradiction between cultural and religious beliefs on the one hand, and the pervasive nature of HIV/AIDS also demand an understanding of the link. The overall implication is to explain and put forward plausible resolution of the OVC problem.

Present day Ghana comprised many smaller independent ethnic kingdoms including Togoland trust territory in West Africa. Initial contacts outside Africa were with Arabs. Later, a crew of Portuguese traders came. What followed was over four hundred years of slave trade. After the Trans Atlantic Trade, Great Britain colonised the territory as Gold Coast for another 83 years. The colonial era stretched from 1874 ending on March 6, 1957 when the country became the first sub Saharan African nation to gain independence. It subsequently changed its name from Gold Coast to `Ghana` meaning `Warrior King`. This was the name of a medieval African empire founded around the 6th century in the area now covered by Senegal, Mali, & Mauritania (Kimball, 2004; Jackson, 2001).

2.3-Portuguese footprints in Ghana

Figure 2.1 shows that Portugal indeed geographically is far from Ghana separated by a distance of 3,788.2 kilometres (4,078 and 4,081.4 kilometres in case of Guimarães and Braga respectively) from Accra.

Figure 2.1 - Relative geographical locations of Ghana and Portugal in the world

Source: Author's own construct, 2011.

In the ‘Age of Discovery’ it might have probably taken several weeks to sail in rafter-like vessels from Portugal to the Gold Coast. Modern air transport reduces travel time to approximately five and quarter hours from Accra to Oporto and further 40 minutes northwards to Guimarães or Braga. The two continents of Europe and Africa are separated by the Mediterranean Sea, the Sahara Desert, and the Sahel. Though Ghana is about two and a half times the land area of Portugal but the two countries share a resemblance in shape with continental Portugal having a longer maritime border. Ghana has no notable island like Portugal. Ghana is virtually inhabited by Black Africans while Portugal predominantly comprises Caucasians.

Notwithstanding the geographical divide, the two nations interacted in the past. History shows that Portuguese explorers, Seafarers, Merchants and Missionaries led by João de Santarém and Pedro D'Escobar were the first Europeans to land at the shores of Elmina in Ghana in 1471. The initial Portuguese interest in Ghana was trading for gold, ivory, and pepper. However, by the end of 1482, crew of twelve sailing vessels led Don Diego D’Azambuja came to put up a fort named *São Jorge da Mina* (St. George of the Mine); this was Europe's first foothold in Black Africa. The *Feitoria da Mina* as it was also called is the oldest European building in existence south of the Sahara. The result was over 400 years of slave trade and tragic loss of generations of Africans conservatively estimated at 11.25million. Portugal accounted for 40% of this obnoxious trade (Kimball*,* 2004*)*. This trade in human beings augmented the labour needed for states formation and development that was characteristic of that period especially in the ‘new world’.

And while doing so, they also left a number of archaeological artefacts as well as certain influence on the Ghanaian culture, language and religion. Their footprints are still visible and legacies permeated generally in several aspects of the Ghanaian national life.

The influences of Portuguese in Ghana are evident in the forms of architecture of churches, fortresses, canons, and castles in Ghana. One of them is the Elmina Castle in the Central Region of Ghana. In 1482, the desire for more gold and to spread Christianity, King John II commissioned Don Diego D’Azambuja and about 600 soldiers, masons, carpenters and other artisans in twelve ships to build St George’s Castle (*São Jorge da Mina*) covering about 100,952 feet or 2.32 acres. Today, a tour to Ghana without a visit to the castle is incomplete. It is a popular historical site, and was a major

filming location for Werner Herzog's Cobra Verde. UNESCO recognises the castle as a World Heritage Site inscribed in 1979 under Criteria VI. This Criteria assessment is based on fact that the castle has been directly or tangibly associated with events or living traditions, with ideas, or with beliefs, with artistic and literary works of outstanding universal significance.

This castle is famous for acting as a trading post for minerals like gold and the infamous transatlantic slave trade that saw estimated 4 million Africans uprooted mainly to Brazil. Subsequently, Africa and Brazil built cultural and origin links. Today, Brazil has the second biggest black population in the world after Nigeria. Brazil 2010 census preliminary results show 50.7% of Brazilians (97 million out of 190.732.694) now define themselves as black or mixed race compared with 47.7% whites. This means the proportion of people defining themselves black or mixed race has risen from 44.7% in 2000 to 50.7% in 2010. This makes African-Brazilians the official majority for the first time. Among the hypotheses to explain this trend, one could highlight the valorisation of identity among Afro-descendants (IBGE, 2011).

The historical evidences linking both nations are still preserved and embedded in Ghana's tradition, dance, folk music and language. One of the origin links is the Tabon People, who came back to Accra in 1836, after they bought their own freedom in the Brazilian State of Bahia. To this day, they have a Brazil House in James Town, a suburb of the capital, Accra and roots to the Brazilian culture and language. During a visit to Ghana in 2005, then President of Brazilian, Luiz Inacio Lula da Silva, approved turning Brazil House (Casa do Brasil, Accra, Gana) into a memorial. The building has since been renovated with financial backing from two Brazilian companies and turned into a memorial-cum-museum. Their own name Tabon comes from the Portuguese expression "Está bom" ("it's ok" or "I'm fine"), because on their arrival, they could speak only Portuguese, so they greeted each other with "Como está você?" ("How are you?") to which the reply was "Está bom", so that the people of Accra started to call them the Tabom People (Schaumloeffel, 2004). The museum and some publication on the Tabon people is contained in Figure 2.2. The museum is situated in the old part of the national capital called British Accra or Jamestown in Accra with inscription 'Cradle of Tabon people'.

The influence of Portuguese in the Ghanaian language is even more profound. We can easily find hundreds of Portuguese words that had been adopted into Ghanaian languages. The cultural blend of the two states can be traced to certain parts of Ghana particularly along the coast. Up to now, people in these areas still use Portuguese surnames such as Azumah, Nelson, Antônio, Faustino and Gomez. Geographical names of Portuguese origin are very common in Ghana: Elmina ("A mina" – the mine), River Volta ("Rio Volta" – "River U-Turn"), Cape Three Points ("Cabo Três Pontas" – in a free translation means "Cape of the Pirate") and Cape Coast ("Cabo Corso") (Schaumloeffel, 2004). Expression "dash me" comes from the corrupted Portuguese "dá-me" (give me). Another very common expression is "palaver" (gossip, to chat). That comes from "palavra" (word). "Panyar" or "panyarring" are terms from the Portuguese "apanhar" (to be beaten or to catch). "Sabolai" in *Ga* for onion comes from the word "cebola"; *Akan* people use the word "*paano*" for bread, what probably comes from Portuguese "pão".

Figure 2.2 – Brazil House Museum for the Tabon people located in Accra, Ghana

Source: Clips from Brazilian Embassy in Ghana website embrazil.com.gh. Images from the inauguration ceremony of the Brazil House) compiled by author, 2011.

In addition, Tabon people in Jamestown regularly practice the Catholic Semana Santa. There is no doubt that the Catholic religion was first introduced to Ghana by the Portuguese missionaries. There was also inter-marriage between the Portuguese and Ghanaians. Until now, the Portuguese descendants still live in parts of coastal Ghana. The earliest history of formal, western-style education in Ghana is directly associated with the history of European activities on the Gold Coast. Their intention to establish

schools was expressed in imperial instructions that, in 1529, encouraged the Governor of the Portuguese Castle at Elmina to teach reading, writing, and the catholic religion to the people. Before the coming of the Portuguese and other Europeans, women were held esteem and were the ones who planned and executed installation of chiefs who were mere caretakers. They carefully selected persons from any family and thus any individual who had initiative and good character could become a caretaker. Lands were not something that were cut up and owned by people and no one bowed to anybody or owed anybody.

In effect the ownership of property was communal. Hitherto, matrilineal descent pattern was more common before the Portuguese introduced the modern pattern of patrilineal descent from which a family name is usually derived and inheritance ascribed as well as entitlement. Additionally, African names were ignorantly considered fetish by the missionaries hence children were forcibly christened with European names erroneously tagged as christian names. Till date, it is common in the *Akan* hinterland to come across the practice where a number of children born to the same biological mother and father bearing completely different surnames from each other as he or she is named after a relative circumstance surrounding their birth. Hierarchically, they helped entrenched the 'caretaker' with power and authority through the use of force and coercive power as was applicable in their own setting at the time. Some of these items and names are depicted in Figure 2.3 including cassava, maize (corn), tomatoes, onion, and bread.

Figure 2.3 - Some heritage items Portugal introduced and bequeathed to Ghana

Source: Images and Photos cuttings compiled by author from Google Images, 2011.

With the fading of barter trade, and coming into use of medium of exchange of some form, communal ownership gradually gave way and a sense of entitlement filled the void. Overtime, the Castle where they (the Portuguese) resided became the symbol of authority and executive power. Up till now, the executive in Ghana is secured within the walls of the Castle. It is not uncommon nowadays to hear phrases like 'the road to the Castle' as a reference to struggle for political power through election.

In fact, the *Akan* name for castle (*aban*) is the same for government and the police. This is an unambiguous testimony to the Portuguese influence in reshaping or re-organising of modern Ghana into its current form. Modern concept of power and how it is exercised is undoubtedly an inheritance bequeathed to Ghana by the Portuguese.

A number of ingredients found in traditional Ghanaian dishes reflect Portuguese influences. Cassava (Manihot esculenta Crantz) was introduced from Brazil during the 16th and 17th centuries (Jones, 1961). In the Gold Coast (now Ghana), the Portuguese grew the crop around their trading ports, forts and castles and it was a principal food eaten by both Portuguese and slaves. The Akan name for cassava '*Bankye*' could most probably be a contraction of *'Aban Kye'* - Gift from the Castle. Cassava is a major crop in the farming systems of Ghana. Cassava is by far the largest agricultural commodity produced in Ghana and represents 22 percent of Agricultural Gross Domestic Product (Ministry of Food and Agriculture, 2005).

Other crops the Portuguese brought in are maize, tomato and onion in the 15th and 16th centuries from the New World. The tomato and onion are now cultivated and consumed throughout much of Ghana. When maize was introduced by the European, the *Akan* called it *aburu*, implying that it was the food of the *'Obruni'* or European/whiteman (Bartle, 2007). Maize is now one of the most widely cultivated food crops in Ghana. It can grow in a variety of conditions and be prepared and consumed in a multitude of ways which vary from region to region or from one ethnic group to the other. Maize is the most important cereal in the world after wheat and rice with regard to cultivation areas and total production (Osagie and Eka, 1998).

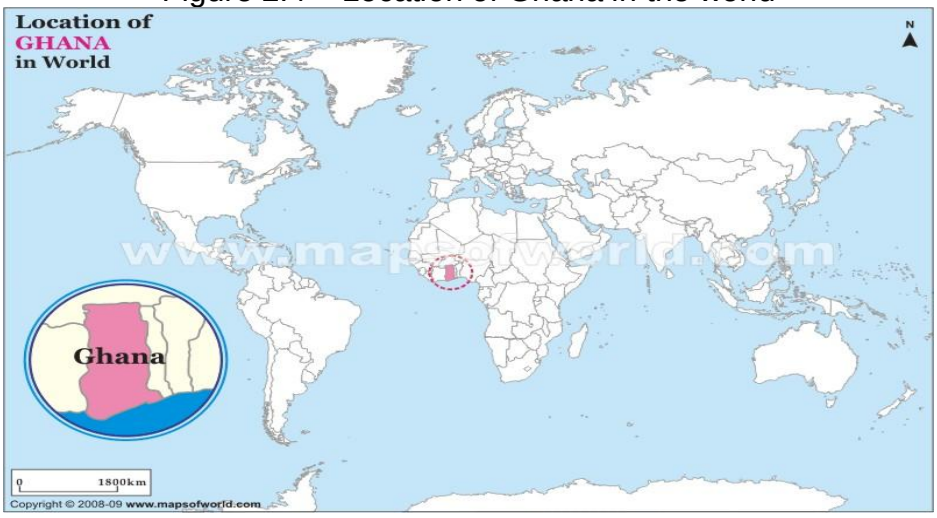
It is clear that although geography keeps us apart, our two nations had interacted intensively in the past. These few examples confirm only a part of the influence of the Portuguese language in Ghana. It is a sign that a language does not travel in a vacuum but changes and always displays the cultural, economic, political and social contacts

between peoples and space. Portuguese left indelible footprints and legacy on the people and soil of Ghana. Regrettably, not many of the present generation in Ghana and Portugal realise this fact. As Brazil has identified this and helping to shed light and preserve the legacy, it is our common tasks to re-energise the historical and cultural links for the benefit of our two countries.

2.4 - The geography of the study area

Figure 2.4 depicts the Republic of Ghana which geographically lies between longitudes 3° 15' W and 1° 12' E, and latitude 4° 44'and 11° 15' N respectively. This puts the country geographically closer to the "centre" of the world than any other country. Longitude 0° (prime meridian) passes through Tema while the southernmost part (Cape Three Points) is on latitude 4°44'N approximately 570 km north of the Equator in the Gulf of Guinea. The notional centre of the world (0°, 0°) is located in the Atlantic Ocean. This spatial location of the country naturally has its implications for the health of the people. Human health is intimately related to one's physical location on earth. Where people live or have lived in the past can have a positive or negative influence on their health. The spatial pattern of disease in a population is vital evidence for public health analysts and decision makers when seeking to understand causes and plan interventions.

Figure 2.4 – Location of Ghana in the world



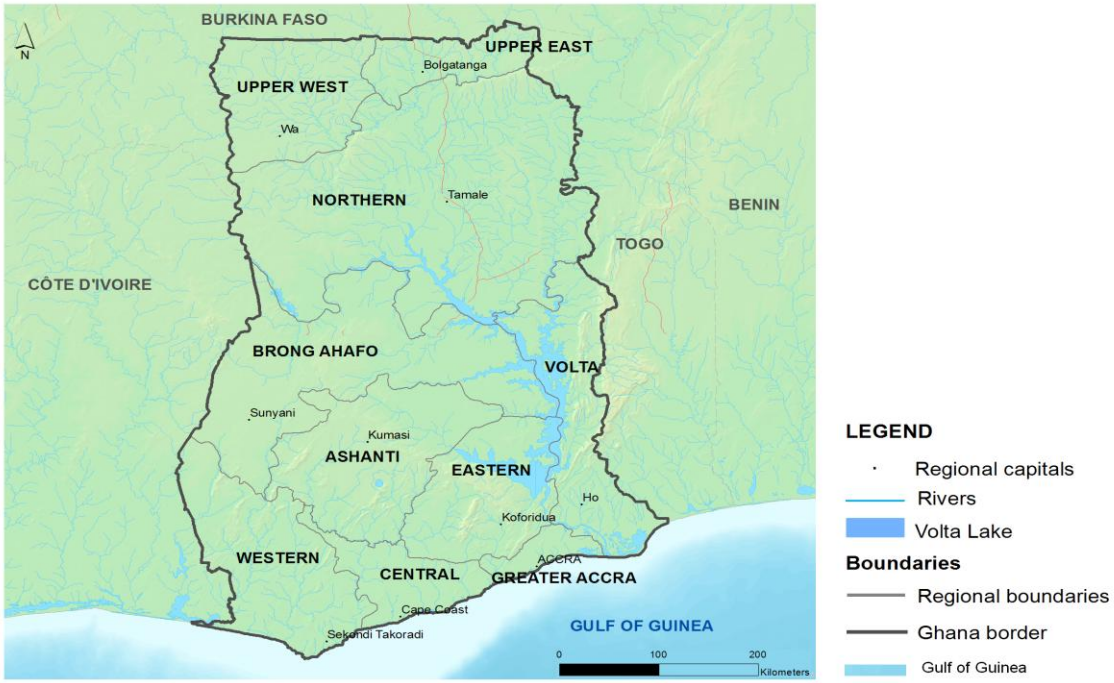
Source: 2008-09 www.mapsofworld.com, 2011.

In short, understanding the “where” helps understand the “why.” Being closer to the equator means there is unabated streaming of solar energy for all the 365 days of the year. The climate is tropical. The coolest time of year is between June and September when the main rainfall occurs. Variations in temperature both annually and daily are quite small. The minimum temperature is around 23°C. The eastern coastal belt is warm and comparatively dry; the southwest corner, hot and humid; and the north, hot and dry. There are two distinct rainy seasons in the south-May-June and August-September; in the north, the rainy seasons tend to merge. A dry, north-easterly wind, the Harmattan, blows in January and February. Annual rainfall in the coastal zone averages 83 centimetres (Tachie-Obeng, et al., 2010). The climate is influenced by two major air masses. These are South-West moisture laden monsoon which brings rain between March and October. Then the North-East dry dust-laden winds called Harmattan which brings drought from November to February (Tachie-Obeng, et al., 2010). The high humidity encourages fast growth, germination and rapid decay of organisms including pathogens that cause tropical infections such as plasmodium-borne vector mosquitoes that spread fatal malaria within the population. Seasonality has also been associated with certain health conditions (Oyane, et al., 2008).

Figure 2.5 shows Ghana which covers an area of 238,500 square kilometres located in West Africa. It has land boundaries totalling 2,093 km. Ghana has 877 km border on the east with Togo, 668 km with Cote d'Ivoire to the west, 548 km with Burkina Faso to the north and a coastline stretching 539 km along the Gulf of Guinea to the south. Its comparative area is slightly more than twice the size of Portugal. Ghana half lies less than 152 metres above sea level, and the highest point is 884 metres. Ghana is divided into ten administrative regions. Ghana is a lowland country except for a range of hills on the eastern border and Mt. Afadjato (the highest point above sea level - 884 metres) which is west of the Volta River. Ghana can be divided into three ecological zones: the sandy coastline backed by a coastal plain, which is crossed by several rivers and streams; the middle belt and western parts of the country, which are heavily forested and have many streams and rivers; and a northern savannah, which is drained by the Black and White Volta rivers. The Volta Lake, created by the hydroelectric dam in the east, is one of the largest artificial lakes in the world. The regions are Eastern, Western, Central, Northern, Upper East, and Upper West. The rest are Volta, Greater Accra,

Ashanti and Brong Ahafo regions. These divisions obviously have their administrative capitals with Accra in the Greater Accra region as the national capital.

Figure 2.5 – Administrative, political and relief regions of Ghana



Source: Author's own construction, 2011.

In Figure 2.5, Accra is located on the Gulf Of Guinea, on the south west of the country. The city has been Ghana's capital since 1877 when the capital was moved from Cape Coast to the west. It contains many public buildings reflecting its transition from 19th century and beyond architectural designs to the modern metropolis it is today. Its structure is certainly various and assorted with modern, colonial, and traditional buildings reflecting Ghanaian style and climatic conditions. The capital is a very important commercial, manufacturing, and communication centre. It has an international airport and is the heart of the country's railroad system, including a connection to the nearby Tema, which since 1962 has served as the city's deepwater port. Koforidua on the other hand is the regional capital for the Eastern region where the study area is located. While these divisions are deemed artificial, in reality they represent movements and interactions between peoples. From Health Geographer's perspective, such activities potentially have risks of health dimensions. So many air-borne diseases like tuberculosis as well as sexually transmitted infections including HIV fester through migration and social mobility. To be found in Figure 2.5 also is the

country's main river; the Volta ("Rio Volta" – "River U-Turn" derived from Portuguese), which is formed in the centre of the country by the confluence of the Black Volta and the White Volta. The Volta enters the Gulf of Guinea at Ada in south-eastern Ghana. The artificial Volta Lake located at 6° 17′ 59″ N, 0° 3′ 34″ E 6.299722, 0.059444 was created after the River Volta was dammed at the Akosombo between 1961 and 1965.

The lake is dendritic in shape and has a generally north- south orientation with an average length and width of 400 km and 25 km, respectively. It has a catchment of 385,185 km^2, excluding its own area of 8,730 km^2. Nearly 60% of this area lies outside of Ghana. It extends from the Akosombo Dam in south-eastern Ghana to the town of Yapei, 520 kilometers to the north. It is the largest reservoir by surface area in the world, and the fourth largest one by water volume. The Lake plays key role in the economic activities of the nation. At the time of the creation, the lake was to store up water primarily to generate hydro- electricity.

Additionally it was envisaged that it would improve inland water navigation and transport (passengers and cargo), boost fishing, ensure enough water for irrigation, domestic and industrial use, tourism and fisheries. However, tree stumps embedded in the lakebed have been a major source of concern as numerous aquatic pontoon accidents had occurred leading to deaths of many passengers. Further, some water borne diseases such as *Schistosomiasis* (also known as bilharzia, bilharziosis or snail fever) have been linked to the creation of the lake. Of much relevance to this research though is Volta's connection to the spread of HIV infection in Manya Krobo. In what Sauvé, et al. (2002: 402) called the 'price of development'; the researchers concluded that "the high HIV prevalence documented in this part of Ghana seems to be, to some extent, a consequence of construction of the Akosombo dam in the 1960s. The flooding of the land, the failures of the resettlement programme and the ensuing poverty prompted economically driven migration, specially to Côte d'Ivoire, where many migrants became infected with HIV." Ghana's other significant river systems are the Densu, Birim, Pra, and Ankobra. All empty into the Gulf of Guinea. Ghana's rivers are navigable only by small crafts, with the exception of the Volta. Located in the Ashanti uplands, Lake Bosumtwi is Ghana's only natural lake.

Bordering Ghana to south between Cote d'Ivoire and Togo is the Gulf of Guinea, which is part of the Atlantic Ocean. This gives Ghana an Exclusive Economic Zone (EEZ) of

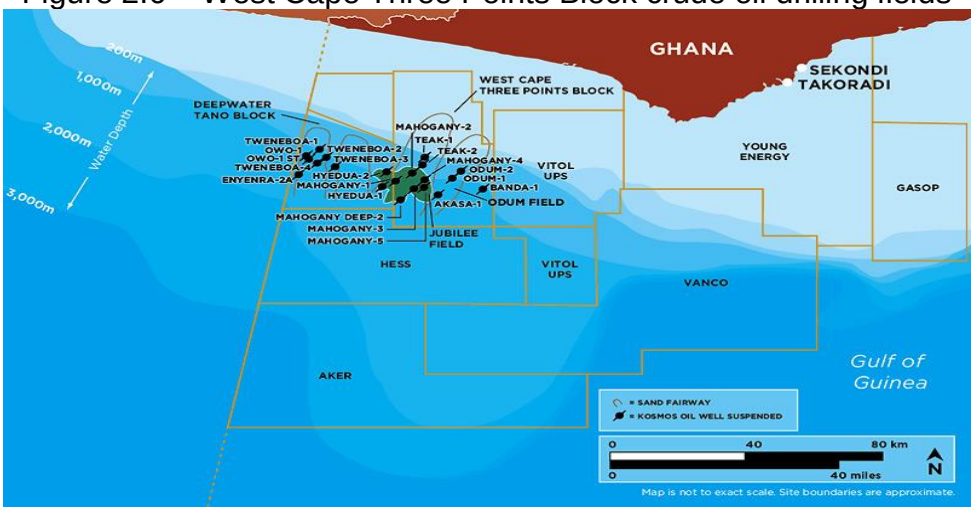
110,000 km^2 of the sea. It has in a way shaped the fate of the country more than any other border or external entry routes. For over four centuries, the country's open ocean served as the door of no return for millions of her citizens shipped off to the new world and Europe as slaves. Evidence of this is still visible with 32 forts and castles built by European slave traders dotted along coastal stretch from Aflao in the east to Half Assini in the west. This is not to talk of huge amounts of various resources foremost of which was gold that were exchanged. Similarly, the British colonial rule came through the ocean which provided the best suited environment both in terms of travelling and dwellings.

Of course it must be pointed that the ocean or coastline did not or does not only bring grim and misfortune to the inhabitants. The country has rich and diverse marine resources and depends quite heavily on her coastal resources for food, human settlements and numerous other benefits. Ghana has a rich fishing tradition especially true for the thousands of fisher folks living along 538km stretch of coastline. The resources are exploited to meet the growing demands of the populace providing livelihood for many people. During the early 1950s through to the late 1970s, Ghana was noted as a leading fishing nation in the sub-region, with her fishing fleets ranging as far as the coasts of Angola and Mauritania. All is however not well with the fishing industry. With the coming into force of the United Nations Convention on the Law of the Sea (UNCLOS) in 1994, all the long distance fishing vessels lost their rights and returned to Ghanaian waters. UNCLOS defines the rights and responsibilities of nations in their use of the world's oceans, establishing guidelines for businesses, the environment, and the management of marine natural resources. These firms have since been competing with the artisanal fisheries for the same resource, resulting in ever increasing conflicts and depleting fish stocks from overexploitation and damage to the marine environment. The current scarcity of fisheries resources, disputes over jurisdiction, inadequate conservation and management measures and the continuing decline in global fish stocks with the resultant influx of foreign fishing vessels in West African fishery waters have impacted enormously on the country's ability to meet domestic demand, threatening fish food security and the livelihood of many as well as the Ghanaians economy. Presently light fishing and pair trawling seem to be creating whole lot of confusion within the sector.

The problem of scarcity in fish stocks represents a very bad omen for the nutritional needs of the people. In Ghana, fish is one of the main sources of nutrition for the people. This is very critical health requirement particularly for young children as the brain food. Consumption of fish provides energy, protein, and a range of other important nutrients. It is also clear that omega-3s in fish can reduce the risks of degenerative and pregnancy-related conditions like suboptimal neurodevelopment in offspring. In other words, babies born to women who eat fish while they are pregnant have a head-start over other kids. With almost a third of the country's children stunted (Ghana Statistical Service, Ghana Health Service and ICF Macro, 2009), this can't get any dire. The social ramifications arising out of unemployment and ensuing poverty spiralling vices as transactional sex leading to long term contagion effects such as increased teenage pregnancies and exposure to STIs/HIV.

The best news yet to come out of Ghana's coast was the discovery of crude oil in commercial quantities in 2007. As can be seemed from Figure 2.6, this is located in an area called the Tano Basin in the Gulf of Guinea about 12 km from the coast shore and 95 km southwest of the Western region twin city capital of Sekondi-Takoradi. The West Cape Three Points Block as it is called has delivered world-class results since drilling began in the last quarter of 2010 and continues to offer significant potential for transforming the economic fortune of Ghana.

Figure 2.6 – West Cape Three Points Block crude oil drilling fields



Source: Kosmos Energy, 2011.

The questions on the minds of many people have been who is going to man the gate and check environmental impact. The answers as to whether Ghana will derive the

maximum benefits from oil or become another resource curse nation with health ramifications will unfold with time.

The coastline vegetation is mostly a low, sandy shore backed by plains and scrub and intersected by several rivers and streams, most of which are navigable only by canoe. A tropical rain forest belt, broken by heavily forested hills and many streams and rivers, extends northward from the shore, near the Cote d'Ivoire frontier. This area produces most of the country's cocoa, minerals, and timber. North of this belt, the country varies from 91 to 396 meters (300-1,300 feet) above sea level and is covered by low bush, park-like savannah, and grassy plains. Ghana like all other community of nations faces environmental challenges. Ghana is not on course to achieve Millennium Development Goal (MDG) 7 in full as critical challenges exist in achieving the targets of reversing the loss of environmental resources. MDG 7 ensures environment sustainability. It integrates the principles of sustainable development into country policies and programmes which seek to reverse loss of environmental resources and reduce biodiversity loss. Almost ten per cent of Ghana's gross domestic product (GDP) is lost annually through environmental degradation. Ghana's forest cover has declined from 32.7% to 24.2% between 1990 and 2005. In 1990, the forest cover was estimated at 7,448,000 hectares, and this has depleted at an average rate of 1.8% (NDPC/UNDP-Ghana, 2010).

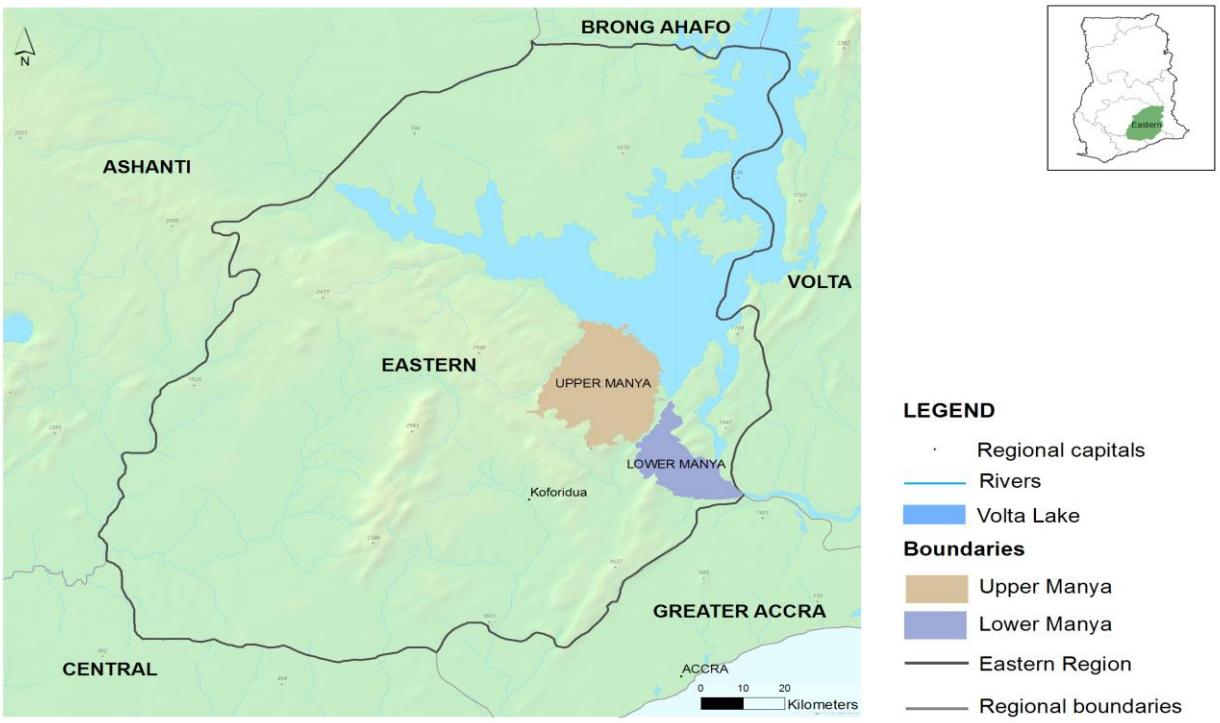
Deforestation, overgrazing, and periodic drought have led to desertification and soil erosion. Ghana's wildlife populations, depleted by habitat loss, are further threatened by poaching. Ghana has ratified international agreements protecting biodiversity, endangered species, tropical forests, wetlands, and the ozone layer.

2.4.1 - Physical features of Eastern region

The Eastern region showed in Figure 2.7 lies between latitudes 6° and 7°′North and between longitudes 1°30′ West and 0°30′East. It is the sixth largest region with a land area of 19,323 square kilometres. The region thus constitutes about 8.1% and sixth largest in Ghana by total land area. It is squeezed in the lower abdomen of south east Ghana with a rich blend of dramatic landscape, historic relics and traditional cultures. Ghana generally has a flat surface area except for Eastern and Volta regions. This uniqueness brings appreciation for the landscape that provides an endless source of

fascination and beauty by way of a number of hills, plateaux, watersheds, gorges and waterfalls just to mention a few. From Figure 2.7, it is shown that Eastern region shares common boundaries with the Greater Accra, Central, Ashanti, Brong Ahafo and Volta Regions. The topography is characterised by four main features. The Atiwa-Ahwiredu range and the Kwahu Scarp which attain an elevation of between 2,420 feet and 2,586 feet above sea level. The third feature is the Akuapem highland of 1,530 feet and then the isolated hills/mountains dotting the relatively low-lying plains to the south, notably the Krobo and the Yogaga mountains. The Kwahu Plateau forms a major watershed in both the region and the country as a whole. The hilly nature of the region has naturally rendered some of the districts geographically inaccessible for health and other development programmes. The topography and special relief features offer tourist attractions notable among them being the Boti Falls and Aburi Gardens. The region has 26 administrative districts including Lower and Upper Manya Krobo Districts Koforidua is the regional capital. Koforidua is also the capital of New Juaben Municipal Assembly besides serving as the main commercial centre. It was founded in 1875 by refugees from Ashanti.

Figure 2.7 - Eastern Region showing Lower and Upper Manya Krobo Districts



Source: Author's own construct, 2011.

The major rivers in the region include Rivers Birim and Densu. River Birim runs almost the length of the region stretching from Apapam near Kibi and joining Prah in the Central region. It is noted for gold and diamond mines and like Densu provides good soil along its valley for farming. It supplies drinking water to the southern part of Eastern region and the western part of Accra. The Volta River, which runs along the eastern border of the region, has been harnessed to become the main source of Ghana's electricity supply. The lake created as a result has also facilitated fishing industry and river transportation.

The forest and savannah type of soils are suitable for the cultivation of a variety of cash crops as cocoa, cola-nuts, citrus, oil palm and staple food crops such as cassava, yam, cocoyam, maize, rice and vegetables. The first cocoa seed which revolutionalised the economy of Ghana from 1898 was planted at Mampong in the region. The region contributes significantly to the production of industrial crops such as cocoa, pineapple, pawpaw, cola nut and oil palm and also has a substantial share in the national production of maize, cassava, and citrus. Available also in the region are exotic crops such as black and sweet pepper, ginger, cashew nuts, Irish potatoes, rubber and mangoes, which are all gaining importance as export commodities. The region also produces some timber and minerals such as gold and diamond.

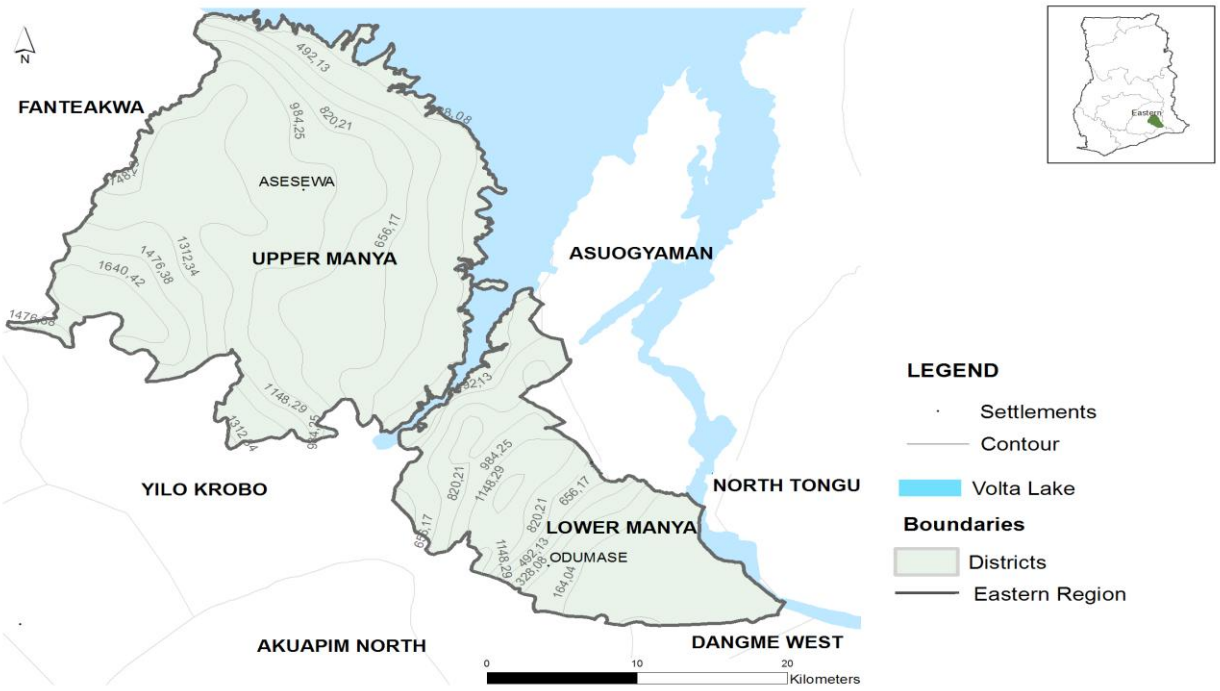
The Eastern region experiences one of the best and pleasant climatic conditions in Ghana partially due to the nature of the topography. Many of the early European missionaries especially those from the Basel sect or the Presbyterian Church settled in this part of the country for the reason of the climate. The region lies within the wet semi-equatorial zone which is characterised by double maxima rainfall in June and October. The first rainy season is from May to June, with the heaviest rainfall occurring in June while the second season is from September to October, with little variations between the districts. Temperatures in the region are high and range between 26°C in August and 30°C in March. The relative humidity which is high throughout the year varies between 70 per cent and 80 per cent (Tachie-Obeng, et al., 2010).

2.4.2 - Physical profile of Manya Krobo area

The *Manya Krobo* district is located in the south-eastern part of Ghana. Lower and Upper *Manya* are two of the twenty-one districts in Eastern region. Manya is located

along the south-western part of the Volta River. It lies between latitudes 6°05'south and 6°30' north as well as longitudes $0^0$8' east and 0°20' west. *Afram* Plains, *Fanteakwa*, *Dangme* West, *Asuogyaman*, *Yilo Krobo*, and North *Tongu* districts border the *Manya Krobo* to the northeast, northwest, southwest, west, and southeast respectively. Figure 2.8 shows the study area, Upper and Lower *Manya Krobo* districts. Manya Krobo is 75 kilometres northeast of Accra and 20 kilometres south of the Akosombo dam (Sauvé, et al., 2002).

Figure 2.8 – Physical relief features in Lower and Upper Manya Krobo Districts



Source: Author's construct courtesy Legon CERGIS shape files, 2011.

The district capitals are Odumase and Asesewa for Lower and Upper Manya Krobo respectively. The area has four agro-ecological zones. Human activities on the vegetation have resulted in scattered patches of secondary or broken forests. The predominant soils in the Manya Krobo Districts can be divided into four main groups (Manya Krobo District Assembly, 2006). The agro-eco zone formed from sandstone is called *Yaya-Pimpimso-Bejna* association. It consists of moderately shallow, reddish and brown well-drained loose, concretionary, overlying slopes. This eco-zone stretches from the northern part of the District south wards through Asesewa to Otrokper. These soils are saturated with water in the rainy season, but dry out in the middle of the dry season.

With suitable drainage, the soils are considered good for the cultivation of rice, sugar cane and vegetables (Manya Krobo District Assembly, 2006).

Another eco-zone type developed over Buem such as sandstone, shales and mudstones is called Dewasi-Wayo association. The association has summit soils shallow, pale-coloured, brashly soils and deeper and brown sandy loams of Nsomia series. These soils are confined to the north-eastern part of the District along the Ponpon River. This is generally found around the Apimsu area. It is poorly drained and is not suitable for most crops but can be used for sweet potato and vegetable cultivation especially along the banks of rivers.

The next class of eco-zone has soils developed over acidic gneiss known as Simpa-Aquantaw complex. It is found between Odumase southward towards Somanya in the Yilo Krobo District. The major lowland soils of Aqantaw series consist of gray brown compact sodic hardpan sometimes-calcareous clays. Cassava is mostly grown on the Simpa soils, sometimes intermixed with yams, maize or cocoyam. Groundnuts, sorghum, millet and banbara beans appear to be suitable for these soil conditions. The last eco-zone developed over basic gneiss and pyroxenite referred to as Akuse-Bumbi associations. It is very poorly drained, very dark gray to black plastic clays. It occurs within depressing and wide flat valley bottoms found south of Kpong in the Volta Lake right down to Akuse. This class of agro-ecological zone is considered very well for rice, sugarcane and vegetables. Essentially, *Manya Krobo* as a district is made up of 371 communities 300 of which are in Lower Manya. Lower *Manya Krobo* is more urbanised in character than the rest of the district. Some of the important functional settlements in the Lower *Manya Krobo* include *Odumase*; the traditional capital of *Manya*, *Agomanya*, the largest market in the district; *Kpong* and *Akuse*. Some of the settlements in the Upper *Manya Krobo* include *Asesewa* and *Sekesua*.

Other important settlements in terms of health, market and educational facilities include *Otrokper* (Health post/education), *Anyaboni* (Health post/Fishing Market), *Ososon* (Catholic Grotto) and *Akati* (Market that links up with *Donkorkrom* in the *Afram* Plains).

A third of the district's original land area was submerged by the creation of the *Akosombo* hydroelectric power dam before *Yilo Krobo* and *Asuogyaman* districts were carved out of *Manya Krobo* district. The district thus currently covers a total physical

land area of 1,476 square kilometres, and divided into Lower and Upper *Manya* with 12 Area Councils.

2.5 - Demographic and socio-economic profiles

In 1960 roughly 100 linguistic and cultural groups were recorded in Ghana (Ghana Statistical Service, 2002). Although later censuses placed less emphasis on the ethnic and cultural composition of the population, differences of course existed and had not disappeared by the mid-1990s. The major ethnic groups in Ghana include the Akan, Ewe, Mole-Dagbane, Guan, and Ga-Adangbe. The subdivisions of each group share a common cultural heritage, history, language and origin. These shared attributes were among the variables that contributed to state formation in the pre-colonial period. Undifferentiated recourse to ethnic categories has obscured the essential fluidity that lies at the core of shared ties in the country. Evidence of this fluidity is observed in the heterogeneous nature of administrative regions, in rural-urban migration, in the shared concerns of professionals and trade unionists, and in the multi-ethnic composition of secondary school and university classes. Ethnicity, nonetheless, continues to be one of the most potent factors affecting political behaviour in Ghana. For this reason, ethnically based political parties are unconstitutional.

Despite the cultural differences among the various peoples, Ghanaian languages are placed in only two major linguistic subfamilies of the Niger-Congo language family. This is one of the large language groups in Africa. These are the Kwa and Gur groups, found to the south and north of the Volta River, respectively. The Kwa group, which comprises about 75 percent of the country's population, includes the Akan, Ga-Adangbe, and Ewe. The Akan are further divided into the Asante, Fante, Akwapim, Akyem, Akwamu, Ahanta, Bono, Nzema, Kwahu, and Safwi. The Ga-Adangbe people and language group include the Ga, Adangbe, Ada, and Krobo or Kloli. Even the Ewe, who constitutes a single linguistic group, is divided into the Nkonya, Tafi, Logba, Sontrokofi, Lolobi, and Likpe. North of the Volta River are the three subdivisions of the Gur-speaking people. These are the Gurma, Grusi, and Mole-Dagbane. Like the Kwa subfamilies, further divisions exist within the principal Gur groups.

The population of Ghana as of 26 September 2010 census was 24,223,431 (Ghana Statistical Service, 2011) as contained in Table 2.1. Women constitute 12,421,770

(51.3%) and men 11,801,661 (48.7%). The overall sex ratio in Ghana is 95 indicating females outnumber males in all regions (Ghana Statistical Serivice, 2011). Although the natural sex ratio at birth is estimated at 105 boys to 100 girls, sex ratio tends to even out in adult population eventually resulting in an excess of females among the elderly due generally to higher life expectancy of females. Even after allowing for causes specific to females such as breast cancer and death in childbirth, adult males tend to have higher death rates than adult females of the same age (Garenne, 2002). The age profile or sex ratio is generally divided into four namely; primary (at fertilization or conception), secondary (at birth), tertiary (sexually active or mature organisms) and quaternary (post-reproductive organisms). However, there are no clear boundaries between them (Coney and Mackey, 1998). The relevance is in helping to predict population trends. The gender imbalance in Ghana's population may arise as a consequence of both natural and cultural factors. Across regions, the sex ratio ranges between 90 in the Central and 104 in the Brong Ahafo region. Only two regions (Brong Ahafo 104 and Western 102) out of the ten regions have ratios above 100. The Brong Ahafo is known as the bread basket while Western region alone produces more than half of cocoa in Ghana and home to a number of mining companies. These economic activities presumably attract more men to the regions hence accounting for sex ratio trends.

Table 2.1 – 2010 population estimates of Ghana disaggregated by sex and region

Region	Area	Density	Male	Female	Total	% Share	% increase	Inter-censal rate	Sex Ratio
Western	23,921	97	1,176,189	1,149,408	2,325,597	9.6	20.8	1.8	102
Central	9,826	214	998,409	1,108,800	2,107,209	8.7	32.2	2.7	90
Greater Accra	3,245	1,205	1,884,127	2,025,637	3,909,764	16.1	34.6	2.8	93
Volta	20,570	102	999,190	1,100,686	2,099,876	8.7	28.4	2.4	91
Eastern	19,323	134	1,252,688	1,343,325	2,596,013	10.7	23.2	2.0	93
Ashanti	24,389	194	2,288,325	2,436,721	4,725,046	19.5	30.8	2.6	94
Brong Ahafo	39,557	58	1,161,537	1,120,591	2,282,128	9.4	25.7	2.2	104
Northern	70,384	35	1,210,702	1,257,855	2,468,557	10.2	35.6	2.9	96
Upper East	8,842	117	497,139	534,339	1,031,478	4.3	12.1	1.1	93

Source: Ghana Statistical Service, 2011.

The population grew by 28.1% from 2000 to 2010. Northern (35.6%), Greater Accra (34.6%), Central (32.2%) and Ashanti Regions (30.8%) recorded highest growth rates.

contrarily, inter-censal growth rate declined from 2.7% in 2000 to 2.4% in 2010. Every hour, there are 86 births, 22 deaths and negative one (-1) immigrant. The highest growth rate between 2000 and 2010 was recorded in Greater Accra (2.8%) and the least in Upper East Region (1.1%). The Ashanti (19.5%) and Greater Accra (16.1%) regions together constitute 35.6% of the total population.

To get a better understanding of what this implies, we need to situate it with the current global population growth trend. The fastest-growing country in the world is Qatar registering some surplus of 514 people per day whilst Moldova has the record of being the fastest-shrinking nation losing an estimated 106 persons per day (UNFPA, 2011). Ghana like in other developing nations, where improvements in health care and sanitation are seeing death rates fall, birth rates still remain relatively high. This is leading to rapidly rising populations. Qatar on the other hand has a large immigrant workforce of about 20 people each hour and has seen its population rising rapidly in recent years (UNFPA, 2011). Moldova, although poor by European standards, has seen its population drop mainly because of emigration of 4 persons per hour. Fewer babies estimated at 5 each hour compared with 6 deaths ensures the population declines.

Ghana's maternal mortality ratio (MMR) remains high despite efforts made to meet MDG 5. This goal aims to reduce by three-quarters, between 1990 and 2015 the MMR and proportion of births attended by skilled health personnel. Result from the Ghana Maternal Mortality Survey (Ghana Statistical Service, Ghana Health Service and Macro International, 2009) showed a slow decline of maternal deaths from 503 per 100,000 live births in 2005 to 451 per 100,000 live births in 2008. However, if the current trends continue, maternal mortality will reduce to only 340 per 100,000 by 2015, and it will be unlikely for Ghana to meet the MDG target of 185 per 100,000 by 2015 unless steps are taken to accelerate the pace of maternal health interventions (NDPC/UNDP - Ghana, 2010). A number of studies have been conducted on causes of maternal deaths and found that 71.1% of cases were direct deaths, 22.4% were indirect deaths and 6.5% were unclassified. While one study found hypertensive states of pregnancy another study identified haemorrhage as the highest cause of maternal mortality. Married women had a significantly higher risk of dying from haemorrhage compared with single women (Asamoah et al, 2011; Lee et al., 2011). With barely three years left to meet the MDG 2015 target date, Ghana needs more financial resources to provide skilled care

and emergency obstetric care services to reduce maternal mortality. Regrettably, the commitment of the government is being called into question as there is a decline in the health sector budgetary allocation from 15% in 2011to 13.2% in 2012. There is no doubt that the reduction would have negative repercussions for progress towards achieving the health-related MDGs particularly the goal of reducing maternal mortality.

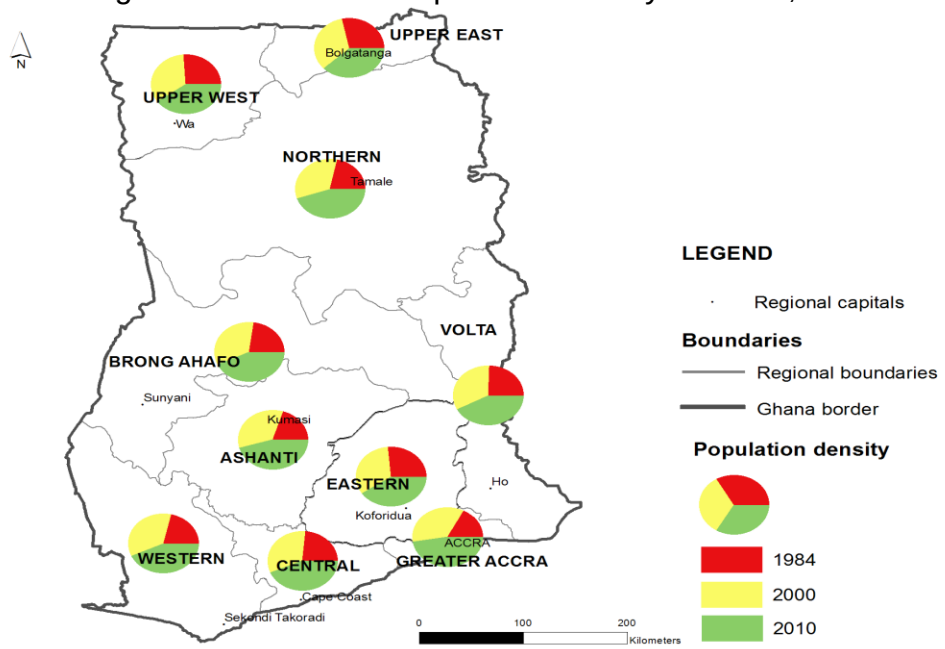
According to the UN Human Development Index report 2011 (HDI), life expectancy at birth in Ghana has appreciated by 11 years from 53.1 years in 1980 to 64.2 years in 2011 (UNDP, 2011). This means Ghanaians now can relatively live longer albeit the country will still need to do more to maintain the momentum in policies aimed at improving livelihood. Life expectancy at birth refers to the number of years a newborn infant could expect to live if prevailing patterns of age-specific mortality rates at the time of birth stay the same throughout the infant's life (UNDESA, 2011). In other words, it is an indicator of how long a person can expect to live on the average, given the prevailing mortality rate. The country with highest life expectancy in the world as of 2011 is Japan where people can live on average for 82.7 years. On the other hand the Central African Republic has the lowest life expectancy of 45.9 years in 2011 (UNDP, 2011). This means people in Ghana on the average live less than 18.5 years than the optimum while exceeding the lowest surviving people by 18.3 years. It means implies a lot more should be done to improve the health of the Ghanaian to increase longevity.

So what is next? The country's population is expected to continue to increase. However, the rate of growth is expected to slow (UNDP, 2011). This is explained largely by longer lives as death and birth rates are falling. This means working-age people will be supporting increasing numbers of older people during the next decades. It is projected that by 2050, there will be just 4.6 working-age people for every person aged 65 or above in a developing nation as Ghana experiencing a decrease of 63% from 2000. This trend creates serious consequences regarding battle for resources. On 30th October 2011 when world population reached 7 billion people, the UN estimated that if prevailing population and consumption trends continue, by the 2030s humanity will need the equivalent of two Earths to support its population (UNDP, 2011).

The density shows increasing pressure on land by population as it doubled from 52 square kilometres in 1984 to 102 square kilometres in 2010 with much more intense on Greater Accra and Ashanti and least in Northern and Upper West regions. Figure 2.9

depicts trends in regional population density shares during the 1984, 2000 and 2010 census periods. A close look at the pie charts for each region shows that the density as at 2010 (green colour) has almost doubled over the combined population densities for years 1984 and 2000 (red and yellow colours). This has resulted in congestion and difficulty in providing resources like utilities and sanitation.

Figure 2.9 - Regional Inter-census Population Density for 1984, 2000 and 2010



Source: Author's own construction from Ghana Statistical Service 2010 Census results, 2011.

The Eastern region has some of the dynamic demographic characteristics as home to one of the friendliest and exceptionally polite people. The 2000 census identified four major ethnic groups in the region namely, the Akan (52.1%), the Ga-Dangme (18.9%), the Ewe (15.9%) and the Guan (7.2%).

The Akan are predominant in 19 of the 26 districts and constitute about 85.4 per cent of the population of Birim South, 75.0 per cent in Birim North and 67.9 per cent in East Akim, Yilo Krobo (79.7%) while the Ewe population is largest in the Asuogyaman (39.1%) and in the Afram Plains is 50.8% (Ghana Statistical Service, 2002). Both these districts share a common border with the Volta Region which is the home of the Ewe. The Guan has a large concentration in the Akwapim North (34.5%) even though they are not the largest ethnic group in the district. They are also significant in the Suhum-Kraboa-Coaltar (17.4%) and Asuogyaman (14.1%) districts (Ghana Statistical Service, 2002). The citizens are culturally bound together by customs and festivals that are

celebrated occasionally by chiefs and elders with their subjects. Such occasions also serve as a common platform for bringing the citizens together for development projects.

The age structure composition of the population of the region broad at the base and reduces gradually in the subsequent age groups until the population becomes relatively small at the top. The 2000 census result shows a relatively large proportion of children (41.7%) and a small proportion of older people 65 years and older is 5.8% (Ghana Statistical Service, 2002). The age structure for the sexes shows that males predominate in the early few years but are overtaken by the female population in later years. The proportion of the male population under 15 years is highest. In all districts, except Kwaebibirem and Afram Plains, there is a greater proportion of surviving females (65 years and older) than males. The highest is in Akwapim North, with 6.3 per cent males compared with 9.8 per cent females. In the Afram Plains, the corresponding figures are 3.1 per cent males compared with 2.6 per cent females (Ghana Statistical Service, 2002). This general pattern is not reflected at all ages and in all districts in the region as a whole. The imbalance in the sex ratio may be due to a higher male mortality and large numbers of young men seeking employment in other regions or outside the country. Only two districts Kwaebibirem (104.4) and Afram Plains (114.9) record higher sex ratios (Ghana Statistical Service, 2002). The reason for the high sex ratios in both districts may be mainly agricultural. The two districts are major agricultural areas which attract many people into the farming and fishing industries.

The 2000 census result showed religious affiliation in Eastern region as Christianity, Islam and Traditional religions. It indicated that those who profess the Christian religion constitute 82.8 per cent of the population, followed by Islam by (6.1%) and Traditional (2.4%). The Christian religion comprises the Catholic (9.6%), the Protestant (26.7%), the Pentecostal/Charismatic (33.4%) and other Christians (13.1%), (Ghana Statistical Service, 2002). The strength of the Protestant Churches in the region has its antecedents in the arrival of the Basel Missionaries in the Akwapim and Kwahu areas in the 18th and 19th centuries (Huber, 1993). The predominance of the Pentecostal and Charismatic churches is a recent phenomenon which has drawn their following from the mainstream catholic and protestant churches.

According to the 2000 census, 63.6 per cent of the population in Eastern region is literate. It also revealed that 46.4 per cent of the population in the region are literate in

both English and a Ghanaian language in addition to 13.4 per cent in English only. This gives a total of 59.8 per cent, which is the effective literacy or the critical mass of the people who can more effectively access information on what goes on around them. There is also the indication that the level of literacy is higher for males (73.6%) than for females (54.4%) according to Ghana Statistical Service (2002).

The main occupations as captured by the 2000 census in the region are agriculture and related work (54.8%), sales (14.3%), production, transport and equipment work (14.0%) and professional and technical work (6.9%) with Services accounting for per cent (5.0%) of the economically active population (Ghana Statistical Service, 2002). The principal occupations for the males are agriculture and related work (56.9%), production, transport and equipment (16.6%), professional and technical work (8.6%), sales work (6.5%) and clerical work (6.2%). The pattern is almost the same for the females, except in sales where females (21.8%) feature more prominently than males (6.5%). The other major occupations for females are agriculture and related work (52.7%), production, transport and equipment work (11.5%), professional and technical (5.2%) while services accounted for 6.7% (Ghana Statistical Service, 2002).

Nearly four-fifth (77.7%) of the population in Eastern region aged 15 years and older in 2000, were self-employed workers without employees, followed by employees (11.5%) while self-employed with employees was 4.3% (Ghana Statistical Service, 2002). The remaining 6.5% of workers are made up of unpaid family workers (2.7%), apprentices (2.9%), domestic employees (0.4%) and others (0.5%). The private informal sector provided employment for 80.5% of the workers of the region, the private formal (12.3%), while the public sector absorbed 6.1% (Ghana Statistical Service, 2002). The semi-public sectors form 0.6% of workers. Significantly, 83.6% of females are engaged in the informal sector mainly in agriculture and sales work. The high ratio of self-employed (without employees) has economic cost as it affects revenue and tax collection.

The size and rate of growth of population is one of the most important statistical measurements of human population. These determine, to a large extent, many developmental factors about a country or district, including its present and future ability to feed, to provide housing and social services. It also determines its ability to deal with poverty. Table 2.2 shows the total population figures for 1970, 1984, 2000 and 2010 with their corresponding inter-census growth rates. It can be seen that figures in 1970,

1984, 2000 and 2010 were 113,072, 134,530 154,301 and 161,338 respectively. The 2010 figure is a sum of Lower Manya (89,246 with area of 322.2km² and 277persons/km² density) and Upper Manya (89,246 with area of 1,044.7km² and 69persons/km² density). The inter-census growth rates during 1970-1984 and 1984 and 2000 were 1.2% and 1.0, which were lower than the regional figures of 2.3% and 1.4% respectively.

Table 2.2 - Population and inter-census growth in Manya Krobo in 1970, 1984, 2000 and 2010

Census Year	Total Population	Inter-census Growth Rate
1970	113,072	-
1984	134,530	1.2%
2000	154,301	1.0%
2010	161,338	-
Lower Manya	89,246	Density 277/ km²
Upper Manya	72,092	Density 69/ km²

Source: Ghana Statistical Service, 1970, 1984, 2000 and 2010.

The *Krobo* ethnic group lives in the hot and humid tropical area of southeast Ghana. The *Krobo* are wedged in between the *Akan* and the *Ewe* ethnic groups to the north-west and north-east and the *Ga-Adangbe* to the south. Manya Krobo (71.4%) has the largest concentration of the Ga-Dangme. The population of Lower and Upper *Manya* districts as at the 2000 population and housing census was 154,301 comprising of 75,254 (49.3%) males and 79,047 (50.7%) females. The 2010 Ghana Population Census result for Districts is as of yet not released; only figures for Ghana and the Regions are available hence the need to rely on 2000 data. There are more females than males which is consistent with the national rate of 48.7 percent males (11,801,661) to 51.3 percent females (12,421,770) giving a total population of 24, 233, 431. This gives a sex ratio of 95.2 (Ghana Statistical Service, 2002, 2011).

The population densities for the years 1970, 1984 and 2000 for the area were 77, 91 and 114 square kilometres, respectively. These figures are greater than the regional figures of 63, 87 and 109 for the same period. The age–sex composition is of much significance in the planning process for poverty reduction. It affords the opportunity to know the numerical strength of each sex and age group. This in turn helps to determine what needs to be done to improve their well-being various census years, giving an

indication of higher pressure on land use in the area. The size and growth rate of a population is important determining factors about the provision of economic and social services including health. The area has a significant juvenile population of nearly two-fifth (38.1%) compared to 1.4% regional figure. The population of *Manya* constitutes 7.3% of the total population in the Eastern region with 153,394 as usual residents while 92,824 live in rural areas and 61,477 in urban settlements. With respect to ethnic background, seven in ten people (70.5%) are *Krobos* while over three quarters (76.4%) are christians making it the leading religion in *Manya Krobo*. The male-female split within each age group in the year 2000 for the area is contained in Table 2.3.

Table 2.3 - Age-Sex Composition of the Population

Age Group	Manya Krobo District			Eastern Region			Ghana		
	Male	Female	Total	Male	Female	Total	Male (%)	Female	Total
0 to 14	18.5	19.6	38.1	21.2	20.5	41.7	22.9	22.1	45.0
15 to 64	29.3	29.2	58.5	25.4	27.2	52.6	25.1	25.9	51.0
65 & above	1.6	1.9	3.5	2.5	3.2	5.7	1.7	2.3	4.0
Total	49.3	50.7	100.0	49.1	50.9	100.0	49.7	50.3	100.0

Source: Ghana Statistical Service, 2000.

The main features of the traditional economy of *Manya Krobo* are agriculture which employs about 40% of the working population (Manya Krobo District Assembly, 2006) comprising food crops, fishing, hunting and livestock. The total land under cultivation is about 20.3 hectares. The main agricultural activity that is carried out in the area is crop farming mainly consisting of maize, cassava, vegetables, plantain with corresponding percentages are shown in Table 2.4. These activities take place in farming villages chiefly in Upper *Manya* district. There is also a native crafts industries consisting of beads, blacksmith's trade, pot-making, manufacture of brooms and baskets among others. Historically, trading, a major economic activity for women as chain of distribution of goods plays important roles in the political economy of *Manya Krobo* trading of various items is very popular.

Table 2.4 - Agricultural produce of Manya Krobo districts

No.	Crop Name	Percentage
1	Maize	50.6%
2	Cassava	39.3%
3	Vegetables	7.0%
4	Plantains	3.0%

Source: Field Survey, Ministry of Food and Agriculture, 2006.

Though *Manya* and *Yilo Krobo* have their respective paramountacies, they share similar cultural practices as also is the larger *Adangme* group including *Osudoku, Shai and Ga.* There are, however, other ethnic groups bordering Krobo whose cultures vary and since interactions influence culture and attitudes, neighbours matter. Traditionally, Kroboland is bounded by *Akwamu* and *Osudoku* in the east, *Akim, New Juaben and Akwapim* areas in the west and *Kwahu* in north-west, while *Shai* is to south.

Essentially, *Manya Krobo* as a district is made up of 371 communities 300 of which are in Lower Manya. Perhaps the economy accounts for the population composition while the arrival of Basel missionaries in the 1820s explains the religious make up. The main features of the traditional economy of *Manya Krobo* are agriculture comprising food crops, fishing, hunting and livestock. These activities take place in farming villages chiefly in Upper *Manya*. There is also a native crafts industries consisting of beads, blacksmith's trade, pot-making, manufacture of brooms and baskets among others. Historically, trading, a major economic activity for women as chain of distribution of goods plays important roles in the political economy of *Manya Krobo* district. Itinerary trading of various items is very popular. Itinerant women traders appear highly vulnerable, as women and as highly mobile people to risk of HIV infection occasioned by the extremely difficult conditions in which the women work which is exploited for sexual gratification of men due to existing contemporary societal norms that support sexual exchange (Anarfi, Appiah and Awusabo-Asare*,* 1997).

2.6 –Health infrastructures and facilities

In Ghana, most health care is provided by the government, but hospitals and clinics run by religious groups also play an important role. Some for-profit clinics exist, but they provide less than 2% of health services. Health care is very variable through the country. The major urban centres are well served, but rural areas often have no modern health care. Patients in these areas either rely on traditional medicine or travel great distances for care. Ghana has a very low health professional-patience ratio. The World Health Organisation points out that fewer than 23 health workers (physicians, nurses, and midwives only) per 10,000 would be insufficient to achieve coverage of primary healthcare needs. The national average of physician to patience ratio was 0.085 to 1,000 by 2009 (CIA World Factbook, 2011). Since 2005, Ghana adapted a new

paradigm for health delivery that emphasises disease prevention through lifestyle and behavioural changes (Ghana Health Service, 2007). This is based upon the premise that the actions of individuals, households and communities contribute to the prevalence of diseases, accidents and injuries. To reduce the prevalence, behaviour change communication becomes imperative. Although evidence shows that there has been significant reduction in both infant and under-five mortality rates in Ghana, it is unlikely that the 2015 target of reducing the child mortality rates will be met unless coverage of effective child survival interventions is increased. The Ghana Demographic and Health Survey (GDHS) 2008 showed a 30% reduction in the under-five mortality rate, as it declined from 111 per 1000 live births in 2003 to 80 per 1000 live births in 2008, while infant mortality rate as at 2008 stood at 50 per 1000 live births compared to 64 per 1000 live births in 2003.

All evidence points to the fact that Ghana is experiencing a “double burden of disease” with a high burden of both communicable and non-communicable diseases. The progress towards the attainment of the health related MDGs is slow though all the cost effective interventions are available. Infant and child mortality rates are basic indicators of a country’s socio-economic situation and quality of life, as well as specific measures of health status. Measures of childhood mortality are also useful in population projections and monitoring and evaluating population and health programmes and policies. The 2008 GDHS reported an appreciable decline in under-five mortality rate to 80 per 1,000 live births from 111 during the period of 2003 and 2006, representing about 28% decline (Ghana Statistical Service, Ghana Health Service and ICF Macro, 2009). Although there has been significant reduction in both infant and under-five mortality rates, it is unlikely that the MDG 2015 target of reducing the child mortality rates to 72 will be achieved unless there is an effort to scale-up and sustain the recent child survival interventions. Twenty-five per cent of children below five years were malnourished in that period. Health spending averaged 4.7 per cent of GDP, of which public expenditure is equivalent to 1.8 per cent of GDP. There are approximately 1.5 hospital beds per 1,000 people. In 2000, around 210,000 people were classified as HIV positive, representing 2.4 per cent of the population.

The National Health Insurance Scheme (NHIS) was introduced in 2003 with the view to improving access especially the poor and the vulnerable to quality basic health care

services. The scheme subsidizes health needs of the poor, the sick and the indigents. A person resident in Ghana other than a member of the Armed Forces of Ghana and the Police Service shall belong to a health insurance scheme licensed under this Act and pay the membership contribution determined by the scheme. The Act sets out three distinct types of health insurance schemes operational in Ghana. These are district mutual, private commercial, and private mutual health insurance schemes. Thereafter, the health insurance scheme has to apply to the National Health Insurance Authority (NHIA) for registration and licensing (National Health Insurance Scheme, 2009). The status of the NHIS as at June 2009 indicates that there are 145 District Mutual Health Insurance Schemes (DMHIS) operating in the country. Registration and penetration rates show that total members registered nationwide as at June 2009 was 13,779,806, representing 67.5% of Ghana's population. Exempt groups constituted 8,425,683, representing 69.4% of registered members (National Health Insurance Scheme, 2009). The implementation of the free maternal care policy of Government in July 2008 has covered many pregnant women and has greatly improved maternal health. Table 2.5 shows the number of schemes per region. Ashanti and Brong Ahafo regions lead with 24 and 19 schemes respectively. The Upper West and Upper East regions have the least number of schemes as 8 and 6 each. As a development project and new concept, there were a number of challenges especially resource constraints.

Table 2.5 - Distribution of DMHIS by region

No.	Region	Number of schemes
1	Ashanti	24
2	Brong Ahafo	19
3	Central	13
4	Eastern	17
5	Greater Accra	10
6	Northern	18
7	Upper East	6
8	Upper West	8
9	Volta	15
10	Western	15
Total	**National**	**145**

Source: National Health Insurance Scheme, 2009.

The implementation of the Scheme in some parts of the country faced delays due to the poor coding of houses, the lack of office accommodation and the low level of awareness

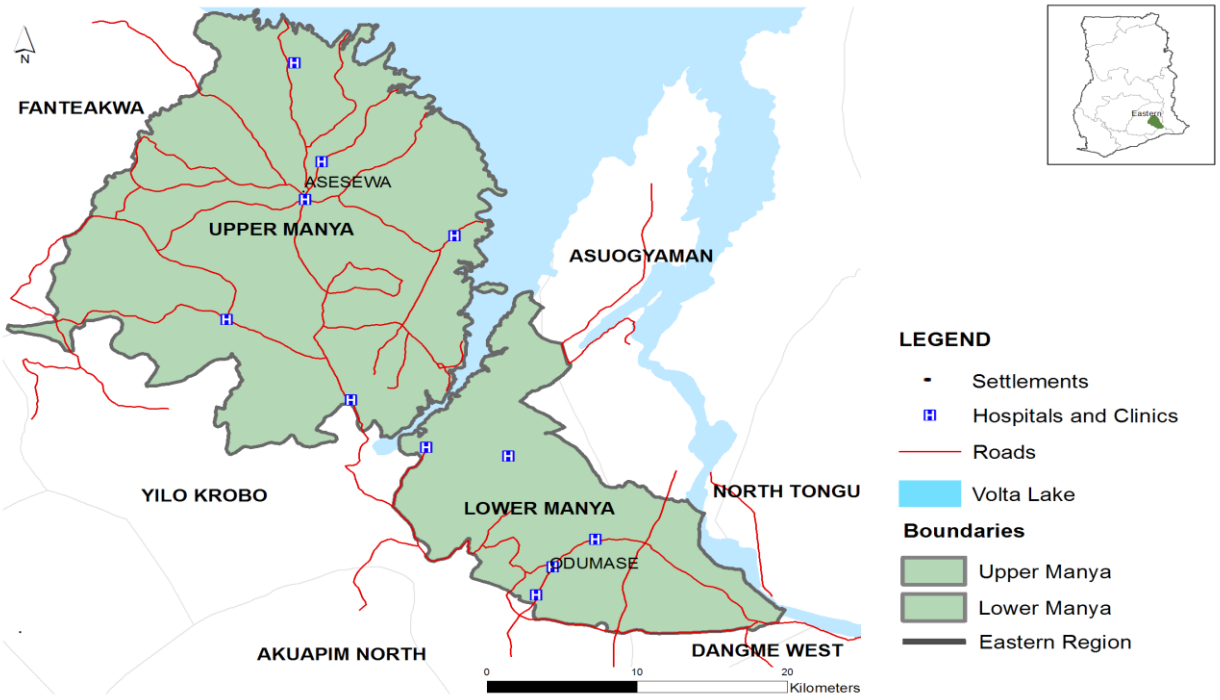
among residents about the Scheme. Another challenge is turning the district schemes into a national scheme to be accessible everywhere in Ghana by subscribers. Scheme set up to ameliorate the health burdens is everything but national after seven years of implementation. By the end of June 2009, the number of pregnant women registered nationwide was 580,753. Currently 1,551 private health care facilities have been given provisional accreditation (National Health Insurance Council, 2009). These comprise 400 hospitals and clinics, 237 maternity homes, 451 pharmacies, 329 licensed chemical shops and 128 diagnostic facilities (laboratories and diagnostic imaging facilities). This compares with 1,135 as at December 2007. The Eastern region has largest number of health facilities in the country numbering 132. As is the case nationwide, the accessibility to these health facilities both terms of affordability and physical distance, it is inadequate for the people of Manya Krobo district. Physical accessibility is variable but generally averages about 60 kilometres. Accessibility to hospital facility increases with distance (Ghana Statistical Service, 2002).

Traditional healing facilities are the most readily available of the three health facilities in all the districts of the Eastern region. Between 63.2 and 99.3 per cent of localities in the districts have traditional healing facilities, within the localities. Of all the districts, Manya Krobo has the highest proportion (99.3%) of localities with a traditional healing facility within the locality, followed by Yilo Krobo (97.4%), Suhum-Kraboa-Coaltar has the lowest proportion (63.2%) of localities with a traditional health facility within the locality. The proportion of traditional healing facilities available to the population decreases with distance. In 2007, there was hardly any inhabitant who accesses a facility beyond five kilometres. The population therefore finds it easier to access the services of a traditional healer than that of a doctor in a hospital or a clinic. The ratio of population to registered traditional medical practitioner is also very low compared with the population per allopathic doctor and population per nurse. The regional ratio is one registered traditional medical practitioner to 762 people (Ghana Statistical Service, Ghana Health Service and ICF Macro, 2009). Asuogyaman (434) has the lowest ratio, followed by Akwapim South (444), with the highest in the Afram Plains (1,192) followed by Birim North (1,112). The distribution of medical personnel in the various districts, particularly doctors, is inadequate and badly skewed in favour of the relatively urbanised districts rather than population size and needs. The uneven distribution of doctors in the region

is best appreciated if one notes that the New Juaben District, with only 6.5 per cent of the regional population, has 36.8 per cent of the doctors in the region. The locations of some of these health facilities and other social amenities such as roads are depicted in Figure 2.10.

There are roughly twenty-three (23) health facilities in *Manya Krobo* district. The hospitals serve *Manya Krob*o and neighbouring districts including *Yilo Krobo*, *Dangme* West and *Asuogyaman*. The private sector is a significant contributor in the provision of basic health care in the district. In addition, there are many chemical shops, Traditional Birth Attendants (TBAs) and traditional healers. Relatively the area has good access to health care and due to the high HIV prevalence more interest has been shown by way of provision of health care by both government and a number of civil society groups. The pilot antiretroviral treatment began in 2003 at St. Martins and Atua hospitals all located in the area.

Figure 2.10 – Provision and location of some social amenities in Manya Krobo district



Source: Author's construct based on shapefiles by Centre for Remote Sensing & Geographic Information Services (CERGIS), 2011.

2.7 - HIV/AIDS prevalence, contraception and nutrition

The HIV/AIDS epidemic patterns observed in Ghana show that initial cases were diagnosed among returning immigrants from the first case in March 1986 and was then followed diffusion with the local population. It is a generalised epidemic with prevalence ranging between a low 1.7% and a high of 3.6%. Like many other health and social conditions, HIV/AIDS shows variations in age, geographic areas, gender, and residence. People within the age bracket 25-39 years are more at risk while the 15-19 year group considered a proxy for predicting future trends is quite low. The Eastern, Western and Ashanti regions as well as urban areas coincidentally mainly in the south carry a heavy burden of the infection. Northern region and rural areas tend to have low prevalence. Initially many more females were getting infected than men but this is balancing out. It ranged from a ratio of 8:1 in 1986, reduced to 3:1 in 1991 and 2:1 by 2009 (Anarfi, 1990; Agyei-Mensah, 2001; NACP and GHS, 2010). At least three reasons account for the imbalance in HIV infection between females and males namely differences in biological characteristics, power relations and gender inequality as well as male circumcision. In many areas, socio-cultural concept of requiring women to play a passive role in sexual behaviour weakens women's right to voice out concerns regarding sex-related matters. Compared with men, sexual contact or exposure of women to their sexual partners' mucosal surfaces is greater due to their bodies' make up hence increases susceptibility to risk of HIV infection. Again, unequal access to economic resources hence power between men and women often constrict the ability of many women to negotiate for safe sex with their sexual partners together with men having multiple sexual partners. Male circumcision reduces the risk of contracting HIV among heterosexual men by about 60%. According to the 2008 Ghana demographic and health survey, only a quarter (25.0%) of women use condom while nearly half (45.0%) although nearly men and women (98.0%) know about HIV infection (Ghana Statistical Service, Ghana Health Service and ICF Macro, 2009; UNAIDS, 2011). The main modes of transmission are heterosexual 80%, mother to-child 15% and others 5%. HIV type I largely (91.8%) accounts for diagnosis in the country, type II is 5.2% and dual I &II type infection is only responsible for 3.0% (NACP and GHS, 2010).

The main reasons often assigned for the generalized infection in Ghana include increased male circumcision of about 95% according 2003 GDHS, low levels of prevalence of concurrent relationships, lack of widespread internal migration, poor transportation networks, increased uptake of VCT services and increased ART accessibility and affordability (Ghana Statistical Service, Ghana Health Service and ICF Macro, 2009).

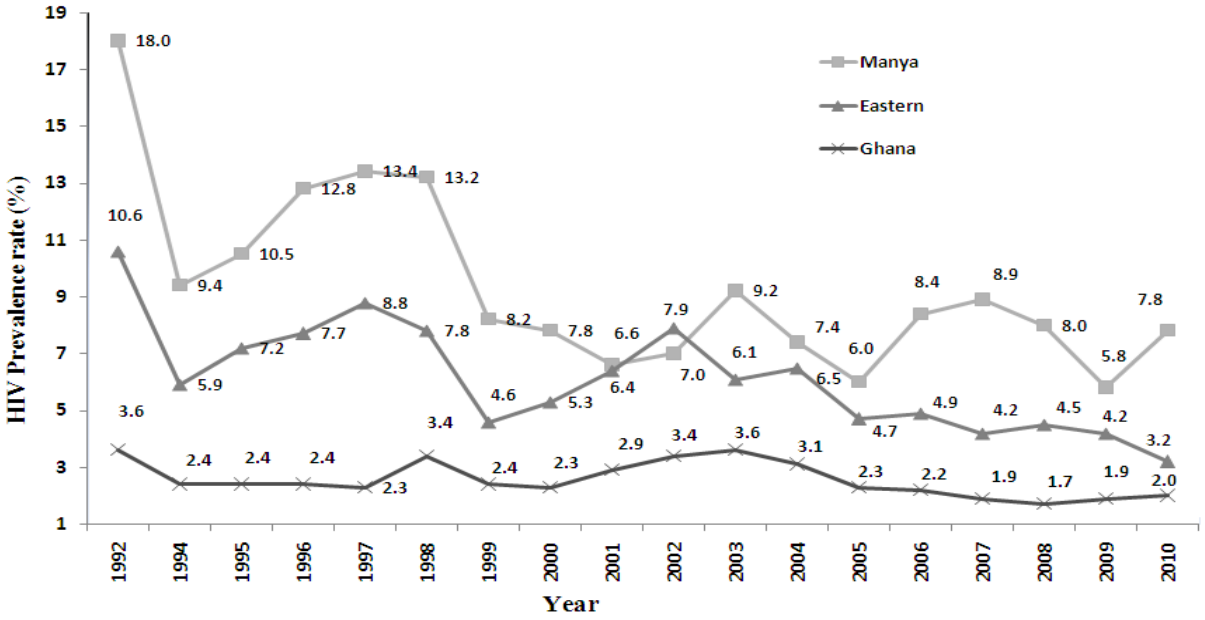
HIV incidence is the number of new HIV infections occurring during a specified period of time while HIV prevalence is the total number of cases of HIV infection at a particular point in time. Prevalence gives an idea of how many people are currently living with HIV infection, and incidence gives a sense of how many people are newly infected. HIV sentinel surveillance systems provide information on trends. The data are useful for understanding the magnitude of the HIV/AIDS problem in certain geographic areas and among special populations and for monitoring the impact of interventions. The HIV sentinel surveillance system in Ghana is implemented by the National AIDS/STI Control Programme (NACP) and on-site laboratory staff of participating districts, and the Public Health Reference Laboratory (PHRL). Data are collected on HIV infection among pregnant women attending antenatal clinics using the unlinked anonymous method. During a period of 8 to 10 weeks each year, all women attending the selected ante-natal clinics for their first visit for their current pregnancy are selected for the sample. The standard sample size at each clinic is 500 (NACP and GHS, 2011). UNAIDS and its international working group on monitoring the HIV/AIDS epidemic define adult HIV prevalence as the percentage of the adult population between the ages of 15 and 49 that is infected with HIV. This is because almost all data used for estimating prevalence comes from antenatal care data, representing women aged 15-49.

With HIV prevalence rate range of 1.7% to 3.6% for 18 years, Ghana has so far avoided the impact of a full-blown national HIV/AIDS emergency threshold of 5.0% and above which might be considered explosive increase. But the situation remains critical. There are pockets of explosive geographic regions with prevalence rates exceeding the dreaded threshold. Figure 2.11 shows that Manya Krobo prevalence has always been above the HIV threshold hovering between a low of 5.8% in 2009 and a high of 18.0% in 1992. It shows that Agomanya and Atua Sentinel sites representing the area have highest prevalence from 1992 to 2010 except in 2002. Eastern Region itself had

exceeded the threshold in 11 out of the 18 years largely fuelled by Manya but stabilising since 2004. Current 2010 prevalence shows Manya 7.8, Eastern 3.2 and Ghana 2.0. The choice of the district as a study area is because it has the highest HIV prevalence in Ghana. Indeed, when Sentinel Surveillance Reporting of HIV began in the country in 1992, the sentinel site at *Agomanya* in *Manya* reported the highest HIV prevalence of 18.0% and latest report of 7.8% in 2010 compared to national prevalence of 2.0%. The setting up of pilot ARV centres and the existence of "dipo" puberty rite which is an 'initiation to womanhood and full tribal membership' (Huber, 1993) influenced the choice of the district for the study.

As can be observed from Figure 2.11, the prevalence rate in Ghana is generalised. There was no sentinel survey in 1993. However, disparities exist over time and space. Eastern region and Manya Krobo have infections that far outweigh the national rates. Even for the national figure, it is interesting to note that few years following a change of government; the rates shoot up probably due to institutional memory loss.

Figure 2.11 - HIV prevalence in Manya, Eastern Region & Ghana from 1992-2010



Source: NACP HIV Sentinel Survey Reports between 1992 and 2010.

After 11 years of military rule from December 31, 1981 to January 7, 1993, democracy was ushered in. While the same regime continued to retain power until January 7, 2001, it ensured institutional stability. The HIV prevalence rates however became unstable following the assumption of a new government in 2001 to 2008. During this tenure, it

initial rose from 2.3% in 2000 peaking at 3.6% before reducing to lowest rate ever at 1.7% in 2008. But since another change in government on January 7, 2009, the rates have been increasing again and reaching 2.0% in 2010. Rates for both Eastern and Manya exhibited similar trends. It will be a good idea if the Ghana AIDS Commission is insulated from political control. Using a definition of age 0-17 years as of 2009, UNAIDS estimates that at least there are 1.1 million orphans in Ghana for children who have lost one or both parents due to all causes. Children who have lost one or both parents to AIDS alone averaged 160,000 with a low estimate of 120,000 and a high end of 210,000 (UNAIDS, 2010). Many more are vulnerable to the same circumstances orphans face even though they may still, for the time being, have at least one of their parents alive (Table 2.6). About 4,500 of these children are in orphanages.

Table 2.6 - Ghana orphans and vulnerable children (OVC) estimates in 2009

Type of orphan	Number
Low OVC estimate	120,000
Mean OVC estimate	**160,000**
High Ovc estimate	210,000
Children whose mother has died due to any cause	500,000
Children whose father has died due to any cause	790,000
Children who have lost both parents due to any cause	150,000
Children who have lost one or both parents due to all causes	**1,100,000**

Source: UNAIDS and UNICEF, 2010 Statistics.

Orphanages face many challenges, but a descriptive study on OVC in the Central region of Ghana indicates that the many OVC who live in households are less likely to have access to education, nutrition and health than those children living in orphanages (Deters, 2008).

Overall HIV/AIDS prevalence in Ghana is stabilising since 2003 with a relatively low rate compared to that of other sub-Saharan African countries. Sentinel Surveillance data seems to suggest that HIV prevalence in the country during the past six years has been fairly stable. In 2008, the median prevalence declined to 1.7% from 1.9% in 2007, then slightly going up to 1.9 in 2009 and 2.0 in 2010 (NACP and GHS, 2011). Over the years, various strategies have been implemented to reduce the spread of HIV in Ghana. These include behaviour change communication (BCC) from March 2002, prevention of mother to child transmission (PMTCT) in July 2002 aimed at preventing unborn

Table 2.7 - Regional distribution of HIV prevalence between 2001 and 2009

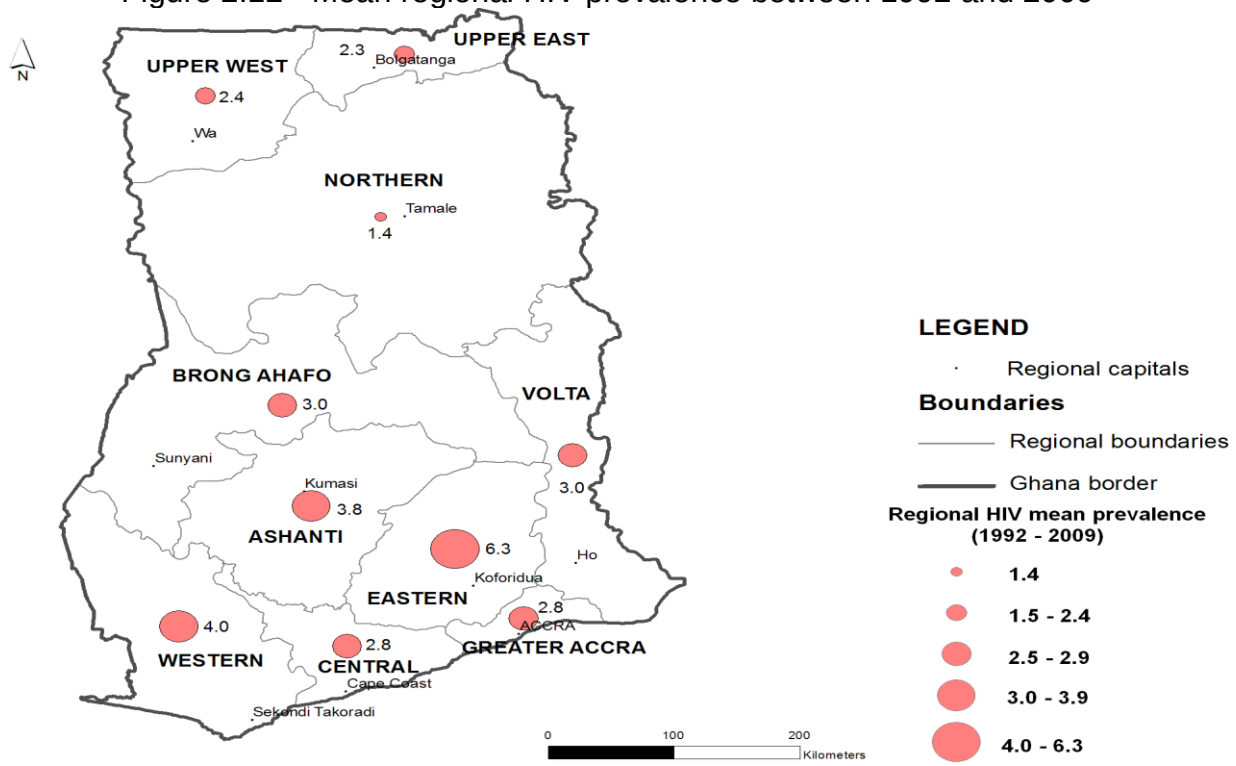
Region	2001	2002	2003	2004	2005	2006	2007	2008	2009
Western	4. 9	5. 1	4 .2	4 .6	2. 9	4.3	3. 2	2.9	3.1
Central	3. 1	2. 6	5 .4	3 .5	2. 9	2.5	2. 9	2.0	3.0
Greater Accra	3. 3	4. 1	4. 3	3 .9	2 .1	3 .4	3.4	3	3.2
Volta	2. 7	3. 2	2 .9	3 .5	1. 9	3	2. 0	1.7	2.6
Eastern	6. 4	7. 9	6 .1	6 .5	4. 7	4.9	4. 2	4.5	4.2
Ashanti	4. 1	3. 9	4 .7	3 .0	3. 0	3.7	3. 8	3	3.9
Brong Ahafo	2. 4	3. 3	4. 0	4 .5	3 .3	2 .8	3.3	2.6	2.9
Northern	1. 6	2. 0	2 .1	1 .8	1. 2	1.3	1. 7	1.1	2.0
Upper East	2.5	3. 9	3 .5	3 .1	2. 6	3.2	2. 5	2.5	2.2
Upper West	4. 1	2. 7	2. 2	1 .7	2 .6	2 .5	3.3	1.6	3.1

Source: National AIDS/STIs Control Programme, 2009.

infections. Then provision of treatment, care and support including anti-retroviral therapy (ART) commenced in 2003 (Family Health International, 2006). Over the years, the sentinel surveillance results show wide regional variations. Figure 2.12 displays the average HIV prevalence for each region in Ghana since sentinel survey started up to 2009. It clearly shows heavier burden in the south than the north perhaps reflecting the population densities. Eastern, Western and Ashanti regions have high prevalence rates above 3.7%. The reasons for the Eastern have been explained in this study. Western and Ashanti regions' high rates are largely due to economic activities and mobility. Both have many mining towns and serve as trading hubs with other regions and countries. Contrarily, Upper West, Upper East and Northern regions have the least below 2.5%. Climatically, religiously, linguistically, and culturally, the Northern region with the least HIV prevalence differs greatly from the politically and economically dominating regions of central and southern Ghana. The Northern Region is much drier than southern areas of Ghana, due to its proximity to the Sahel, and the Sahara. The Northern Region is the least densely populated area of Ghana. Most inhabitants (52%) speak a language of the Mole–Dagbani subfamily in the Niger–Congo languages. The largest ethnicities within this group are the Dagomba and the Mamprussi. Perhaps the biggest determining factor that underpins the low HIV in the region is religion. Over 56% of the population are followers of Islam, 21% belong to traditional religions, 19% are Christian and about 3% other religions (Bogner, 2000). It is the only region in Ghana where Islam followers dominate the population. Islamic constraints on sexuality may have consequences for the transmission of HIV. Several Islamic tenets may have the effect, if followed, of

reducing the sexual transmission of HIV. A survey of published journal articles containing data on HIV prevalence and religious affiliation showed that six of seven such studies indicated a negative relationship between HIV prevalence and being Muslim (Gray, 2004). This is very interesting recognizing that this religion promotes polygamy and multiple sexual partners is one of the risk factors for transmission of HIV. It is possible the level of fidelity among the women is extremely higher. It is an important factor for further studies.

Figure 2.12 - Mean regional HIV prevalence between 1992 and 2009



Source: Author's own construct based on NACP HIV Sentinel Surveillance Reports (1992 to 2009), 2011.

The lowest prevalence of 1.7% was recorded in the Northern region while the highest prevalence of 4.3% was reported in the Eastern Region. Six regions showed increase in prevalence in 2007 compared with 2006 with the Northern region showing the highest percentage increase (36%) from 1.3% to 1.7%. However, since the prevalence in these regions was relatively low, the overall national prevalence actually declined. In spite of the decline in prevalence from 4.9% in 2006 to 4.2% in 2007, the Eastern region retains the position of the region with the highest prevalence in the country. Even though the HIV prevalence in 15-19 years group is still the lowest, it is showing an increasing trend (Table 2.8). Prevalence among this age group is a proxy for new infections and

therefore an increasing trend is a cause for concern. The prevalence in the 20-24 year age groups also showed an increase while the prevalence in the 25-29 and 30-34 years age group decreased.

Table 2.8 - Age structure of the HIV prevalence between 2001 and 2007 in Ghana

Age Group	2001	2002	2003	2004	2005	2006	2007
15 - 19	2.4	2.3	1.9	2.0	0.8	1.4	1.6
20 - 24	3.4	3.8	3.5	2.7	2.4	2.9	2.9
25 - 29	3.9	4.5	4.4	4.5	3.6	4.2	3.5
30 - 34	3.5	4.0	4.7	4.4	3.2	3.7	2.9
35 - 39	3.0	3.4	4.5	3.9	2.4	2.8	3.5
40 - 44	2.6	2.8	3.3	2.3	3.7	3.3	1.7
45 - 49	2.3	3.8	6.0	0.0	5.0	2.5	1.3
15 - 24	**3.1**	**3.4**	**3.0**	**2.5**	**1.9**	**2.5**	**2.9**

Source: National AIDS/STIs Control Programme, 2007.

The 2008 Ghana Demographic and Health Survey results show that general awareness of AIDS is nearly universal among women and men of reproductive age in Ghana, with little difference by background characteristics. Men are more aware than women of ways to avoid AIDS but the least educated a man is the less likelihood that he will know ways to avoid getting the AIDS virus. There are noticeable variations by residence. As with women, men from the Northern region are less likely to be aware of safe sexual practices than men from other regions. However, differences by urban-rural residence or age are small (Ghana Statistical Service, Ghana Health Service and ICF Macro, 2009).

Access to anti-retroviral therapy (ART) has improved since it began in July 2002. The number of districts providing ART rose from 32 in 2006 to 69 in 2007 while the number of hospitals with capacity to provide ART increased from 46 to 95 within the same period. The number of new cases put on ART increased from 3,278 in 2006 to 6,085 in 2007. With the enrolment of these additional cases, the cumulative number of people who have initiated ART rose to 13,249. Despite this significant increase in the number of sites, positive persons provided with ART only increased from 7,338 in December 2006 to 11, 534 by December 2007 (total PLHIV in need of ART was 69,599). A stigma and discrimination reduction campaign is underway in a bid to increase uptake of ART. Vulnerable groups like female sex workers (FSW) and men who have sex with men

(MSM) continued to have limited coverage in the national response. Contraceptive prevalence rate is useful in tracking progress in health, gender and poverty goals like HIV and STIs infections. Overall contraceptive use among married women has increased steadily, and has nearly doubled over the past 20 years, from 13 percent in 1988, peaking at 25 percent in 2003 and remaining at 24 percent in 2008. It continues to grow at a slow rate compared to other countries such Portugal in Western Europe where contraceptive prevalence rate grew to 86.8% between 2000 and 2010 (World Health Organisation, 2011). According to the WHO's World Health Statistics rank table of contraceptive prevalence rate as a percent of women for the period 2000 to 2010. Portugal ranks second behind Norway while Ghana is ranked 102. Out of the 221 countries and territories listed, no statistics were available for 93 nations. Similarly, the use of modern methods nearly doubled, from 10 percent in 1993 to 19 percent in 2003, before it slightly declined to 17 percent in 2008. The result of the 2008 GDHS indicates that both public and private sectors are strategically important in the provision of family planning services (see Table 2.9). Non-clinical short-term methods such as pills and condoms are widely distributed by the private sector (Ghana Statistical Service, Ghana Health Service and ICF Macro, 2009). There are differences by method among the sectors. Pills and male condoms are commonly obtained from private sources (84 and 71 percent, respectively), while clinic-based methods such as injectables and implants are provided predominantly by public facilities (Ghana Statistical Service, Ghana Health Service and ICF Macro, 2009).

Among contraceptive methods, only condoms are effective in preventing HIV transmission. Since the condom use rate is only measured amongst women in union, it is supplemented by condom use in high-risk situations and HIV/AIDS knowledge. MDG 6 target 7 deals with the percentage of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS and condom use rate of the contraceptive prevalence rate. The 2008 GDHS results indicate that knowledge of HIV/AIDS prevention by condom use is 79.0%, faithfulness to one partner is 86.5%, and abstinence is 80.5%. Contrarily, while the proportion of women who engage in higher-risk sex increased slightly from 21% in the 2003 GDHS to 23% in 2008 GDHS, the proportion using condoms during last higher-risk sex declined from 28% in 2003 GDHS to 25% in 2008 GDHS. Some studies have suggested that more women use natural

contraceptive methods, cost of contraception and level of education attained are some of the major reasons accounting for this trend. Other factors include worry about the side effects of some of the modern methods, a spouse's lack of interest and commitment to family planning and reproductive health matters, unequal gender and power relations as well as the desire for relatively large family size as total fertility rate still remains at 4.2 (Asante-Sarpong, 2007; Ghana Statistical Service, Ghana Health Service and ICF Macro, 2009; Creanga et al., 2011). The proportion of men who engage in higher-risk sex increased slightly from 38% in 2003 GDHS to 42% in 2008; however, the proportion who used a condom at last higher-risk sex did not change 45% in both 2003 and 2008 (Ghana Statistical Service, Ghana Health Service and ICF Macro, 2009). Education to encourage and active inclusion of men in family planning programmes and activities are major factors necessary for improving contraceptive usage in Ghana.

Although Ghana is among countries with a low prevalence, the strategies for fighting the epidemic need to be sustained and scaled up to maintain and even lower the prevalence by acting smart in the wake of aid cut to the fight against HIV/AIDS. Cash crisis hit the HIV/AIDS battle as the Global Fund which has paid for about 70 per cent of Ghana's anti-HIV campaign activities has announced withdrawing its support for the treatment of the disease by 2013 because of the global financial crises (Global Fund, 2011). This shows how important it is to prevent infections especially among young people. The fight will likely be won with continuous emphasis on the need for abstinence, delayed sexual debut among young people, mutual fidelity, regular and consistent condom use among those who are sexually active. By so doing, the country does not only stand to meeting the MDG 6 but the new emphasis on "getting to zero", achieving zero deaths, zero new infections and zero discrimination by 2015.

MDG 1 links the reduction of poverty and hunger. Nutrition is an economic issue. It is also a health issue, a social issue, and an issue of basic human rights. Nearly 1 billion people in the world are hungry or unable to meet their minimum daily calorie requirements. In 22 countries, 40.0% of the population are hungry. Those most vulnerable are children under 2 years of age and pregnant women. Inadequate maternal and child nutrition is the underlying cause of 3.5 million deaths every year and 35 percent of the disease burden for children under 5 burdens (Black, et al., 2008; Bryce,

et al., 2008; Victoria, et al., 2008; Food and Agriculture Organisation, 2010). Nutritional damage in early life can lead to permanent impairment, including lower IQ and school performance, lower economic status in adulthood, and lower birth weight in the next generation.

Table 2.9 - Distribution of users of modern contraceptive methods by source

Most recent source of method	Type of Modern/artificial Contraceptive Method				
	Pill	Injectables	Implants	Male Condom	Total
Public Sector	**12.7**	**86.9**	**79.2**	**2.7**	**39.4**
Government Hospital /Polyclinic	3.7	45.2	41.7	1.7	19.5
Government Health Centre	6.5	29.6	33.6	0.0	14.4
Government Health Post /CHPS	1.2	5.8	0.0	0.0	2.3
Family Planning clinic	0.5	5.0	3.8	0.0	2.3
Mobile Clinic	0.4	0.0	0.0	0.0	0.1
Fieldworker/Outreach/Peer Educ.	0.5	1.3	0.0	1.0	0.9
Private Medical Source	**84.3**	**11.0**	**17.8**	**70.9**	**51.1**
Private Hospital /Clinic	1.2	7.1	11.6	0.0	3.5
Pharmacy	8.4	0.0	0.0	16.6	7.6
Chemical /Drug store	74.7	0.2	0.0	54.0	37.9
FP, PPAG Clinic	0.0	0.4	6.2	0.0	0.9
Maternity Home	0.0	3.3	0.0	0.3	1.2
Other Source	**1.4**	**2.0**	**0.0**	**6.5**	**3.0**
Shop / Market	0.6	0.0	0.0	1.1	0.5
Church	0.0	0.6	0.0	0.0	0.2
Community Volunteer	0.0	0.6	0.0	0.0	0.2
Friend / relative	0.8	0.8	0.0	5.4	2.0
Other	**0.0**	**0.0**	**0.0**	**3.6**	**1.0**
Don't know	0.7	0.7	0.0	16.3	5.1
Missing	0.9	0.1	3.0	0.0	0.4
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Number of women	178	207	33	175	612

Note: Implants Figures are based on 25 to 49 unweighted cases.
1. Total includes weighted cases of 8 users of IUD, 2 users of female condom, 1 user of diaphragn, 8 users of foam jelly and other modern methods.

Source: Ghana Statistical Service (GSS), et al., 2009.

Height-for-age at 2 years is the single best predictor of human capital in a population. Universal coverage of proven nutrition-related interventions could reduce overall mortality of children under 3 by 25 percent. Poor nutrition undermines achievement of all other development goals. Yet it remains one of the lowest health priorities, even in

many countries with the highest burdens (Black, et al., 2008; Bryce, et al., 2008; Victoria, et al., 2008). Malnutrition places children at increased risk of morbidity and mortality and has also been shown to be related to impaired mental development. According to WHO (2006), a child is considered fully vaccinated if he or she has received a bacillus Calmette-Guérin (BCG) vaccination against tuberculosis; three doses of diphtheria, pertussis, and tetanus DPT vaccine to prevent diphtheria, pertussis, and tetanus.

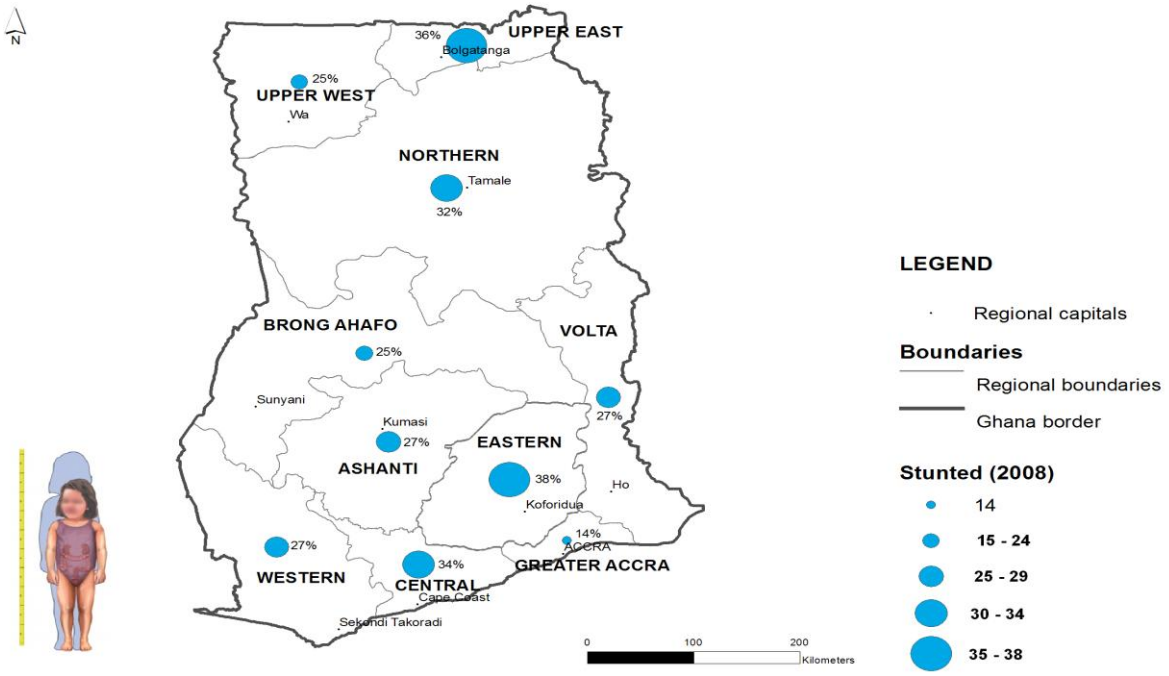
Further three doses of polio vaccine and one dose of measles vaccine completes the regimen. These vaccinations should be received during the first year of life. Overall, 79 percent of children aged 12-23 months are fully vaccinated (70 percent were fully vaccinated by 12 months of age (Ghana Statistical Service, Ghana Health Service and ICF Macro, 2009). Only 1 percent of children have not received any vaccines at all. The data indicate that there has been a marked increase in vaccination coverage since 2003, from 69 percent fully immunised at any time before the survey in 2003 to 79 percent in 2008. The coverage levels for various vaccines have also improved, with the proportion not receiving any of the vaccines dropping from 5 percent to 1 percent over the past five years (Ghana Statistical Service, Ghana Health Service and ICF Macro, 2009).

Anthropometry provides one of the most important indicators of children's nutritional status. The height and weight data are used to compute three summary indices of nutritional status: height-for-age; weight-for-height; and weight-for-age. The World Health Organization has developed an international reference population out of these three indices expressed as standardized scores (z-scores) or standard deviation units from the median (World Health Organization, 2006). Children who fall more than two standard deviations below the reference median are regarded as undernourished, while those who fall more than three standard deviations below the reference median are considered severely undernourished. The duration of breastfeeding in Ghana is long; at age 9 to 11 months, 96 percent of children are still being breastfed, and at 20 to 23 months, nearly half (44 percent) are still breastfed (Ghana Statistical Service, Ghana Health Service and ICF Macro, 2009). By 24 to 35 months, only 10 percent are being breastfed, most children having been weaned.

According to the 2008 GDHS findings, 28 percent of Ghanaian children are stunted, with 10 percent being severely stunted. Stunting becomes more widespread among older children; one in four children aged 12 to 17 months is stunted, and stunting peaks at 40 percent among children aged 18 to 23 months. Stunting levels are slightly higher for boys than girls and markedly higher for rural children (32 percent) than for urban children (21 percent). The prevalence of stunting varies by region from 14 percent in Greater Accra to 38 and 36 percent in the Eastern and Upper East regions, respectively as shown in Figure 2.13 (Ghana Statistical Service, Ghana Health Service and ICF Macro, 2009).

Children of mothers with at least some secondary education are considerably less likely to be stunted than children whose mothers achieved only the primary level or never attended school. Greater Accra's population is more urbanised and educated. Nine percent of Ghanaian children are wasted, with 2 percent severely wasted. Wasting levels are highest at ages 6-11 months which is unusual since it is before the time the child is being weaned and thus more vulnerable to illness. Wasting is more common in the Upper West Region than elsewhere. Fourteen percent of Ghanaian children are underweight, with 3 percent classified as severely underweight.

Figure 2.13 – Stunting by region in Ghana as of 2008



Source: Ghana Statistical Service (GSS), et al., 2009.

Peak levels of low weight-for-age are found among children aged 18-23 months. Children living in rural areas are more likely to be underweight than urban children (16 percent and 11 percent, respectively (Ghana Statistical Service, Ghana Health Service and ICF Macro, 2009). The proportion of underweight children ranges from 7 percent each in Greater Accra to 27 percent in the Upper East Region. Children born to mothers with the lowest level of education are substantially more likely to be underweight (Ghana Statistical Service, Ghana Health Service and ICF Macro, 2009).

2.8 - Education policy and infrastructures

Available data and trend analysis on MDG 2 of achieving universal primary education show that Ghana is on track to achieving both the gross and net enrolment targets by 2015 (World Bank, 2009; NDPC and UNDP, 2010). On MDG 3 target of ensuring gender parity especially at the primary and Junior High school (JHS) levels, trends show that Ghana is on track in achieving both targets, although primary level parity has stagnated at 0.96 since 2006/07, while the parity at the JHS increased slightly from 0.91 in 2006/07 to 0.92 in 2007/08. In 2008, literacy rate, youth female as percentage of females ages 15-24 was 75.8% (World Bank, 2009; NDPC and UNDP, 2010). Over the years, successive governments since independence have consistently placed considerable emphasis on the development of education on the premise that it forms the bedrock for the development of the country's human resources and the socio-economic development. Education is a systematic delivery of intellectual, social and moral instruction. It is also a training in skills geared towards specific purpose. It could span over several years. Education could be formal or informal and or both. The literacy rate for the country as a whole is 57.9 per cent (Ghana Statistical Service, 2002).

In the immediate past, formal education was limited to class-rooms. Presently, with the emergence of Information Communication Technology Age, we need not be confined to class-rooms. Formal education can now be pursued from a virtual class room (online or teleconference). The home is a veritable environment for informal training/education. It is in this milieu that knowledge/skills are transmitted from one generation to another. It is this same place where what is known as 'common sense' is taught and learnt. Common sense is territorially inscribed.

The earliest history of formal, western-style education in Ghana is directly associated with the history of European activities on the Gold Coast. The Portuguese were the first Europeans to arrive in the Gold coast in 1471. Their intention to establish schools was expressed in imperial instructions in 1529 that encouraged the teaching of reading, writing, and the Catholic religion (Quist, 1999). "The primary focus of the finest schools was the acquisition of literacy and the study of the bible, the spiritual values and teachings of the church. European cultural values were also emphasised, (...), eating and living habits" (Growth and Change in Lesotho, undated: 2 cited from Muzvidziwa and Seotsanyana, 2002: 2).

This approach to formal education led to collision with traditional practitioners who viewed it with suspicion and unease.

In today's competitive globalised economy which is increasingly becoming knowledge-driven, an efficient, credible and sustainable education system is inevitable. Ghana has since independence in 1957 made significant strides in its education system. The education landscape in Ghana today is the result of major policy initiatives in education adopted by succeeding governments. Some of the laws, policy documents and reports, which have helped in meeting the educational needs and aspirations of the people are:

- The Education Act of 1961;
- The Dzobo Report of 1973 (Recommended the Junior Secondary School (JSS Concept);
- The New Structure and Content of Education 1974;
- The Education Commission and Reform Report on Basic and Secondary Education 1987/88;
- The University Rationalisation Committee Report 1988;
- The Free Compulsory Universal Basic Education and Policy Document and Programme of Operations, 1996;
- The Ghana Education Trust Fund - GET Fund Act 2000 (Act 581).

At the time of independence in 1957, Ghana had only one university and a handful of secondary and primary schools. The number of kindergarten schools has increased from 14,246 in 2006/2007 to 15,449 in 2007/2008. The increase from 2004/2005 to 2007/2008 is 120%. The reason is primarily the government's policy that each primary school should have a kindergarten attached to it but the overall progress in access in the kindergarten sub-sector has been slow (Ministry of Education, Science and Sports,

2008). The number of primary schools increased from 16,903 in 2006/2007 to 17,315 in 2007/2008 academic years. The number of Junior High Schools also increased from 9,334 in 2006/2007 to 9,507 in 2007/2008 academic years. The increase, however, is higher in the private sector (2,083 in 2006/2007 to 2,240 in 2007/2008) than the public sector [7,251 in 2006/2007 to 7,267 in 2007/2008], (Ministry of Education, Science and Sports, 2008).The duration for Junior High School (JHS) is 3 years of academic training combined with technical and vocational training. This level of education leads to the Basic Education Certificate Examination (BECE). The number of Senior High Schools (SHS) increased dramatically between 2005/2006 (492 schools**)** and 2006/2007 (700 schools). The 2007/2008 general enrolment rate was 32.24%. Enrolment in Senior High has increased overall, but inconsistently with the admission rate decreasing between 2006/2007 and 2007/08 to 31.5% (Ministry of Education, Science and Sports, 2008). In 2008, there were 13 schools for the deaf, 2 schools for the blind, 12 for the mentally handicapped, 1 school for the deaf and blind, and 129 inclusive schools. However, the schools and units are mainly concentrated in the Southern part of the country. Furthermore, the concentration appears to be at the basic level with 5,347 students versus 307 at the secondary level (Ministry of Education, Science and Sports, 2008).

There were a total number of 273 technical and vocational education and training (TVET) institutions in 2008 but infrastructure was found to be poor with only 80% having functional electricity. Further, TVET is limited in scale, scope, quality and relevance; largely orientated towards formal rather than informal employment. The system usually excludes the poor and offers women limited opportunities (Ministry of Education, Science and Sports, 2008). The number of Teacher Training Colleges in 2007 was 38. The tertiary education system in Ghana comprises a public and a private sector. Within the public sector, there are 13 universities and specialized institutions. The second public sub-sector is comprised of 10 polytechnics, one in each region. Between 2003 and 2008, 9 private universities were opened. Since the early nineties, tertiary education in Ghana has increased at an impressive rate. Total enrolments were at about 10,000 in 1990 but were close to 100,000 in 2008; a tenfold increase. The enrolment ratio between males and females favours males disproportionately (Ministry of Education, Science and Sports, 2008). In the past decade, Ghana's spending on education has been between 28 percent and 40 percent of its annual budget. There is a

mismatch between government priority and practice on the ground as most of tertiary funding goes to support students pursuing liberal arts, humanities and business programmes. In state universities, the ratio of enrolment in humanities and science and technology based programmes is about 65:35.

Table 2.10 - Structure and distribution of formal education by 2008

Level of education	Age ranges	No. of schools	Percent
Pre-school	0-5	15,449	35.64
Primary Schools	6-12	17,315	39.95
Junior High Schools	12-15	9,507	21.93
Senior High Schools	15-18	700	1.62
Special Schools	1+	28	0.06
Technical & Vocational Education	15+	273	0.63
Teacher Training Colleges	18+	38	0.09
Tertiary institutions	18 and above	32	0.07
Total no. of institutions		**43,342**	100.00

Source: Ministry of Education, Science and Sports, Accra 2008.

Pre-primary and Junior High School are the fastest expanding areas. Between 2002/2003 and 2009/2010, the pre-primary gross enrolment rate went from 21.8 to 97.3 percent (net enrolment, from 19 to 63.6 percent for 2008/09). At junior secondary school, gross enrolment rose from 64 to 79.5 percent (net, from 30 to 47.8 percent) during this period. The mean years of schooling which refers to the average number of years people spend in school increased from 3.4 years in 1980 to 7.1 years in 2011 (UNDP, 2011).

As enrolment and completion have increased at basic levels, demand for post-basic education has also increased but supply hasn't followed suit. Only about 35–40 percent of students who finish Junior High School (officially the end of basic education) go on to enrol in a Senior High School, and even this limited transition would be lower were it not for the increase in the capacity of private senior high schools (SHS) (World Bank, 2011). The Bank's analysis concludes that extensive growth in basic education seems to have reached a point where services cannot be stretched much further. The gross admission rate to primary education is now over a hundred percent, gross enrollments are considerably above 90 percent, and upper secondary enrollments have reached the maximum capacity within the available infrastructure. The education sector employs

about 40 percent of the total civil service and uses about a third of the public budget (see Table 2.11).

Table 2.11 – Ghana education statistics database

Element of education	Data	Year
Gross enrolment ratio. Pre-primary. Total	23.4	2008
Net enrolment rate. Primary. Total	93.8	2009
Net enrolment rate. Secondary. All programmes. Total	..	..
Gross enrolment ratio. Tertiary (ISCED 5 and 6). Total	30.6	2009
Gender parity index for gross enrolment ratio. Primary	0.9	2009
Gross intake ratio. Primary. Total	100	2009
Drop-out rate. Primary. Total	7	2007
Percentage of repeaters in primary. All grades. Total	10.8	2009
Out-of-school children. Primary. Total	141052	2009
Primary completion rate, total (% of relevant age group)	90.5	2009
Percentage of repeaters in secondary. All grades. Total	16.1	2009
Percentage of trained teachers. Primary. Total	99.3	2006
Percentage of trained teachers. Total secondary. Total	..	..
Pupil-teacher ratio. Primary	23	2009
Pupil-teacher ratio. Secondary	..	..
Public expenditure on education as % of GDP	4.3	2008

Source: Education and Development Data Groups of the World Bank, 2011.

The question of efficiency in education remains a huge challenge. Education Reform harmonisation exercise in 2008 reported that the fact that the state was paying more than GH¢217,000,000 annually in inequitable subsidies to a small number of children, while millions of children at pre-school, primary and JHS levels lacked desks, classrooms and learning materials (Ministry of Education, Science and Sports, 2008). From all indications, pragmatic steps will be required sooner than later if the intended goals are to be realized in the long run. Unless stakeholders address the emerging problem of massive enrollment at the elementary phase, many pupils will be forced to drop out of school not because they failed or due to lack of resources from the family but lack of space by the state.

In the Eastern Region, about a quarter (22.5%) of the pupils terminates their education at the primary or elementary level, made up of almost the same proportion of males (25.8%) and females (25.2%). At the Junior High School (JHS) level, 30.1 per cent complete the level, made up of a third (33.4%) of the males and a quarter (26.8%) of the females, while at the senior secondary school level, 5.8 per cent, comprising 7.3 per

cent of males and 4.4 per cent of females, complete the level. A significant number of pupils and students drop out of school at the various levels, mainly because of lack of adequate facilities at the next levels. The number of JHS is just about half the number of primary schools, while there are only 74 senior high schools and five vocational and technical institutes, and one polytechnic in the region to absorb all the JHS leavers. This highlights to the urgent need for more physical infrastructural facilities and staff for the schools in the districts of the region. To address the imbalance and inadequate physical facilities at the higher level on the educational ladder, a policy decision was directed to make a model senior high school in each district. Similarly, Koforidua Polytechnic has been upgraded and into a fully-fledged degree awarding tertiary institution.

Manya Krobo was one of the areas in Ghana where European missionaries first introduced formal education. Table 2.12 show educational facilities, enrolments and staff strength in the area. Enrolment is a problem when compared to the 38.1% juvenile population. The first concern apparent is male-female ratio discrepancy of enrolment right from nursery through SHS. While male enrolment increases from 53.0% in nursery to 65.0% in high school, that of the female rather plummets from already comparatively low 47.0% in nursery to 35.0% by SHS phase. Further, it looks as if many toddlers are not enrolled in nursery as only a fourth (5,779) compared to 21,365 enrolling in elementary. Ideally the enrolment at nursery should outnumber primary school. This low figure apparently reflects relatively less number of schools (98) for that level of education. Another significant point to note is the sharp school drop rate from primary to JHS. Over two-thirds of children leaving primary never continue to JHS. It even becomes more disheartening if you consider that every ten pupils who start elementary school only one completes high school. Again one-third of teachers is not trained and will affect quality of education.

The World Bank (2011) has identified persistent problems and emerging issues that require new solutions. These include out-of-school children, disparities and limited learning outcomes. Gender parity has nearly been achieved at primary level, where girls enrol at almost the same rates as boys but at higher levels, girls' participation drops off significantly. Ghana's stake in gender parity goes beyond giving girls more opportunities.

Table 2.12 - Number of schools, enrolments and teachers in *Manya Krobo*

Education category	No. of schools	Enrolment	Boys (%)	Girls (%)	No. of teacher	Trained (%)	Untrained (%)
Nursery	98	5,779	53.0	47.0	145	48.0	52.0
Primary	132	21,365	53.0	47.0	664	77.0	23.0
Junior High School	52	6,795	56.0	44.0	331	85.0	15.0
Senior High School	5	2,915	65.0	35.0	115	63.0	37.0

Source: Ghana Education Service, Manya Krobo, 2003.

Greater education levels among women are closely associated with a delayed start of child bearing, smaller families and healthier children. Whatever the difficulties, education has become a core priority for Ghana. Meeting the challenges requires a new definition of performance focusing on more equitable and more efficient services, more informed policies, and strengthened accountability.

The past decade, the government has expanded access to higher education, which has served as an inter-link with economic growth leading to a decline in poverty. With about 30 per cent of its budget spent on education, Ghana has grown the number of its public and private universities tremendously between 2004 and 2011. University enrolment in Ghana has increased 13-fold, from 14,500 students to over 150,000 by 2010. What ought to be done is to keep the momentum to expand access to quality education at all levels which should serve as a mechanism for Ghanaians to climb out of poverty. Ghanaian education authorities need to pay more attention to quality and relevance of especially higher education to economic growth and competitiveness. There is the urgent need to leverage her collective strengths across all segments of society and build linkages with existing pools of world class knowledge. This demands a more dynamic and visionary leadership of education institutions to redefine their roles to achieve excellence, particularly in science, technology and innovation. There is an overemphasis on interventions aimed at improving access to basic education as against improving the quality of education in Ghana. This effort invariably has resulted in a superfluous outcome whereby the existing situation records impressive indicators in gross enrolment ratio, net enrolment ratio and gender parity index but declining learning outcomes. Therefore there is the need for the education authorities in Ghana to initiate and provide specific measures to reverse this trend.

2.9 - The socio-cultural traditions of the people

The capital is Accra located in the south. English is the official language in Ghana but since the literacy rate for the country as a whole is 57.9 per cent (Ghana Statistical Service, 2002), it means over two-thirds of Ghanaians don't speak English. However besides English, there are nine government sponsored and twenty-six non government sponsored local languages. Of all these languages, by far in terms of population, coverage and number of speakers is Akan. In effect, Akan in its varied dialects is considered a de facto lingua franca (i.e. largely accepted working language) of Ghana. Regarding units of measure and electricity, Ghana follows the metric system of measurement and the official unit of electricity is 220 V to 240 V and 50 Hz. The standard time of Ghana is the same as Greenwich Mean Time without Daylight Saving. The currency in use in Ghana is the Ghana Cedi (GH¢ - €1 = GH¢2).

The system of government in Ghana is a mixture of the American executive presidential system and a parliamentary democratic republic. There are 10 regions and 212 districts. Vital to Ghana's governance evolutionary process is the decentralisation of power to regional, district, local and unit levels across the country. This is a kind of regionalisation called Local Government system. It consists of a regional Co-ordinating Council, a four-tier Metropolitan and a three-tier Municipal/District Assemblies (MMDAs) Structure. The ten regions are subdivided into metropolitan, municipal and district assemblies. Population is the criterion used for demarcation into either Metropolitan (population over 250,000), Municipal (population over 95,000) or District (population 75,000 and over).

Each political administration is headed by a Minister for the region and Chief Executive at the district. They are directly appointed by the President. However, the districts are administered by assemblies 90% of whose membership is directly elected by the communities while the remaining 10% is appointed by the president. The political-administrative head in each district is the district chief executive – similar to an executive mayor. The district chief executive is first nominated by the President of the nation and must gain the approval of two-thirds of the district assembly political caucus (assembly members). Both the regional minister and the district chief executive are appointed for terms of four years although can be dismissed at anytime. The district assembly is required to meet at least three times each year. Assembly men and women

play a significant role in the socio-economic development of our communities. They spearhead development projects such as drainage system, rural, urban electrification among others at the local level. Most Ghanaians can readily identify with names of popular politicians but give very little or no attention to politicians who are directly linked and closer to them. The District Assemblies are largely funded from the Common Fund. This is a pool of resources created from national revenue. It is 5% of the national revenue which is shared among all the district assemblies. Ghana spearheaded the political liberation of colonised Africa from the very first day of its Independence. The first president, Dr. Kwame Nkrumah championed the cause of African Unity which led to the formation of Organisation of African Unity (OAU), now the African Union (AU). Ghana became a sovereign member of the United Nations, the Commonwealth and the Non-Aligned Movement.

Between 1966 and 1992, the country experienced a period of instability. There were as many as 5 successful military *coup d'états* and many more foiled. There only two democratically elected governments in 1969 and 1979 each surviving just 27 months in office. The latest and most enduring democratic experiment started in 1992 with four successive elections. Ghana's governance structure includes the representation of the people through a unicameral parliament.

There are 230 constituencies in the country and each constituency is represented by one Member of Parliament. Each member is elected through universal adult suffrage. The two dominant political parties are the National Democratic Congress (NDC – ruling since January 2009) and New Patriotic Party (NPP – opposition minority).

Each of the ten regions has a majority ethnic group of its own. Ghana's ethnic groups conduct several rites and rituals that are performed throughout the year in various parts of the country. The Northern Region has its people known as Dogombas and Mamprusi. The Upper East Region comprises of a tribe called Frafra and the Upper West Region is mainly occupied Dargarti bordering northern neighbour, Burkina Faso. Brong Ahafo region consists largely of Bono and Asante while Western region has Wassa along the Ivoirian western border. The Asante occupies the whole of the Ashanti region and Fante largely shares Central region. Eastern region is mostly inhabited by Akyem people. In Greater Accra which is the capital, there lives the Ga-Adangbe group while the Ewe ethnic group largely completes the groupings in the Volta region on the eastern

boundary with Togo. Since Ghana comprises about 44 various ethnic groups, it is natural to see so many languages and dialects however the Akan language is widely spoken in the country becoming a de facto lingua franca or language of commerce though English is the official language.

Climate and ecological conditions influence what food crops and livestock are practical to grow locally. Dietary patterns are also influenced by aforementioned conditions alongside cultural and religious norms, history of contact with foreign foodstuffs and cultures through trade, migration, and colonisation. In the second half of the 20th century, Ghanaian food systems were particularly transformed by urbanisation and related changes in women's work and by foreign donations of food aid. In Ghana, many people structure their diets around a relatively small number of starchy or carbohydrate-rich foods. Grains like millet, sorghum, rice, and maize (corn) and tubers such as yams and cassava (manioc) form the central ingredients of the most common meals. They provide the bulk of the daily caloric intake traditionally accompanied by protein-rich legumes, such as peas, beans, or peanuts, and by smaller quantities of foods that add both flavour and nutrition, such as vegetables, oils, spices, and meat or fish. The staple of Ghanaians depends on the part the country they reside. However "Fufu" is consumed by majority of the people especially in the forest vegetation zone. It is made from a mixture of cooked cassava and plantains pounded together. The by-product is a sticky dough-like food which Ghanaians eat by tearing a piece with the fingers and dunking it into a bowl of soup, and then swallowing.

The people who live in the south eastern part of the country prefer a diet called ‘banku’. It is made from corn dough and eaten with an okra prepared soup. The people in northern in Ghana depend on mostly yam, millet, sorghum, maize, and rice they mostly grow these foods. The Ga-Adangbe people in the Greater Accra region have their main food called Kenkey. This is also made from corn dough, but it is wrapped with dried corn shells and cooked for over three hours. Besides, rice, wheat-cereal, and all flour food is eaten all over the country.

Finally, Ghanaian food habits have changed along with the patterns and pressures of daily life, especially in the cities. As more and more people—especially women—commute across large cities to work and attend school, midday meals at home have become less practical. Instead, students, marketplace traders, and industrial and office

workers rely on so-called street foods for one or more meals daily. Sold from “chop bars,” kiosks, head trays, and carts in cities throughout Ghana, street-food fare is diverse: offerings range from the traditional rice-and-sauce dishes popular among the cities' various Ghanaian ethnic communities to Ghanaian "fast foods" like fried or roasted plantains to Middle Eastern-style kebabs and European-style sandwiches and pastries (see photos of some of these dishes from Figure 2.3). Due to the humid temperature in northern Ghana, residents have adapted their housing to round shape, constructed out of mud like those photos displayed in Figure 2.14. The roofing is wrapped of dried thick grass, to form a shape of a hat at the top. Most of the heat is absorb by the grass and therefore making the room a little bit cool. Many rural dwellers in Ghana construct their homes with mud with varied roofing which is most economical resource available. However, large number of the populace along the coast uses from asbestos and aluminium to wood for roofing.

Figure 2.14 - Mud huts found in the northern part of Ghana

Source: Adrienne Lanchantin, Abroad View, 2002 (www.abroadview.org – accessed 24/11/2011).

Buildings in the urban areas are quite different constructed with cement and bricks with any roofing ranging from asbestos, aluminium, brick tile and others.

Ethnic groups in Ghana employ various means to indicate the advancement of their members through various stages of life. Rituals which accompany this advancement from stage to stage are termed ‘rites of passage’. Puberty rite generally marks transition from the unmarried state to the married and in Ghana it is done only for females. In

Ghana only a small section of ethnic groups usually found in the northern parts of the country have initiation rites for men and where they occur they are done in secret and not given as much prominence as that for young women. It is an orientation to secret lore and moral instruction, including proper sexual behaviour. Female puberty rites in Ghana tend to focus on building competencies of the girl to fulfil her future obligations and are impressed with the importance of her role. According to Krobo traditional law no woman is allowed to get married without having gone through the *dipo* puberty rites and every young woman must remain a virgin prior to this. These laws ensure that young women grow up disciplined enough to control their sexuality and to prevent them from premature motherhood and unwanted babies. So important are these laws that any woman who gets pregnant or breaks her virginity before the rites are performed is sometimes ostracized together with the man responsible for it. On top of that, a heavy fine is imposed on the guilty party after which purification rites are performed to rid the society of the negative repercussions of their actions.

After the child naming ceremony, puberty rites are the next set of rituals of social status transformation which children undergo in Ghanaian culture. Dipo by the Krobo ethnic group and Bragoro by Akans are some of the most well known and preserved puberty rites. It appears that the Manya Krobo Dipo focuses a great deal of attention upon the teaching of adult skills during puberty rites. Krobo initiates entering womanhood are presented to the community during the annual outdooring ceremony. Beginning with a ritual that severs all ties with their childhood, the initiates start a three-week period of seclusion, during which they learn the ways of adult women. To celebrate the completion of their training, they adorn themselves for their outdooring ceremony. Here, they publicly demonstrate their dancing skills for the chief, relatives, and, most importantly, prospective suitors who gather to admire their display of feminine grace and beauty.

Around the world, women are seriously fighting violence against their sex in whatever form it takes. One of the four cardinal pillar outlined in the UN Charter is the urgent need to protect the fundamental human rights and uphold the dignity and equality of all humans declaring that all including women are born free and equal in dignity and rights. Consequently, voices are being heard from all over the globe agitating with one accord against certain cruel cultural practices that are being imposed on them not by religion

but by the society they live in (Ehrenreich and Barr, 2005). One of these harmful and cruel practices is Female circumcision also called female genital mutilation (FGM). It is designed to reduce the woman's sex drive and remove her temptation to have sex before marriage. The World Health Organisation defines the practice as 'comprising all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. It has no health benefits and harms girls and women in many ways' (WHO, 2010).

It is estimated that between 100 million and 140 million girls and women worldwide have been subjected to type I, II or III procedures (WHO, 2010). FGM has been documented in 28 countries in Africa and in several countries in Asia and the Middle East (WHO, 2010). In Ghana FGM is perpetrated mainly in the three Northern Regions. Some ethnic groups including the Kusasis; Frafras; Kassenas; Busangas; Wallas; Dagarbas; Builsas and Sisalas practise it (Akapule, 2008). Due to migration the people have carried along their customs and practices to some ethnic groups in the Brong Ahafo and Volta Regions as well (Odoi-Agyarko, 2003; Akapule, 2008). He explains that to the Frafras, Kassenas, Nankanas and Builsas, an uncircumcised woman was not entitled to traditional funeral rites and without these rites their souls would not go to the ancestors (Akapule, 2008).

The Criminal Code, 1960, ACT 29 contains Sections that affect the implementation of reproductive health. The Code was amended in 1994 to include the offence of female circumcision. The Code also contains a Section on abortion. Abortion is illegal in Ghana but is permitted under circumstances such as rape and incest (Odoi-Agyarko, 2003). Those who perform the operation in Ghana face a prison sentence of at least three years. However, FMG is still common in the north, where it was widely practised before the ban, and there are relatively few prosecutions. Another study carried out by Rural Help Integrated in the Bawku District in 2003 indicated a prevalence rate of 85 per cent (Odoi-Agyarko, 2003). Oduro, et al. (2006) reported in northern Ghana where the practice is seen as a passage rite to women adulthood that although there is a high rate of FGM and is associated with a higher proportion of stillbirths and caesarean sections, practice has shown a significant decline in recent years due to the prevailing campaigns and intervention studies. However, there are many general community enforcement

mechanisms that allow the practice to continue. There is no known record of FGM in Manya Krobo district or among the Dangbe people.

Like most other African nations, Ghana has rich traditional cultures that differ from one ethnic group to the other. In a trenchant analysis of the effect that culture has in determining perceptions and expectations, Airhihenbuwa (1995) challenges traditional models by asking for cultural appropriateness of behaviour. He affirms this view by saying important aspects of cultural expression in African countries are found in aesthetic values and meanings as evident in arts, music, and clothing. Such values and meanings are laden with desires, emotions and expectations. Traditional practices are based on customs and beliefs of the people. The people of *Manya Krobo* have a rich culture that has survived up to date. However, with the advent of HIV/AIDS, some people suggest the need for adaptation and modification of certain cultural and customary practices notably "dipo" and "la pomi", "yalɔ-gba, "yosedofiermi" and "kaduba fiame" (traditional scarification) 'Dipo' is a traditional ritual of encampment through which the Krobo girl officially enters adulthood and obtains full status in the tribal community…no Krobo girl can ever become a mature *Krobo* woman and a wife worthy of a *Krobo* man, unless she can show on her body and on her hand the visible marks of her initiation (Huber, 1993). Every girl who prior to or during the ritual is found pregnant, is regarded as an outcast. The transitional dipo custom is also practised among the *Shais*, *Osudokus*, and performed in one form or another throughout *Dangmeje* or *Ga-dangme* areas. It has three goals and these are preparation for marriage, purification, and outdooring rites. The purification rite consists of attitude to blood and its impacts on the community. Also the outdooring rite addresses issues of toiletry shaving, dressing in beads and expensive cloths, dressing of hair, oiling of the skin and adornment of the body. Thus the "dipo" custom has three aspects being; the social, religious or ritualistic, and the outdooring aspects (Teyegaga, 1985). The custom originally lasted two to three years for girls aged fifteen years and above with emphasis on purity but its present duration has been reduced to ten to twenty days while a good number of girls are made to pass their initiation already at the age of seven years or even less (Teyegaga, 1985; Huber, 1993). The reduced age for the initiation process and demise of betrothal are of significance to HIV study and question the relevance of "dipo" in contemporary times. This and high cost of dowry result in cohabitation termed

“la pomi” which denies men the right to name the offspring though responsible for their upkeep.

A practice known as second-hand or widow marriage (“yalɔ-gba”) where a widow after the death of the husband is given in marriage to a brother is most prevalent in rural areas and poses serious implications for HIV/AIDS. Others are “yosedofiermi” and “kaduba fiame*”.* The former refers to the status of a woman in the society. The fundamental difference of status between a man and a woman is the woman’s social inferiority. A woman is not the head of a kin does not inherit a house or landed property, has no authority, does not go to war and take charge of a burial. These prohibitions had resulted in a situation where many women are itinerant traders making them greatly vulnerable to the risk of HIV. It is needless to say that also among the *Krobo*, female education, the general economic and political development, the trends toward increased individual liberty and responsibility are also leading to a greater independence and social emancipation of the women (Anarfi, Appiah, and Awusabo-Asare, 1997).

Bodily scarification particularly by traditional healers and previously during “dipo” initiation rites also exposed participants to risks of HIV infection. This bodily scarification comes about as a result of incisions or marks made on the participants’ person. The same implement, normally blade, is used to make the cuts without sterilising it. This aspect of the practice is where the risk of transmission of blood-related diseases including sexually transmitted infections such as HIV. It is important to say also that education and other forces of social change have altered the manner in which these practices are done if not stopped. All these practices and some yet unknown ones might have contributed greatly to the high HIV prevalence in *Manya Krobo* district and this is what the study would try to find out so that modifications could be effected accordingly. It must however be borne in mind that the aforementioned practices may be just contributory factors working in either isolation or collaboration with other social and human factors.

2.10 -The Ghanaian concept of Queen Mother, the vulnerable and the excluded

In Manya, Krobo Queen Mothers play important role in supporting and caring for the HIV/AIDS orphans and vulnerable children. The concept of Queen Mother, however, needs a contextual definition from the English phrase in view of the fact that it is

distinctively unique from hereditary monarchies. Queen Mother in native English is a title or position reserved for a widowed queen consort whose son or daughter from that marriage is the reigning monarch.

The term Queen Mother often raises objections because it does not represent the direct translation from the native language of any society. Nevertheless it is the term widely used in English to describe the female counterpart to the chief throughout Africa. In contemporary African societies, the term will likely translate differently (Peek and Yankah, 2004). The relationship to the chief is likely to be that of aunt-nephew, uncle-niece, sister-brother, or cousin.

In many matrilineal societies of West Africa, such as the Ashanti, the Queen Mother is the one through whom descent is reckoned and thus wields considerable power. In fact the dual-gender system has proven to be so attractive that those neighbouring patrilineal societies, ones that have never had Queen Mothers (the Ga and the Ewe), began to create the position during the 1990s (Peek and Yankah, 2004). The *Krobo* title “Manye” (or its equivalent “Nana” in Akan, “Mama” in Ewe and Magajia’ among groups in northern Ghana) literally means traditional women leader or mother of the community or queen referring to the female counterpart to the chief. This is distinctively unique from hereditary monarchies (Obeng-Asamoa, 1998 and Steegstra, 2009). In Ghana, governance is shared asymmetrically between the state and the traditional leaders because of the divided nature of legitimacy and sovereignty. For this reason, the involvement of traditional leaders such as Queen Mothers in HIV/AIDS programmes could increase programme success rates because they add their legitimacy and credibility in convincing their subjects of the usefulness of the programme. However, if Queen Mothers are to play a more prominent role in the provision of care and support for OVC, we need to confirm their practical competence and capacity to do so.

Like other human institutions, it continues to face setbacks, and its survival would depend on the extent to which pragmatic measures are employed. Though Ghanaian law grants traditional leaders authority to codify customary laws, Queen Mothers in Ghana in reality do not participate in the local, regional, and national assemblies of traditional leaders; only male chiefs participate in these bodies. By denying Queen Mothers equality in governance and exclusion from Traditional Councils (Regional and National House of Chiefs), Ghanaian women's concerns and rights are not adequately

advocated for, represented, nor protected. The ability of the Manyemei to provide care and support is primarily reliant on the level of knowledge and skills. The influence and action taken depends on the qualities, personality, and capabilities of individual Queen Mothers.

Regrettably, Illiteracy, lack of resources, incomplete knowledge of HIV and AIDS and reproductive health and poor coordination among stakeholders have constrained community intervention. Queen Mothers do not control resources and the position is largely symbolic. No wonder Steegstra (2009) reported various initial emotional breakdowns including attempts to escape when the title is conferred on someone. A number of them struggle financially and technically to fulfil their roles.

In spite of the mounting difficulties, *Krobo* Queens are doing their best by providing safety net for children orphaned by HIV/AIDS and others economically rendered vulnerable.

Manya Krobo applies the definition of vulnerable by the Ghana Living Standard Survey (GLSS) identify such individuals and groups. The district assembly identified such groups as rural agriculture workers, especially migrant farm hands, settlers and traditional fishermen, children in difficult circumstances, people living with HIV/AIDS, disadvantaged women, physically challenged persons, people suffering from chronic diseases, victims of abuse, victims of harmful traditional practices, and unemployed as vulnerable (Manya Krobo District Assembly, 2006).

The following are some of the problems associated with the vulnerable and excluded in Manya Krobo District: high illiteracy rate among the vulnerable, low awareness in gender main streaming, high incidence of child labour and child delinquency (especially on market days), large number of single parenting women in difficulty, inadequate facilities and resources for training the vulnerable and excluded and difficulty integrating the trained disabled back into the community as productive members (Manya Krobo District Assembly, 2006).

2.11 -Conclusion

This chapter gave clarity on the background of the study area particularly on issues relating to the main objective of the research which is finding the nexus between the generations regarding the impact of HIV and AIDS. Fairly large volume of information

was provided on the demographic and geographic characteristics of the region. It revealed that the prevalence, incidence and burden of HIV/AIDS in the study area far exceed the rate at the national level by a ratio of nearly four to one. It can thus be equally inferred that children affected at the local study area comparatively are many more and thus require greater attention. References where made to some studies with respect to pertinent issues such migration, HIV vulnerability and efforts at curbing the spread and ameliorating effects particularly on the orphans. Impliedly, the interface between socio-economic developmental and the root cause of the disease at the initial phase before diffusion took over was vividly captured. Inadequacies of social amenities apparently hamper the delivery of efficient services particularly to the remote rural communities in the study. The practice of exorbitant dowry and disproportionate power relations in favour of men, create opportunities for behaviours such as *la pomi* or cohabitation likely to HIV risky in nature. Statistics were also provided on critical preventive indicators like sources and use of modern contraceptive methods as well as nutritional information.

PART II:

THE SOCIAL AND HEALTH CARE FOR OVC – THE ROLE OF WOMEN TRADITIONAL RULERS AND OTHER CIVIL SOCIETY GROUPS

CHAPTER THREE

RESEARCH METHODOLOGY AND DESCRIPTION OF THE RESPONDENTS

3.1 - Introduction

This chapter explains the research methodology employed in the study. It basically outlines specific methods used to achieve the stated objectives. Ideally, a study on HIV/AIDS orphans and vulnerable children should be longitudinal in nature. As a cohort study, it would have allowed studying life events throughout lifetimes or generations. This would have enabled us to track the same people, and therefore account for the differences observed in those cohorts accurately across generations.

Most of the key sources of data were obtained from the majority of primary sources conducted between January and May 2011. Secondary sources were used only where primary sources were not available. The need to follow a systemic procedure in acquiring data stems from the fact that decisions regarding OVC related activities must be based on true information on profile of the epidemic as well as OVC and caregivers living conditions in the various households and communities in Manya Krobo area. This is expected to provide information that will contribute to a better understanding of the Manya Krobo Queen Mothers Association OVC Safety Net project's absorptive capacity, as well as on issues about empowerment and skills training. We considered in first place accessing or acquiring empirical field data by following the methodology prescribed or decided on. This stage involved designing, pre-testing, deploying, and operating research instruments selected. Empirical field data is the most relevant and useful information for validating the research goals by sorting and classification of data.

The research considered emotional well-being, experiences of stigma, household living condition and relationships, and sources of support for OVC and caregivers. The sample frame was derived from OVC population of 1,065 and caregivers population of 396. The sample size of Caregivers was 50 which correspond to 12.63% of 396 caregivers of Manya Krobo and OVC was 100 which correspond to 9.4% of OVC in the same area. The data entry was done for a period of one and half months using a template designed from SPSS Version 16.0. The same software was used for data cleaning before data analysis was done.

HIV/AIDS is not just a health issue. It is also a social, developmental and economical issue. The impact has a huge repercussion for development. It adversely affects growth rate in complex ways not least on orphans. Its impact on households, families and the nation is immense. The negative outcomes of the growing OVC population on social, economic, and human rights is a top priority for stakeholders in Ghana. The very fabric of Ghanaian society can tear apart because of intense burden of suffering among individual families. Business and school suffer when the most productive sector of society in terms of human resources aged between 15 and 49 years are lost to AIDS related illnesses. Already, 160,000 children in Ghana have been orphaned by HIV/AIDS. Without the appropriate social and life skills, these children will not be equipped as adults to drive the economic engine of Ghana making the struggle for development and growth even tougher. This chapter comprises two parts dealing essentially with results of interviews conducted with OVC and their caregivers. Assembling the pertinent facts on OVC and identifying the gaps that still exist in knowledge will aid stakeholders to make informed choices about how best to allocate resources and programme activities to maximize positive outcomes for both OVC and their caretakers.

This section presents the background information of the caretakers and OVC of the Manya Krobo Queen Mothers Association OVC project interviewed during the survey. As already defined, a caregiver is a person who regularly voluntarily assists a household, whose members are related or not related to him/her, in doing household chores, offers advice, giving spiritual, psycho-social and material support. In all, 50 caregivers and further 100 OVC were interviewed. The interview questionnaire covered information relating to the demographic characteristics of the caregivers themselves and the OVC in their care. Other themes this section delved into their perceptions, knowledge and opinions on relevant OVC issues.

3.2- Research methodology

The study was a cross-sectional descriptive population survey. In preparing for this investigation, we were confronted with a number of methodological options. Firstly, we had to decide whether or not to make this research work primarily quantitative or qualitative. The exercise of this option is to a large extent influenced by the nature of the

story I wanted to tell and how I wanted it to be told. That is to say whether to use only numbers or relate the experiences of the subjects being studied. What did I want my data to say, and in what way? I did not want this investigation to be neither a study of numbers comprising categories and variables nor only experiences providing narratives and changing histories. Issues relating to OVC and women have proven hard to quantify by traditional research means for a variety of reasons. Therefore, data collection involved a triangulation of qualitative and quantitative set of methodological tools complemented by experiential field notes which tried to capture various situations that considered indicative of the themes wished to develop. There were several advantages to using a combination of qualitative and quantitative information as detailed in the subsequent explanations.

3. 2.1 - The selected study analysis and some remarks about the sample

As it may, due to both time and budgetary constraints, this study is a cross-sectional analysis. We hope by adapting this approach, the study provides us with the relationship between different variables at a point in time. Further, since cross-sectional analysis relates to how variables affect each other at the same time and period, it provides variety, richness, and individual character. We hope we also managed to establish the trustworthiness by way of transferability, confirmability and dependability (Guba and Lincoln, 2005).

This research aimed at gathering an in-depth understanding of community behaviour towards less privileged in the society. It sought the reasons that govern such attitudes hence both quantitative and qualitative research methods were largely and jointly applied. This is because a combined approach helps to investigate and offer insights into the *why* and *how* of decision making and not just the *what*, *where* and *when*. Hence, smaller but focused samples were more often needed, rather than large samples. This offered some advantages. First, cases could be selected purposefully, according to whether or not they typified certain characteristics or contextual locations. Secondly, it allowed us (researchers) the flexibility in the choice of interpreting tools in practical and/or philosophical terms. And finally, it provided variety of forms in the focus on language, signs and meaning as well as approaches to analysis that was holistic and contextual.

The probability sample was used. This method was the best way to avoid bias or unrepresentative sample. This gave every member in the population an equal chance of being selected. This sampling offered the probability where any individual member from the population could be selected. The study relied on the following methods for gathering information Non-participant Observation, Field Notes, Reflexive Journals, Survey Questionnaires, In-depth Interview, Analysis of documents and materials.

Formal in-depth interviews and survey questionnaires were applied. The selection of respondents was done by adopting a combination of systematic random, simple random and purposive sampling procedures.

3.2.2 - Simple random sampling

A simple random sample gave each member of the population an equal chance of being chosen. It was, however, not a haphazard sample. One way of achieving a simple random sample was to number each element in the sampling frame (e.g. gave everyone on the enumerated area a number) and then used random numbers to select the required sample.

Random numbers were obtained using calculator. The optimum sample was the one which maximised precision per unit cost, and by this criterion simple random sampling was bettered by other methods (Hunt and Tyrrell, 2005).

3. 2.3 - Systematic sampling

This technique which is also called an N^{th} name selection technique was employed because of its simplicity (StatPac Inc., 2007). From the sampling frame, a starting point was chosen at random, and thereafter at regular intervals. After the required sample size was calculated, every N^{th} record was selected from a list of population members. In a random sample every member of the population has an equal chance of being chosen, which is clearly not the case here (Hunt and Tyrrell, 2005).

3.2.4 - Judgment or purposive sampling

This common non-probability popular qualitative research method was to select respondents who we judged to offer informed data. Their selection was based on judgment being confident that the chosen sample was truly representative of the entire

population (StatPac, Inc., 2007). This method followed new leads during fieldwork, taking advantage of the unexpected, flexibility and random purposeful sampling Patton (1990) which added credibility to sample.

A balance of the stratification factors was needed; so, where one factor was under-represented, the purposive sampling was used to ensure a balance thus reducing possible bias.

Key women leaders providing care as well as few OVC with particular backgrounds and circumstances were interviewed while Caregivers and other OVC were surveyed or given survey questionnaires.

EPIINFO software was be utilised in calculating the desired sample size while Statistical Package for Social Science (SPSS) and MicroSoft Office Suite as well as other available and useful software packages were employed in the data analysis and discussion.

3.2.5 - Sample size determination and variables to measure

We calculated sample size using EPIINFO 6.04 based on 1,461 populations of OVC and caregivers. Using 3.1% rate, an expected frequency of 8.0%, worst acceptable frequency 8.5% and a confidence interval of 95%, we obtained a sample of 150. The independent variables included age, sex, ethnicity, and parental status while the dependent variables included caregivers, nutrition, education, healthcare and shelter. Questionnaires, in-depth interviews, focus group discussions and observation were used to acquire primary data covering OVC, caregivers and MKQMA. Secondary data was based on journals, published and unpublished materials, Internet, District Health and Assembly offices, oral tradition accounts, research documents and other reports.

Respondents were drawn from 25 selected settlements for the study. The sites were carefully chosen to ensure spatial balance for distribution of social amenities and rural-urban dimensions to ensure fair representation.

3.2.6 - Techniques Employed

The In-Depth Interview (IDI) was used as a mean of verifying and validating the reliability of some of the information obtained by the quantitative methods. This technique helped to reach targeted individuals and institutions in mandated positions

with extensive knowledge on socio-cultural issues pertinent to the study. This was one of the three research techniques used to collect primary data. This technique together with focused group discussion helped to verify and validate the reliability some of the information obtained by the quantitative methods. The use of this technique targeted individuals in privileged positions but also people known to have special interest and extensive knowledge on socio-cultural issues pertinent to the study. In all, fifteen (15) respondents were interviewed using this method. This comprised OVC, opinion leaders, health officials, Ghana AIDS Commission, caregivers, and Department of Social Welfare.

Focus Group Discussion (FGD) was used to solicit explanations for some observed phenomena particularly psychosocial care and needs. The focus group technique involved a moderator facilitating a small group discussion between selected individuals on a particular topic. It was mostly be used for OVC. The question guides were the same as topics or questions as those for administrating IDI and questionnaires, but adjustments were made to suit the characteristics of each group interviewed. Care was taken on issues like age, class, gender and abilities. Background of FGD consisted of similar categories of respondents but not the same people. Eight FGD groups of five people each. The guides for these discussions were similar to the topics or questions as those for IDIs and questionnaires but adjustments were made to suit the characteristics of each group being interviewed. The respondents for FGDs were purposely selected to represent the major social domains in the communities. The 40 members of the FGD included groups of OVC; males and females, and another two groups made up of caregivers.

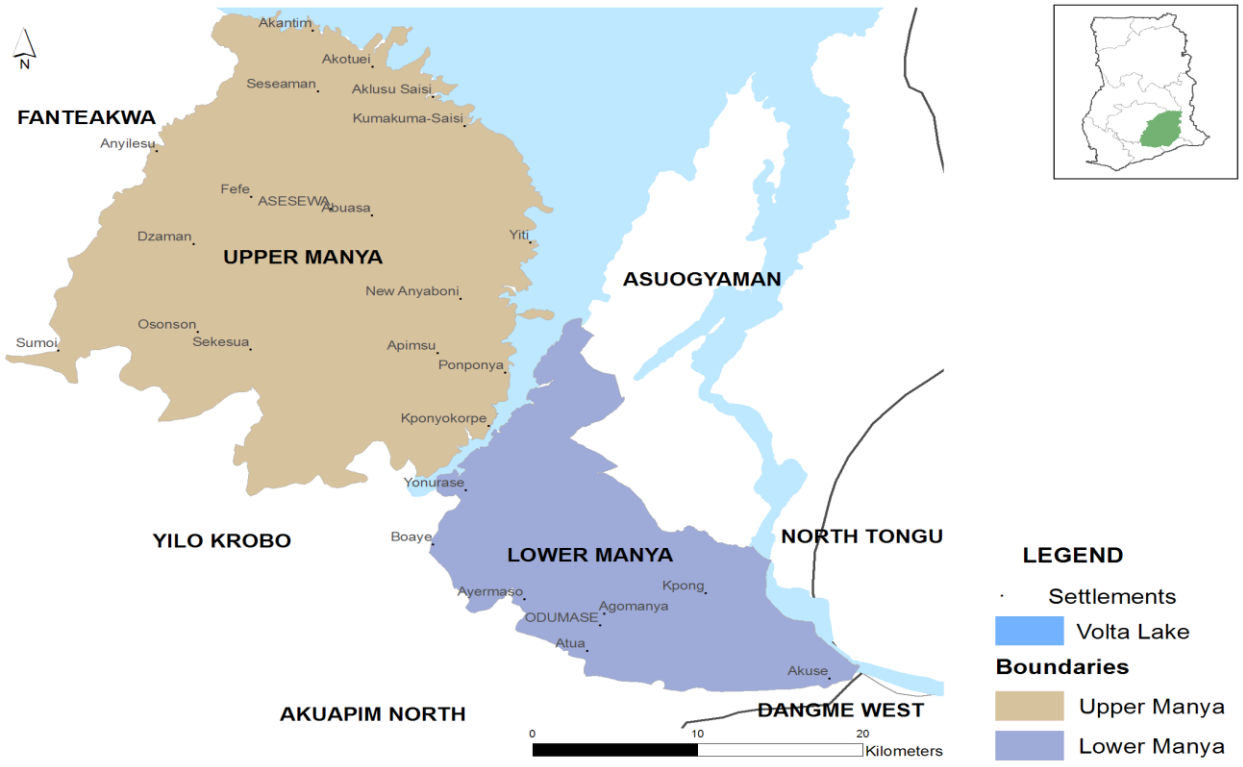
3.3 - Study design and study areas

It is important to harness geography to manage, analyse, and leverage spatial data effectively when planning, monitoring, and evaluating health sector programmes. This orphans and vulnerable children care study was a cross-sectional design in nature. The study adapted a deductive non-experimental approach to data collection. The study was conducted in Ghana, where HIV prevalence is 2.0% among adults aged 15-49 years for 2010 (NACP and GHS, 2011). Manya Krobo area where the study was conducted has

HIV prevalence of 7.8% among adults aged 15-49 years for 2010 and the identified OVC population is approximately 1,065 children.

The discipline of geography is concerned with the identification, analysis, and explanation of patterns, that is whether natural or man-made, on the surface of earth, and provides a solid foundation for the study of human health. Medical or Health Geography applies this principle to public or human health. Almost all human activity occurs on the surface of the Earth. What essential information does this provide for public health analysts to help ask better questions and plan interventions to improve human health? Geographic locations are the answer as modern medical geography uses computer-assisted mapping to identify patterns of human health. Human activities have a geographic component. Mapping helps recognise spatial patterns, deepens insight into data, highlighting of data quality issues and provides a useful tool for decision support, analysis, and data display. A map creates a picture worth a thousand words. Figure 3.1 illustrates the relationship between where and why creating a quick and useful tool for visualising data and making decisions based on evidence rather than non-validated assumptions.

Figure 3.1 – Location of towns where selected respondents lived



Source: Author's own construct based on CERSGIS Shapefiles, 2011.

The study was conducted in Manya Krobo traditional area comprising Upper and Lower Manya Krobo Districts (herein referred to as Manya Krobo). These are the two districts where the Manya Krobo Queen Mothers Association has been involved in supporting OVC activities in Ghana since 1998. It was conducted in 25 randomly selected communities out of the 371 communities in Manya Krobo area. Manya Krobo traditional area is located in the Eastern Region of south-east Ghana. It is predominantly rural especially in the Upper District and more urbanised in the Lower District. It is about three-quarters of an hour drive from the Regional capital, Koforidua on north-west and two hours from the national capital, Accra to the south.

Manya Krobo is located along the south-western corner of the Volta River in the eastern part of the Eastern Region. It lies between latitude 6.05S and 6.30N and longitude 0o08E and 0.20W. It is bordered to the north-east by Kwahu West Municipal, to the North-west by Fanteakwa, to the South-West by Dangme West, to the East and West by Asuogyaman and Yilo Krobo Districts respectively and to the south-east by North Tongu District. The District covers an area of 1,476 km^2, constituting about 8.1% of the total land area within the Region (18,310 km^2).

The major towns in the district include Odumase township (which incorporates Atua, Agomanya and Nuaso), Akuse and Kpong in the Lower Manya area. The major towns in Upper Manya area are Asesewa, Sekesua, Akateng and Otrokper. The population is predominantly of the *Krobo* ethnic group, which is an of the Adangbe sub-ethnic group.

3.3.1 - Questionnaire development

The same set of questionnaire for the two categories of respondents; caregivers and OVC, were developed. The standard OVC SCOPE Questionnaires (Strengthening Community Participation for the Empowerment of Orphans and Vulnerable Children) were adjusted to suit the Manya Krobo context.

3.3.2 - Focus group discussion and in-depth interview questions for OVC and caregivers

The in-depth interviews and focus group discussion guides (see in Appendix 1) reflected twelve thematic issues as summarised in Table 3.1.

Table 3.1 - Themes of the focus group discussion and in-depth interviews

Themes	Focus Group discussion and in-depth interview questions for OVC and caregivers
1	Care and support structures for OVC
2	Care for OVC
3	The living conditions of OVC
4	Complications in caring for OVC
5	Attitudes of people towards OVC especially incidents of stigma
6	Extent of HIV/AIDS as a problem in Manya Krobo traditional area
7	Personal knowledge, beliefs and behaviour in relation to HIV
8	Care and treatment of OVC living with HIV/AIDS in Manya Krobo traditional area
9	Profile and evaluation of the Queen Mothers Association's OVC intervention project
10	Challenges for the Queen Mothers Association in providing care and support
11	Suggestions on how to help OVC in Manya Krobo traditional area
12	The level and nature of external support if any

Source: Script of the FGD and IDI conducted March - May 2011.

Since different geographical or cultural groups working with children affected by HIV/AIDS interpret different words to mean the same thing or the same word in different ways, sensitivity and unambiguous communication are required. Ethical practice often requires finding a balance. This balance is the need to maximise children's participation by hearing their own opinions on the issues affecting their lives with the need to minimise their exposure to harm. The FGD and IDI themes in Table 3.1 explored possible responses and promote discussion and collaboration among people who address them from different perspectives. As can be seen from the Table 3.1, it is a structured conversation that allowed for in-depth information from a group of caregivers and OVC about twelve topics. The purpose was to collect information about their feelings, values, and ideas, not to come to consensus or make a decision. This technique was used as a way to get feedback on the twelve enlisted themes. In this case, we were seeking information on how complicated and difficult caring for OVC can be. It served as a good data collection option because the main concern was with depth of opinion, or shading of opinion, rather than simply with whether people agree or disagree. Further, it was a good option as it allowed questions that could not easily be asked or answered and supplemented the knowledge gained from written survey. It reinforced the reliability and validity of the findings.

These themes ranging from personal data without names, living conditions, complications in caring, stigma and psychosocial needs to knowledge of modes of HIV/AIDS and causes of illness and death of parents. The aim is to gain holistic

information on OVC living conditions. In order to ensure that goals for the exercise were achieved, the role as the facilitator was very important to the success of the focus group. To this end, the facilitation role was responsible for leading the discussion, keeping the group on track, and making sure everyone had a chance to participate. Primarily, this role involved encouraging discussion, keeping the group focused, keeping individual participants from dominating the conversation, encouraging shy participants to contribute and avoiding group pressure.

Discussion was encouraged by maintaining a warm and friendly attitude throughout the focus group. Care was taken not to judge what participants were saying either through verbal response or body language while establishing eye contact with participants to encourage them to speak. At certain juncture, the group was getting too far off the topic or finding some questions difficult hence were reminded of the original question by summarizing the responses and then rephrasing the question before repeating it. In some instances specific individuals who tended to dominate the conversation were nicely but firmly persuaded to let others have an opportunity to participate. Likewise, some quieter participants needed extra encouragement by eye contacts or gently asking for their opinions during pauses in the conversation to make them feel comfortable giving their opinions. Being wary of group pressure, alternate views were sought by specifically asking for other opinions.

An in-depth interview is a qualitative research technique that allows person to person discussion. It can lead to increased insight into people's thoughts, feelings, and behaviour on important issues. This type of interview is often flexibly semi-structured to permit or encourage an informant to talk at length about the topic of interest. With the in-depth interviews, there were some critical decisions that needed to be made. Firstly, needed to decide in advance which main topics the interview was to cover. The outline in Table 3.2 was settled on. Then of course needed to decide whether everybody will be asked the same questions, or change the questions, depending on the respondent. The latter option was exercised as respondents' backgrounds and knowledge differed. In order to have a holistic and opportunity to review aspects at a later time, the decision was that the interview needed to be recorded in some way in addition to note-taking or filling. In selecting or finding respondents, the consideration was on the fact we were trying to obtain a true and many different types of respondents were interviewed. This

was best done with maximum-diversity sampling being fully representative of the population. The next stage involved booking appointments and choosing the settings where the respondent feels most comfortable. Before the interview, all respondents were told the purpose of the investigation, why this respondent was chosen, the expected duration of the interview, and answered questions asked by respondents. During the interviews, observations were combined with follow-up questions to seek clearer understanding.

Table 3.2 - Summary of key steps in conducting in-depth interview

Steps	Activity undertaken
Step 1	Planned how to conduct the in-depth interviews
Step 2	Decision respondents to interview
Step 3	Prepared interview guide for each category of informants
Step 4	Conducted the actual interviews
Step 5	Analysed the data
Step 6	Wrote a report and recommended interventions

Source: Script of the in-depth interview conducted March- May 2011.

3.3.3 - Questionnaire for OVC and caregivers

The questionnaires asked about respondents' knowledge, attitudes, beliefs, feelings, motivations, anticipations, future plans or past behaviour. There were two sets of similar questionnaires designed and administered to caregivers and OVC respectively according to the 13 themes outlined in Table 3.3. With the exception of a handful of questions which partially close-ended to make for more flexibility in responses, the majority of the questions were close-ended. With close-ended questions, they provided specific answer choices although some question had an "other" value with brief space for adding an additional value. The questionnaires had six sections and sought information in four categories namely attitudes, beliefs, behaviour and attributes. The questions on attitudes sought to gather information on what caregivers and OVC respondents see or understand about certain things, beliefs was about what they thought was true, behaviour concerned what they do while attributes regarded what they are. Sequencing of questions involved the consideration of approaching the ordering of the questions. Care was taken to ensure that the design and expected responses would gather valid and reliable information. In order to achieve these

important elements, certain processed were observed in the design of the questionnaires. These included identifying what information was needed, decision on what sort of questionnaire to use, creating the first draft, editing and revising, pre testing and revising, and specifying procedures for its use. The option was to begin with easy questions in order to build confidence and make the respondent comfortable. The placement of demographic questions was at the end presuming that some respondents don't like to answer any "personal" questions. In any case, we thought that an incomplete response would still yield some useful data.

Table 3.3 - Themes of the interviews

Themes	Questionnaire for OVC and caregivers
1	Demographic information of the OVC
2	Demographic information of the Caregiver
3	Beliefs, attitudes, and experiences regarding HIV/AIDS and related issues
4	Caregiver-OVC communication on HIV/AIDS and related issues
5	Sources of income and general support for the upkeep of the OVC
6	General livelihood issues in the households
7	Food intake
8	Psychosocial issues
9	Emotional well-being and Health related issues
10	Experiences of stigma
11	Cultural modes of caring
12	Education related issues
13	Sexual involvement, abuse and risk taking issues

Source: Script of the questionnaire survey conducted March - May 2011.

After developing a protocol to clarify aims and procedures for collecting, analysing, and using the information to which all partners agree, we finalise the questionnaire containing activity in Table 3.3 to get valid information. The aforementioned areas captured in the interviews where appropriate, had prompts that were used to elicit discussion.

3.3.4 - Ethical considerations

We recognise that children must have the opportunity to express their views about activities that affect their welfare, and these views should be respected. Gathering information in a geographic area like Manya Krobo seriously affected by HIV/AIDS

which has left large OVC population and challenges required careful attention and planning. Firstly, Manya Krobo due to its strategic role with respect to HIV/AIDS and OVC may be said to be experiencing something close to research fatigue. It had already been subject to a progression of all manner of people who had come, asked their questions, and left (Anarfi, 1990; Sauvé et al., 2002; Tuakli-Ghartey, 2003; Atobrah, 2004; Brown, 2005; Lund and Agyei-Mensah, 2008; Steegstra, 2009; Addo et al., 2011). The Queen Mothers, families, caregivers and OVC have had their fair share of this experience and were a little suspicious in cooperating with yet another analysis of their situation. Moreover, being aware that asking about OVC problems could raise expectations for assistance, we took care not to create an incentive for respondents to exaggerate needs in the hope of receiving some benefit. By so doing, we thus prevented the distortion of the information they provided. Most importantly, we recognised the need to put the best interests of the OVC first. Even when an OVC was willing to participate and voice his or her views, we took steps to promote and protect his or her rights by ensuring that no OVC respondents experienced any harm, including emotional harm.

One solution we adopted to deal with these ethical conundrums was to consult and involve the Queen Mothers Association and the OVC safety net programme managers on the most appropriate ways to conduct the data collection. They in turn graciously provided input on timing, location, and facilitation of engagement of stakeholders in the survey.

Letters introducing the study, its purpose and requesting permission to collect data were sent out to the paramount Queen Mother of Manya Krobo area (Appendix A) and the Project Director of the Manya Krobo Queen Mothers Association OVC Safety net Project in order to formally gain access to the required data. Subsequently, series of meetings were held in the month of January 2011 with their officers or persons to iron out strategies to carry out pre-test.

3.3.5 - Pre-testing of the instruments

A pre-test exercise was conducted in January and February 2011 in Manya Krobo area prior to the actual field data collection exercise. A member of staff from the UNO-UU Every Child is Our Child Program component was assigned by the Manya Krobo Queen

Mothers Association OVC Project Director as a local liaison officer to help with administration and validation of the questionnaire. He advised on how to gain entry into caregivers and Queen Mothers households especially regarding customs, cultural and ethical etiquette that had to be observed when meeting respondents. One of the gains of conducting the trial run was to get advance warning whether proposed methods and instruments were appropriate or too complicated. In sum eight respondents comprising OVC and caregivers were interviewed. The pre-test helped us to:

-develop and test adequacy of research instruments;

-assess sequencing of the questions;

-assess the content validity of the questions;

-assess the clarity of instructions in the questionnaire;

-drop irrelevant questions;

-estimate variability in outcomes to help determine sample size and modify questions;

-assess the practicability of administering the questionnaire;

-estimate the time needed to administer the questionnaire;

-identify some field-related logistical challenges that were likely to be faced.

At the end we changed, modified or added some questions before the final version was produced.

3.3.6 - Field work activities

Prior to the commencement of the study, approval was obtained from the traditional leaders as well as the leaders of the Manya Krobo Queen Mothers Association, who operate the OVC safety net project in the communities.

Furthermore, we sought verbal consent from each respondent. Children were only interviewed or allowed to take part in a focus group discussion after informed consent supported by a caregiver's permission. Where the caregiver consented to the interview but the child refused to give consent we did not go on with the interview and that child do not participate in the focus group discussion. After informed consented was secured, the interview or focus group discussion was conducted in an isolated area to avoid distraction and maintain privacy during the discussion. In order to protect the identity of

participants, all names of children and caregivers in this report are fictitious names or pseudonyms.

We interviewed the children and caregivers in a conservational and informal way, the language most familiar to them; *Krobo* or *Akan*. For each interview, different sections of the interview schedule were prioritised and some of the areas of the discussion fell away. Responses were sought beyond the immediate prompts as long as the discussion stayed within the broad objectives.

The note-taking method was applied to record the data from in-depth interviews, observation and focus group discussions were transcribed, organised thematically and content analysed.

3.3.7 - Sampling procedures

The study followed a system of data collection that involved the systematic capturing of relevant information that was representative of the stakeholders; being caregivers, OVC and opinion leaders. The participation of the leadership of the Manya Krobo Queen Mothers Association and OVC Project in the pre-test and dissemination of information to caregivers and OVC contributed to the successful publicity of the study field activities. The caregivers and OVC were well informed regarding the objectives of the research. As a consequence of this sensitisation exercise, the study was well received by all the stakeholders.

Most of the key sources of data were obtained from the primary sources.

For study participation, we selected a random sample of children who lived in family care as well as interviewed the child's main caregiver. The target population consisted of households in Manya Krobo area that had orphans and vulnerable children to take care of. A total enumeration of the households with OVC in the area was made to comprise the population from which the caregivers were chosen for the study as indicated earlier. Twenty-five communities out of the 371 communities were purposively picked. Factors taken into consideration in choosing those communities included land-use patterns such as availability of health care facility, educational facility, and market, the rural-urban consideration as well as traditional role of the community. OVC in the sampled households were surveyed from 25 communities (Figure 3.1) chosen based on social, geographical and economic relevance.

Determination of households caring for OVC was an important initial consideration of the study since a large majority of OVC resides in households of surviving parents or other relatives. The sample frame for the household was obtained from the selected communities where OVC resided. The needed sample size for each community was calculated proportional to its size. This then formed the basis of the sampling frame for the targeted respondents. The sample sizes for both the caregivers and OVC were picked accordingly. For the caregivers' questionnaire, the caregiver of the OVC in the predetermined household was the respondent, and for the OVC, they were the respondents. In a household, the sex of the OVC was considered but was not the most crucial determinant for selection. In the course of administering the questionnaires, any problems faced in the field were recorded in detail as well as how they were overcome.

3.3.8 - Data management

The study data collected was first checked and balanced. All the information obtained/collected was verified as far as possible, to ensure the validity of data.

After the questionnaires data had been gathered, they were verified to ensure consistency and correctness of data, entered into SPSS Version 16.0 data file and checked for errors and inconsistencies. The objectives of the data cleaning exercises were to check all data entry errors, assess any inconsistencies in data filling, assess any inconsistencies in data entry, and assess completeness of the data entered. After data entry errors had been reconciled, the data was checked for values that were out of range and or were inconsistent with questionnaire interview.

Interpreting responses, coding and checking, and running frequencies at the end of each data entry session as well as continual checking of methods and tabulation were done for increasing quality control during data entry. Quantitative data analysis was done through descriptive summary statistics such as means and proportions.

3.3.9 - Analysis of secondary data

In addition to using the primary data collected from the processes enlisted as aforementioned, data from secondary sources was greatly utilised in the study design. Reviewing secondary data sources significantly reduced the amount of time and effort required to gather primary data for this study. That is, existing data sources provided

sufficient information on defining the problem of the OVC situation in Manya Krobo area. Analysing this source of data involved reviewing variables in existing quantitative data sets and determined how far analysis of any of the variables informed the situation analysis of HIV/AIDS-affected children. A summary report of secondary data analysis in Chapter Two called *Literature Review/Conceptual Framework - What the Literature says about the OVC Problem* indicated information gaps.

The under-listed points were some of the objectives of a secondary data analysis that were adapted to the Manya Krobo OVC situation. It provided information about the increasing dependency burdens in Krobo communities and the changes that have occurred over time within and across families. Its examination vividly highlighted the spatial dynamics of HIV prevalence in Manya Krobo as an area relative to both regional and national rates which helped determine changes over time. As a result, it brought to the fore a description of the trends and differences in living in households affected by HIV/AIDS.

Analysis of the secondary data mainly from scientific publications and reports also helped to determine the extent to which children's living circumstances compromised their welfare and other living conditions. Significantly, it helped to design and streamlined the investigation of the factors that have the greatest effect on children's well-being and developed and discussed the empowerment conceptual framework for the study.

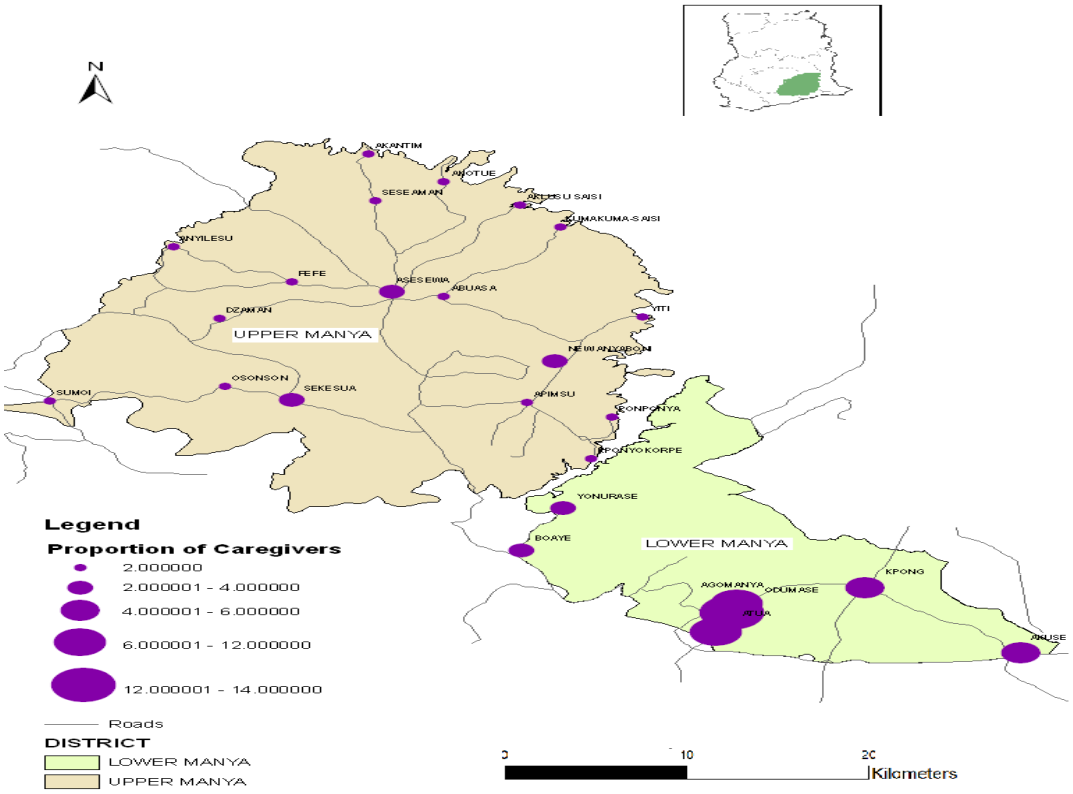
3.4 - The demographic characteristics of the caregivers

This section provides information on the demographic characteristics of the caregiver respondents. It covers five broad areas. These are household economic status, relationships in household, children's education experience, psycho-social issues and background characteristics or personal information. All these are contained in the caregivers questionnaire covering 63 questions in all attached as appendix 1 (OVC survey questionnaire). This part also discusses age, sex, household members, meals, dependency just to mention a few.

Almost all the caregivers (82.0%) were from the Krobo ethnic group. The remaining caregivers (18.0%) belonged to the Ga-Adangbe, Akan and Ewe groups thus there is one to four ratio. About 60.0% or three-fifths said they were the head of household while

two-fifths (40.0%) were not. The concern about the skewed nature of the dominance of the Krobo ethnic will be likelihood of lack of little exposure to other cultural practices especially those that prevent the spread of sexually transmitted infections including HIV. The good thing about such trend is that the issue of generation nexus which is one of the study objectives could be properly addressed. With the older generation bringing up the OVC, heritage transfer is potentially assured or guaranteed. One of the cardinal roles in parenting is the education of the child. In this respect, it concerns the development of the child's personality, talents and mental and physical abilities to their fullest potential. Parenting beliefs generally play many telling parts in the story of child development. Figure 3.2 shows the proportional representation of caregiver respondents distributed within selected towns. The more urbanised Lower Manya provided more respondents albeit fewer towns than Upper Manya.

Figure 3.2 – Relative spread of caregiver respondents in Upper and Lower Manya



Source: Author's own construct based on CERSGIS Shapefiles, 2011.

Nine in ten (92.0%) of respondents professed to be Christians while Muslims and Traditional believers were 4.0% each. Religious education and sensitisation in all its

forms tends to have a major impact on the upbringing of young people because religion commands a great sense of respect and obedience among Ghanaians. Religious faith is therefore one of the best tools to use in positively mentoring, influencing and shaping children growing up. The basic message is that God is chaste hence challenging all those that follow him to also stay holy for His bountiful favours and blessings. Fifty caregivers were interviewed from 25 selected communities across Manya. The sex distribution of the caregivers was in the main females (86.0%) with a ratio of almost nine females to one male (9:1). This trend is not surprising as the work of caring for OVC just like caring for the aged, the infirm and sick people including those living with HIV/AIDS has been feminised in many societies. This development arises from the fact that in many cases, the mother or father to the OVC dies when the child is already with the grandmother or aunt and thus remains as an orphan being still very young and in need of maternal care. While it is true that traditionally women are the caregivers, orphanhood effect of HIV/AIDS seems to be reinforcing this role by leaving women to carry the social responsibility of caring for OVC. As a result, the findings of the study will provide more insight into socio-economic conditions of life of women caregivers than men. However, as females are more prone to risk of HIV infection and HIV/AIDS effects than males, the greater focus on women can be viewed as a plus for the study.

3.4.1 - Age and marital status of caregivers

Regarding caregivers background, Table 3.4 shows overall mean age of 54 years (Standard deviation –SD 11.5). Just about 4.0% of caregivers were below 35 years. Majority of caregivers (54.0%) were in the 55-79 years age groups. About over a fifth (22.0%) of all caregivers were 65 years and above. It follows from Table 3.4 that the answers of respondents will mainly reflect the opinions and information of elderly group of caregivers between 50 and 79 years of age. Reducing poverty by supporting caregivers, people living with AIDS, and orphaned and vulnerable children requires that data be collected and disaggregated by age, gender, and socio-economic status, particularly in high prevalence areas. Through such data, deeper insights are gained about the fact that caregivers are overburdened with responsibilities and that older people and other economically disadvantaged persons provide care to PLWHA and OVC. With these indicators, targeted policies and assistance that is based on actual

needs and at a level that reduces poverty and prevents poor health can be developed and implemented (DFID and Helpage International, 2005).

Table 3.4 - Caregivers background by age

Age of OVC caregivers	frequency	(%)
30 - 39	6	12.0
40 - 49	10	20.0
50 - 59	19	38.0
60 - 69	10	20.0
70 - 79	5	10.0
Total	**50**	**100.0**

Source: Field Survey data, March - May 2011.

The respondents who said they were head of household had a mean age of 56 while those who were not household heads mean age was 50 years. A little than a third of the OVC caregivers were either married or co-habited (36.0%), while nearly about two-thirds (62.0%) were either divorced/separated or widowed. In Table 3.5, few respondents (2.0%) had never married. A person's priorities, life principles, ideals, values and outlooks really change over time and this applies to marriage as well. The age at first marriage affects values and stability of the family as regarding settling into a career, learning to manage finances and deciding to have and support children. The earliest age at first marriage for caregivers was 18 years (10.0%) and oldest 45 years (2.0%) while median age was 20 years (18.0%). Marriage according to Krobo customs is very elaborate thing and quite expensive relative to standard of living and customs of neighbouring ethnic groups. Married caregivers were slightly more likely to have higher performance ratings (Clark, et al., 2010).

Table 3.5 - Marital status of caregiver respondents

Caregiver marital status	frequency	(%)
Single	1	2.0
Married	15	30.0
Divorced	12	24.0
Separated	4	8.0
Widowed	15	30.0
Co-habitation	3	6.0
Total	**50**	**100.0**

Source: Field Survey data, March - May 2011.

Among the *Krobo*, to marry is a woman's vocation and creates a new relationship which brings new enjoyment and pleasure. It is largely conceived as a bond between two

kinship groups rather than between two individuals. Marriage is defined in terms of specific rights, duties and customary behaviour and is protected by very elaborate and peculiar ritual sanction failure from which the father loses the right of paternity of the offspring. As a result, there are many men and women who live together by either partially performing some of the rites or without having gone through any form of ceremony at all. Such couples are not regarded as man and wife though they perform all the obligations towards each other.

3.4.2 - Level of education attained by caregivers

In Ghana, education is seen as one of the principal determinants of social status and a means of a lift from poverty. Thus it has a clear relationship between economic well-being and household income and expenditure. The majority of caregivers constituting over a third had attained basic education (Junior High School - JHS) as their highest level of education (36.0%), while equal percentage (18.0%) attained primary and Senior High School as the highest level of education respectively. In Ghana, a child begins primary school by age six and enters Junior High School (JHS) at 12 years. Senior High School (SHS) starts from age 15 and lasts four years after which a student progresses to the tertiary level if they choose to continue. It is not very surprising to find that many of the respondents had either no education or completed just elementary or basic levels as it corresponds to the general trend of the population in the countryside. In Table 3.6, nearly a quarter (24.0%) of all caregivers reported having no education at all with just 2.0% indicating either higher level or offering no response.

Table 3.6 – Educational level attained by OVC caregiver respondents

Caregiver education	frequency	(%)
None	12	24.0
Primary	9	18.0
JHS	18	36.0
SHS	9	18.0
Higher (tertiary)	1	2.0
No response	1	2.0
Total	**50**	**100.0**

Source: Field Survey data, March - May 2011

In rural Ghana, levels of educational attainment are less than urban area residents. Further, women as group of the population are less fortunate when it comes to family

allocation of resources for the education of the children. Vital to this study is the observation that there is an association between poor literacy and harmful consequences of older age. Research suggests that one in three adults aged over 65 years have difficulty understanding basic health-related written information (Bostock and Steptoe, 2012). This function relates to the degree to which caregivers have the capacity to obtain, process and understand basic information and services needed to make basic decisions (Ratzan and Parker, 2000). Regarding OVC parenting, being able to apply reading skills and basic knowledge in a specific context correlates strongly with general literacy (Nutbeam, 2008; Parker, *et al*., 1995). The limited literacy capabilities among caregivers have implications for the design and delivery of services with respect to the capabilities needed to effectively manage the OVC in their foster care. This may however have negative care outcomes considering that they may not be able to abreast themselves with current parenting trends beyond their immediate environment.

3.4.3 - Employment status and source of income of caregivers

Poverty takes a great toll on the human spirit everywhere, and the diseases of poverty as HIV/AIDS choke out life. The children in fosterage need many things in life, but for many of them the prospect of getting basic needs of life is as remote as a decent meal. Table 3.7 shows that the overwhelming majority of caregivers stated informal income as their main source of household income (88.0%).

Table 3.7 – Households sources of income

Sources of income	frequency	(%)
Beads making	3	6.0
Pension	2	4.0
Relatives	9	18.0
Other	6	12.0
Hawking items	7	14.0
Marketeering	7	14.0
Stone crushing	4	8.0
Agriculture	4	8.0
Crafts	2	4.0
Teaching	4	8.0
No sources of income	2	4.0
Total	**50**	**100.0**

Source: Field Survey data, March - May 2011.

Ideally, biological parents who were the people best suited to providing these needs and can quickly work out solutions were regrettably either unavailable or were deceased.

Considerable percentage of caregivers (88.0%) was underemployed/unemployed, while just a tenth (12.0%) had formal employment. No more than 12.0% of the caregivers named formal salary (pension – 4.0% and teaching – 8.0%) as their major source of household income and some (18.0%) mentioned donations chiefly by relatives as supplementary incomes. Petty trading (beads making, hawking items, marketing, stone crushing and crafts) constituted 44.0% of sources of household incomes. In the 30 days preceding the interview, the total amount money that was earned by all members of a household ranged between zero Euro (GHC0.00) and One hundred and fifty Euros (GHC300.00) with a mean of forty-two Euros, five Cents (GHC84.10.) For the same period, the same amounts were received from sources other than through working but had a lower mean of twenty-three Euros, seventy Cents (GHC47.40). Regarding the ownership of current place of residence, there was a ratio of almost one to six with just a sixth of respondents (16.0%) indicating rental while greater percentage (84.0%) owned their houses. On the contrary, just a quarter of caregivers own other property (24.0%) whilst three quarters of them (76.0%) indicated that they have no other property. When asked if the OVC living with them earns money for the household, about only one in ten (12.0%) responded in the affirmative, nearly nine out of ten (88.0%) respondents answered in the negative.

3.4.4 - Household composition

The average number of all children per household surveyed aged 24 years and below was 4 (3.9) for both males and females. Table 3.8 shows that the actual number of children per household was between a child (4.0%) and 12 children (2.0%).

Table 3.8 – Household composition

No. of children Under 24 years	frequency	(%)
1 child	2	4.0
2 children	6	12.0
3 children	17	34.0
4 children	13	26.0
5 children	4	8.0
6 children	5	10.0
7 children	1	2.0
10 children	1	2.0
12 children	1	2.0
Total	**50**	**100.0**

Source: Field Survey data, March - May 2011.

For the 50 households of the caregivers, there were a total of 196 children in their care. Households with 3 children (34.0%) constituted the highest number of households for females and males as well as by towns of residence. From the caregivers perspective, the ages of the OVC in their care was from as young as three years (2.0%) to as old as twenty-one years (2.0%). Thus the mean age was about 13 years (12.7 years, SD – 4.3) and the age with more OVC was 12 years (18.0%). From Table 3.9, there is a depiction of caregiver – OVC relationships. Less than a tenth (8.0%) of all OVC in foster care is not related by blood lineage. The greater number of OVC (30.0%) is being cared for by either a brother or sister. Brother/sister and grandchild caregivers have in their custody and care for more than half (54.0%) of OVC whilst just a mere fraction of caregivers (4.0%) indicated that the OVC in their care were their own biological children. Grandmothers, aunts and sisters dominated the list of the caregivers of OVC (Table 3.9). The high percentage of grandmothers serving as caregivers raises some concerns. The grandmother phenomenon suffers from aging frailty which puts great strain on family resources. In areas devoid of sufficient intervention strategies, children (including OVC) might have to supplement family resources, and also care for the 'caregiver' in their critical formative years. This could negatively interfere with their proper development.

Table 3.9 – Caregiver–OVC relationships

Relationship to OVC	**frequency**	**(%)**
Own child	2	4.0
Brother/Sister	15	30.0
Grandchild	12	24.0
Nephew/Niece	9	18.0
Cousin	8	16.0
Neighbour	2	4.0
Other	2	4.0
Total	**50**	**100.0**

Source: Field Survey data, March - May 2011.

Caregivers' responses on whether the mother of the OVC is still alive show that nearly two in ten (18.0%) respondents said OVC mother is alive. Regarding OVC fathers, almost a quarter of caregiver respondents (24.0%) indicated yes. This could be a reflection of the high death rate among women especially mothers. There are gender differences in the incidence of AIDS as women are particularly vulnerable due to their

biological predisposition and unequal power relations borne out of both cultural and economic factors.

The death of parents (72.0%) followed by economic hardship on parents (20.0%) or no one to care for the child (8.0%), were the common reasons that influenced guardians to take in OVC. When asked about the length of time for which the OVC had been in guardian custody, the result of the responses by the caregivers shows long term relationship. The minimum length of time of stay was one year (10.0%) and the longest was twenty years (2.0%). This outdates the formation of the MKQMA OVC project itself. The mean number of years of OVC stay in foster care was 7 years (7.4 years). The respondents indicated some of the OVC had stayed in between one (74.0%) and three (4.0%) previous homes.

3.4.5 - Effects on household following taking in OVC

The demand for care and support sometimes simply overwhelm many households by reducing the caring capacity of families thereby deepening poverty through feeding, medical and educational costs. The appraisal of the effect on the caregivers' household following the arrival of the OVC in Table 3.10 brought out some main challenges which can be classified as finance, education and health-related. These were increased income expended (52.0%), shortage of food (10.0%), and shortage of money for children's education (12.0%). Other caregivers reported stress (24.0%) in view of the fact they no longer have enough time for themselves since the OVC was taken into their foster care.

Table 3.10 – Effects on household after arrival of OVC

OVC effect on foster household	frequency	(%)
It gets hard financially	26	52.0
There is less food to go around	5	10.0
Some children can't go to school	6	12.0
Too much pressure	12	24.0
Other	1	2.0
Total	**50**	**100.0**

Source: Field Survey data, March - May 2011.

3.4.6 - Caregivers' perspective on effects of being an OVC

The ill effects associated with orphanhood include poor socialisation, poor nutrition, inadequate schooling, psychological scarring, and living in poorer households than non-

orphaned children. OVC often have to cope with the loss of either one or both parents and without strong support mechanisms, they suffer emotionally. The impact on education is that OVC could have poor school attendance as well as worsened academic performance. The caregivers further answered questions on what they considered as the main effects of the loss of parents on OVC in their foster care. The main effects on the OVC as perceived by the caregivers were food/financial (36.0%). Nearly a third (31.0%) of respondents mentioned adjustment and psychosocial needs as they indicated that OVC school attendance has either declined or grades have worsened. Table 3.11 shows that some caregivers did not feel the being an OVC per se had affected life circumstances as they were cited by (14.0%).

Table 3.11 – Effects of being an OVC

Effects on OVC	**frequency**	**(%)**
Their school attendance has declined	14	28.0
Their grades have worsened	2	4.0
They do more house work or fieldwork	2	4.0
They have to take care of smaller children	1	2.0
They have to take care of a living parent	1	2.0
We have less food/money as a family	18	36.0
It has not affected their life circumstances	7	14.0
Other	2	4.0
Don't know	1	2.0
No response	2	4.0
Total	**50**	**100.0**

Source: Field Survey data, March - May 2011.

3.4.7 - Household economic situation and dependency burden and challenges

Orphans unlike non-orphans potentially add on to the large female-headed households where more people become dependent on either non-existent or fewer income earners. In gauging the standard of living within the households where OVC lived, the caregivers were asked to indicate their household economic situation on the most basic necessity as meal types and intake. Nearly nine out of ten of the caregivers (88.0%) answered that they ate three meals on the day prior to the interview. Just a token of respondents (12.0%) indicated they had two meals.

To look after OVC in a tough economic environment as it is in Manya Krobo is daunting and very strenuous task. HIV/AIDS affects the economic situation of children and their families in many ways. Income and assets can be depleted as families absorb more orphans and other vulnerable children. This can increase the financial burden on the family. There can be a range of challenges. The caregivers were questioned on what they saw as their greatest challenges in heading the household. From Table 3.12, about two out of five caregivers (40.0%) mentioned inadequate finances and stated their desire to be helped with money to start a business venture to generate sustainable income. Almost a third (30.0%) said support for children's school fees. There were just few complains (4.0%) about challenges of discipline and adjustment implying many of the respondents did not consider these issues as of much concern to them.

Table 3.12 – The challenges of supporting OVC

Kind of support caregiver need	frequency	(%)
Medical care	4	8.0
Food	2	4.0
Support for children's school fees	15	30.0
Clothing	2	4.0
Someone to talk with	1	2.0
Someone to watch kids for me from time to time	1	2.0
Training or education	5	10.0
Money to start a business venture	20	40.0
Total	**50**	**100.0**

Source: Field Survey data, March - May 2011.

In addition to the cost burden shouldered by the caregivers, nearly two out of five of respondents (44.0%) indicated that they financially support other children who do not live in this household. The amount of mount spent on this extra child ranges from €2.50 to €50.00 (GH¢5.00 to GH¢100.00) within intervals of either monthly, quarterly or annually.

In Ghana the complete education programme includes six years of primary school, three years of junior high school, and further three years of senior high school. Primary school is supposed be mandatory once there are enough facilities and teachers to accommodate all of the children. This hurdle requires that policy addresses supply side constraints of education. This takes the form of the provision of more textbooks, classroom blocks, and trained teachers. Primary school begins when a child is six, and s/he will complete senior high school at the age of 18.

In line with the Ghana's subscription to the MDGs and also her own local constitutional requirement to improving the quantity and quality of education by making it progressively free, there was the need to ease the demand-side constraints to education. The 1992 Constitution of the Republic of Ghana under Article 25 (1) guarantees the right of all persons to equal educational opportunities and facilities by ensuring free, compulsory and universal basic education. The provision under the Constitution also ensures that secondary and higher education shall be made available and accessible to all by every appropriate means, and in particular, by progressive introduction of free education. Functional literacy is also ensured under the constitution and provision is made for resourcing schools at all levels with adequate facilities. However, many school aged children are not in school to receiving the benefits of improvements. One of the major barriers to the demand side constraints to children attending school in Ghana is that their parents cannot afford to pay the levies charged by the schools. I use the term levies since there has never been tuition charges in Ghana at the public schools. Abolition of school fees especially at the basic education level has been adopted by many countries as one of the key policy interventions for influencing education outcomes. Fees charged at schools especially public schools, have been identified as one of the main barriers to education access especially among the poor, orphaned, and vulnerable children within societies (USAID, 2007). The main argument advanced by proponents of school fees' abolition is that, school fees and other direct education related costs to households represent a significant obstacle to enrolment especially among the poor and vulnerable households. Abolishing school fees will therefore make it easier and less costly for children with these challenging backgrounds to enrol in schools and eventually help in achieving some of the education related goals within countries (USAID, 2007; Osei et al., 2009). In order to remove this obstacle to education, the government set up the capitation grant which commenced in the 2005/2006 academic year. Under the scheme, every public primary school receives an amount of money for each pupil enrolled per year. Consequently, there was a significant increase in the gross and enrolment ratios (Osei et al., 2009; World Bank, 2009; NDPC and UNDP, 2010). Some public primary school managers however complain that the capitation grant amount is both inadequate and often released late into the academic year. As a result, unauthorised levies continue to be imposed in some

form in some school to bridge the deficit which is what the respondents termed to erroneously as school fees. One official of the only external body still helping to fund some group of OVC from the MKQMA OVC safety net project, Unitarian Universalist United Nations Office aptly tells the impact of this cost: “with the high cost of living and inflation, many of the families who take in additional children are not able to provide the required school fees and access to sports, book bags, school uniforms, notebooks, stationary supplies and science resource centers”. Funding school fees is critical to provide the education required by this vulnerable group of children.

3.4.8 - Family communication on HIV/AIDS-and death-related issues

With regard to responses by caregivers on communication about HIV/AIDS-related issues, the study reported mixed responses. There was very poor attitude to family communication despite caregivers’ claim of high levels of knowledge of HIV/AIDS. In order to evaluate caregivers’ level of awareness and knowledge of HIV/AIDS, proxy question by way of awareness of Ghana AIDS Commission was posed. Overwhelming number of caregivers (86.0%) stated that they had heard and were aware of HIV/AIDS prior to the interview. However, as shown in Table 3.13, a big percentage over two-thirds of caregivers (68.0%) either said they don’t know or gave no response when asked to mention any AIDS organisation.

Table 3.13 – AIDS organisations mentioned by caregivers

Mention AIDS group	frequency	(%)
Don't know	24	48.0
No response	10	20.0
Catholic Relief Services	1	2.0
Food & Agric Organisation, Family Health International	1	2.0
Family Health International	4	8.0
Many (more than three)	1	2.0
Manya Krobo Queen Mothers Association	1	2.0
Opportunities Industrialization Center International (OICI)	1	2.0
Toronto	2	4.0
United Way, OICI, Uniterian Universalism-UN Offices	1	2.0
United States Agency for International Development	4	8.0
Total	**50**	**100.0**

Source: Field Survey data, March - May 2011.

The respondents were in addition questioned if they had talked about issues relating HIV/AIDS and death of OVC parents in general with their children. Approximately just

over a tenth of caregivers (12.0%) said they had mentioned death of OVC parents once to their children about death or cause of death of OVC's parents while (6.0%) mentioned every three months and (4.0%) stated that they talked to their children about these matters monthly respectively. The explanation put forward is that there is a belief in the traditional Ghanaian setting that prohibits children from knowing about such issues as death of close relations like parents. The underlying principle is that children do not have the mental and emotional capacity to handle or cope with such issues. The tradition presumes that to discuss such issues might bring discomfort to both the children and their caregivers. This might be an influencing in preventing discussions of this nature. It would be useful to identify and propose the factors that promote the discussion of these topics in other households elsewhere to assist with the development of appropriate interventions for increasing family communication in Manya Krobo. Some of the civil society groups or non-governmental organisations mentioned by the respondents are profiled subsequently.

The Ghana AIDS Commission (GAC) was established in September 2000 and subsequently promulgated by ACT 613, in 2002 as a supra-ministerial and multisectoral advisory body to direct and coordinate the involvement of all ministries, the private sector and non-governmental organisations in the response against HIV/AIDS in Ghana according to www.ghanaids.gov.gh, the official website. As the highest policy making body on HIV and AIDS, GAC provides effective leadership in the coordination of the programmes and activities undertaken by all stakeholders of the national response through advocacy, joint planning, research, monitoring and evaluation towards comprehensive prevention and total control of the disease. The Commission comprises 47 members. The President of Ghana is the chairman, the Vice President is Vice Chairman, 15 Ministerial representation and 27 representatives of civil society groups.
The functions of the GAC cover policy formulations, high level advocacy for HIV and AIDS prevention and control. It is also expected to provide effective leadership in coordinating, expanding, mobilising, fostering, promoting and evaluating all HIV and AIDS activities.

Catholic Relief Services (CRS) was founded in 1943 by the Catholic Bishops of the United States to serve World War II survivors in Europe. Since then, CRS has expanded in size to reach more than 100 million people in more than 100 countries on five continents. Its mission is to assist impoverished and disadvantaged people overseas, working in the spirit of Catholic Social Teaching to promote the sacredness of human life and the dignity of the human person (www.crs.org/Ghana). CRS is a longstanding partner in Ghana's development. CRS Ghana was established in 1958, just one year after Ghana gained independence. The Catholic Church is among the strong network of partners working with CRS throughout Ghana. CRS Ghana works to tackle poverty by providing care and support to people living with HIV; improving the education and health of children; increasing access to clean water and sanitation; finding ways to increase farm profits and production; and promoting peace in areas of conflict. The CRS provided food relief, health care and educational materials to a number of people including some of the OVC and their families affected by HIV/AIDS in Manya Krobo area.

Family Health International (FHI) is a Christian humanitarian, relief and development organisation which helps handicapped people. It begun as a contraceptive research project at the University of North Carolina in 1971 before incorporating family planning, reproductive health and HIV/AIDS. In Ghana, FHI works with the hearing impaired, blind, physically challenged, crippled and/or mentally ill. FHI also helps people whose development, education, training and well-being are often neglected. FHI currently has more than 500 beneficiaries in Ghana, of which over 150 children are sponsored children in nursery, primary, junior and senior high schools (www.fhi360.org/NR/rdonlyres/.../GhanaSTARTRepFinal061606.pdf*)*. FHI gives direct educational materials such as school uniform, house/chapel dresses, text/exercise books, shoes/sandals, boarding facilities like beds, foam mattress, payment for their PTA and school levies and other personal belongings throughout their period of schooling. FHI is implementing the Strengthening HIV/AIDS Partnership with Evidence-Based Results (SHARPER) project in Ghana. It is about reduction of new HIV Infections in vulnerable groups and the general population project. FHI works with local partners to reach these target groups with HIV prevention information and services through peer

education; to provide them HIV counselling and testing services, and to strengthen partnerships with STI and HIV service delivery points as a means of promoting referrals. FHI was instrumental in the establishment of the first ART pilot centres in Ghana at Atua and Agomanya hospitals in Manya Krobo in 2003. It also teamed up with the Ghana AIDS Commission to help establish the MKQMA OVC safety net project.

Opportunities Industrialization Center International (OICI) is a non-profit organisation headquartered in Philadelphia, USA. The subsidiary in Ghana is Opportunities Industrialization Center (OIC Ghana), with its mission being to improve the quality of life of low income and disadvantaged society. It was established in Ghana in 1971 and has trained thousands of least-educated and mostly deprived people and implemented developmental projects in all 10 regions of Ghana (www.oici.org/where-we-work/ghana). OIC Ghana has offered skills training to some of the people affected by HIV/AIDS in Manya Krobo area. The group has been able to undertake initiatives that cater and support Persons Living with HIV/AIDS (PLWHA) and OVC. In collaboration with the USAID, OIC Ghana is helping in the fight against HIV/ AIDS through various schemes and modules such as HIV counselling, Food for Peace Programmes, and scholarships for vocational training for orphans and venerable children (OVC's). The OIC operates HIV/AIDS Orphans and Vulnerable Children and PLHIV Care, Support and Economic Enhancement Programme (HOPE) in four regions namely, Greater Accra Region, Ashanti, Eastern and Western. HOPE offers care and economic support to people living with HIV/AIDS (PLHIV) and provides orphans and other vulnerable children the opportunity to attend OICI Ghana's skills training programme. The primary objectives of OIC's health, nutrition and HIV/AIDS programmes are to reduce prevalence of malnutrition, reduce levels of morbidity, improve infant and young child feeding and care practices for women and children, prevent and manage diseases, including HIV/AIDS and promote sound nutrition and healthy lifestyles.

OIC undertook capacity building and training of 2000 PLWHA and OVC care and support providers through development of psychosocial counselling training manual, development of basic home-care guides, training of Queen Mothers in psychosocial counselling and home-based care, income generating activities and train OVC in

vocational skill, entrepreneurship and business development (www.givewell.org Ghana / OIC International).

Unitarian Universalist United Nations Office (UU-UNO) was founded in April 1962 by the Universalist Church of America and the American Unitarian Association to support the United Nations. It engages in the work of the UN to advance a peaceful, just, sustainable and pluralistic world community that promotes human rights. It website (www.uu-uno.org) says the UU-UNO's Every Child is Our Child (ECOC) Program started in 2005 and fosters the hopes and dreams of children who have suffered from the devastating consequences of HIV/AIDS. It operates in three communities in Manya Krobo area of Ghana namely; Yokwenor, Okwenya, and Asitey where there are a total of 106 OVC and 76 caregivers. The Manya Krobo area of Eastern Ghana was chosen for the ECOC Program because it has one of the highest concentrations of AIDS and children orphaned by AIDS in Africa and the successful leadership of the Queen Mothers Association. Working in partnership with a traditional community organization, the Queen Mothers Association, ECOC provides health care and opportunities to education for these AIDS-orphaned children. The ECOC Program resulted from meeting directly with the Manya Krobo Queen Mothers Association, learning about the community issues and having joint planning session to prioritize their requirements. School fees and health care were the highest priorities.

United Way Ghana (UWG) is a not-for-profit organisation that provides support through funding, expertise and professional knowledge to the needy. The organisation was established in November 2003 by a group of dedicated corporate and community leaders in Ghana. Information at its website (www.unitedwaygh.org) shows that United Way brings together businesses, labour, non-governmental organisations, institutions and associations where appropriate to develop capacity to build a caring community. UWG is a member of United Way Worldwide, a global network that shares links with more than 4,500 United Way and Community Chest Organisations in 47 countries and territories. UWG collaborates with corporate and charitable institutions to support the sustainable development of communities in the areas of health, education, and income generation. It has been successful in establishing a network of corporate institutions that

support community investment projects and provide a platform from which communities can mobilise resources, strengthen their foundations, and continue on the road to self-sufficiency. On February 14 2007 (Day of Caring), UWG in partnership with 50 employees and spouses of Newmont Ghana Gold Ltd, assisted in constructing the a phase of the Queen Mothers resource centre project

UWG works with communities in care of OVC, educational infrastructure development, health and sanitation promotion, enhancement of aged care facilities, care and support for the physically challenged. Its Scholarship programme provides scholarships for brilliant but needy children throughout Ghana. Currently, 110 pupils in Akropong, a town in the Eastern region of Ghana are benefitting from UWG projects. Some of these pupils are orphans and others too are the children of poor peasant farmers.

The United States Agency for International Development (USAID) plays a vital role in promoting U.S. national security and foreign policy by addressing poverty fuelled by lack of economic opportunity. Available information from its website (ghana.usaid.gov) shows the USAID headquarters in Washington, D.C. The website indicates its strength is its field offices around the world where the USAID works in close partnership with private voluntary organisations, indigenous organisations, universities, the private sector, international agencies, other governments, and other U.S. Government agencies USAID promotes peace and stability by fostering economic growth, protecting human health, providing emergency humanitarian assistance, and enhancing democracy in 100 developing countries including Ghana. The types of assistance USAID provides include technical assistance and capacity building, training and scholarships, food aid and disaster relief, infrastructure construction, small-enterprise loans, budget support, enterprise funds and credit guarantees. The USAID Programmes in Ghana include enhancing good governance and decentralisation; increasing private sector-led economic growth; improving the quality of and access to primary education; and improving the quality and coverage of family planning, maternal/child health, and control of HIV/AIDS. USAID assists the Ghana government, civil society organisations, and communities in promoting and establishing decentralisation across the targeted sectors. In partnership with other group like FHI and Ghana AIDS Commission, USAID has provided assistance to the HIV/AIDS response in Manya Krobo.

The Manya Krobo Queen Mothers Association (MKQMA) was formed in 1998 and consists of 371 Queen Mothers across the six divisions of the Manya Krobo Traditional Area in the Eastern Region of the Republic of Ghana. In partnership with Family Health International (FHI) and the Ghana AIDS Commission, have developed community-wide HIV/AIDS prevention and support programming initiatives. According to the Queen Mothers' OVC project manager, Manye Esther Nartekie, the female chiefs are responsible for the welfare of women and children under the communities they control. As part of their HIV/AIDS prevention and care programme, the Queen Mothers provide support and education to rural women, orphans and vulnerable children in the district of Manya Krobo. Currently, they oversee the welfare and education of AIDS orphans in the area. MKQMA places children with their own or local families, and provides basic shelter and food with the help of other respected private and public alliances. The MKQMA has been working to build the capacity of the Queens and other opinion leaders to provide relevant HIV/AIDS information and supporting behaviour change intervention activities, including materials development, community outreach programmes, condom promotion and sales for community HIV/AIDS prevention, care and support programme for women and people of Manya Krobo District – Upper and Lower Manya Krobo. Over 1,065 orphans and vulnerable children have been identified through the home visit programme. A Queen Mother cares between one and six orphans, providing them with shelter, food, clothing, health care and education. These children are growing in a stable environment, free from stigmatisation and discrimination, as they have been absorbed into the wider community instead of orphanage homes. This is due to integration of the children into their local communities, taking them out of isolated existence at orphanages. The MKQMA has also been able to conduct HIV sensitisation campaigns and establish income-generating activities to enhance the financial security of women in the area.

Other sponsors

Aside of these organisations mentioned by the respondents, there were other groups that had at one time or the other assisted the MKQMA with materials, in kind or in cash to care for the OVC. These are listed as follows. Ghana Education Service, Department

of Social Welfare of the Republic of Ghana, UN System Gender Programme, University of Calgary, University of Ghana and Research for the Improvement of Infant Nutrition (RIING). The rest are Rescue Mission Ghana, African Women Development Foundation and PLAN Ghana.

3.4.9 - Household relationships between OVC and others

Involvement of children in delivery of OVC services, planning processes, monitoring and evaluation systems, aiming to demonstrate the value of children's influence in decision making processes is imperative within the household. The caregiver's biological children's feelings towards the OVC were assessed using self-esteem indicators including family-relationships. On the general moods and feelings of the OVC in their foster care, nearly three out of five respondents (58.0%) mentioned that the OVC is very much happier. About a third of the caregivers (36.0%) thought the OVC is the same; sometimes happy but other times unhappy while fewer caregivers (6.0%) felt that the OVC was unhappy. The main causes of these conflicts according to respondents in Table 3.14 were ranked as ownership of household items (12.0%), ownership of clothes (8.0%), house work and jealousy (6.0%) apiece.

Table 3.14 – Common causes of conflicts in the household

Common causes of conflicts	frequency	(%)
House work	3	6.0
Jealousy	3	6.0
Wanting attention	1	2.0
Ownership of clothes	4	8.0
Ownership of household items	6	12.0
Other	4	8.0
Not applicable	16	32.0
No response	13	26.0
Total	**50**	**100.0**

Source: Field Survey data, March - May 2011.

Relationships within the household were accessed by examining the reaction and attitude of the caregiver's biological children to the OVC. When asked if there are conflicts between the OVC and own children, almost two-third (68.0%) of caregivers

said no while just under a third of respondents (32.0%) admitted the existence of conflict.

3.4.10 - Psychosocial and emotional conditions

The psychological effects of orphanhood are many and include the impact of psychosocial distress on children and families such as anxiety, loss of parental love and nurturance, depression, grief and separation of siblings among relatives to spread the economic burden of their care. It is a biological fact that human children do not grow up as solitary individuals; parenting constitutes an all-encompassing ecology of a child's development. Mothers and fathers, as well as siblings, other family members, and even children's non-familial contacts guide their development by many means. Individual growth and human development depend on experience as either the principal source of or as a major contributing component. Such experiences provide the basis of a number of emotional feelings and reactions that affect OVC.

Psychosocial support is a set of interventions used to meet a person’s emotional, social, mental and spiritual needs. It is very important for the healthy development of all children and especially critical for OVC. An empowering psychosocial support interventions use a dynamic and participatory approach that help community partners especially caregivers to build competencies in identifying, addressing and managing the emotional needs of vulnerable children.

To evaluate the psychosocial and emotional state of and support for the OVC, a series of questions were posed to the caregivers. Regarding how often the OVC cries during the course of normal day, over half of the caregivers (52.0%) answered sometimes, a third (32.0%) said never but just a respondent (2.0%) indicated that the OVC cries often. About how often the OVC feels unhappy, two out of five caregivers (42.0%) mentioned never, sometimes (40.0%) and never (2.0%). With respect to OVC refusing or resisting to go to school, half of the caregivers (50.0%) said sometimes, a quarter (24.0%) mentioned never, nearly one out of five (18.0%) indicated on rare occasion but just a handful (4.0%) said often or gave no response. And a little over half of the caregivers (52.0%) indicated that the OVC never refuses to eat meals, go to bed, feel like running away or ever ran away. Almost two out of three (38.0%) mentioned sometimes while a tenth said either on rare occasion (6.0%) or often (4.0%).

3.4.11 - Caregivers view on health challenges of OVC

The OVC population is a group that is particularly vulnerable and has a number of unmet health needs as a result of their precarious situation. They may miss out on provision for primary care in vaccinations, untreated common infectious and non-communicable diseases, delayed development or malnutrition. In order to assess the health conditions of the OVC, caregivers were asked a series of questions on issues relating to health. Responses by respondents to a question with respect to whether the OVC has suffered any ill health condition in the past six months prior to the survey brought out interesting patterns. According to information shown in Table 3.15, the greatest health challenge facing many of OVC was malaria attack as a third (32.0%) of the caregivers mentioned that disease followed by diarrhoea (16.0%) and bed-wetting/thumb sucking (14.0%). Only couple of caregivers (4.0%) said the OVC had no ill health with don't know (2.0%) while no response represented (6.0%).

From in-depth interviews and focus group discussions, it might appear that caregivers' health spending was much bigger than revealed by the survey data. What could have accounted for this deficiency in the data collection was the fact that question asked for health spending relating to only the preceding thirty days to the interview. Secondly, it is certain that almost (98% from Table 3.16) all the OVC and at least 10% of caregivers (Table 3.4) may be covered by National Health insurance scheme (NHIS) free of charge. The NHIS system did not involve out-of-pocket payments at point of service. There are three main categories of health insurance in Ghana. The first and most popular category is the district mutual health insurance scheme, which is operational in every district in Ghana including Upper and Lower Manya Krobo Districts.

The second category of health insurance comprises the private commercial health insurance schemes operated by companies. The last category is the private mutual health insurance scheme where any group of people comes together and raises a fund to cater for their health needs. The district mutual health insurance scheme which is public and non-commercial is the one operating in Manya Krobo area. Anyone resident in Manya Krobo is required to register with this scheme. Apart from the premium paid by members required to do so, this scheme receives regular funding from central government. This central government funding is drawn from the national health

insurance fund. Every Ghanaian worker pays two-and-a-half percent of their social security contributions into this fund and a two-and-a-half percentage component of the Value Added Tax rate in Ghana also goes into the fund.

Table 3.15 – OVC health challenges

OVC Sickness in the last six months	frequency	(%)
Malaria	16	32.0
Diarrhoea	8	16.0
Fear of the opposite sex	1	2.0
Lying	2	4.0
Pregnancy/Sexually Transmitted Infections	1	2.0
Bed-wetting & thumb sucking	7	14.0
Stealing	4	8.0
Other	5	10.0
No ill-health	2	4.0
Don't know	1	2.0
No response	3	6.0
Total	**50**	**100.0**

Spending on health care	frequency	(%)
Off-the-counter drugs	18	36.0
Prescription drugs	6	12.0
Payment for National Health Insurance Scheme	11	22.0
Herbal drugs	2	4.0
Don't know	8	16.0
No response	5	10.0
Total	**50**	**100.0**

Source: Field Survey data, March - May 2011.

To sign up for this scheme, the caregiver if is required, is the only who pays premium while all children in their care below the age of 18 years are registered upon payment of a processing fee of GH¢4.00 (€1.75). Membership and payments of premiums are renewable annually. Certain categories of people are however exempt from payment of premiums. These groups are children below the age of 18, elderly people 72 years and above as well as indigents. The indigents are defined as people considered being too poor, without a job and lacking the basic necessities of life to be able to afford insurance premiums.

Similarly, in Ghana antiretroviral therapy for people living with HIV and AIDS is free of charge at selected public health centres. Beneficiaries or patients are however expected to pay a small processing fee for the services. All the drugs are free. Thus if there were any OVC infected with HIV/AIDS, (which I suspect is the case as I chanced on the burial of a ten-year old AIDS OVC boy in April 2011) they are entitled to free treatment. I could not however ascertain how many of the OVC are positive living because the Queen Mothers do not allow disclosure of OVC HIV status for fear of stigmatisation and discrimination. Manye Esther Kpabitey Nartekie, deputy paramount Queen Mother and MKQMA OVC programme manager explained that OVC have already gone through enough pain from loss of parents and considering their age and emotional state, it does not make sense to add to that suffering by disclosing OVC HIV status. With this attitude, she effectively censored all enquiries relating to ascertaining OVC HIV status.

Subscribers to NHIS all of the country have for some time been lamenting about the quality of services and treatment meted out during attendance at accredited health facilities. Indeed the Ghanaian media landscape has been inundated with claims and counter–claims of the gloomy nature of the implementation and the sustainability of NHIS. The signs of troubles in the implementation of the scheme appeared as endless reports of shortage of essential drugs at some hospitals. There were also reports of indebtedness of the scheme to the Tamale Teaching Hospital to the tune of about GH¢1,700,000.00 (€790,697.67) and the Upper East Region of about GH¢2,800,000.00 (€1,302,325.58). One such concrete evidence came to the fore in September 2011 when notices were posted at the University of Ghana Hospital announcing the suspension of services to NHIS clients (Figure 3.3). This suspension notice points to the fact that the scheme is facing serious challenges. It is however necessary to state that on October 3, 2011, the National Health Insurance Authority (NHIA) sought to downplay seriousness of the report. The NHIA clarified suspension as due to what it termed charging ‘unapproved top up consultation fees’. If anything, this state actually succeeded in giving credence to perception that all is not going with NHIS implementation and questioned its future. It supported claims of payments of extra fees by client patients.

Figure 3.3 – Signs of trouble ahead for Ghana's health insurance scheme

Source: The New Crusading Guide newspaper, 2011 (accessed 12/02/2012).

The Ghana Medical Association (GMA), the umbrella body of medical practitioners in Ghana, in the third quarter of 2011 warned of the imminent collapse of the scheme if adequate steps were not taken to secure its future. The GMA claimed health institutions have overdrawn their credit facilities and some are no longer in the position to procure drugs. A claim the NHIS vehemently downplays but has always assured NHIS ID card holders that the scheme was on course.

The scheme is the most crucial intervention as far as health care financing is concerned in Ghana but it may soon collapse if urgent steps are not taken to resolve the teething challenges it faces. This scheme should collapse; the health situation of the OVC could become very precarious as there is no other healthcare provision system available. Considering, the income earning abilities of caregivers as captured in Table 3. 8 on sources of income and Table 3.12 on caregiver needs, it will be extremely difficult if not impossible to give the OVC any safeguards.

3.4.12 - Challenges of OVC education for caregivers

Education has been regarded in all societies and throughout human history both as an end in itself and as a means for the individual and society to grow. It is not only the key to sustainable development but also a fundamental human right (World Education Forum, 2000). In contemporary society, the cost of raising a child is blown up the roof top by education. Perhaps besides food, there is no other constant cost on the child upbringing as that constituted by education. Every other cost can be considered as either periodical or contingency. Fees represent a significant proportion of household

spending, although this proportion varies widely from country to country. It is universally the case that the proportion is highest for the poorest households. Too little is known about the determinants of enrolment and learning, but fees are certainly obstacles in many, but not all, cases (World Bank, 2004). The responses from the caregivers on status of the OVC schooling show that almost all OVC (94.0%) in their care are currently in school while every respondent (100.0%) mentioned that the OVC in their care had ever been in school. For those OVC currently in school, a ratio of 4:1 (82.9% and 17.1%) exists between those attending government owned schools and private schools. Their grades range from Kindergarten 2 (KG2) through primary (P1-P6) and Junior High School (JHS 1 – JHS 3) to Senior High School (SHS 1 – SHS 3). Nearly half (54.5%) of the OVC currently in school as indicated by the caregivers are in elementary school (KG and primary) while a quarter (25.0%) are in basic school or JHS (see Table 3.19 for detailed profiling and analysis). In 2004, Ghana adopted a school fees abolition policy, and introduced the capitation grant to spur the attainment of universal access to basic education goal in line with MDG2 targets 2 and 3. Subsequently in 2005/2006 academic year, the Ministry of Education in Ghana set up a capitation grant scheme where every registered public primary school in Ghana received an amount of €3.63 (GH¢3.00) per pupil enrolled per year. The Ministry of Finance transfers the amount to the Ghana Education Service directly and they in turn transfer to the district directorates and finally to the schools. Pupils do not individually apply for the amount. The amounts are allocated to all public basic schools based on their enrolment (Centre for Democratic Development Ghana, [CDD-Ghana] 2010). The policy is to support the implementation of the school performance improvement plan. It is intended to be spent on the day-to-day running costs of the school, for example, cleaning, lighting, and maintenance of school. Primary aims of the grant were to replace revenue lost to schools because of the abolition of fees and to improve the quality of education by making real resources available at the school level (CDD-Ghana, 2010). Nonetheless, caregivers still bear incidental costs on education. The cost components include school fee (private schools), Parents-Teacher Association (PTA) fee, uniforms, books, pencils/pens and other supplies. Respondents mentioned that amounts paid on these incidental costs range from anything between €5.35 and €116.28 (GH¢11.50 to GH¢250.00), a mean of €26.45 (GH¢56.86). According to the government of Ghana

budget statement for 2012 presented in November 2011, an amount of GH¢15.3 million (€7,116,279.07) was released during the 2011 fiscal year. This was payment of Capitation Grant for 5,252,683 pupils in all public basic schools for the second and third terms of the 2010/2011 academic year (see Figure 3.4).

Figure 3.4 – Capitation grant for 2nd and 3rd terms of 2010/2011 academic year

Source: Ghana Business News website, 2011 (accessed 12/02/2012).

A simply analyses of this information shows that an amount of GH¢1.46 (€0.68) was spent on each pupil per term. Therefore for the three terms that make up the 2010/2011 academic year, the capitation grant per pupil was GH¢4.37 (€2.03). The implication is that even those caregivers, who paid the least extra levies, had borne nearly 60.0% more while those on the high side contributed about 6,151.0% more than the capitation grant. Considering that six in ten of the OVC (60%) are in primary school (Table 3.19) and ten percent of caregivers are over 70 years (Table 3.4) while only 12% of caregivers have formal regular and secure sources of income (Table 3.7), cost of education appears to be very challenging for foster families.

This confirms the findings of CDD-Ghana (2010) which tracked possible leakages and inefficiencies in the disbursement and usage of the capitation grant in thirty public basic schools in Ghana that only a small proportion of people concluded that the capitation grants had significantly reduced the financial burden of parents. Indeed the study also found that nearly half of parent teacher association and school management committee executives indicated that in spite of the capitation grants, parents still pay some levies. And majority of parents admitted paying levies ranging from GH¢0.10 [US$0.15] to

GH¢60.00 [US$90] for school text and exercise books, examination and printing fees. In general, majority of the stakeholders believe the capitation grant per pupil is inadequate. There is clearly a cause for concern or apprehension about the sustainability of capitation grant as the amount paid has reduced from €3.63 in 2005 to only €2.03 by 2011. This represents nearly a drop by half of €1.60 (44.1%). It is important to note however that the actual capitation grant per pupil in Cedis terms has increased from GH¢3.00 in 2005 to GH¢4.37 in 2011 (GH¢1.37) representing almost a third percentage wise (31.5%). There are two reasons responsible for this state of affairs. In the intervening six year period, the national currency, the Cedis, has experienced serious instability. In spite of redenomination on July 1, 2007 with four zeros knocked off, it is still unable to hold its own. It has depreciated by more than 70% of its value since inception of the capitation programme. This obviously leads straight to a concomitant inflation which tends to eat away the value of the Ghana Cedis and its purchasing power. The inevitable outcome the school running cost deficit gap is pushed on guardians by school authorities using whatever justification deemed reasonable.

The Commission on Human Rights and Administrative Justice (CHRAJ) in December 2011 recommended an increment in the capitation grant to GH¢7.00 (€3.26) in ensuing academic year. This followed an investigation conducted by CHRAJ which revealed that despite government's provision of the capitation grant about 60% of schools monitored continue to charge fees to support their operations due to the inadequacy of the grant and late release of funds. The Commission noted that delays in release of the grant are seriously undermining the efficacy of the government's Free Compulsory Universal Basic Education policy (FCUBE). As a result, CHRAJ expressed concern that a large number of schools especially basic schools in rural communities lack adequate teaching and learning materials hence a good number of Ghanaian children were being out of school. The current trend of development with the capitation grant is disturbing and immediate steps should be taken to correct the administration of the policy in such a manner that will ensure all Ghanaian children benefit from high quality basic education.

The repercussions of this disturbing development can be felt particularly on retention rate in future. At least three scenarios can be simulated. Foremost is that government will not be probably able to sustain the demand for more resources to support the capitation grant programme hence will offload the burden on to parents (caregivers) as

the current cohort of students move up the educational ladder. This assertion comes from the fact that the policy is encouraging more enrolments at the elementary phase of education without corresponding investment in higher education to absorb the rate of increment. Educational resources like teachers and physical infrastructure either remain the same (may even deteriorate from wear and tear) or will not be able to improve at the rate of progression of student cohorts. This situation effectively cropped up in 2010/2011 academic year at the senior high school level when dining halls had to be converted into dormitories in order to accommodate overflowing number of pupils progressing from junior high schools. In the ensuing academic year, 2011/2012, prospectus of students admitted to SHS included building materials. For instance, on October 2, 2011, Kapital Radio station based in Kumasi reported that parents whose wards were given prospectus by St. Louis Senior High School in Kumasi were asked to buy Azar Shield Grey Emulsion Paint or pay GH¢80.00 (€37.21) besides paying GH¢300.00 (€139.53) as cement fees to construct new buildings for the school before their wards were admitted to the school.

Secondly, the whole capitation grant policy may collapse being overstretched beyond available and competing national resources. Finally, parents (caregivers) may be forced to take uneasy decisions concerning the education of their wards. Parents' and communities' attitudes, which are often based on traditional cultural beliefs regarding the ideal gender roles and characteristics, affect their perception of girls' academic abilities and this in turn influences the level of support they provide for girls' participation in education if they have to choose between male and female for support. Many families do not understand the benefits of educating girls, whose role is often narrowly viewed as being prepared for marriage, motherhood and domestic responsibilities (UNICEF, 2007). Regrettably, this act view may reinforce the vicious cycle of the risk of falling into poverty, weakened economic power leads to less empowerment and high risk of contracting HIV infection through transactional sex, early marriage or from a spouse with multiple partners. Educated women are more likely to know how to prevent HIV infection, to delay sexual activity and to take measures to protect themselves. Education also accelerates behaviour change among young men, making them more receptive to prevention messages. Universal primary education is not a substitute for expanded HIV/AIDS treatment and prevention, but it is a necessary component that complements

these efforts (UNICEF, 2007). The USAID (2007), a U.S. agency that specialises in monitoring and evaluating educational quality improvement programme (EQUIP) has advised that government should not be encouraged simply to drop school fees before securing adequate sources of public funding to replace them.

3.4.13 - Forms of support and kind of needs of caregivers

There is no doubt that caregiving can take a heavy toll if the provider doesn't get adequate support. This toll comes from many sources which may involve many stressors like changes in the family dynamic, household disruption, financial pressure, and the sheer amount of work involved. The rewards of caregiving are intangible and far off, and often there is no hope for a happy outcome. As the stress piles up, frustration and despair take hold and burnout becomes a very real danger. Even though the Manya Krobo Queen Mothers Association operates the OVC safety net project, it does not command the financial muscle and other resources needed to provide the requisite help to the caregivers. Support of all forms is one way to relieve a caregiver's troubles. As a result, external help is highly desirable and imperative to sustain the momentum and willingness of the caregivers to continue their charity work. When asked if the past six months they had received any kinds of services or assistances, three quarters (76.0%) of caregivers mentioned that they had received no support. Only one out of five (20%) of respondents said they received some kind of assistance. According to the caregivers, a third of those who got help (35.7%) received it in the form of financial assistance, followed by clothing (21.4%), support for children's education (14.3%) and training/education (14.3%). The least form of help received was in the form of psychological as emotional (7.1%) and support or counselling (7.1%) was indicated by respondents.

3.5 - Demographic characteristics of orphans and vulnerable children

This portion presents data on the demographic characteristics of the OVC respondents. It covers five broad areas. These are household economic status, relationships in household, children's education experience, psycho-social issues and background characteristics or personal information. All these are contained in the caregivers questionnaire covering 54 questions in all attached as appendix 2 (OVC child survey

questionnaire). This part also discusses education, OVC status, emotional conditions, type of nutrition fed with and health status among others.

The OVC problem refers to the construction of a society in which social relations systematically ignores or devalues the needs of underprivileged children especially AIDS orphans thereby leading to their economic, political, social, and cultural marginalization. This implies that it is within the structures and organisation of society rather than in the OVC that we are to find the answers to questions about their unequal status. In other words, the living conditions of the OVC or the distress within the structures and organisation of society rather than in the OVC themselves that we find the answers to questions about OVC's unequal status. In spite of the recognition of the youth as a valuable resource for the advancement of the Ghanaian society, a large number of them are affected by such factors as poverty, social exclusion and economic marginalization. The details of the background information of the OVC will hopefully shed greater insight into the society and its structures regarding the less fortunate ones.

There were 100 OVC selected randomly from all over the Manya Krobo Queen Mothers Association OVC safety net project for interview. There were almost equal in terms of sex comprising 51 (51.0%) male respondents and 49 (49.0%) female respondents. Though the selection on the respondents was random, the almost equal representation of males and females cannot only be good but also a reflection of the fact that both sexes have been equally exposed to the vulnerabilities prevailing in the study area. Hopefully their collective responses in this study will offer deeper insight into their conditions of living. Although an 'orphan' is defined by the United Nations as a child below 18 years who has 'lost one or both parents', this study operates with the age limit of 24 years or below (refer to 1.6 for operational definition). According to Table 3.16, both ends of the group (0-4 and 20-24) have least representation of 2 (2.0%), age groups 5-9 and 15-19 years represent a quarter each of respondents 26 (26.0%) and 25 (25.0%) while the majority of respondents 45 (45.0%) are found within the age group 10-14 years. This age representation seems fairly consistent across countries as surveys suggest that overall about 15% of orphans are 0-4 years old, 35% are 5-9 years old, and 50% are 10-14 years old. An analysis of national surveys from 40 sub-Saharan African countries including Ghana, Senegal, Nigeria, Zambia, Rwanda, Zimbabwe, Lesotho, Botswana, Swaziland, Cameroon and South Africa showed that overall,

approximately 50% are 10-14 years old (Monasch and Boerma, 2004). This growing cohort of vulnerable children will have an all-pervasive effect on society.

Table 3.16 - Ages of children in foster care

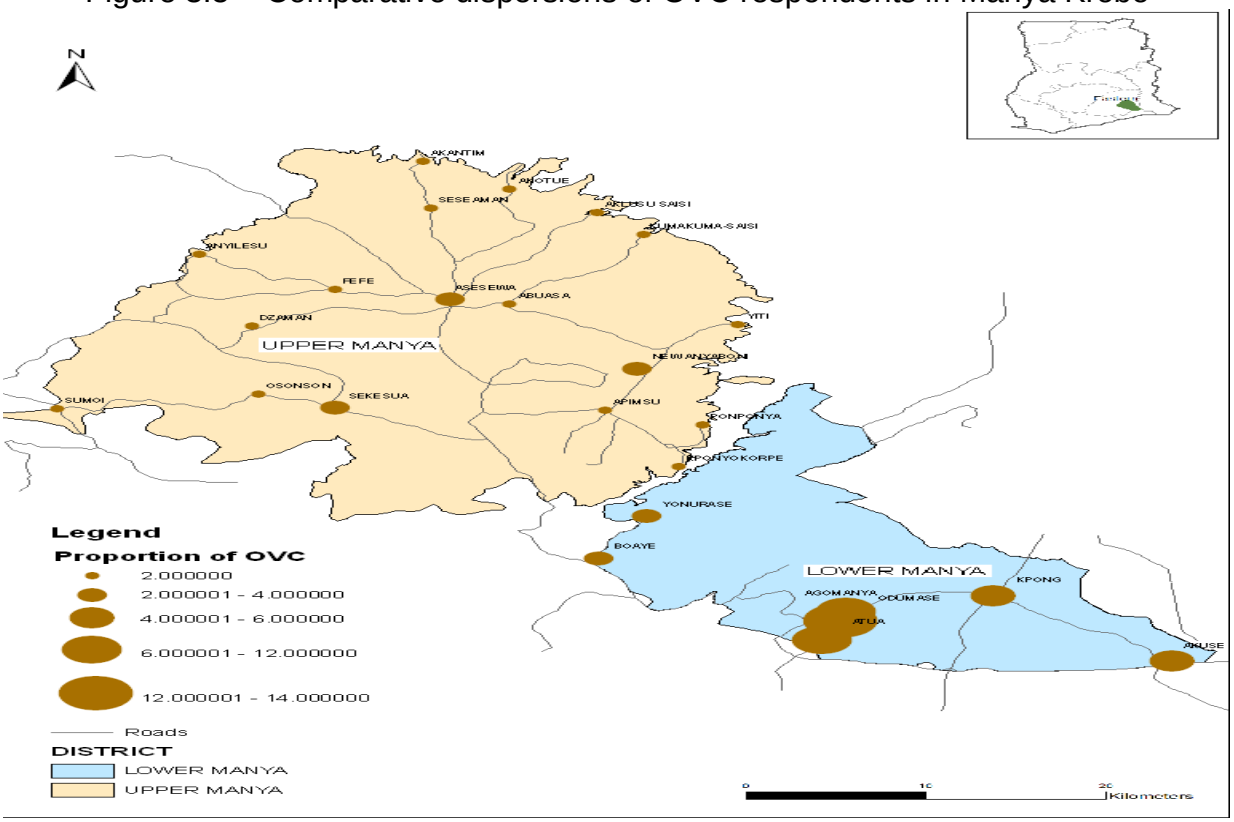
OVC age group	frequency	(%)
0-4	2	2.0
5-9	26	26.0
10-14	45	45.0
15-19	25	25.0
20-24	2	2.0
Total	**100**	**100.0**

Source: Field Survey data, March - May 2011.

Regarding spatial representation, Figure 3.5 shows that 7 towns selected in Lower Manya Krobo had 58 respondents. This is because this part of Manya is more urbanised and heavy absorption of OVC population. Following the trial run, a background research was conducted on the various communities taking into consideration language and fosters families across Manya Krobo. This exercised involved reviewing existing descriptions, documentation and talking to people to get a sense of the community, the field conditions and builds connections with contacts. The communities selected from Lower Manya were less due to higher density of OVC and therefore the intention was to place more weight on the number respondents selected for the study.

Figure 3.5 contains details of towns and number of OVC respondents selected in Upper Manya Krobo. There were 18 towns chosen from this district in view of the fact that is scattered. The area is largely farming settlements and concentration of OVC population is equally dispersed. The reason for this dispersion is the due to the desire of the Manya Krobo Queen Mothers Association to ensure that as much as practicable, OVC remain within close proximity of their biological relations.

Figure 3.5 – Comparative dispersions of OVC respondents in Manya Krobo



Source: Field Survey data, March - May 2011.

3.5.1 - Status of OVC

The concept OVC generally refers to groups of children more exposed to risks than their peers and are most likely to fall through the cracks of regular programmes or experience negative outcomes. Such outcomes relate to morbidity, malnutrition and loss of education at higher rates than peers. For this reason, it is necessary to determine which components of the respondents really have lost their parents either due to HIV/AIDS or all causes. From Table 3.17, more than half of the respondents (53.0%) mentioned that their mother is dead with a little under half (47.0) indicating that they are vulnerable children. However, nearly two-third of respondents (64.0%) said the father is not alive while a third (36.0%) was vulnerable children. This means overall three out of five children interviewed (58.5%) were true orphans with at least one parent having expired while the remainder two out of five respondents (41.5%) were vulnerable children due largely to economic and social conditions. Caregivers said 20.0% of OVC have lost both parents.

Table 3.17 – Real status of children in foster care

Mother Alive	frequency	(%)
No	53	53.0
Yes	47	47.0
Total	**100**	**100.0**

Father Alive	frequency	(%)
No	64	64.0
Yes	36	36.0
Total	**100**	**100.0**

Both parents deceased (Caregive	10	20.00%

Source: Field Survey data, March - May 2011.

3.5.2 - OVC relationship with caregivers

AIDS orphans may also miss out on valuable life-skills and practical knowledge that would have been passed on to them by their parents. Caregivers and their families need to create culturally sensitive guidance systems and provide the resources needed for the proper growth and development of OVC to contribute to their personal well-being as well as respective societies and/or communities. No one needs love, care and attention than young children more so those without anyone to defend their interests as OVC. What OVC needs is mentoring which is a powerful personal development and empowerment tool. Thus there is therefore the need to deliberately inculcate mentoring in OVC development programmes. The facilitation role of the *Manye* or the Queen Mother in helping the OVC to obtain exposure to leadership and decision making situations, as well as transit smoothly into adulthood is imperative. Notably, the Queen Mothers who are recognised as leaders in the community provide a mentoring framework by serving as role models worthy of emulation by the OVC. Through their community visits, the Queen Mothers create the appropriate platforms and opportunities for interaction with children as role models in society. By so doing, the young ones are being helped to build the needed self-confidence to maximize their potentials for their future development. Table 3.18 confirms the assertion that blood relations are caring for OVC. Nearly half (51.0%) are grandparents to the OVC, close to a quarter (22.0%) are biological parents, followed by uncle/auntie (12.0%), brother or sister (7.0%) and cousin (5.0%). Only a few respondents (2.0%) were neighbours.

Table 3.18 – OVC relationship to caregiver

OVC relationship with caregiver	frequency	(%)
Parent	22	22.0
Brother/sister	7	7.0
Grandparent	51	51.0
Uncle/Auntie	12	12.0
Cousin	5	5.0
Neighbour	2	2.0
Don't know	1	1.0
Total	**100**	**100.0**

Source: Field Survey data, March - May 2011.

About the composition of the household, the number of other children aged 24 years and below living with OVC, responses show there are between one to ten children. A quarter of the respondents (25.0%) mentioned two and three other children. With respect to the length of time OVC has stayed with caretaker, the responses indicated from birth to 18 years. More than half of respondents (54.0%) have been living with foster family since birth. The inference is that some of the OVC did not come to live with foster family upon the demise of a parent but was already part of it. It is common in parts of Ghana especially rural areas for parents to let a child go and live with a relation mostly for schooling as well as help lonely grandparents. Overall, just a sixth of OVC (16.0%) reported that they earn income for household. Over eight in ten of OVC (84.0%) said they do not earn any income for the household.

3.5.3 – OVC education

Without parental knowledge and a basic school education, children may be more likely to face social, economic and health problems as they grow up. Children orphaned by AIDS may miss out on school enrolment, have their schooling interrupted or perform poorly in school as a result of their situation. Expenses such as school fees and school uniforms present barriers to school attendance if orphans' caregivers struggle to afford these costs. Regarding schooling status in Table 3.19, three out of five OVC respondents (60.0%) said they were in primary school, followed by Junior High School (JHS – 15.0%), Senior High School (SHS – 10.0%) and pre-school (9.0%). Only a few (6.0%) indicated that they were not in school. There also seems to be an attempt at ensuring that all OVC programmes are gender sensitive and that all gender-related

discriminatory practices are discouraged. The cardinal point to take note of here is a semblance of mainstream gender development approach and interventions in the allocation of resources for the education of the OVC. This is inferred from the provision of equitable conditions for both the male and female. The MDG calls for the elimination of gender disparity in primary and secondary education in all levels of education. The most important factor here is to ensure that children everywhere, boys and girls alike, will be able to complete a full course of primary schooling.

Table 3.19 – Level of OVC Schooling

AGE	NO EDUCATION	KG/ NURSERY	PRIMARY	JHS	SHS	NUMBER	MEDIAN YEARS COMPLETED
1-5	0.3	0.45	3	0.75	0.5	**5**	1.00
6-9	1.38	2.07	13.8	3.45	2.3	**23**	4.60
10-14	2.76	4.14	27.6	6.9	4.6	**46**	9.20
15-19	1.44	2.16	14.4	3.6	2.4	**24**	4.80
20+	0.12	0.18	1.2	0.3	0.2	**2**	0.40
% of Total	**6.00**	**9.00**	**60.00**	**15.00**	**10.00**	**100**	**0.00**

urrent grad	Not in school	Percent	Government school	Percent	Private School	Percent	Number
None	6	6.00	0	0.00	0	0.00	**6**
KG 1 - 2	0	0.00	7	7.00	2	2.00	**9**
Primary 1 -	0	0.00	25	25.00	6	6.00	**31**
Primary 4 -	0	0.00	27	27.00	2	2.00	**29**
JHS 1	0	0.00	6	6.00	0	0.00	**6**
JHS 2	0	0.00	4	4.00	0	0.00	**4**
JHS 3	0	0.00	5	5.00	0	0.00	**5**
SHS 1	0	0.00	4	4.00	0	0.00	**4**
SHS 2	0	0.00	1	1.00	0	0.00	**1**
SHS 3	0	0.00	4	4.00	0	0.00	**4**
Above SHS	0	0.00	1	1.00	0	0.00	**1**
% of Total	**6**	**6.00**	**84**	**84.00**	**10**	**10.00**	**100**

Source: Field Survey data, March - May 2011.

3.5.4 - OVC ethnic background

Demographically, Ghana consists of numerous ethnic groups, including multiple spoken languages. As said in previous chapter, there are four major ethnic groups in the country: *Akan*, *Mole-Dagbani*, *Ewe* and Ga-*Adangbe* of which the *Akan* are the most numerous. *Akan* is by far the most widely spoken language by some 75% of Ghanaians (Ghana Statistical Service, 2011) partly because six out of the ten regions are Akan and Akan is a defacto official language after English. Manya Krobo though ethnically belongs to the Ga-Adangbe group, is geographically situated in *Akan* area of Eastern region. This ethnic diversity reflected in the ethnic make of the OVC respondents. When respondents were asked about their ethnic group, Table 3.20 shows that majority

(86.0%) mentioned *Krobo*, followed by *Ga-Adangbe* (7.0%), then *Akan* (4.0%) and *Ewe* (3.0%).

Table 3.20 – OVC Ethnicity

Ethnic group	frequency	(%)
Krobo	86	86.0
Ga-Adangbe	7	7.0
Akan	4	4.0
Ewe	3	3.0
Total	**100**	**100.0**

Source: Field Survey data, March - May 2011.

Ghana has a reputation for being an openly and proudly spiritual country composed of dominant Christian beliefs alongside Muslim and indigenous beliefs. When asked about their religious affiliations, almost universally (98.0%) answered that they were Christians with only one respondent (1.0%) indicating islam and no response. This is not unexpected as the area is the first place where European Presbyterian missionaries began their evangelical work in Ghana. Presumably, many of the respondents have 'borrowed faith' inherited from their families. On the question of marital status, nine out of ten OVC (89.0%) said single but no response constituted a tenth (11.0%).

3.5.5 – Nutrition for OVC

Good nutrition is fundamental to growth and cognitive development; to produce energy for the body to stay warm, move, and work; to resist and fight infections; and to support reproduction and nourish new life. The science of nutrition is complex. Our understanding of the range and importance of nutrients and the chemical processes involved in their utilization is always advancing, leading to revised policies and new interventions. Good nutrition requires access to food on a regular basis and consumption of adequate quantity and quality of nutrients each day. It further requires prevention or treatment of the many nutrition-related threats caused by unhealthy environments and infectious disease. Eating is a social activity and often a care-giving activity, especially for children and those who are sick or have special needs such as pregnant women. Time, knowledge, and skills are important factors in nutrition. Food is steeped in social and cultural tradition, influencing how ingredients are acquired and prepared, as well as who consumes what and when. Food and status are closely

connected. Gender issues permeate almost every aspect of nutrition. Efforts to improve the nutritional status of a population inevitably confront questions of resources and equity. Poor nutrition is both a consequence and a cause of poverty. For this reason, programme efforts often distinguish between short- and long-route strategies for change; according to how deep the targeted determinants lie within the structure of a given society. Effective programmes are based on the epidemiology of priority nutrition problems as well as their institutional, social, and behavioural contexts. Food security within a family and the larger community is an underlying requirement for good nutrition. Access to food is just one component of food security. Others include availability and stability of food supply (via local production, imports, or aid). Proper utilization and consumption of food are components of both food security and adequate nutrition (World Bank, 2006; Bhutta el al.; 2008; Black et al., 2008).

Adequate nutrition is critical to child development. Nutrition is important for optimal growth, health, and development. Malnutrition results in reduced productivity, an increased susceptibility to infections, slow recovery from illness, and heightened risks of adverse outcomes. According to the 2008 GDHS findings, 28 percent of Ghanaian children are stunted with Eastern region where the study is conducted having the highest prevalence of 38.0% (see Figure 2.9). It revealed that stunting levels are markedly higher for rural children (32.0%) than for urban children (21.0%) and slightly higher for boys than girls (Ghana Statistical Service, Ghana Health Service and ICF Macro, 2009).

Body size plays a critical role in mammalian ecology and physiology. Research has shown that changes in mammal body size are negatively correlated with shifts in temperature and possibly high atmospheric Carbon dioxide concentrations, thus the body size decreases as temperature increases (Secord, et al., 2012). There is evidence today that temperatures and mammal size are linked essentially that mammals of smaller size live in warmer environments and mammals of larger size live in cooler environments (Bergmann, 1847). It has been observed that human populations who live near the poles are on average heavier than populations from mid-latitudes (Holliday and Hilton, 2009). This postulation might offer partial insight into the relatively smaller physique or body mass index of people especially children in warmer countries as Ghana compared to children of same age in Western Europe such as Portugal. This

rule, however, describes a tendency of body mass variation within groups; it *does not* suggest that large-bodied animals do not occur in warm climates. Thus there are a lot of factors involved as evidenced by the fact that right now, human beings are getting bigger and that is generally due to better nutrition. Humans could also adapt to rising temperatures by spending more time in air conditioned spaces (Secord, et al., 2012).

There is paucity of studies addressing differentials of sex with respect to health inequality in the early childhood period, sex differences in anthropometry with females having an advantage over males. Wamani et al. (2007) identified three theories that have been propounded to explain this situation. Firstly, attribution of sex differences centres on behavioural patterns. Svedberg (1990) proposed a historical pattern of preferential treatment of females in sub-Saharan Africa due to the high value placed on women's agricultural labour. Second is a biological hypothesis. Aside from the specific sex-chromosome factors, more vulnerability has been suggested (Green, 1992). The last is evolutionary selective male mortality theory which counters an excess of males at conception for any given degree of environmental stress in the first 4 years of life (Wells, 2000). It would seem that forces of nature and nurture conspire against the proper nourishment of boys causing to them suffer from stunted growth more than girls. How exactly this happens still remains clear except it is rampant in deprived areas than economically affluent countries. It is probably the case that poverty aggravates a natural health inequality of boys.

Thus it was necessary that the study collected information from respondents to evaluate the nutritional status of the young children. To access the level of nutrition the OVC get, they were asked to tell the number of meals they had on the day preceding the interview. In Table 3.21, nearly every two out of three OVC interviewed (63.0%) took three meals while a third of the OVC interviewed (35.0%) had two meals on the day. Only insignificant number of respondents (1.0%) indicated that they either had four or more meals and no meal at all respectively. While it is true that the number of meals given offers an insight into consumption levels by the OVC, it might not give a complete picture of the nutritional values.

Box 3.1 Food security

- Follow up on the OVC who indicated she had no meal on the day before the survey, brought to the fore the issue of food security for foster families and OVC.
- She is 12 years and lives with her elderly grandmother with three other children. Two boys and two girls; one boy is older than her. All are in primary school.
- The caregiver travelled a day earlier, left enough food for the day and promised to return same day. Unfortunately, she could come and they could not find food on the following.
- This illustrates that many foster families of OVC are having food one at a time. Food security is a situation in which people do not live in hunger or fear of starvation. It refers to affordable, nutritious, and culturally appropriate food for all people at all times. Food security means to not have to worry about where the family's next meal is coming from, whatever that meal might be and for whatever reason. Clearly there is a problem of food security which might manifest itself in other health-related conditions such as lack of balanced diet, lack of functional food and ultimately malnutrition and disease.

Ghanaian cuisine is heavy with starch, light on meat and generous on fat. A healthy diet requires both appropriate quantity and quality of nutrients. The body needs to burn sufficient "fuel" every day to support basic functions. The energy or amount of calories needed varies according to a person's age, weight, sex, and level of physical activity or energy expended.

These needs increase during periods of rapid growth and when a person is fighting infections. To try and get a better appreciation of the depth of nutrition, the respondents were required to mention all the meals taken the previous day.

Table 3.21 – Number of meals per day for the OVC

Number of meals	frequency	(%)
Just one meal whole day	1	1.0
Two meals for the day	34	34.0
Three Meals	63	63.0
Four or more meals	1	1.0
No meal	1	1.0
Total	**100**	**100.0**

Source: Field Survey data, March - May 2011.

From Table 3.22, the main types of food the OVC stated are largely carbohydrates and starches. Nearly a third of the respondents (30.9%) indicated eating *banku* including some eating it twice on the same day, followed by rice (17.9%), *fufu* (12.3%), *ampesi* and porridge/oats (11.7% respectively) among others. Poor families tend to have monotonous diets consisting mainly of whatever starchy foods are easily available and cheap (CSHGP, 2007). Carbohydrates generally provide the body with most of the daily energy needed both for normal body functions such as heartbeat, breathing and

digestion and for physical activity and exercise. High-carbohydrate foods are the best and sometimes only sources of many essential nutrients like fiber, vitamins C and E, the majority of B vitamins, carotenoids and other beneficial phytochemicals, potassium and a variety of trace minerals. When measured at the household level, dietary diversity reflects a family's access to food. Household dietary diversity is therefore a key indicator of food security. It affects the nutritional status of individual family members (Swindale and Bilinsky, 2006). *Banku* is a food made with cooked corn and cassava dough. *Banku* also called *Akple* in some parts of Ghana is prepared from fermented corn/cassava dough mixed proportionally and cooked in hot water into a smooth whitish consistent paste. It is served with soup, stew or a pepper sauce with fish. The dietary implication is that because this food abounds in starch, the energy content can be quite high when eaten in excessive quantities.

Table 3.22 – Types of meals consumed by OVC

Type of meal	Eaten once/day	Eaten twice/day	Total	(%)
Banku	43	7	50	30.9
Ampesi	18	1	19	11.7
Konkonte	3	0	3	1.9
Gari	9	0	9	5.6
Rice	28	1	29	17.9
Fufu	19	1	20	12.3
Kenkey	9	2	11	6.8
Porridge/Oats	19	0	19	11.7
Tea/Bread	2	0	2	1.2

Source: Field Survey data, March - May 2011.

Ampesi is the general name given to dishes like boiled yam, boiled plantain, boiled cocoyam and other tubers. They are frequently eaten with vegetable stews but they can also be eaten with soups particularly oily soups like palm soup and groundnut soup. Since yam, plantain and cocoyam are starches that provide plenty of energy, eating them in large quantities beyond the body's energy requirements may lead to unnecessary weight gain hence moderation is needed. Frying makes these carbohydrates staples even more calorie-dense and it is imperative that consumption is limited to a few times a week particularly.

Kokonte is made by milling cassava which has been sun-dried (to eliminate moisture) into a fine powder. This powder is then mixed with adequate water and cooked amidst

constant stirring (to prevent lump formation) to obtain the desired consistency. Figure 3.6 displays some of the common Ghanaian dishes the OVC mentioned.

Kokonte can be enjoyed with most Ghanaian soups but the preferred one is groundnut soup. It has even higher starch content than the cassava from which it came. The nature of its starch is worthy of note as it is readily broken down into simple sugars in the digestive tract and may as a result cause sudden spikes in blood sugar levels. *Gari* also known as tapioca is peeled cassava tubers grated, fermented, sifted and roasted by heating. For a full meal, *gari* is usually cooked by adding to hot water and kneaded into dough. This is usually eaten with different types of stew or soup with vegetables added (tomato/pepper soups with vegetables like okro, thick, leafy vegetable stews and peanut stews).

Figure 3.6 – Types of meals mentioned by OVC

Source: Compiled from Google images (accessed 15/10/2011).

In Ghana, rice is predominantly eaten as plain rice (boiled raw rice with salted water), *waakye* (rice and beans), fried rice also called *check check* (prepared by "frying" pre-boiled plain rice in oil and "tonnes" of artificial flavour enhancers with a scanty amount of chopped vegetables added), *jollof* (rice and variety of vegetables and spices cooked together with lean beef or chicken) and rice balls (mashed rolls of cooked rice served with groundnut or light soup).

Fufu as we have it in Ghana is commonly prepared by pounding boiled plantain and cassava together (in a mortar with a pestle) to obtain the desired texture. *Fufu* can also be made by pounding either boiled yam or boiled cocoyam. *Kenkey (Ga* and *Fante)* is

Ghanaian staple made from predominantly whole grain corn/maize dough. The good thing nutritionally from this food is that, the corn/maize is not dehusked (the outer coat is not removed), so the body obtains fibre as well as a wealth of other micronutrients.

3.5.6 - OVC health and knowledge of HIV/AIDS

Health is the foundations for the achievement of potentials. There is no gainsaying that a person's optimum state of health is equivalent to the state of the set of conditions which fulfil or enable a person to work to fulfil his or her realistic chosen and biological potentials. Some of these conditions are of highest importance for all people. Others are variable dependent upon individual abilities and circumstances. Despite the increase in life expectancy, epidemiologists have found that not all groups have the same opportunities to achieve good health. There are population patterns which make it possible to predict the likelihood that people from different groups will die prematurely (Seedhouse, 1986; Naidoo and Wills, 2009). There are a number of health definitions depending on the purpose. The current study takes the view that health is defined as something more other than being just ill or diseased but as a subjective variable. There are ways of measuring health as a subjective factor including health as a vacuum (not being ill), health as a reserve (of strength and resilience) and health as equilibrium (balance and well-being). There are five dimensions of subjective health namely functional ability, health status, psychological well-being, social networks and social support, and life satisfaction and morale.

Most OVC are more exposed to health risks than other poor children, and commonly face some typical obstacles to participation even in health programmes meant for the poor due to vulnerability. As a result of their living conditions and relocation or transfers, OVC may miss out on health participation in well-child activities such as immunizations, growth monitoring among others. The OVC were asked to indicate the health and behaviour challenges (Table 3.23). A number of surveys have revealed that OVC may have worse health than non-orphans due to a variety of factors.

Table 3.23 – Health and behaviour challenges of OVC

Health and Behaviour	frequency	(%)
Never sick	18	18.0
Malaria	42	42.0
Diarrhoea	10	10.0
Fear of the opposite sex	1	1.0
Lying	3	3.0
Bed-wetting & thumb sucking	2	2.0
Stealing	1	1.0
Other....	20	20.0
Don't Know	1	1.0
No Response	2	2.0
Total	**100**	**100.0**

Source: Field Survey data, March - May 2011.

These factors include interconnected biological, economic, and caregiving reasons, ranging from their own HIV infection; being cared for by destitute and/or sickly caregivers; facing stigma or neglect in foster care and lost or inadequate access to public services (Ainsworth and Filmer, 2002; Heymann et al., 2007; Case et al., 2004). One out of five OVC respondents interviewed (18.0%) said they had no challenges during the period in question. Sanitation related conditions or induced-diseases; malaria and diarrhoea contributed over half (42.0% and 10.0%, respectively) to all health problems reported by the OVC respondents. Responses to emotional and psychosocial behaviour challenges such as lying, bed-wetting/thumb sucking, fear of the opposite sex and stealing elicited the least outcome altogether contributing less than a tenth (7.0%). It is difficult to tell if this reflects the real scale of the situation or the OVC felt shy to disclose honestly. It could be concealed in the usually large percentage of 'other' responses (20.0%) by the OVC. Although scientific and medical advances allow more people to live with HIV/AIDS conditions, there still are many people contracting HIV, and numbers are beginning to outpace resources. There is a perceptible decline of urgency in imbibing HIV/AIDS prevention steps because fewer people perceive the disease as a personal threat even among caregivers and OVC. As a result, OVC respondents were asked about their knowledge and awareness of HIV/AIDS. Four questions were thus posed in a proxy form. When asked if the OVC has heard of Ghana AIDS Commission (GAC), three quarter of respondents (76.0%) answered in the negative. Just one out of ten OVC respondents surveyed (9.0%) could mention at least one organisation involved in HIV/AIDS activities. GAC is the national body responsible for coordinating and overseeing all HIV/AIDS related activities in Ghana.

BOX 3.2 - Funeral rites of a positive living OVC

- As morbid as it sounds it is inevitable that life ends in death. For a person living with HIV, conceivably it just a matter of time. The ways in which people deal with death and the funeral rites they carry out are usually very closely linked with their beliefs about life after death. Among the Krobo people, funeral rites are very important for two reasons: they show respect for the dead, and give the relatives and friends time to mourn and show their grief in a certain way. Showing their grief formally helps them to get over their loss The Krobo people largely follow the Presbyterian faith but perform various traditional rituals they believe are necessary to ensure that the dead goes on to whatever their next life will be. Krobo people are known for their funeral celebrations and processions. The Krobo believe that when someone dies, they move to another life. Therefore, special coffins are often crafted by highly skilled carpenters. Many families spend excessive amounts on coffins because they often feel that they have to pay their last respects to the deceased and being buried in a coffin of cultural, symbolic as well expensive taste is seen as fitting.
- In the course of the data collection, I came across the funeral rites of a 10-year old boy. He was living with HIV/AIDS. He presumably contracted the disease through mother-to-child transmission. He had been put on antiretroviral therapy for a couple of years till he gave up the ghost in April of 2011. He was one of the OVC sponsored under the UU-UNO project.
- On the morning of his passing, the MKQMA Programme manager informed the paramount chief Queen Mother. The UU-UNO Every Child Is Our Child administrator was invited and a decision was reached to bury the boy. A simple unpolished casket was prepared by a local carpenter. In less than two hours, the ritual had been completed. There was no funeral after burial. There no were mourners as is usually the case for such event. There was no priest to offer prayers and the coffin was not taken to a church or chapel either before burial.
- When asked why the funeral rites were truncated for this 10-year old OVC, the MKQMA Programme manager, Manye Esther Kpabitey Nartekie, explained that as leaders who are trying very hard to end expensive funerals, this was an opportunity to demonstrate modesty in saying a final goodbye to the little.
- While her explanation is true, it is also true that his HIV status, OVC status and possible drain on MKQMA funds account for the simple rite. Perhaps other OVC are HIV positive and is a way not to dampen their spirit by letting them see the end of this 10-year old OVC. This also shows how the health and life of an OVC can be very precarious.

Further, a ratio of one to five (17.0%) have been told or knew the cause of death of their parents. Most importantly, a quarter of OVC surveyed (25.0%) admitted that their caregiver or guardian has talked to them about the death of their parents. The goal of these questions was to find out OVC level of awareness and identify gaps to aid in redesigning interventions to improve OVC knowledge about preventive health care. Further, it is to assist OVC avoid practices that expose them to or make them vulnerable to the vicious cycle of infections including sexually transmitted infections (STIs) such as HIV. It was therefore considered a good proxy to assess the level of OVC awareness of the HIV/AIDS problem.

3.5.7 - OVC participation and socialisation activities

On how happy the OVC are compared to other children, responses in Table 3.24 show that two in five OVC respondents (41.0%) said happy, happier, a third of them (34.0%) indicated the same, sometimes happy, sometimes not while only a fraction of respondents (6.0%) mentioned that they felt very unhappy, sad.

Sports and recreation enhance one's physical well-being, and self-esteem, while contributing to socio-economic development in the form of improved health. Arts, games and folklores depict the life of a people. It is an important vehicle for appreciating and understanding the heritage of the people. It represents a sense of identity, self-respect, and the medium through which generations learn and transfer progressive skills, techniques of social relations, and survival.

Table 3.24 – Psychosocial behaviour challenges of OVC

OVC happiness	**frequency**	**(%)**
Very unhappy, sad	6	6.0
Somewhat unhappy, less happy	9	9.0
The same, sometimes happy, sometimes not	34	34.0
Happy, happier	41	41.0
Don't Know	4	4.0
No Response	6	6.0
Total	**100**	**100.0**

OVC fun activity	**frequency**	**(%)**
Nothing	1	1.0
Football, other sports (Physical)	58	58.0
Dolls (Non-physical games)	12	12.0
Being with friends (Talking)	3	3.0
Being with Family	1	1.0
Eating (Food)	1	1.0
Dance, music (Drama)	9	9.0
Having, getting new clothes	3	3.0
Reading	7	7.0
Crafts, weaving (art)	1	1.0
No Response	4	4.0
Total	**100**	**100.0**

OVC feeling unhappy or sad	**frequency**	**(%)**
Never	26	26.0
On rare occasions	20	20.0
Sometimes	46	46.0
Often	7	7.0
No Response	1	1.0
Total	**100**	**100.0**

Source: Field Survey data, March - May 2011.

The promotion of young children's participation in socialization activities helps build their self-confidence, integration and cohesion among their peers and general interactions. Many of the traditional socialization structures involve the transfer of cultural values and the creation of cultural awareness among young children as a social, political, and economic development strategy. A number of questions were consequently asked to assess their mood in various situations and activities. Regarding what OVC do for fun, overwhelming majority of the respondents (58.0%) stated engaging in physical activity such as football and only one percent indicated engaging in no activity. A significant number of the respondents (14.0%) declared their involvement in programmes that demanded teamwork as drama, talking with family and friends. When asked how often the OVC feels unhappy or sad, a quarter of the respondents (26.0%) indicated never, almost half of the OVC respondents (46.0%) stated sometimes while a few (7.0%) indicated that they often feel unhappy or sad.

3.5.8 - OVC adjustment

Psychosocial well-being of children in Table 3.25 is essential to ensuring their healthy growth and development, and the ability to achieve their full potential.

Adolescents generally and particularly OVC tend to have their own cultural construct, and may manifest differently in different contexts. For OVC in difficult circumstances, the capacity to assess, recognize and mobilize social support from different quarters may be critical to their achieving a reasonable quality of life. OVC psychosocial adjustment makes them vulnerable to various forms of abuse, exploitation, harassment, and neglect. To measure psychosocial vulnerability and resilience of OVC, some questions were put to the respondents.

In Table 3.25, one out five OVC (41.0%) stated experiencing some form of difficulty due to either the illness or death of the parents. However, a third of the respondents (34.0%) indicated no change in living conditions. When asked what is difficult living with another family, over half (55.0%) indicated lack of money or food. It looks like adjustment was not a serious challenge for the OVC as only a few (7.0%) mentioned they either have too much pressure or less time to rest. On refusal or resisting going to school and or act disobediently, majority (69.0%) stated never.

Table 3.25 – Adjustment challenges

Effects of parents' condition	frequency	(%)
N/A	15	15.0
My school attendance has declined/stopped	11	11.0
My grades	4	4.0
I do more housework or field work	15	15.0
I have to take care of smaller children	5	5.0
I have to take care of a living parent	1	1.0
I get less food/money from the family	5	5.0
It has not effected my life circumstances	19	19.0
Other	1	1.0
Don't Know	11	11.0
No Response	13	13.0
Total	**100**	**100.0**

Difficulty in living with another family	frequency	(%)
It gets hard financially	34	34.0
There is less food to go around	21	21.0
Some children can't go to school	2	2.0
I have no time to rest	1	1.0
Too much pressure	6	6.0
Other	1	1.0
Don't Know	10	10.0
No Response	16	16.0
Not applicable	9	9.0
Total	**100**	**100.0**

Resisting/refusing to go to school/act disobedien	frequency	(%)
Never	69	69.0
On rare occasions	11	11.0
Sometimes	11	11.0
Often	4	4.0
Don't Know	1	1.0
No Response	4	4.0
Total	**100**	**100.0**

Source: Field Survey data, March - May 2011.

As regarding how often OVC cries during the course of a normal day (not shown in table), the responses were mixed as half of the respondents (50.0%) stated either sometimes or often while almost the same figure (47.0%) mentioned either never or on rare occasions.

3.6 - Shelter and housing conditions

Humans need a certain amount of warmth and a safe spot to survive. Shelter is one of the most crucial survival human needs. For young people and children especially OVC housing is even most important that they live in a place where their welfare and proper development was seen as a key setting that could encourage the OVC to adopt

lifestyles conducive to wellbeing. Shelter helps disconnected youth including OVC to make better life connections that will assist their successful transition to adulthood. OVC needs opportunities to get housing that helps them to socialise in positive ways, to be involved with their communities, to develop basic life skills and to learn about and connect to their culture. Shelter permits OVC to individualised case management, independent living skills programming, and opportunities for OVC to connect and re-connect with their cultural identity, such as drumming, dancing and interaction with elders. In order to evaluate the living conditions of the OVC in foster care, a number of questions were put to both the caregiver and OVC respondents (Table 3.26).

Table 3.26 – OVC shelter and housing conditions

OVC knowledge of shelter ownership	**Frequency**	**%**
Rented building	11	11.0
Own building	45	45.0
Dont know	26	26.0
No Response	18	18.0
Total	**100**	**100.0**

OVC knowledge of caregiver's other properties	**Frequency**	**%**
Owe no other property	30	30.0
Yes, own other property	24	24.0
Dont Know	26	26.0
No Response	20	20.0
Total	**100**	**100.0**

Caregiver ownership of house	**Frequency**	**%**
Rent	8	16
Own	42	84
Total	**50**	**100**

No. of previous homes OVC has stayed	**Frequency**	**%**
1	37	74
2	11	22
3	2	4
Total	**50**	**100**

Reasons for OVC relocation	**Frequency**	**%**
has been living with OVC since infancy	28	56
death of mother	8	16
death of parents	10	20
Father mental	2	4
no one to care for	2	4
Total	**50**	**100**

Source: Field Survey data, March - May 2011.

Nearly half of the OVC respondents (45.0%) indicated that the house they live in belonged to the caregiver while one tenth (11.0%) said they stay in a rented place. About 30.0% of OVC said caregiver had no other properties while 24.0% said yes. Almost one in four OVC (44.0%) said they either did not know or gave no response regarding the ownership of their place of abode. However over four out of five caregivers (84.0%) affirmed ownership of property with just 16.0% living in a rented apartment. About three quarters (74.0%) had relocated once while 22.0% and 4.0% respectively had moved twice and thrice respectively since bringing in OVC. With respect to reasons for taking in or relocation of OVC, one in five (20.0%) said due to deaths of parents, death of mother 16.0%, father's mental instability and no one to care for OVC 4.0% each while over half (56.0%) said they had stayed with OVC since infancy.

Compared with Table 3.20 (OVC ethnicity) and Table 3.18 (OVC relationship to caregiver) gives the impression that many of the OVC are fostered in the immediate community they hail from. This is very important as this can promote assimilation and adjustment for the OVC. Normally, mental state and physical development of young people such as OVC could be seriously affected by change of living environment. Living within a close proximity and largely same ethnic group influences the OVC belief and value systems. From a developmental standpoint it is important to note the impact of developmental issues on the youngsters and their attitudes. The responses of the young people about how they feel about their parents or about themselves at a major life transition, during in-depth interviews and focus group discussions need to be understood within a developmental context. The outcome of the responses showed that undoubtedly entering a foster home and separating from living with biological family was a stressful time. Some indicated that it is difficult to separate from their parents and familiar surroundings. Trying to form and initiate new relationships could be a shock. But these stresses are not ones likely to lead to lasting health problems due to the nature of the foster arrangement. It is imperative to note here that as part of modern way of life leaving home and moving from one developmental phase to another which these young people are engaged in doing is a must for instance to study.

Assessing the OVC responses brought out an important factor that needs consideration. This is about the knowledge of the circumstances and the details of the relationship with

deceased parents in order to pass judgment. Furthermore it is likely that foster parents or caregivers who were related would get along more easily as OVC stay in the same neighbourhood where they resided prior to the demise of the parents. Perhaps there was less internal motivation or external pressure to remake their lives.

3.7 - Conclusion

Admittedly, this study is cross-sectional in nature and covered only Manya Krobo Traditional Area, which is considered a limitation. Ideally, a study of this nature should preferably been longitudinal covering a wide geographic space with larger sample frame and size but we did not had the time to do it. Nonetheless, the survey methodology helped assessed the scope and magnitude of the OVC problem, areas of greatest need, proportion of study population affected, existing supports or safety nets, most critical needs and unmet needs.

Youth form a large proportion of the global population. They represent a valuable asset and an important potential resource for Ghana where they constitute the majority of the population. They are usually endowed with a sense of innovation, creativity and dynamism and are the entrepreneurs of tomorrow and can potentially overcome the today's challenges. They possess the drive and capacity to modernise and innovate where right conditions are created. Regrettably, AIDS orphans and vulnerable children suffer from unacceptable levels of a deficit of decent opportunities their peers take for granted. Thus a scientific study seeking to explore cooperatives of OVC empowerment needed to follow systematic procedure as outlined taking into account particularly ethical considerations. This chapter described various data collection methods and the related tools for analysing the well-being of OVC. We were sensitive to issues of being reliable and replicable giving confidence that information generated can support use for future programming purposes. Overall, the survey methodology helped to bring out the plight and the pressing need for concerted approach to improve the standard of living of OVC.

OVC caregivers profile shows that they are not very much a diverse group but with variety of experiences. All the caregivers are heavily involved in providing care including psychosocial support, shelter, nutrition, health care, education and catering for all OVC

needs. Most part of the family and OVC resource needs are internally generated by the caregivers themselves with very little and if any, unreliable external support. A large proportion of caregivers carry a heavy burden which appears to take a toll on them by increasing their own vulnerability to financial hardships, physical strain and emotional stress. The brunt of HIV/AIDS on adult mortality together with the impact of poverty has resulted in a significantly higher percentage of children who are orphans or vulnerable in Manya Krobo area than in other areas of Ghana. The MKQMA has identified 1,065 children as orphans and vulnerable. OVC are equally likely to be male as female. The average age amongst this group of orphans was 12.2 years. Nearly half of the orphans (51.0%) were living with a grandparent, around one quarter each (22.0%) with a single parent and (24.0%) with other relatives, most commonly aunts or uncles. The deaths of parents followed by economic hardship on parents and lack of responsible person to take care of a child were the common reasons that influenced guardians to take in OVC. The work of caring for OVC has been feminised in Manya Krobo as large proportion of the caregivers are women largely blood relations. This situation is not unexpected given that AIDS is claiming the lives of many people. As the full ripples of HIV/AIDS epidemic continues to unfold, it will likely result in increasing numbers of OVC and less number of caregivers as the current crop will give way due to old age and care fatigue. The fraction of OVC care needs may increase while the availability of community members willing to fill in the care giving role may decrease. There is therefore the urgent need for immediate implementation of the OVC national action plan to help support or expand services to assist both themselves and their OVC beneficiaries. An encouraging development to note is that a large number of families are now taking care of children and that community leaders are giving moral, and to a less extent material, support to OVC. Although this special community initiative addresses cultural and gender norms specific to the Krobo people, it is not largely aligned with national policies. This may have its own merits but considering that the external support especially those consisting of materials or in kind are dole-outs, the future outlook of the project is perilous. This development ought to sway intervention agencies to channel resources towards strengthening the family unit and the community, as a means of providing safety nets for the vulnerable child while maintaining the generation nexus.

CHAPTER FOUR

INSTITUTIONAL ARRANGEMENTS, FRAGILITY AND ADAPTIVE STRATEGIES OF MANYA KROBO QUEEN MOTHERS OVC SAFETY NET PROJECT

4.1 - Introduction

Care is central to OVC existence. It is also a key factor in reducing poverty, improving livelihoods, and promoting economic growth. And yet, statistics on OVC without adequate access to proper and regular care is increasing thus making efforts at tackling the problem an uphill task. Every human endeavour thrives on a vision but vision without action is a day dream while action without vision is a nightmare. Informal practices of caring is better conceptualised as a series of precarious achievements mediated by culture, training, discussion, institutional structure, procedures and the strength of the voices of the receipt of care (Parr, 2003). Integrating children previously dwelling in a separate household into an entirely new one is a whole challenge. Understanding the MKQMA OVC operational features and governance arrangements helps to put in the right perspective questions regarding accountability and performance relevant to the needs and circumstances of the OVC in Manya Krobo area. The type of institutional arrangement allows for examination of the extent to which MKQMA services qualitatively differ from similar types elsewhere and the ways in which patron-caregiver dynamics influence OVC's access to services. Further, it helps to gain valuable insight into the informal institutional arrangements that govern MKQMA OVC operations through which stakeholders are held accountable and the impact on the performance of services.

As patron-caregiver dynamics regrettably often indicate overburdened households due to higher dependency ratios, there is always tendency for the safety net project to be very fragile to a myriad of challenges. Consequently, OVC are more likely to live in households experiencing food insecurity, decreased emotional and psychological wellbeing, miss out on educational opportunities and dramatic life changes (UNICEF, 2006). These patron-caregiver dynamics impinge on the well-being and sustainability of the OVC project. Overcoming challenge imperatives implies innovations and success depends on the interplay of a particular practice or crosscutting idea on basis of OVC

numbers, local culture, socio-economic conditions and other factors seen as reflecting level of flexibility. This chapter reviews these basic determinants underpinning the institutional arrangements, challenges and coping strategies. It explores the pragmatic role of traditional women leaders in a contemporary and fast changing Manya Krobo including what happens when ancient beliefs and practices of the Queen Mother institution and the twenty-first realities collide.

4.2 - Features and governance characteristics of the Manya Krobo Queen Mothers OVC Project

The failure of the state to adequately address the poverty of the majority in the rural areas and the rapidly swelling ranks of the working poor in the informal sectors is a major challenge to efforts at reducing poverty, vulnerability, unemployment and underemployment (Mkandawire, 2006; African Union, 2010). Social protection remains a huge public policy challenge across Ghana although it is an imperative for inclusive development as it is crucial for successful prevention of social exclusion and offers measures that strengthen household or individual coping capacity (UNECA, 2009).

The examination of the features and governance characteristics of the MKQMA OVC Project helps to identify gaps and opportunities potentially relevant to understanding of institutional capacity, coordination, transparency and accountability mechanisms. These characteristics help to spot both systemic strengths and weaknesses which are the backbone to achieving objectives of the MKQMA model. Spotting these factors makes for remedial actions to stay the cause of the safety net project. To get a better grasp of the interplay of the patron-caregiver dynamics requires an acquaintance with the prevailing legal and regulatory frameworks governing child care and protection practices in Ghana.

4.3 - An overview of child care and protection practice in Ghana

Childcare refers to the behaviours and practices of caregivers (i.e. mothers, fathers, siblings and childcare providers) to provide the food, healthcare, stimulation, and emotional support necessary for healthy survival, growth, and development of children (Engle, Lhotska, and Armstrong, 1997). These practices bear a direct relation between income per capita and child nutritional status as they translate food security and

healthcare resources into a child's well being (Engle, 1999). Affection and responsive behaviours alongside proximal factors like the social environment and status of women primarily tend to produce powerful effects on normal emotional, cognitive and physical development due to their unique and enduring bond.

The use of time tested norms and traditions consolidated into authorised regime to form childcare practices is desirable as it achieves improved outcomes. It fosters connections, collaboration and the coordination of activities because every society fashions out regimes based on a series of processes reflecting peculiar societal needs and objectives. Incorporating inputs from interested and proactive individuals and groups help to reform, enrich and consolidate gains.

The authorised regime explains how children who are at risk or being abused together with vulnerable families should be cared for and helped. It usually provides the procedure detailing what happens when a report is made or a child can't safely live with their family. It outlines the responsibilities of parents, authorised caregivers, community and other agencies. Additionally it shows ways of working with children and families to help them to remain safely at home to reduce the need for them to enter care. It promotes working with children and families in flexible, responsive and innovative ways to meet their needs by treating child care as a responsibility shared by families, agencies and communities working in partnership. In order to assess and make valid judgement on the quality of care practices prevailing within the Manya Krobo OVC safety net programme, necessarily calls for revision of the existing legal and regulatory framework.

A wide range of options exist for the care of orphans and vulnerable children (OVC). The most common types of orphan care include:

- A statutory residential care facility, serving primarily HIV infected children;
- A statutory adoption and foster care programme, where a welfare society owns homes and appoints community mothers to care for a group of children (preferably no more than six);
- An unregistered residential care setting, which houses HIV+ and destitute mothers with their children and offers continued care for the children when the mothers are ill or die;

- Home-based care and support, where caregivers are identified and children are legally placed in foster care, and assistance is given through foster care grants;
- Community-based support structures, where grandparents or other close relatives care for their orphaned grandchildren, with no government support;
- Informal fostering or non-statutory, where women in the community volunteer to care for orphans in a group home setting, with no government support.

From the foregoing, it is obvious that the Manya Krobo Queen Mothers' project is a mixture of the last two types of options for OVC care having non-statutory community-based foster care support structures. Community queens and grandparents or other close relatives volunteer to care for orphans with no government support.

Traditionally, the family in Ghana is the main provider of child care and parenting is on trial and error basis but generally authoritarian parenting style is widely practiced. Caring capacities measured by child welfare indicators as stunting, wasting, malnourishment and delinquency vary from family to family, one area to another and time. For instance available evidence GDHS 2008 indicates that the Eastern region ranks least in terms of stunting and wasting (Ghana Statistical Service, Ghana Health Service and ICF Macro, 2009). As a result, the role of the extended family and the community is very critical to the wellbeing of the child. Often referred to as kinship care or relative care, grandparents and other relatives provide children the benefit of more stability of care when they cannot live with their biological parents. Traditionally, Ghanaians place their children in kinship care for varied reasons such as to provide assistance to an aging parent or relative or for educational purposes. The benefits of the kinship care are enormous. It provides love and care in a familial setting necessary to foster trust, assurance of sustaining family connections continuing lifelong family traditions and memories. It further builds cultural identity, positive self-esteem, healthy relationships within the family, and creates a sense of safety, well-being, and stability in the life of a child.

Unfortunately the caring capacities of families are weakening and the structure of kinship care is altering. The alternate arrangement of grandparents or more distant relatives replacing usually aunts and uncles as a result of weakening of the extended family and increasing orphan numbers. The weakening is due to the severe saturation of the caring and absorptive capacities thus challenging socio-economic foundations of

the community (Foster and Williamson, 2000). Other contemporary social situations as HIV/AIDS, abandonment of traditional lifestyles, migration, modernisation, urbanisation, rising middle class and emerging class of career women are contributory factors producing new domestic care groups. In most urbanised homes, for instance, where the demands of employment grossly affect the time spent at home by the career woman, domestic workers popularly known as 'House helps', 'maids', or 'domestics' have come to permeate the family households. The situation however becomes more complex when the parents get infected with HIV and eventually die from AIDS-related conditions thereby placing undue burden on kinship care. The question then is how do surviving relatives respond to the pressing needs of their orphans? How is Ghana addressing this and several pertinent questions related to the family institution in an era of societal transformation and rapid globalisation?

Whether by accident or design, young people in Ghana have not been helped to channel their energies productively but instead taken for granted over course of history. There has not been any systematic policy to ensure continuum of transfer of knowledge between generations. Such generational gaps are evident in three distinctive periods of the country's history. In pre-colonial times, they were sold and shipped off as slaves in the infamous transatlantic trade, then in colonial era as hewers of wood and drawers of water, and as instrument for acquiring political power in post independence Ghana. This runs contrary to expectation that young people speak up against patronage and participate in the developmental process by taking control of their destiny to making change from the bottom up. In order to streamline childcare practices and further the interests of the child, a number of forces have been at work.

A formal child protective system has been developing in Ghana since 1992. A combination of forces, including Ghana's democratic process, UN Convention on the Rights of the Child, UN Committee on the Rights of the Child Ghana Report of 1997, and the African Charter on the Rights and Welfare of the Child of 1997 prompted the development of this system, which has culminated in the enactment of the Children's Act 1998. The Act is a comprehensive law for children, which consolidated and revised existing law and filled in gaps. It sets out the rights of the child, parental duties, maintenance, adoption, care, protection, and regulates child labour and apprenticeship. The formal system for representation of the child comprises various institutions,

including family tribunal courts, the Ministry of Women and Children's Affairs, Child Panel, Department of Social Welfare, foster care system, SOS villages, children's homes and orphanages and specialised probation officers and social workers. Sources like the Constitution, statutes, case law, court and ethical rules informed the role of counsel in the representation of the child in the law court and advocacy on behalf of the child.

Section 5 specifically emphasises the right of the child to grow up with parents unless harm, serious abuse or not in the child's best interest. For the avoidance of doubt, Section 18 of the Act outlined 14 orphanhood situations that may put a child in need of care and protection. It subsequently gives power to the Social Services Sub-committee of the District Assemblies take prescribed remedial actions that best serve the welfare of the child.

Some of the prescribed activities include home visits by Social Welfare as well as to investigate reports of abuse or endangerment and in matters concerning parentage, custody, access and maintenance of children. When Social Welfare receives a report and it is determined that the child is not in immediate danger, the matter is referred to a Child Panel, a non-judicial board charged with mediating matters concerning children. However, if the investigation shows abuse or immediate need of care and protection, the Act authorizes the removal to a place of safety. When removed, the child must be brought before a Family Tribunal within seven days. The Family Tribunal can then make a care order to determine the placement of the child or a supervision order setting out the terms under which a child may remain in the custody of his parent(s), guardian(s), or relative(s).

Of much interest to the study is the adoption condition that 'any person above the age of twenty-one years of high moral character and proven integrity may be a foster-parent to a child'. The Act goes further to define a foster parent as 'a person who is not the parent of a child but is willing to undertake the care and maintenance of the child'. It determines three circumstances in which foster-care placement may arise. Firstly, committal to an approved residential home under a care order, then a probation or social welfare officer recommending that an approved residential home is the most suitable place for a child or a child has been placed in an approved residential home by any person.

The Act is variably applied seeing that the Ghana OVC plan of action indicated that anecdotally there are few children who have gone through the legal processes with regard to admission into the non government homes. The use of formal foster care by non-relatives is minimal as for instance only 13 foster care orders were made in 2004 but 255 permanent care or adoption cases were handled in 2006 (Ministry of Employment & Social Welfare and UNICEF, 2010). The third condition applies to the OVC in Manya Krobo where many of the children were placed in the care of close relatives or responsible people in the community. Such a foster-parent in whose care a child is placed or committed shall have the same responsibilities in respect of the child's maintenance as the parent of the child while the child remains in his or her care. Similarly, a foster-parent is liable for contravention of any of child welfare provisions.

Ghana developed a National Policy Guidelines on OVC in 2005 informed by the outcome of situation analysis of OVC carried out in 20 districts between 2002 and 2003. Over time, Ghana increasingly saw social protection as an overarching framework, in which social transfers are accompanied by an integrated range of support services and policies that focus on family support, child protection, alternative care and livelihoods promotion, which will in turn enhance social equity for the most vulnerable. Thus the National Social Protection Strategy (NSPS) was designed titled 'Investing in People' in 2007 and implemented through the Livelihoods Empowerment against Poverty (LEAP) programme.

However, there was neither an up-to-date national situation analysis of children nor any national plan of action for children from which a plan for the most vulnerable children can be developed. Consequently, the National Youth Policy was finally launched in 2010 for OVC which tries to develop and integrate international definitions for OVC within a framework of rights. Thus it condenses hitherto the many uncoordinated existing child welfare documents into a framework covering the period 2010-2012. The goal is towards an empowered youth to impact positively on national development. At the heart of this OVC Action plan is the view that preventative social protection measures like cash transfers, improved access to education and health will keep parents alive and support families to stay together and look after their children. This should reduce the number of children, becoming orphaned or homeless, needing protection and counter the cycle of poverty and violence. However the protective

services will still need to be in place for those children who fall through the safety nets. Alongside social and child protection is the need for transformative policies and upgraded systems that improve the capacity of government, in particular Department of Social Welfare to deliver quality services. It considers the youth as a valuable resource that must be harnessed for national development. This comprehensive document enables the Government to engage the youth and other stakeholders in meaningful partnership to develop appropriate interventions and services for youth empowerment and development. It is intended to provide guidelines for all stakeholders involved in the implementation of policies, programmes and projects for the development of the youth. It is also intended to help the country demonstrate its commitment to all international conventions and charters it has signed relating to the youth.

While child welfare policies and documents appear modern and consistent with Ghana's obligations under national and international conventions, under-resourced district assemblies fail to live up to expectation. The role of the assemblies in child welfare are hampered in two ways; insufficient resources and qualified persons to conduct the expected assignments. In particular raising the capacity of Social Welfare is critical to improving social protection and child protection.

4.4 - Benefactor generation, roles, activities and programmes management

In *Manya Krobo*, networks of non-government and government actors working within the traditional area have been instrumental in mobilising support and care for OVC in order to achieve equality and MDG 6 as a system. The system drives this traditional community-based OVC care approach to solicit a national and international response. Benefactors form a key component of the strategy for MKQMA OVC project by working together with government agencies and civil society groups to form a unified front for promoting the welfare of OVC. This welfare promotion includes reducing the vulnerability of girls and boys as well as female caregivers in *Manya* traditional area. By the actions of the benefactors, OVC are empowered through the mobilisation of another group of selfless individuals collectively refer to as caregivers who offer to live with the OVC. Thus the triangular resources are put into motion and by providing shelter, nutrition, education, healthcare and psychosocial support, long-lasting effects on the OVC, *Manya Krobo*, Ghana and the world as a whole are initiated.

The concept of empowerment involves the creation of a congenial environment for equipping the youth with knowledge, skills, attitudes, values and ethics. Provision of resources required to enable them contribute to the economic, social and cultural advancement of themselves, their families, and the community is a major responsibility of governments and other stakeholders. Consequently, youth empowerment involves the process of preparing young people to meet the challenges of adolescence and adulthood through series of activities, and experiences, which help and motivate them to become socially, morally, emotionally, physically, economically independent and cognitively competent (Ministry of Youth and Sports, 2010).

The idea of a generation to some school of thought represents the link (nexus) between older and younger age groups. It is about the question of the current and future generations connecting to each other as the term is often attached to a demographic buzz phrase usually defining a clump of folk. Normally and in the logical senses, a generation is a next in a line evolved from a former. This is unfortunately not the case in the era of HIV/AIDS epidemic. This natural sequence of transferring cultural traits between parents and children is often abruptly broken as the reproductive generation or parents are suddenly taken away in the jaws of AIDS. As a result the disease affects dependents (usual children) when the breadwinner is infected and becomes either critically sick or die at a time when the offspring is still a toddler or adolescent. Such situation brings an abrupt end or reduction to source of family income and support. This could easily breakdown the family. This is aggravated by the fact that Ghanaian family structure is rather extended and usually only one member, mainly male adult, of the family generates income. Further, as the mode of HIV transmission in Ghana is via heterosexual contact (Ghana AIDS Commission, 2008) it mostly infects both parents hence no responsible and capable adult is left to take care of the couple's offspring.

According to a 2004 World Bank study, a wide range of options exist for the care of orphans. The most common types of orphan care the Bank identified include:

- A statutory residential care facility, serving primarily HIV infected children;
- A statutory adoption and foster care programme, where a welfare society owns homes and appoints community mothers to care for a group of children (preferably no more than six);

- An unregistered residential care setting, which houses HIV+ and destitute mothers with their children and offers continued care for the children when the mothers are ill or die;
- Home-based care and support, where caregivers are identified and children are legally placed in foster care, and assistance is given through foster care grants;
- Community-based support structures, where grandparents or other close relatives care for their orphaned grandchildren, with no government support;
- Informal fostering or non-statutory foster care, where women in the community volunteer to care for orphans in a group home setting, with no government support.

Whichever form or type of care adopted is often informed by existing practices within the society in question. Such adaptation tends to be more successful in views of the fact that it is culturally sensitive to the needs of both the community and the OVC. Therefore it is tried and tested and caregivers are accustomed to its tenets. As a result, every culture and society in Africa is devising innovative means to carter for this epidemic crisis. However the form this solution takes, you can always find the benefactor generation at play.

The *Manya Krobo* Queen Mothers OVC programme tends to be a combination of more than one of the types of orphan care listed by the World Bank with slight modifications. It is closer to the last two of the aforementioned; community-based support structures and informal fostering or non-statutory foster care. While the community-based support structures is very ideal, it is highly implausible as some things in life that don't always go the way expected to or the way thought to be. The extended family although remains the predominant caregiving unit for orphans in communities in Africa with severe epidemics, the extended-family support network itself suffers systemic changes in household composition in the event of HIV/AIDS. It is either a relative who moves into households to care for children who survive their parents or orphans move into households of one or more relatives in response to the overwhelming demands of the epidemic. But the extended family is not a social sponge with an infinite capacity to soak up orphans. “This traditional safety net is becoming saturated, overwhelmed, and weakened by a combination of three factors: a huge increase in the number of orphans, a significant decrease in the number of prime age caregivers, and a systemic change to the social structure that underpins the traditional safety net” (Foster and Germann,

2002: 665). Henceforth as shown in the previous chapter, it is not all the caregivers that are blood relations to the OVC and more significantly the OVC don't stay in a group home.

It is this type of community-based model that operates in *Manya* which attempts to create a natural family for OVC by relocating the child to someone close to the family. This foster family steps in to assist the young one and guide him or her through life till they are mature to establish themselves. According to the Joint Learning Initiative on Children and HIV/AIDS report on children, AIDS and poverty, services that are "provided through integrated, family-centred delivery models" work best for children. Programmes obtain the best results for children when they adopt integrated intervention strategies providing a range of services to the whole family. The most effective delivery systems integrate HIV and AIDS services with family-centred primary health care and social services provided through community-based models (Irwin et al., 2009: 48). The significant point though is that everything is invented and that if society acts, in however small a way but does not wait for some grand utopian future, there is the promise of hope for a better future for the OVC. The emergence of these home-grown support models did not surface out of nowhere. They are indeed a response to current challenges and needs but most importantly, they are products of ideas mooted by a group of individuals we can call benefactors.

The word benefactor comes from Latin *bene* (good) and *factor* (maker). A benefactor is a person or a group of persons who gives some form of help to benefit a person, group or organisation to help a cause. Benefactors are humanitarian leaders and charitable patrons providing assistance in many forms. Usage of the phrase benefactor generation refers to humanitarian leaders, charitable and other non-profit making organisations influencing and galvanising communities affected by HIV/AIDS to act by devoting a large proportion of their time to a wide range of causes. The aims include mainly affecting government policy or to raise funds to facilitate the design, development and execution of OVC care and support as well as HIV/AIDS advocacy programmes.

This group of people ought to have very strong sense of leadership and dedication to meet challenges and accept failures. Benefactor generation takes responsibility for actions of the caregivers and OVC and tries to find out reasons for things that do not go well with the project. This is normally done by putting high value on people and

credibility at the top of the list. This generation uses positive emotional relationship in running their programmes and activities while they keep learning along. They keep the effects of the epidemic from exploding in the face in many communities. “Many communities in Africa are organising their responses and moulding them into coordinated child support programmes. For the most part, these initiatives, programmes, and emerging community organisations are unknown outside their immediate locale because they have not been documented. Few organisations or networks have sought to partner grass-roots clusters or support their development, yet community initiatives along with extended families represent the frontline response for increasing numbers of children affected by AIDS” (Foster and Germann, 2002: 673). It is imperative to recognise that integrating the various players in the life of an OVC in a coherent way is a very challenging task. It is even more important that all the players envision that proper development of children revolves around the expansion of their freedom, choices and capabilities to lead lives that they value and have reason to value. Freedom, choices and capabilities are a more expansive notion than basic needs but all are necessary for good life and can be intrinsically and instrumentally valuable. Promoting growth of children requires addressing supervisory roles in a sustainability manner at household, community and national levels. This should be done in ways that are equitable and empowering by way of human made-capital resources. The intervention groups consist of at the simplest level three with sub-visions of their own depending on the roles required of them at every point in time and place. These are the locality or the community, state agencies and civil society groups.

4.4.1 - The role of Krobo community in orphan care

In contrast to the state, the concept of community is frequently used in discussions about care as the context is taken to be desirable. This is because services provided by and in the community are viewed as being more appropriate and sensitive (Naidoo and Wills, 2009). There are different ways of defining a community, but the most commonly cited factors are geography, culture and social stratification. Synchronising these various contexts, community has been defined as ‘a number of individuals with something in common who may or may not acknowledge that connection’ (Health Education Authority, 1987). In another context community is characterised as ‘a specific

group of people who share a common culture, values and norms, and who are arranged in a social structure according to the relationships the community has developed over a period of time' (Nutbeam, 1998). And yet Smithies and Adams (1990:9) further described community as people with a basis of common interest and network of personal interaction, grouped either on the basis of locality on a specific shared concern or both. All these definitions highlight certain factors that are viewed as being linked to the subjective feeling of belonging or identity which characterises the concept of community. Most definitions of community tend to suggest homogeneous entity but the reality is that any community will include people whose primary identity is based on different factors. In practice, people may find their allegiance to different communities shifting at different point in their life span (Naidoo and Wills, 2009).

In Manya Krobo, all the elements mentioned in the various definitions of a community play out. The name "*Krobo*" or more correctly "*Kro Obo So Fo*," shortened to "*Krobofo*" means 'Rock or Mountain Dwellers' given by their dominant neighbouring group in the region, the *Akan*. It is a reference to the geographic terrain this community occupies. With respect to the physical setting, the Accra plains, the Volta River, and *Klo-yo* (the Krobo Mountain) were the important geographical factors that shaped the earliest Krobo history (Dickson, 1969). They were perhaps originally driven here to Krobo Mountain from circa 1700 to the 1740s to escape warfare and slave raiding (Steegstra, 2002) as it offered refuge from invading Asante armies (Huber, 1963). However, Brown (2005) believes *Manya Krobo* traditional area was formed much earlier about the 1500s but does not say exactly where. Huber (1963) suggests that these original groups immigrated as linguistically and ethnically diverse small kinship groups, who subsequently employed a single language and system of rule. Today geographically, politically and socio-economically, Manya Krobo traditional area consists of both Lower and Upper Manya with 371 settlements in all.

Ethnographically, the Krobo people are the most numerous of the Adangme-speaking peoples, form the fourth largest ethnic group in Ghana. During the twentieth century, though numerically small compared to the rest of the population of Ghana, the Krobo people have determined events in south-eastern Ghana more than any other ethnic group. The Krobo people were economically and politically the most important group because of their dominant role in commercial crop production for export (Wilson, 1991).

According to Steegstra (2002) the Krobo area was originally colonized by the Danish Gold Coast protectorate before it was taken over by the British in 1849. At that time, the Krobo people were one of the largest producers of palm oil for the Gold Coast colony. Krobos continue to this day to be extensively engaged in farming and agricultural activities.

In terms of social stratification, the governance structure has evolved from theocratic to secular rule. Traditional tribal leadership was primarily religious in function, and not up to the task of protecting the interests of an emerging farming class which fully participated in the international cash economy. A new cadre of secular decision-makers emerged, led by the *Konors* (war chiefs) whose political roles were modelled after the paramount chiefs among the *Akan,* their neighbours and the major political/cultural in southern Ghana (Wilson, 1991). The Manya Krobo traditional area comprises the six divisions of the traditional area. The society and system of chieftaincy are patrilineal in that children belong to the kin group of their father. As such chiefs and Queen Mothers are selected from the royal homes of the father's line. This *Manya Krobo* chieftaincy system has an organisational, reporting, authority, structure and practices. The organisation and structure as well as reporting authority has the paramount chief (*Konor*) as the highest and most powerful chief in the traditional area and represents the districts at the Regional House of Chiefs. *Djase* follows next in the hierarchy. After *Djase*, there are six divisional chiefs, representing the six divisions of the Manya Krobo traditional area. These are *Djebiam* clan, *Akwenor* clan, *Piegnua* clan, *Dorm* clan, *Suisi* clan and *Manya* clan. Sub-chiefs follow next in the hierarchy and each represents and is responsible for a particular community or village in Manya Krobo. The reporting structure follows the hierarchy in the sense that sub-chiefs raise issues and discuss problems particular to their community with their divisional chief *before* going to the paramount chief or Manya Krobo Traditional Council. The Council includes representatives from the Queen Mothers.

The Krobo who have agnatic kin groups, reckon descent through the male line. In addition, the Krobo see members of both their matrilateral and patrilateral kin groups as their relatives, using the term *wekuli*, (literally translated as family member). The basic kinship relationships may be reduced to the father (*tse*), mother (*nye*) and child (*bi*). The term *tse* could have other classificatory uses, but it basically refers to one's rightful

genitor, who should be properly married to the mother of the child at the time of, or before, its conception. Thus a lover who begets a child without marrying the mother of the child has no paternity rights over it. The corresponding term *bi* also refers to one's own child and this may also be applied classificatorily to one's brother's or sister's children (Huber, 1993; Atobrah, 2004).

Huber (1963) defines a 'house' as "a minor agnatic group of various spans". Houses contain monogamous or polygamous households and are multi-generational (Huber, 1963). Members of the house grant significant respect and cooperation to the head of the house. When the head of the house dies, the next senior male member of the house automatically succeeds the former head. Members of a house are subject to its rituals and customs and the elders of the house exercise considerable and lasting authority over members of the house. Traditionally, females cannot perform this role and are not allowed to inherit landed properties. It is at this stage that the traditional provision for the Krobo orphan surfaces. It appears that the levirate practice or widow marriage (*yalogba*) whereby the successor usually a younger brother absorbed both the widow and the offspring. The exception is when the widow refuses to remarry, in which case the responsibility of care falls on the new husband after rituals for complete dissolution of the old marriage are carried out. Even till this is done, the trustee (successor) remains responsible for care. On the contrary, a widower simply pours a special libation at the funeral rites promising to nourish and care for the children to grow and take the deceased's place (Huber, 1963).

The *Krobo* people have strong and enduring traditional belief systems and practices. There is a strong sense of community solidarity and commitment to one's neighbours and family. It has functioned well and kept all at peace and served as a form of ensuring social equity and justice. However, the present time is no ordinary period in the life of the *Krobo* people. It is a trying time when the endurance and capacity of the established order is being put to test. HIV/AIDS has not just affected the reproductive generation in this part of Ghana more than anywhere else but has also left in its trail an enormous number of orphans that the traditional provision for care is no longer able to cope with adequately. And necessity is the mother of invention; a pragmatic approach that deserves critical scrutiny.

4.4.2 - The institutional and governance structure of the OVC project

For the benefactor generation effort to succeed there must be a strong community mobilisation component to promote community knowledge, involvement, ownership of the project, and in the long run, accountability and sustainability. In sum, this is the vital and essential catalyst role play by the MKQMA beside the initiation, design and implementation of the OVC safety net programme in *Manya* traditional area. They function toward collaboration and action coordination which is closely coupled activities in which benefactor, caregiver and OVC team members work together to produce or carry out the OVC safety net action. The Queen Mothers Association focuses on the mental aspects of problem solving for the purpose of achieving the empowerment of OVC through heritage transfer. The traditional women principally do so by synchronising and supporting actions of various key government ministries, departments, agencies, donors, the private sector, and caregivers in pursuit of assisting and building the capacities of OVC. Such coordination leverages the mobilisation of resources via shared understandings, group decision and creates intellectual products as situation assessments, courses of action, plans, analyses and recommendations in the interest of gender and OVC welfare.

When the republic of Ghana was founded in 1957, it was agreed that the chieftaincy system which includes Queen Mothers should be respected. Thus chieftaincy is officially accepted as catalysts in development within and beyond their immediate communities. Politicians ask traditional leaders for advice because usually they are closer to the people. The highest committee is the National House of Chiefs in Accra. There are also ten Regional Houses of Chiefs for each region as well as many Traditional Councils. In case of problems between the queen mothers, the House of Chiefs has a legal function. The Judicial Committee of a Regional House has original jurisdiction in all matters relating to a paramount stool or skin or the occupant of a paramount stool or skin, including a Queen Mother to a paramount stool or skin. It also has jurisdiction to determine appeals from the traditional councils in the region in respect of the nomination, election, selection, installing or deposition of a person as a chief or queen. This legal jurisdiction covers any cause or matter affecting chieftaincy and appeals lie as of right only to the Supreme Court.

The Manya Krobo Queen Mothers Association OVC project (MKQMA) is a community development programme. According to Naidoo and Wills (2009) community development is defined as building active and sustainable communities based on social justice and mutual respect. MKQMA represents one of the faces of female traditional rulers groups whose role has attracted exceedingly a renewed interest in the new relevance of traditional authorities in Africa (Steegstra, 2009). This is because MKQMA is not just a grouping of traditional rulers but it has taken upon itself to engage the people in critical consciousness-raising especially in working for the welfare of women and children. This involves helping the people at the centre of the problem to understand their circumstances and why they have been shackled by ignorance and poverty. It is about changing power structures by removing the mental barriers that prevent people from participating in the issues that affect their lives. It 'is about developing the power, skills, knowledge and experience of people as individuals and in groups, thus enabling them to undertake initiatives of their own to combat social, economic, political and environmental problems, and enabling them to fully participate in a truly democratic process'. (Standing Conference for Community Development, 2009:5). The MKQMA best efforts are in the areas of coordination, consultation and networking, community profiling, capacity-building, negotiating and funding. Greater part of this work takes place with stakeholders including government to secure commitment, planning and action. The active and growing presence of this crop of traditional leaders in social marketing campaigns against HIV/AIDS in Ghana suggests the effectiveness of traditional authority in HIV/AIDS strategies (Brown, 2005).

Whereas it is often assumed that their position in general eroded because of colonialism and missionary activities, and that in patrilineal societies they have little significant power, to the contrary, their position in Krobo is expanding and adjusting to modern demands. The combination of holding traditional offices and acting as members of NGOs and other organisations makes it possible for Queen Mothers to address current challenges and exert power (Steegstra, 2009). It is therefore very reassuring that traditional women leaders are re-inventing themselves and their offices in terms of how they promote development for their communities. The extent of this re-invention varies widely between and within Ghana. The Manya Krobo traditional authorities command the respect of large numbers of their people and communities particularly in the rural

areas. MKQMA particularly is dedicated to the development of their traditional areas and the education and enlightenment of especially the young people. They have a part to plan in facilitating government policies and mobilising their people for development, of particular importance is their role in support of the protection of the vulnerable and excluded. This offers positive contribution to economic and social transformation and can therefore be regarded as part of the decentralization process. The Queen Mothers work in partnership with other groups by creating a mechanism for consultation and co-operation. The association is providing shelter, food, clothing, health care and education to vulnerable children, such as AIDS orphans.

As part of building a comprehensive approach, psychosocial support provides vulnerable children with the necessary tools for good health and positive development. The importance of fostering children's resilience by exposing them to tools that allow them to express and overcome grief and adversity cannot be taken for granted. Consequently, the association has developed tools and other resources that assist programmes that serve children infected and affected by HIV/AIDS. MKQMA carries out researches on issues affecting OVC and uses data to design and improve programmes and approaches. The association raises resources from stakeholders as well as trains caregivers to understand the psychological and social factors that affect a child's psychosocial well-being. In this regard, the Queen Mothers association has developed, produced and implemented a series of psychosocial support activities by making information more easily accessible. They build on the capacity and enable caregivers to educate OVC, learn about nutrition, hygiene, stress management and child protection.

The competencies or otherwise of the association in executing its mandate can be assessed by examining how the fundamental layers of building teamwork manifest themselves on the ground. These criterions include knowledge, understandings, taskwork know-how, setting up structures and back up plans. Knowledge is central to collaboration and teamwork. This attribute requires that team members know what they need to know so that they can work together effectively. Those that do not are prone to various kinds of predictable errors depending on the specific knowledge inadequacy. Secondly, the channel of communication and dissemination of information must be closely link to the distribution of knowledge and understandings among partners. Every organisation does not need to know exactly everything for effectiveness but every

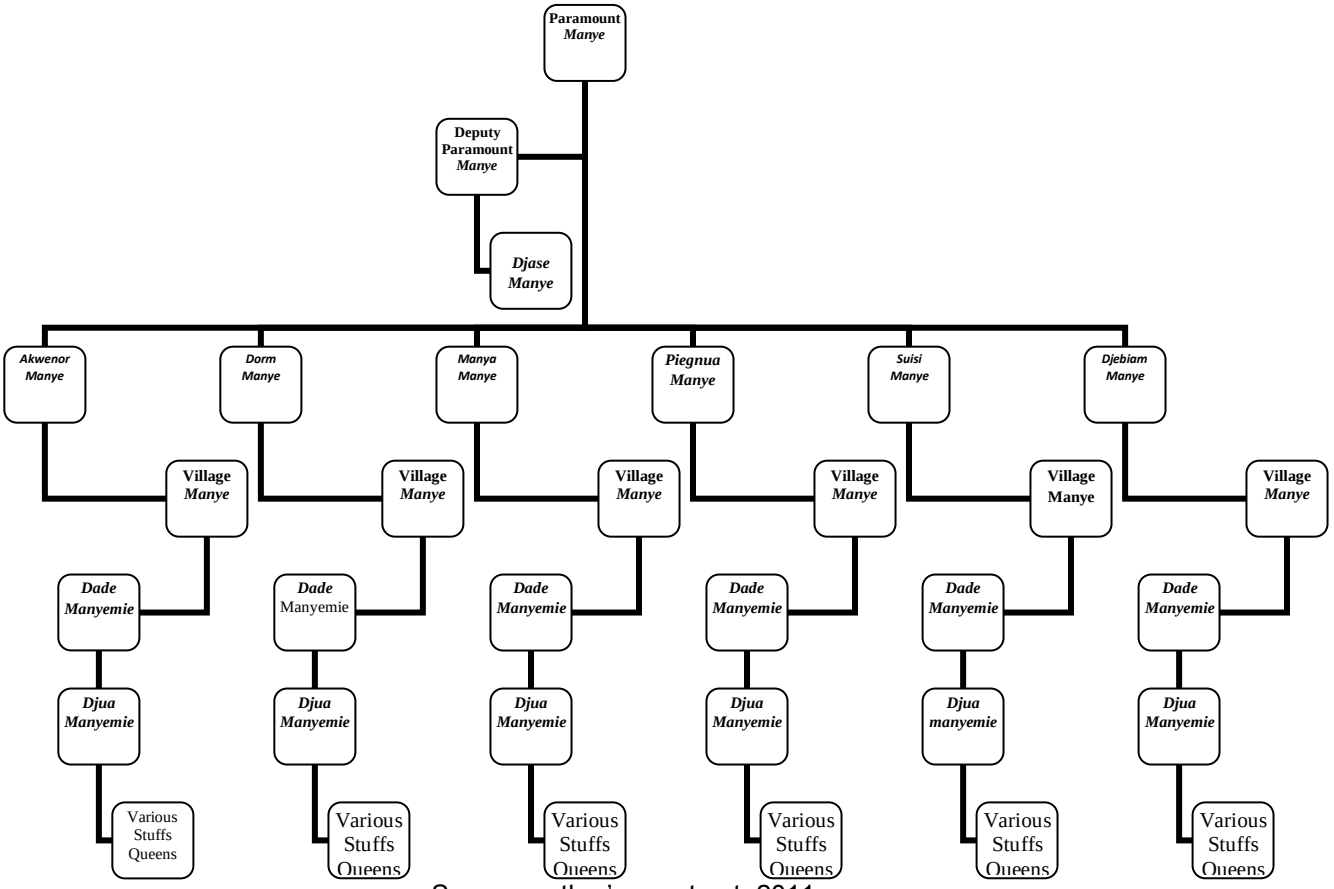
organisation representative does need to know how to get the information needful. The actual knowledge that members need is of two kinds namely one to carry out their tasks were they acting alone and the one to support taskwork needed to work together effectively. To build clear consensus on how to exchange ideas, it is important to put in place the knowledge and understandings that partner organisations must have to achieve the OVC mission. In order to be successful, it is necessary to ensure that each partner back each other up. This means partner organisations need to monitor each others' performance, determine incipient problems and then act to prevent the problem.

One way of evaluating this effectiveness on evidence based nature is looking at the way the association is organised and networked for purposes of mobilisation. The patrilineal kinship system does not permit female children of Queen Mothers become Queen Mothers but may become Queen Mothers in their fathers' area if the father belongs to a royal home. The title of Queen mother can relate to the rank of a paramount queen, a queen or a sub-queen. The *Krobo* name is either "*Nana*" or *Manye* (*Manyemie*). When using English, Ghanaians say "queen mother". This woman is not necessarily the respective chief's mother. Her role in the system is to have an eye on the social conditions especially women and children. A queen arbitrates and decides female political and economical questions in her area. The Manya Krobo Queen Mothers Association (MKQMA) was established in 1989 and ordinarily should consist of 371 Queen Mothers from the 371 communities across the six divisions or clans of Manya Krobo (i.e. *Akwenor* clan, *Dorm* clan, *Manya* clan, *Piegnua* clan, *Suisi* clan and *Djebiam* clan). The actual structure in reality is much larger and comprises a complex network of other queens who do not necessarily have stools but command considerable economic influence. Ideally, a Queen Mother from any part of southern Ghana typically like the chief counterpart has a symbolic stool which indicates status, power and succession to office. The stool is a symbol of authority and also signifies a warm welcome. A typical Ghanaian traditional stool is crafted from wood. There are several stool designs with different meanings for different occasions. Each stool design is based on an age old stool design theme. *Portugal ancient* of King Sancho I of Portugal is its equivalent.

The association comprises eight levels of hierarchical structure headed by the paramount Queen Mother who is the female equivalent to the *Konor*, the supreme traditional ruler in the *Manya* state (Figure 4.1). She is the most powerful female

traditional leader in *Manya Krobo*. She has no function in the Ghanaian state, but has an enormous effect on the Krobo people that constitute it.

Figure 4.1 - The hierarchy of the Manya Krobo Queen Mothers Association



Source: author's construct, 2011.

Underneath the paramount Queen Mother is the deputy paramount Queen Mother who is next in line in terms of ranking. She is the project manager of the MKQMA OVC programme. Following immediately next in the hierarchy below the deputy is *Djase* Queen Mother whose function is closest to the paramount Queen Mother. *Djase* is responsible for installing the paramount Queen Mother and other Queen Mothers. She controls and organises visits to and responsible for the well-being of the paramount Queen Mother.

Underneath *Djase* are six sub queens or clan divisional Queen Mothers, representing the six divisions of the Manya Krobo traditional area. These are *Akwenor*, *Dorm*, *Manya*, *Piegnua*, *Suisi* and *Djebiam* clans. Coming directly under the Divisional clan Queen

Mothers are the village Queen Mothers representing each of the 371 communities. A sub queen or village queen can be compared to the mayor of a village. The queens have their own territory, and apart from that, they have a function at court. Most of the functions are traditional; some have been created recently including fostering HIV/AIDS OVC.

Figure 4.2 – *Manye* Esther Kpabitey Nartekie and *Manye* Mamle Okleyo

Source: Author, March 25, 2011.

Next in line after this group is *Dade* (landowners) Queens who represent the interest of farming women in the communities. The last but one on the MKQMA hierarchy is *Djua* (Market) Queens whose subordinate at the base of the hierarchy is Products/Stuffs Queens. The Manya area has many important markets and each market has a queen. Within each market are also found Stuffs Queens such as Plantain Queen, Yam Queen, Cassava Queen, Tomato Queen and Cosmetics Queen among others. The *Dade*, *Djua* and Stuffs Queens are represented at MKQMA meeting for decision-making purposes. All others have full representation at Traditional meetings.

The philosophy of the MKQMA largely encompasses development and empowerment. MKQMA has shown a commitment to equality and challenging of attitudes and practices which discriminate against and marginalise some of the people especially women and children. As a result, Queen Mothers have been admitted into the Manya Krobo Traditional Council and the Regional House of Chiefs to partake in decision-making. Hitherto only men were the king makers in nominating and installing a new *Konor* or paramount chief but today that has changed. The paramount Queen Mother and her

elders are consulted before this is done. The association has placed a great deal of emphasis on participation and enabling all communities to be heard as they promote gender equality which has re-ignited the need for education for all particularly OVC and women. Perhaps the association is best known for its emphasis on lay knowledge and valuing of people's own abilities. MKQMA set up and is obtaining support for selected OVC in terms of feeding, clothing, schooling and HIV and AIDS awareness. This gained them recognition such that the association assisted in formulating a national policy and plan of action on OVC in Ghana. They are helping in collectivizing of experience and seeing to problems as shared by working together to identify and implement action. This MKQMA did by helping break the culture of silence surrounding the HIV and AIDS pandemic in the area which contributed to the reduction of the HIV and AIDS prevalence rate from 18% in 1992 to 5.8% in 2009 (Figure 2.11). Another great achievement scored by MKQMA is the recognition of the skills, knowledge and expertise that people contribute. This regard, the association initiated income-generating activities for young girls in tie and die batik, bead-making and soap making as a way of empowering them. Working with individuals and communities for change whereby MKQMA has been involved in sensitising the rural population to reduce practice of risky behaviours and actually succeeded in banning aspects of traditional and cultural practices (puberty rite or *dipo)* that degrade and endanger females.

The MKQMA is the main catalyst for the OVC programme based on the idea that sharing is caring and caring is love and that action speaks louder than words. In view of its huge network of members across the traditional, MKQMA is best placed to network, organise, build capacity, and identify children in need to be cared for. It does not do this alone although it is the main group that initiated and still runs the programme. The other partners are state and civil society actors.

4.5 - The caregiver generation: operations and capabilities

In an era when considerable segments of our populations are inclined to turn their back towards processes of communality and to flight into all kinds of neo-isolationism, rallying volunteers of caregivers for OVC care is a herculean task. Nonetheless, the factual unavoidability of global citizenship in a world that is already economically and politically interconnected cannot be lost on any responsible member of any traditional community.

There needs to be a push of knowledge centre and extension programmes to foster awareness and to engender empowerment in the young people more so the underprivileged. The world is a large quilt and its people are the fabric all joined together by a common thread of heritage. A child is an imitator and an adult is an initiator. The common thread between the generations is knowledge transfer through instruction. As a result, it beholds on all and sundry to look for shared values and issues that connect rather than clash. Following the bold initiative by the MKQMA to establish the OVC foster care project, it was only logical that a crop of people were commissioned to promote the awareness of OVC by taking on the responsibilities of caring. They seek and dedicate their efforts to go into the other direction where justice, solidarity and interdependence is the order of the day. This includes but not limited to provision of shelter, education, nutrition, health care and psychosocial support. This generation is the caregivers some whom also belong to the benefactor group as *Manye*. Although the caregivers also have their own challenges to contend with, there is in their opinion the need for sacrifice and a shift of the points from self-centredness to the conviction that none of the major problems and challenges in their communities is solvable without harnessing all their human resources potentials. This process ensures security, sustainability, economic growth and so many other dimensions of human development that have become indivisible in the caregivers' broad approach. It is out of this kind of tutoring process that we see the importance of empowerment as guardians imbibe in the OVC an appreciation of cultural diversity to help equip him or her navigate the uneven terrain of life to fend for their needs. The caregiver cannot control what happens to the OVC but can control the OVC attitude toward what happens to the OVC. In that the OVC will be mastering change rather than allowing their circumstances to master their destiny. This is because the only disability in life is a bad attitude as weakness of attitude becomes weakness of character. While the caregiver's attempt to inculcate a positive attitude in the OVC may not solve all OVC problems, it will at least improve the perspective and prospects of the OVC to make it worth the effort. Caregivers contribute to the development of communities in Manya.

Children are not meant to live on their own, they must be dependent on adults particularly their biological parents. Tragically, HIV/AIDS often interrupts this birth right and privilege for many children and the burden of taking care of the children falls on

foster families instead. Children whose parents have died of AIDS face a loss of family, stability, education, economic uncertainty, emotional insecurity and stigmatisation. These children need someone to guide, care, support and ultimately empower them. However, in *Manya Krobo* communities and for that matter Ghana at large where is there is no proper social welfare system or any safety net in place for these children, their woes can get even tougher. It is in such situation that one can begin to appreciate the invaluable role of the caregiver generation. The caregiver generation refers to the group of people largely female Queen Mothers in the various communities across *Manya* who take it upon themselves to intervene and see to the proper and normal upbringing of OVC. The commitment to take care of and bring real change to the lives of the less privileged children is the subject matter of interest in this section. The desire of the caregiver to take in the OVC into the house must be borne out by clearly laid out implementation plan on how to guide the OVC at home as foster parents.

Children who come from troubled family backgrounds as OVC need support from people they consider as role models to provide emotional and a sense of continuity and stability often lacking in their lives. As such the caregiver must of necessity be able to mentor the OVC out of which constructive friendships are borne, in which the OVC learn to trust and value the caregiver. In order for the caregiver to successfully mentor the OVC, she must be enthusiastic, trustworthy and able to motivate the OVC. It is important she should be friendly and approachable while able to provide a patient, listening ear and balanced advice when necessary. During the in-depth interview with one *Manye*, she attested that “showing a strong interest in the OVC’s life and interests helps to build up a valuable mentoring relationship. This resulted in the creation of an opportune atmosphere which enables the OVC to learn to develop essential social skills, recognise his own strengths and grow in confidence”. Research by the University of Luton Vauxhall Centre for the Study of Crime has shown that mentoring children especially OVC leads to a reduction in offending behaviour or delinquency. What is more, many children who are properly mentored tend to become less disruptive at school and more able to re-engage with mainstream education. Each mentoring experience varies greatly from the next and much depends on the personality and needs of the OVC who is being mentored. One caregiver fostering a 12 year old OVC explained the mutual benefits of mentoring. “Providing care courtesy mentoring is

important to me because I've had my challenges raising my own biological children in the past. This opportunity offers me a second chance to do the right thing. The boy is lucky that presently all my parenting and guardian decisions are evidence based from accrued experiences. There is little room for try and error without recourse to dig into my depth of parenting knowledge to support him. This is however not the case for everyone and he should feel very lucky indeed".

Many of the caregivers seem or appear to be rural poor as they depend so much on natural resources for their income. Even those who do not normally engage in such activities may do so as a coping strategy if experiencing household food insecurity.

The groom who bears the cost of the dowry lays stress upon the full legality with the term 'ikpee yo' or I wedded the woman. The main reasons responsible for the declining marriage rate must probably be seen in the huge socio-cultural transformations and economic changes induced by a number of factors including Christianity, colonization, urbanization and migration. This lifestyle usually entails young females migrating from their parental home. Outside the influence of parents and without their parents' knowledge they usually develop their first relationships, which are not necessarily geared towards marriage. It can also be expected that young men and women living away from home feel less obliged to adhere to the moral conduct expected from them and feel less inclined to evade any sexual temptation.

4.5.1 - Types of caregivers: Family members

Four categories of caregivers for OVC in *Manya Krobo* are identified as family members, queen mothers, *Akyeame* and benevolent citizens.

The untimely passing away of parents is a momentous event for children but also for many family members particularly grandparents. Table 3.10 depicted that the greater number of OVC (92.0%) are in the care of family relations including 4.0% living with their own biological parent with 72.0% citing the death of parents for taking in OVC into care. Actually, in many instances some of these children were already in the custody and care of a family member long before disaster befell their own biological families. As family members and grandparents, they were already involved in the lives of their grandchildren. Many studies have indicated that the burden of care for orphaned children. Most orphans are in the care of their female maternal kin, particularly their

maternal grandmothers, aunt, or other female family member(s). This arrangement where the responsibility of caring for children affected by AIDS falls on family members prevails in many other societies stricken with the HIV/AIDS epidemic (Nyambedha et al., 2001; Gilborn et al., 2001; Atobrah, 2004).

For some of them, it was the sheer desire to share the benefit of their parenting experience so that their children didn't have to make the same mistakes they did. For others, it was the need to get an errand from the young relative whilst others still it was to allow for the opportunity either affords the child access to attending a good educational institution or learn a trade. The involvement of family members most especially grandparents in caring for grandchildren usually takes place for one or more of four reasons namely; support, relationship, money and break.

Sometimes the best way grandparents can help parents is to offer emotional support and reassurance that the children are developing normally and the parents are doing the right thing. Family members and grandparents can provide a safe place for parents to vent and take out their frustrations. After all they have been there before, so even their words alone carry some weight. Raising children overwhelms even the best parents sometimes so older family members are best positioned to watch for signs and offer a kind word whenever they can.

With urbanisation and modern lifestyles making many mothers to work outside the home, children were already cared for regularly by family members and grandparents. And elderly family members may enjoy the role of babysitting as it offers a break to the young mother. Family members offer their young relatives the opportunity to have a different kind of relationship with an adult to whom they are related. For instance, when children and parents clash, grandparents can relieve some of the pressure by providing a listening ear for both sides. They don't have to take sides, but they may be able to help both see things from a different perspective. Family members who are in a better financial position than their relatives or children often help them financially, from contributing to the grandchild's education fund to living with them.

4.5.2 - Queen Mothers

The Queen Mothers constitute the majority of the caregivers. They told us in an interview that only 5 of them are not caregivers. This implies there are 366 Queen

Mothers who are caregivers and greater number of them is in anyway related to OVC. The reasons for this lopsided preference may not be farfetched. They explained, firstly, that when OVC are left in the care of other members of the community, they (the caregivers) keep reverting to them (the Queen Mothers) for resolution of all challenges including very minor ones. Therefore caring themselves save everyone the trouble of dealing with household misunderstands.

Figure 4.3 – Queen Mothers as OVC mothers

Source: Author: April 22, 2012.

Secondly, as every Queen Mother should always set an example to other women, she naturally fits the role of a perfect caregiver. She is supposed to be an "ideal woman," as the logo of the MKQMA membership card (*Pi yo gu*) portrays. Crucially, for the Queen Mother, the importance of a decent appearance in public is measured above all other dress code considerations. she has been taught things about her behaviour in public such as she should never eat or drink in public; she should "dress like a mother," which means decent, never in an offensive way, and preferably covering her hair. With these attributes, obviously there can never any reason to look beyond the Queen Mother in seeking a qualified caregiver.

Thirdly, Queen Mothers do carry out some important traditional and ceremonial duties such as at funerals and at other functions where Krobo culture is performed largely using their presence to reinforce group identity and solidarity. Besides, people, especially women, come to them to confide in them while others ask them to settle disputes in an informal way. These disputes can range from witchcraft accusations and

marital problems to land disputes. These skills flowing from the trust the people repose in the Queen Mothers can be passed on to the OVC as a way of preserving and transferring the local culture.

The power conferred on Queen Mothers makes them legitimate leaders to local values with which they combine forces and reinforce group solidarity to gain moral authority. Thus the symbolic capital, which Queen Mothers use to assert their authority, is a quality worthy of being passed on to the OVC to enhance their status and self-esteem. All these reasons make the Queen Mother the ideal choice for the role of a caregiver for the OVC.

4.5.3 – *Akyeame*

This name suggests that the position and tradition was probably borrowed from the *Akan*. Akyeame simply refers to speech intermediaries. Traditionally, People who wish to converse with the chief speak instead to the *okyeame*, who in turn speaks for them to the queen. Conversely the queen does not speak directly to her subjects or guests but speaks through the counsellor who embellishes her words with appropriate proverbs and other sayings. In short, the *okyeame,* singular form of *akyeame* (linguists or counsellors) serves as mediator between the queen and those who wish to speak with her and repeats the words of the Queen Mother and those of her guests. The *okyeame* is said to “make the Queen Mother’s words sweet.” The ability to speak with wisdom, confidence, and conviction is especially valued by traditional communities, and best understood through the office of *okyeame*, wise advisor to the ruler. The *okyeame* acts as queen’s advisor, judicial advocate, foreign minister, prime minister, and political trouble-shooter. She offers prayers and toasts, is known as the authority on local lore and traditions.

Recently, some 15 of them have taken on the extra duty of caring for some of the OVC in the MKQMA project. Considering their strong communication, public speaking skills and knowledge of customs, this group of caregivers should make good foster parents. Secondly, since they are more or less a part of the MKQMA, this group of caregivers give the association much more less negative feedback about the behaviour and cost of raising the OVC that characterised some other volunteer caregivers. The ability of the *akyeame* to provide care and support is primarily reliant on the level of knowledge and

skills because the influence of the action taken depends on the qualities, personality, and capabilities of individual *akyeame*. They understand the need for this assistance and how relevant this project is to the development of the Manya Traditional area. *Okyeame* Maku Korkor summed up this view. “We think we are an integral part of the solution to the negative effects of urbanization, modernisation, and high vulnerability to hunger, malnutrition, and diseases including HIV and AIDS as well as inadequate access to quality education or inappropriate training,” she intimated. There is no other motivation or incentive besides the fact that these vulnerable children deserve what all other children have.

4.5.4 - Benevolent citizens

Apart of the aforementioned categories of caregivers, there are also people who have volunteered to take in OVC. The word volunteer is applicable considering that this group of caregivers does not have any link to the OVC unlike the others. Their main aim is a concern to see to the improvement of the living conditions of the OVC. The determinants of their inclusion in caregiving are largely based on the ability to care for the children in the areas of nursing, health care, education and importantly income generation. From interviews with the executives of the MKQMA project, these caregivers have received sensitivity training on issues of HIV/AIDS. The caregiver must be somebody well equipped to take care of the OVC and so these workshops generally taught HIV awareness, prevention, and anti-stigma skills. Regrettably, a careful scrutiny of the profile of the caregivers in terms of marital status, employment, age and education (Table 4.1) give cause to worry. These variables are very important to bridging and sustaining the generational nexus. The main challenge is the fact that elderly, divorced or widowed, who form the majority of caregivers are in most cases incapable of providing adequately for orphaned children. In terms of generating financial resources, the family purse is limited to only the caregiver which puts a strain on expenditure. The ability to satisfy human needs is linked to dignity and this is ultimately dependent on income that must be sustainable.

Table 4.1 - Profile of foster parents on UU-UNO Every Child is Our Child

Category	Frequency	Percent (%)	Category	Frequency	Percent (%)
Age			**Education**		
20 - 29	3	3.9	**Primary**	31	40.8
30 - 39	11	14.5	**JHS**	20	26.3
40- 49	22	28.9	**SHS**	6	7.9
50 - 59	18	23.7	**Higher**	2	2.6
60 & Above	22	28.9	**None**	17	22.4
Total	76	100.0	**Total**	76	100.0

Occupation			Marital Status		
Petty Trader	31	40.8	**Single**	12	15.8
Peasant	22	28.9	**Married**	22	28.9
Artisan	13	17.1	**Divorced**	18	23.7
Public Servant	3	3.9	**Widowed**	20	26.3
Others	7	9.2	**Co-habitati**	4	5.3

Source - Field Survey Data, March - May 2011.

4.6 – The OVC generation and mechanism for determining a vulnerable child

The greatest discovery of any generation is the belief that a human being can alter their life conditions by altering their attitudes. In building a better tomorrow for OVC, the stakeholder generations owe it as an obligation to understand the link between current investments and equity in mutually reinforcing ways. This kind of investment satisfies the need to integrate with the new generation. The community should not expect the young OVC to fit in with their ways of life and expectations, the older generation needs to fit in with the OVC generation. Many of the OVC do not the same opportunity their peers in their communities to learn, develop as well as use their abilities and to express themselves. The ageing caregiver leadership finds it difficult to stay abreast with the fast evolving information technology generation gap. Other reasons for this may vary from place to place but the fact remains that most OVC view himself as being marginalised from the mainstream community. This is a challenge which the leadership must confront. This section articulates the elements constituting the OVC generation and examines the process of graduation or programmes to ease transition for OVC as they approach maturity including ways to assist OVC in tapping existing social welfare and economic programmes.

Figure 4.4 – A group of orphans in the Queen Mothers care at Odumase

Source: Author, March 25, 2011.

This involves assessment of priority activities to facilitate OVC guidance for income-generating or vocational programmes as a way of empowerment. OVC empowerment can be measured by attainment and or acquisition of certain qualifications and personal skills by the OVC. This progression refers to the efforts to ensure access for OVC to essential services, including education, health care, birth registration and others.

A collective action from a collective group cannot come about if there is no unifying voice, vision and goal. If every person took shape when their parents relatively guarded them in the youth in the right way they should grow, the OVC generation can only arise in far more intensively mass mediated contexts. Only by being true to the full growth of all of the individuals especially underprivileged children who make it up, can society by any chance be true to itself. Guardians have a responsibility to teach OVC by not just telling as the whole care process is about empowering the disadvantaged kids. To teach the OVC is to provide the time, experiences and supports necessary for this generation of needy learners to develop personally valued knowledge, understanding and skills. The role of the caregiver as a mentor is to collaboratively construct and ferociously protect that learning space. Such mediated futures draw attention to technologically mediated processes and accounts of social change that transcend areal boundaries and can help illuminate the practical means and imagined ends of modern social project.

The OVC generation relates to the actions and intentions of the community to put in place measures that nurture new generations of socially deprived background by mobilising necessary resources to foster innovation and personal development.

Proper upbringing of children including HIV/AIDS orphans and vulnerable anywhere largely revolves around transfer of adequate and culturally appropriate knowledge needed to survive through the right channel of instruction. Such human heritage or development is an essential part of the present we live in and of the future we hope to build or bequeath. It is the range of inherited traditions, monuments, objects, and culture regarding a contemporary activity with far-reaching effects. This is because it can be the platform for the potential basis for local economic development being simultaneously local and particular, global and shared. This kind of instruction of necessity encompasses the full range of contemporary activities, meanings, and behaviours that the society draws from. It is both tangible and intangible, in the sense that ideas and memories of songs, recipes, language, dances, and many other elements which define the uniqueness of the group entity that members identify with.

The desire of every parent and for that matter society is to provide their wards an upbringing that can change attitudes, behaviours, laws, policies and institutions to better reflect values of inclusion, fairness, diversity and opportunity. However, since no change occurs in a vacuum; it takes active efforts of change agents to build community-based responses that address underlying social problems on an individual, institutional and community level. Such change connotes any significant alteration over time in behaviour patterns, cultural values and norms. This involves a collective action of caregivers and benefactor generations who are closest to the OVC problems to develop solutions that address social issues. The ability to lead is vital to creating a mediated social change. Leadership herein refers to a process of which social change is distributed, promoted and expressed by caregivers to OVC who come from diverse backgrounds. Caregivers help to shape and provide a space for OVC to unite and reach towards their goals. They inspire and motivate the young and growing OVC through their actions, behaviours and words. For social change to occur within the Manya communities, the youth including OVC would need to know what type of agents they want to be in the social change process and how their leadership can have an impact within these arenas. This knowledge can only transferred to the caregiver-OVC nexus

formulated by the Queen Mothers benevolence. This addresses subject of active contemporary reflection, debate and discussion like what is worth saving and forgetting. What memories can the community enjoy, regret, or learn from? Who owns "he past" and who is entitled to speak for past generations? Active contemporary discussion about material and intangible heritage of individuals, groups, and communities is a valuable facet for developing personal skills.

4.6.1 – Identifying and placing OVC in foster care

Can you imagine the processes involve identifying and placing to give foster care for 1,065 children every day? Can you think of helping 1,065 get ready for school, feeding, healthcare and psychosocial support needs? If these activities seem tough, how do you fancy paying their school fees and medical bills as well? This is exactly what many women volunteering in Manya Krobo traditional area do.

Manye is the traditional woman leader of the community here and plays a pivotal role in the OVC project. She is in her mid 60s and just re-married an old school mate after years of divorce from her previous marriage out of which she has a 35 year old teacher daughter. *Manye* is a royal here but is all too aware of the poverty that abounds all around this community. *Manye* says when anyone comes around with a story of a child who is suffering, 'I forget every other consideration.' "We've been struggling all these years trying to place the disadvantaged children in fosterage. Little did we know that we will be the *manyemie* (mothers) to so many children! Ironically, perhaps many of the caregivers either longer have young children of their own or have just an average of three children. This is because many of the caregivers were determined not to have more children than they could provide for. *Manye* confided us; "I've to admit; this wasn't my original idea, it was *Manyemie's* dream (referring to the Queen Mothers Association). It took a great deal of prompting to persuade me to take in an OVC the first time round. Maybe I need someone now to stop me but it won't be anyone within this traditional area. They all literally live, eat and sleep with the OVC problem as such all women here feel the mother instinct in them to help out just as I am doing. Others follow our initial example and soon after nearly every community in Manya Krobo traditional area had a child or more benefitting from the novelty project. Before long, the dream OVC project was born."

A hearty looking three and a half year old Ben and 13 year old Bea in their smart-looking school uniforms sandwiched me in the three-in-one sofa opposite the Manye. Ben is one of the newest arrivals to have captured *Manye's* heart. Ben was brought here by the HIV/AIDS Focal Person of the Department of Social Welfare at Odumase-Krobo, the Lower Manya capital. Bea on the other hand was referred by leaders from her village beyond Asesewa in Upper Manya Krobo District. They gazed me with melting dark eyes, the moment I feel exactly *Manye* must have done. She said when she heard their story, she couldn't say no. *Manye* recounts a familiar story. For Ben, his mother died hours after he was born and his father abandoned him. Bea's pathetic history differs slightly. Both parents migrated to an unknown part of the country in search of greener pasture and left her to fend for herself alone in the village. She has been living with *Manye* for the past six (6) years. At the time of her neglect, she was attending school in tattered clothes. Like most of the children in the MKQMA fosterage, Ben and Bea have families. No other family member, however, has come forward to help.

Twelve years ago, the MKQMA decided to set up a foster care project for orphans and other vulnerable children. This OVC project was based on the traditional African extended family system where affected children are absorbed within the community instead of an orphanage. The Manya Krobo OVC project is housed in an abandoned 18th century Basel Missionaries wooden structure at the centre of Odumase Krobo. The structure also serves as the vocational training centre for the OVC. It is used to receive a stream of well-wishers. Churches bring bags of clothes, a local grain mill donates a few kilos of flour, a neighbour presents tomatoes and other vegetables, and someone pays schools or health insurance premium for a couple of OVC. Though Manya Krobo traditional area is home to a dozen or more foreign aid organisations, so far this kind of support has come almost entirely from individual philanthropists and Ghanaian businesses.

Both Ben and Bea have been doing well at school and like many other children catered for by this OVC project, they will now go on and have the chance to pursue their dreams and develop their talents to become useful law-abiding, contributing and responsible citizens one day. *Manye* affirms her belief in this proverb: "talents are best nurtured in the solitude. Character is best formed in the stormy billows of the world."

4.6.2 – An orphan child

An orphan is defined by the United Nations as a child who has lost one or both parents. An AIDS orphan is a child who became an orphan because one or both parents died from AIDS. However the phrase AIDS orphan is avoided in the literature because of stigma. The term is used for a child whose mother has died due to AIDS before the child's 15th birthday, regardless of whether the father is still alive. Some of these children have also lost, or will later lose, their father to AIDS. As a result of this definition, one study estimated that 80% of all AIDS orphans still have one living parent The AIDS epidemic has created many orphans (Stuijt, 2009). The cumulative figure quoted for AIDS orphans includes orphans who have since died, as well as those who are no longer under age 15. In some assessments, paternal orphans being those who have lost only their father to AIDS are included in estimates of children orphaned by AIDS. A child whose father dies typically experiences serious psychological, emotional, social and economic loss. But because reliable data on the number of paternal orphans are not available in many countries, the orphan statistics used by UNAIDS and UNICEF do not include children who have lost only their fathers. The MKQMA OVC project has made orphan estimates for up to the age when the child marries or finds job and leave the house in the future. From the survey, more than half of the respondents (53.0%) mentioned that their mother was dead while nearly two-third of respondents (64.0%) had lost their fathers. This implies overall three out of five children interviewed (58.5%) were orphans. This study used ages up to 24 years. UNAIDS and UNICEF believe the possible margin of error in such long-term estimates to be too great to make them worthwhile or reliable for planning purposes. The lack of parents leaves the characters to pursue more interesting and adventurous lives, by freeing them from familial obligations and controls, and depriving them of more prosaic lives. It creates characters that are self-contained and introspective and who strive for affection. Children orphaned by AIDS are often the first to be denied education when their extended families cannot afford to educate them. The crisis is unique for children because of the huge scale of the problem, an AIDS-weakened infrastructure, the vulnerability of orphans, grief before death and the tragedy of losing both parents, and the AIDS stigma. The MKQMA OVC project intervention therefore seeks to support each individually by promoting an

economically stable family life and healthy environment at home. The other objectives are to provide financial support for basic education of orphans, monitor their educational progress periodically and remove obstacles that hinder their progress.

4.6.3 – An orphan and a positive living child

If being an orphan is a whole challenge, then children who are growing up living with HIV or HIV-positive is even tough enough. All HIV-positive children suffer from the additional burden of growing up with a chronic disease that requires life-long therapy and medical follow-up. For such children there are additional physical, social and emotional challenges for the child and for their foster parents. Some could have difficulties focusing in class thereby failing in school as a result of suffering from post traumatic disorder syndrome. The possibility of having a few friends from the opposite sex is as real as their status. This is a serious challenge to confront and overcome if the positive living OVC is to be empowered.

Depending on the age of the child, the OVC often forgets to take their HIV antiretroviral medications as some may rightly wonder why they have to take medicine every day, why they have to miss school to attend the clinic and have blood tests unlike other siblings or children. Some don't like the ARVs anyways because they remind them that they have HIV. Thus compliance is difficult for children because there is usually no immediate consequence of stopping their medications or taking them irregularly, since they probably won't feel sick for a while.

Beyond the challenges of treatment compliance, there is the equally tricky issue of disclosure. Around the age of six to eight years, children with a chronic disease like HIV/AIDS will ask questions. Just as caregivers are reluctant to tell OVC about both cause and death of their biological parents so also the foster parents maybe very reluctant to tell HIV positive OVC that he or she has HIV, because he or she is just a child and needs to be happy. The caregivers could also genuinely fear that he or she will tell friends or teachers, thereby causing inevitable rejection from their community, school, or church. Some caregivers are also reluctant to inform the positive living OVC child because they feel children should have a carefree life. However, children who aren't told their diagnosis will generally find out by themselves, by connecting what they read on signs or pamphlets at the clinic and on their medication bottles with information

from the media or some other sources. They may then feel that they have been lied to, imagine that they are going to die soon, and may lose trust in their caregivers; all this can compromise their cooperation in their future care.

Positive living OVC children have a right to a truthful status disclosure, even if it is a partial one, as soon as they are able to understand. Caregivers must be taught that disclosure is a continuous process that should begin after the initial visit when the child receives age-specific HIV education, which becomes gradually more detailed. The caregivers are informed to start the disclosure process at home, in a way that suits their personal beliefs, culture, and past history with the disease. OVC children growing up with HIV teach endurance and resilience that "yes, you can!" Although they face extra challenges, they can now look forward to the future and hope for the much awaited cure.

4.6.4 – A neglected or a socio-economically vulnerable child

While the preceding sections described the care arrangements for orphans, there are some other children in Manya Krobo being fostered as well but who by their circumstances do not strictly speaking qualify to be called orphans. Most of the children in this category by virtue of their parenthood do not qualify for the traditional orphan support and yet must be. Some children in Manya Krobo have certain characteristics in common that make them vulnerable hence the need for foster care. These are children who are either neglected or their socio-economic conditions do not promise them any better tomorrow. According to the result from the field survey, nearly two-fifth of the OVC respondents (41.5%) either had at least a parent alive or did not know the whereabouts of their parents. Some of the common reasons that caregivers offered as factors influencing bringing in OVC were economic hardship on parents (20.0%) and no one to care for the child (8.0%).

Some earlier studies in the area show that migration is a contributory factor to the vulnerability of these children. Agyei-Mensah (2001) traced this phenomenon to the exhaustion of fertile farmlands for oil palm plantation cultivation while Sauvé, et al. (2002) attributed it to the construction of the Akosombo Dam in the 1960s which submerged a third of the land surface. Atobrah (2004) validated the labour migration concept as a dominant feature in vulnerable children fostered households. She

discovered that out of 183 different foster households, mothers of 123 of the children had migrated and lived extensively outside the country, particularly in Abidjan and Nigeria. A total of 15 mothers had migrated internally to Kumasi, Obuasi and Tarkwa. In the case of 28 others, although it was known that the mothers did migrate, their actual whereabouts was uncertain.

The Krobo people are distinctively defined by their unique and rich culture. Regrettably, two aspects at least have been identified as contributory factors to child vulnerability; paternity rights (*yobi*) and puberty initiation rite (*dipo*). An important aspect explaining children vulnerability in the area is the fact that the fathers of most those in care are unknown. This situation can be attributed to the people's own concept of paternity and the fact that most the children in question were born while their mothers were abroad possibly while keeping multiple sexual partners. Customarily, the Krobo accord paternity rights only to a man who has married his lover before conception or else performed elaborate rites later on to claim his child's paternity. Thus parents who find their unmarried daughters pregnant may not even be interested in knowing who impregnated her because the baby automatically belongs to its maternal kin (*yobi).* Considering the fact that most of the mothers were migrants and unmarried, and their children were born while they were abroad, the fathers are not known to the relatives or caregivers (Anarfi, 1995; Atobrah, 2004). It is important to point out that inheritance and succession is mainly through the male line, except in cases of married daughters. When a man dies, there is the customary rule that his wife and children are taken care of by (a successor) usually a younger brother of the deceased. Ramifications here include forfeiture of right to inheritance and consequently care for the child.

Again according to Atobrah (2004) it was also common to find that most male children aged 14 years and above had been fostered out to relatives and non-relatives by their mothers living in urban towns or engaged in farming in some of the Krobo villages. The caregivers' explanation for this preference was that they need to keep "eagle eyes" on the girl especially prior to the performance of *dipo* puberty initiation rite. As mentioned earlier elsewhere in this study, for the Krobo people, the passage of the *dipo* rite is non-negotiable subject and it is considered a taboo for a family whose child fails to undergo the rite. If a girl gets pregnant before the performance of *dipo*, she becomes an outcast but not her child.

4.7 - Appraisal of OVC empowerment

In conducting the focus group discussions and in-depth interviews with HIV/AIDS orphans and other vulnerable children (OVC), one of the principal goals was to establish OVC understanding life and appreciating it. We considered this aspect very relevant as perception affect proper goal setting and a focused lifestyle. Any self improvements start with personal thought and then follow by goal setting. To address this, we posed three questions to the children namely:

How do you see or perceive yourself?

Of what are you normally found being praised of?

And what has been your interest of late?

Young people growing up are often obsessed with their personal appearance which informs them of how they assume other people perceive and regard them. The position and shape of the nose, eyes, ears and some other parts of the body would not have gotten any better place. Yet the vast differences found between individuals distinct each and everyone apart. There are times children and even adults see other people more privileged in beauty or knowledge than themselves. The study sought from the OVC perspective whether they considered slight individual differences as making them unique and special or lacking. Some stated that “they do worry a lot about their complexion, height, mould, nose, eyes, ears as well as overall outlook that rather make them feel angry, jealous, bitter and envious”. According to them, “they look how they think they look”. They wondered why some peers appear to do so well in many fields than themselves. It was very obvious what these young chaps were going through in life. It is not a new thing, they simply haven’t grasped or realised the meaning of life. What they lack is someone who took the interest to help them to realise what life entails with their own experiences and the collection they have gathered from other people’s stories.

It was however, not all of them who felt that way based on negative assumptions. For instance one girl gave a good articulation of the matter when she said “beauty is only skin-deep”. Her remark arouse keen interest hence was asked to elaborate on her statement. She explained that “there is more to beauty in life than just the looks; the most important is the character”. In other words, she felt beauty is not in the face;

beauty is a light in the heart remembering how beholding beauty with the eye of the mind will enable to bring forth not images of beauty but realities of true virtue. The respondents indicated that they seek respect and understanding for their feelings about a particular situation or circumstance and not to be sympathised with because of their age and background.

The kind of feedback children get from guardians, teachers and other adults as they grow up has a major impact on the implicit beliefs they develop about their abilities. This impact includes whether children see such abilities as inmate and unchangeable or as capable of developing through their own effort and practice. When children do well and are told that they are “so smart”, “so clever” or “such good”; this kind of praise implies that traits like smartness, cleverness and goodness are qualities they either have or they don’t. This difficulty to distinct inmate and capable abilities tends to have a gender dimension. Young girls learn to self-regulate more quickly than boys by sitting still and paying attention. Consequently they are more likely to be praised for “being good” and more likely to infer that “goodness” and “smartness” are inmate qualities. Thus they continue to carry these beliefs often unconsciously throughout their lives. And because bright kids are particularly likely to see their abilities as inmate and unchangeable, they grow up to be adults who are far too hard on themselves as they will prematurely conclude that they don’t have what it takes to succeed in a particular arena and give up way too soon. When we posed the question ‘of what are you normally found being praised of’, we intended to establish the fact that through their mistaken beliefs about their abilities, they may be their own worst enemy. Their responses included science subject, math, dancing, beauty, good manners, cooking and artwork. Surprisingly, some OVC did not know what is good for them or ignorantly take life as so easy.

Every inequality of opportunity, every unfair stereotype, and all the challenges we face balancing work and relationships, demands seriousness and hard work to benefit massively from it. The number of attempts one tries avoiding challenges and playing it safe by sticking to goals known would be easy to reach, the higher the probability of not succeeding. As one caregiver stressed “I take my maternal role in the OVC’s daily life seriously and, for me, his welfare and happiness comes first. I know he's not my child, but that doesn’t stop me loving and caring for him. A child has one set of biological parents, but I’d argue that I, and many caregivers like me, bring something very special

indeed to the lives of the children we inherit. And many of us make better mothers than the women who actually go by that name."

4.8 - Challenges, fragilities and adaptive mechanisms of the project

Fighting HIV/AIDS with community-based programmatic approaches achieve better outcomes as knowledge of local conditions offer much better understanding for designing well informed and suited strategies. Poorer understanding is associated with higher resistance. The Queen Mothers are harnessing local resources to build a community resistance but they come up against a number obstacles weighing heavily against them. This section highlights group modes of alleviations, adaptabilities, fragilities and limitations of the MKQMA programmatic approaches in which the resistance of stigmatised communities is utilised as a resource for social change.

4.8.1 - Help for OVC who experience trauma, stigma and grieve

One of the greatest challenges faced in raising all OVC of any description is handling episodes of psychosocial distress or post traumatic disorder syndrome. Many of the OVC groups have been victim to some form of psychosocial distress or trauma such as having watched their parents die from illness or suffered abuse or exploitative situations. Common symptoms of children under psychological distress include sleep-related problems – nightmares, bed-wetting, insomnia and irregular sleep patterns. Fear is also a common symptom – fear of darkness, fear of sleeping alone, fear of leaving the house, and fear of strangers. Other problems include anxiety, irritability, inability to concentrate, regression to developmentally earlier stages of behaviour, withdrawal from friends and family, rebellion, aggression, and psychosomatic symptoms, such as headaches and skin diseases. Children become pessimistic about the future and feel as if they have no control over their lives (World Bank, 2004).

Post Traumatic Stress Disorder (PTSD) occurs when a past trauma has not healed. The symptoms of PTSD are flashbacks, compulsive re-exposure to trauma, avoiding and numbing of emotions, inability to control emotions, attention and distractibility, alterations in defence mechanisms and changes in personal identity (World Bank, 2004).

Intrusions or flashbacks refer to intense emotions, nightmares, and re-enactments. These intrusions often leave an OVC feeling a sense of great loss, anger, helplessness, or betrayal. Compulsive re-exposure to trauma simply means victims of trauma are more likely to be re-victimized. Self-destructiveness is a common reaction of children who have been abused. Avoiding and numbing of emotions denote avoidance of the memory of the traumatic event which can be done by staying away from reminders, consuming drugs or alcohol, and detachment from everyday activities. Inability to control emotions actually implies OVC with PTSD can react with intense emotions, such as anger, fear, or panic, when they see something that reminds them of the source of their trauma. The OVC afflicted by this condition often over reacts by threatening others or by seeing the world as an unsafe place. The OVC often regress under these circumstances. Attention and distractibility refer to OVC with PTSD have difficulty sorting out relevant from irrelevant information. This disorder affects performance at school and can hinder OVC education progression and personal development. Alterations in defence mechanisms and changes in personal identity concerns trauma which is usually accompanied by feelings of shame and inadequacy, but since these feelings are too painful to live with; the OVC with suffering from this condition often denies them, which opens the door to further abuse.

People affected by HIV/AIDS including OVC find themselves discredited in the eyes of other members in the community. Stigma which is a barrier to change is borne out of a wide range of reasons arising out of fear, ignorance, and lack of a desire to get more information about the myths surrounding HIV/AIDS. This results in the reproduction of social difference that leads to denial and withdrawal. The knowledge ordering to counter this menace is necessary for participation in one's own culture and the right to intergenerational equality.

The extent of communication rights knowledge among the MAKQMA constituents provides insights that allow to better direct programmes dealing with stigma. Communication rights are those rights that enable all people everywhere to express themselves individually and collectively by all means of communication in order to improve their lives. Communication rights are vital to full participation in society and are, therefore, universal human rights belonging to every man, woman, and child. Communication rights encompass freedom of expression, freedom to seek, receive, and

impart information and knowledge. But they add to these freedoms, both for individuals and communities, the concepts of accessibility, participation, and cultural diversity. Communication rights include democratization of the media, protection of traditional means of communication, linguistic rights, and the right to enjoy the fruits of human creativity. These are questions of inclusion and exclusion, mutual respect and human dignity.

The concept of communication rights as it applies to the battle against HIV stigma is very fluid. This plays a useful and relevant role in HIV stigma because it allows peoples and communities the flexibility to fashion out locally-based responses to their needs. In the history of humankind, communities that learn to collaborate and improvise most effectively prevail. Thus survival is not simply a question of being the strongest or most intelligent but being able to accurately perceive the environment and successfully adapt. Much of MKQMA's communication rights work has been to increase awareness and recognition of communication rights of OVC, people living with HIV/ADS communication rights, women's communication rights and access to appropriate Information. These objectives effectively address communication rights of HIV related stigma.

Manya Krobo is in dire-need of new approach to help minimize the harm of HIV transmission and stigma by promoting safe practices and better understanding of the condition. The MKQMA uses their network spread and takes advantage of new modes of disseminating HIV messages to distribute educational materials to smaller communities for public consumption. They also use workshops to education opinion leaders in these sub-communities. These sub-communities do not have regular access to radio or television broadcasts hence are unaware of safe practices in HIV prevention and stigma suppression. These programmes reaffirm the right to freedom of expression and opinion; which includes the freedom to hold opinions without interference and to seek, receive and impart information through any media and regardless of frontiers. They primarily involve persons and are focused on supporting communication between individuals which gives rise to right to live in a healthy environment that promotes freedom to give and receive information enhancing the right to self-determination. The MKQMA informs these sub-communities on safe practices and the need to support people affected by HIV/AIDS including OVC.

It is without doubt not easy to break the news to an adult about the cause of illness or death of a loved one. But imagine having to tell an OVC. For many OVC the experience of losing a parent can be confusing. For the caregiver helping an OVC through this phase presents a test of character. Some caregivers either try to soften the blow by telling the OVC that the deceased one has gone away or avoid the whole subject altogether. However such expressions and excuses are misleading and deceptive which may cost the caregiver the OVC trust in them when the OVC eventually discovers the truth. *Manye* Zagbaki (MZ) and Teye Tetteh (TT) faced such a challenge. TT was one of three OVC in *MZ*'s foster care. She took him in at age 3 and TT is now 21, completed Akropong Teacher Training College and teaching at Dawa in Upper *Manya*. When MZ brought TT, she had to help him to cope with the loss. How she went about it is captured in the interview below.

Question: How did you explain the deceased parent's death to TT?

MZ: "Fortunately for me, we were introduced at the time the deceased parent was attending VCT. The counsellor explained the need for me to be honest and entirely open about it. So when the deceased parent finally passed away, I encouraged TT to ask questions, and I always tried to answer them in terms of a child his age could understand."

Question: Do you think TT could grasp all that information?

MZ: "Surely, the VCT counsellor informed me that he could. Children deal best with death when given accurate, simple, clear, honest explanations. Death is a reality; there is no need to be secretive about. So regardless of my emotional concerns, I needed to teach TT how to deal with the loss."

Question: Did you take TT to the funeral?

MZ: "The custom and practice is that family members must be present during burial rites so I took TT to the funeral ceremony. I believe that it was a good opportunity to tell him exactly what to expect. When tragedy as death strikes the family, children tend to feel insecure. So if I as the new mother am open and honest about my feelings, I knew TT was going to be open too. After listening carefully to what was troubling him, often I was in a position to reassure him and ease his fears."

Question: How did you help your foster son, TT to come to terms with the reality?

MZ: “I encouraged questions by creating the atmosphere that allowed TT to talk about death and its meaning. This was done by avoiding the use of vague, abstract phrases but explained death in simple terms as the deceased parent’s body had stopped working and could not be fixed. I explained to TT that his deceased parent would not be able to see or hear what was happening and allowed him to grieve by letting him see that it is natural to do so.”

Question: How long did this reassurance go on after the funeral?

MZ: “For one thing, I understood that young children like that easily got over the tragedy and so I thought there was no need to continually attempt to disturb the hornets’ nest. It was better to let sleeping dogs lie, at least so I thought.”

Question: Did the whole process of the death and absorption of TT into your family affect you in anyway?

MZ: “Obviously, there were no two ways about that. That was a distressing time for me spiritually, physically and emotionally. I needed to inculcate in him faith in God. These activities took their toll on my physical health and emotional stability. Initially I was concerned about letting TT see me cry. However after consultation with the VCT counsellor, I understood that TT seeing openly showing grief made it clear to him that breaking down in tears is not wrong. I needed to let TT feel that he could express his feelings too, rather than bottle them up. It was just a way to express emotions. The MKQMA members were also very helpful. Through the regular home visits, other Queen Mothers bore me up. It was a gesture of loving support from a big family. With all visits, I got tremendous help and morale boost and TT could see how much they loved and cared for us.”

4.8.2 – Facing up to reality of contemporary parenting

Every parent especially woman knows, deep down, that the much-vaunted maternal instinct though not nearly as 'natural' as society makes it out to be poses great hurdle to caring for a child. Developing personal skills of OVC to cope with or manage their lifestyles or behaviour is a very important part of the caregiver’s role. These personal skills comprise the roles of beliefs, attitudes and values in making personal decisions and confidence building. They also include the influence of social norms. An

understanding of the barrier between the youth and adult generations helps in assessing the level of management in place to meet OVC psychosocial challenges.

Caregivers act as crisis counsellors who usually provide assistance to OVC. The work conditions demand that work with OVC who have gone through traumatic and life-altering events as the loss of parents are rehabilitated through various intervention programmes and to manage their anxieties by helping them develop new coping skills. These skills are interpersonal skills which presume that since caregivers handle with OVC from diverse social backgrounds, it is essential that they not only enjoy working with people but also have excellent communication and interpersonal skills. Caregivers also need organization skills which emphasize the need to maintain and update a history for each OVC. This requires being well organized and setting priorities to accomplish tasks. Further, caregivers need to objectively assess individual cases in order to determine whether an OVC is undergoing a crisis and the level of intervention needed. This requires having strong problem-solving and critical thinking skills. Since the caregiver is part of a larger network, in the community, being able to work effectively with other members is essential to developing practical solutions in meeting the OVC's needs or goals. The caregiver needs to have an outgoing personality and often needs to take part in community outreach programmes or appeal to policy makers as advocate. To succeed, the caregiver must have a strong sense of purpose and a desire to help people and to be of service. They must be self-motivated. Because OVC are traumatized, a good caregiver is comfortable in dealing with stressful situations on a day-to-day basis without feeling burned out. Finally, good listening skills and an ability to empathize are vital to providing guidance and support to OVC who are trauma victims.

The question during one session of the focus group discussions was ‘how happy the caregivers were with the way young people regard them and treat their instructions’. While some felt the behaviour of young people was ‘understandable and expected’, others thought otherwise. One discussant said “some of us [i.e. caregivers] are not happy with the way the young people these days all social backgrounds take all of us for granted. We need to stop them before things get out of hand”. This generated a lot of hot at the discussion. It turned out that the complaint was about the way the young people exhibit their ‘attitude’. Those who supported the criticism of the young persons cited the case of some OVC who are too exuberant, noisy, unreliable and unstable in

their ways. The logical question was how to help young people use their potentials despite their apparent weaknesses. The consensus was “we can do this through dialogue with the OVC by listening to their concerns and creating space for them to express their youthfulness. We must avoid being judgemental; we need to distinguish between ‘youthfulness’ and ‘arrogance or ignorance. We all have different skills, and children can benefit from having additional adults to guide and support them. Sometimes it can be an advantage for children to have an adult who isn't Mum or Dad, but who they can talk to.”

Parenting or care-giving, the art of nurturing OVC is becoming a challenge to many of the caregivers in *Manya Krobo*. The art is to be a partnership between a man and a woman, but due to a combination of factors including widowhood, divorce and separation cases, many of the OVC are growing up living with only a woman caregiver. Often the caregiver and the OVC struggle financially and emotionally. It is not an experience desired by anyone as it leads to a number of undesirable situations including limited financial resources, loneliness and sorrow over broken home as well as limited time for the OVC. In terms of generating financial resources, the family purse is limited to only the female often weak and elderly caregiver which puts a strain on expenditure. This causes very stressful situations to both caregiver and OVC. Marriage provides companionship and mutual support thereby killing loneliness. All this is lost and the single caregiver is left on her own to think through issues or carry burdens by herself. By its very nature, a home is meant to be a place of protection and security; this includes spiritual protection. The gap created by the absent partner breaks the strength of the family thereby leading to emotional trauma.

On the other hand, the age of the caregiver plays an important part in the quality of psychosocial support given to the OVC. Traditionally, Krobo people and for that matter generality of Ghanaians have revered good stories and storytellers rooted in oral cultures and traditions. Oral tradition in *Manya Krobo* encompasses stories, songs and folklore which are related by the older caregivers to the new generation of OVC at the end of the day while sitting around the campfire. A lot of the cultural ways and beliefs are thus transferred between the different generations through oral tradition. From discussions and interviews, it came out strongly that the older caregivers are helping to keep alive this dying tradition of storytelling. Old ladies are particularly good at this art

which is orally composed and transmitted to be verbally and communally performed. It is an integral part of reinforcing generations' connectedness as caregivers stress the importance for the OVC not to "lose sight of the need for their mother tongue through dance and music". The participatory nature of this tradition encourages the OVC to foremost learn how to speak in public as well as help them to memorise and retain information. Importantly, it is one aspect of social life in Ghana that is as unique as it builds communal spirits and for the OVC drives away the fearful feeling of loneliness and any other negative tendencies.

Oral tradition plays an important role in the caregiver's roles of being a nexus to the OVC as history and the stories of the old times are relayed verbally rather than through the written mode. During focus group session, an elderly respondent asserted that "oral storytelling is essentially a communal participatory experience when everyone in the community plays a part in formal and informal interactive performance. The participation forms an essential part of traditional communal life and basic training in Krobo oral arts and skills. This forms an indispensable part of girls' traditional indigenous education on their way to *dipo* initiation ceremony that paves the way for them into full humanness."

Among the middle aged and much younger caregiver groups, however, they were critical of this tradition. While acknowledging the importance of oral storytelling to parenting the OVC, one person said "the situation rapidly changing and may well develop in the future, in which oral storytelling may not be important when the next generation takes over. Of course we are all fascinated by the oral tradition, and it's right that we should be fascinated. But if it's not going to work anymore in the future, then why don't we find out what has come to replace it? I am not a prophet of doom, but looking at the ongoing trend we should not be overly concerned if the long-established tradition of oral storytelling dies out. It could be revived if we decide that it is absolutely necessary but whether oral, or written, or televised, I have no right to lay down the law."

Perhaps one should not be overly concerned if the long-established tradition of oral storytelling seeming is dying out. It is a rich part of Krobo history and to this day some aspects have survived the turbulent past proving that oral literature can be passed on across the generations as effectively as the written word can irrespective of prevailing changes taking shape.

OVC who by reason of their circumstance live in severe poverty face the greatest pressure to be dishonest. In such an environment, admittedly, dishonesty often brings rewards, at least in the short term, thus cheating is considered normal, necessary and acceptable as long as one is not caught. As a result, those who try to be honest are subjected to intense pressure and children especially OVC are particularly prone to give in to peer pressure. The question during focus group discussion was 'is it practical for caregivers to coach the OVC to be honest'? If so, how is it possible considering perceived communication gap between caregivers and OVC? As it were, it turned out that proverbs and riddles came handy to caregivers in teaching about the good and bad qualities in human beings and how to judge a good character. According to the caregivers, use of proverbs and riddles help them to teach such principles as being truthful (not lying to one another), dependable (keeping word, yes means yes, no, no), trustworthy (not reveal confidential talk of another), honest (not to accept bribe, bribe blinds clear-sighted persons), fair (equity and equality) and legal (render to all their dues, to the person who calls for the tax, the tax). It is used to help define and distinguish different ethnic groups and cultures while teaching children about the usage of their native language as a primary means of learning and transmitting the culture. Riddles are not just a form of entertainment; they play an important role in the social and cultural education of children. Riddles are also useful tools in children's cognitive development. They teach rules of behaviour, explain and interpret natural phenomenon, and are a socially sanctioned avenue for questioning social taboos and restricted subjects. In the educational role, riddles provide a safe avenue for transmitting restricted information as well as intimate and vital knowledge (Pellowski, 1977).

A proverb on the other hand is a brief popular epigram that condenses common experience into memorable form. It is the horse that can carry one swiftly to the discovery of ideas by painting vivid pictures of precepts which accelerate understanding. Caregivers mentioned they use proverbs for many pedagogical purposes like in character colloquies as part of character education programmes. Some caregivers explained that 'proverbs can provide focus to gatherings and closings, either used singly to emphasize one idea, or with each individual or group getting a different one and asking for a few people to share ones that are meaningful to them. They are useful as springboards for discussions of the implications and ethical dimensions of

historical events as Krobo migration to Ivory Coast, scientific controversies surrounding the origin of HIV, local beliefs about AIDS, learning styles for HIV prevention, and local behaviour towards sexuality. Thus proverbs as a proxy for good storytelling provide wonderful nuggets of discussion-provoking wisdom for caregivers in Manya Krobo to get around the adult-adolescent communication barrier.

Proverbs help caregivers too to learn. For instance, one respondent quoted this proverb "roast something for the children that they may eat" to illustrate how a mother denies herself to satisfy her children first when hungry. Caregivers can learn much from this proverb. This teaches caregivers that in order to fulfil parental obligations to their children, it is necessary for them to be self-sacrificing and forego certain things in their lifestyle. It is their obligation to care for their children by providing what is necessary for their health, education and right conduct. When probed to elaborate further on how to maintain a balance, four principles were outlined. These are to determine priorities, decide in advance, make position known, and seek support from others. This implies when facing a temptation or an ethical dilemma, ask for advice from someone who shares your values.

In view of the fact that the single caregiver has to work to meet the needs of the children including OVC, there is little time spent with them. Considering the emotional trauma OVC had endured as a result of their loss, this deprivation can further cause a wedge between the caregiver and the OVC. Since the OVC need emotional support in the form of companionship, they often look for alternatives, often in negative forms. The OVC could end up being delinquent thus creating other social problems in the medium to the long term.

This trend is worrisome and calls for a concerted effort to address the causes and minimise the consequences. The Department of Social Welfare, civil society groups, including religious bodies can give support by way of partnering the caregivers with regular home visits and providing emotional counselling. The "faith" community can rely on the Biblical resources to point to God's intervention in single care-giving situations.

Upon close examination of the occupational and income earning profiles of the caregivers in *Manya Krobo*, the statistics paint an alarming situation for the future of the project. Without doubt, virtually all the caregivers are engaged in concealed employment. Humans have needs and the ability to satisfy such needs is crucial not just

for survival but to live in dignity and to have the capacity to cater for others in need as well. This ability is ultimately dependent on one's income earning source and how such source is fulfilling and sustainable. Failure to meet a minimum and certain acceptable level of descent living greatly hinders one's progress in life. Even more dangerous, is the possibility of the situation creating a sense of dependency syndrome in the OVC. They cannot live the anticipated empowered and decent lives which may win the respect of others.

Poverty is a word that is commonly seemed across. While it is very difficult to clearly define who is poor as it varies from situations and places, Abraham Maslow's (1954) five levels (hierarchy) of human needs is most useful. He identified physiological, safety and security, social, ego-status-and-esteem, and self-actualisation needs. Physiological needs are the necessities of life such as food, water, clothing, shelter and health. Safety and security needs refer to the sustainability or assurance of basic necessities for the future. Social needs concern friendship, a sense of belonging and satisfaction. Ego, status and esteem needs refer to individual's desire for achievement, confidence to face the world, and independence. Self-actualisation needs concern an individual's desire to fulfil their God-given potential and give to society the benefit of their experience.

While acknowledging the fact that not everybody gets through to the highest level, everybody wants to live in dignity. If caregivers themselves cannot have the basic necessities of life, then they are not just poor but that raises doubt about the safety-net the OVC project is expected to deliver. The most crucial question though is what could a poor caregiver do to get out of poverty?

The caregivers must learn to devote themselves to being good role-models and generating income, in order to provide for the daily necessities of life. They must make it their ambition to lead good lives and work hard so that their daily lives may win the respect of others and not be dependent on anybody. If poor people consider and learn from the modus operandi of ants, they can grow wise and prosperous. Maxwell (2002) summarised the lessons the ant teaches as attitude of initiative, nature of integrity, thirst for industry, and source of insight. Caregivers and OVC alike must know and understand that there is no short-cut to success in any area of life; whether it is in business, academia or philanthropy. One ought to be well informed, have aptitude and desire for learning and quick to understand. The caregivers must necessarily

demonstrate the characteristics of a creative survival by being positive and creative, starting with either nothing or something little, being an initiator and a hard worker. Although job opportunities in Ghana are sometimes sparse, with a little assertiveness and forward planning, one can set herself free from the unemployment or concealed employment trap. What is required is self-discipline by avoiding procrastination and doing what they ought to, when they ought to, they will worry much less about failure, scarcity and needs. They must not seek subterfuge in giving excuses for non-performance.

Civil society groups must not only provide support to the caregiver, but must play an advocacy role to get government and other stakeholder to initiate and implement good policies for the caregiver in particular, and the poor in general. The government must not just pay lip-service to care for and support OVC and other poor people but must put up realistic policies that can get people out of poverty. Finally, the international community has a responsibility to help implement policies that can get poor people including OVC and caregivers out of poverty than giving hand-outs. A Chinese proverb aptly captures this essence that “it is better to teach someone how to fish than to give him fish”.

The 2008 Ghana Demographic and Health Survey showed that stunting reflects malnutrition, wasting reflects acute malnutrition and underweight reflects chronic or acute malnutrition or a combination of both. It shows that 28 percent of children under five are stunted, 9 percent wasted and 14 percent underweight. Stunting and Wasting decrease as mother’s level of education and wealth status increase. The proportion of underweight children born to women with no education is 17 percent compared to 7 with secondary education. The most common problem with feeding practices is inadequate number of feedings; only 46 percent were fed the minimum number of times. Anaemia in children is associated with impaired mental and physical development and with increased morbidity and mortality. Anaemia can be a particularly serious problem for pregnant women, leading to premature delivery and low birth weight. The prevalence of anaemia among children has increased slightly over the past five years, from 76 percent in 2003 to 78 percent in 2008. The level of anaemia observed among young children in Ghana is considered to be a major public health concern (World Health Organisation, 2001; Ghana Statistical Service, Ghana Health Service and ICF Macro, 2009).

The menace of indiscipline in Ghana today has been exacerbated by the Information Communication Technology (ICT) age. Knowledge and its influence both negative and positive are impacting on the youth of today. Easy access to ICT equipment such as mobile phones, internet facilities and the lack of knowledge of use of these facilities by the older generation make it difficult for parents and guardians to monitor what their wards are exposed to. Parents have it as a duty to guide and interact with the youth in order to filter the good from the bad. I wish to emphasise that the Holy Bible should be the benchmark while the good traditions of our country should not be overlooked.

There exists a growing body of literature on the role of education in the development process. The central argument is that qualities such as responsibility, accountability, trustworthiness, integrity, motivation, commitment, emotional maturity, honesty, love, tolerance, loyalty and personal caring, hold the key to the totality of development. The underlying assumption put forward by experts is that these appropriate principles can be taught in schools and need to be made an ideal part of the education curricula. This is what the mission schools are committed to doing and caregivers must hold sacred.

Change is a reality in every society and *Manya Krobo* is no exception. Probably what is new is the rate of change. It is now too rapid because of ICT. This is widening the generation gap which must be handled with a lot of care and wisdom. There is no doubt that the young people of today are living in a world that is rapidly changing not only in technology and related issues but more critically in the value systems that their parents know and follow. These challenges occur in every aspect of life and it makes it difficult for today's young person to dare to be different. How does the caregiver handle this gap in their dealings with the OVC? How do other family members handle this gap in the home and society? How can the adult generation mentor the young generation to bridge the gap? These are the empowerment issues explored in this section.

Manya Krobo Queen Mothers Association is the strongest of its kind in all of Ghana. It is spear-heading transformation and empowerment of women in their communities. As a feather in their cap, *Manya Krobo* Queen Mothers Association is represented at the *Manya Krobo* Traditional Council. Significantly, concerned Queen Mothers are consulted by the king-makers before a new chief is installed. The king-makers are the royal lineage clan that has the responsibility of nominating and installing a successor upon the demise of the reigning chief. Hitherto, Queen- Mothers and for that matter

women, were not consulted in this process. Significantly, the Queen Mothers have fought for the practice of levirate which used to be common to be banned. This is in view of its tendency to spread HIV infection from a surviving wife to the new husband and his other spouses or vice versa. Similarly, widowhood rite duration is reduced from one year to one week. The practice of "tse we nie yemi" which hitherto forbad women from inheriting landed property, houses and taking charge of burial are being modified due to the intervention of the association. There is also positive change to the age for girls to undergo traditional puberty rite called *dipo.* The inclusion of informal education during the *dipo* helps to build the skills thereby empowering girls to attain certain level of self-esteem.

While applauding the efforts at reformations of customs and traditions, the values are not easily reformed by edicts. They are imbibed by the OVC by following the caregiver or 'the teacher'. The conscience is what differentiates human beings from animals. It is the judge in us which allows us to have a sense of what is right and wrong. Therefore, if the caregivers who are supposed to lead have their 'consciences seared as with hot iron,' then expect them to become wayward children. Gullibility, where OVC easily accept any idea is another value in danger. This often manifests itself in cohabitation and immorality in marriages, hypocrisy and practice of occultism.

It is imperative that training is given to the caregivers to expose them to this all important aspect of child-upbringing. The caregiver's life must reflect his teachings, set examples for the OVC; in speech, in life, in love, in faith and in purity. The caregiver must have a positive self-image by accepting and practising leadership, and encourage the OVC not to neglect their gifts or talents through fear or intimidation by the traditions of the environment they live in.

A caregiver should also be a mentor in both formal and informal training to the OVC. A mentor relationship is a deliberate pairing of a more skilled or experienced person with a lesser skilled or experienced person, with the agreed-upon goal of having the lesser skilled person grow and develop specific competencies (Murray & Owen, 1991). This approach is particular useful where parents are either unavailable or unable to provide responsible guidance for their children and designed the facilitated mentoring. It is usually a long term mutual relationship in which the caregiver comes alongside the OVC to help them achieve their vision. In this respect, the caregiver must be specific skills to

inspire confidence and build the OVC up. The caregiver must seek to unearth and help develop the potentials already deposited in the OVC. Importantly, the caregiver must point the OVC to the roots of their common traditions and customs and offer explicit reasons.

The lack of government support and clear-cut guidelines on quality standards does not help to monitor and evaluate effectively and efficiently activities and programmes on OVC. Such standards of care should aim at accurately documenting the magnitude and characterisation of the OVC population in terms of numbers, age, gender, geographical location, and care-placement whether numbers in residential or family care. These issues include lack of consistency in measuring standards of care, balancing global standards to specificity, understanding and addressing gender dimensions in the context of domestic workers, caregivers, transitional shelters, and addressing the absorptive capacity of families.

In all matters, it ought to be remembered that the gem cannot be polished without friction, nor a man perfected without trials. The caregivers and OVC best understand that things turn out best for people who make best out of the way things turn out.

4.8.3 - Bail-out options or transition plans for maturing young adults

Every human endeavour has a beginning and logically has to develop a strategy on how to exit or transit from one phase to another. This is very important for potential sponsors who will want to know the enterprise's long-term plans. A clear and explicit exit plan shows purpose of mind because it will dictate how to operate the venture. An exit strategy is basically a plan to get out of a situation.

With respect to an OVC project, an exit strategy refers to a plan for getting young maturing adults out or graduating at a certain point when they are considered capable of fending for themselves. In modern social entrepreneurial scheme, it is considered risky to enter a project without a very clear exit strategy. This includes quantifiable measures of success and limits of acceptable continuous support beyond certain stages, in tandem with plans for equipping the OVC with employable skills without which a large dependency burden is borne. An exit strategy is recognized as being crucial to help bring about a positive conclusion to an OVC undertaking. A plan for positive closure is usually determined at the outset of the social enterprise modelling. An exit strategy is

often presented as a bail-out option or transition from the scheme, in case the project appears to lack future direction and not as bright as predicted. An exit strategy allows those involved in supporting the endeavour to have more confidence that they won't have to continue pumping resources into forever.

There are two ways via which children leave the parents to be on their own. These are the normal way and abnormal route. The normal way consists of situation as going to the boarding school and occasionally visiting other relations or family friends. On the contrary, abnormal route involves situations when children abandon the home of the parent due to a misunderstanding with the parent or someone living in the household.

Age is a key determinant of time for exiting care by a child. In Ghana, marriage with parental consent is allowed at age 16 when a child is supposed to have graduated from Junior High School. A child can marry or vote at age 18 years however a child is considered fully mature at age 21. Unfortunately, these are not the only factors which help to take the decision to leave the family to start life on one's own since it involves a huge challenge. For many people and families, there is a hope and expectation even if not pre-determined that the child will exit one day. This can be more daunting in times like the present when job opportunities are almost non-existing. It all depends on each individual child or young adult and their state of mental toughness, morality and skills acquired for self-supporting initiatives.

4.8.4 - Financing Options

Every venture or enterprise requires resources which could be in the form of money or materials to aid implementation of programmes but how transparently and accountably they are applied enhances confidence to augment regularity of giving. Discussions around Manya Krobo Queen Mothers Association's operations have so far not being clear with clearly defined financing options, though several options are available for consideration with the stronger contender being internally generated funds, which will entail guaranteeing reliability and certainty. There is the imperative to examine the methods of fundraising, the frequency and consistency of delivery necessary to offer assurance of continuity and hope. In as much as the MKQMA needs resources, reliable and transparent best practice measures developed to ensure high level of accountability

on the part of leadership and caregivers on utilisation of fund raised is equally significant.

4.8.4.1 - Internally generated resources

When one hears or thinks of project related resources, what often comes to mind first is financial. It is not that the internally generated resources are not either known or understood but the problem is that it is in most cases come in the form of intangible resource hence all too often overlooked or taken for granted. Despite the prevalence of poverty among the Manya Krobo folks in the form of claims as no shoes, no clean water, poor nutrition, high child mortality, illiteracy, apathy, disease, ignorance, intolerance, and no facilities, the Queen Mothers OVC organisation possesses resources. No community is totally and absolutely poor. So long as there are living human beings in Manya Krobo, then it has resources, enough to allow OVC project to survive. A resource is any good or service that is relatively scarce and relatively useful; in short it has value, it is wealth. Not just any wealth, however, it should be something that can be used, or potentially can be used, as an input, as something that can be used for the fosterage of OVC. It is the raw material of building a vibrant future; in the case of Manya Krobo, it is the input for the OVC safety net project. The most commonly considered resource of the Manya OVC project is cash. This commodity is the most fluid or convertible form of resource as it can be exchanged for real resources as either goods or services. Cash is usually scarce, however, and projects located in poor areas like Manya Krobo would have to seek non-cash resources, and try to turn them into cash, or into resources that would be useful to the OVC project. For the OVC project here resources include many non-cash goods and services. It needs tools to operate the project. It needs raw materials that it would convert into OVC project outputs, it needs labour to provide human energy for the conversion. Another kind of human resource is mental, people who will help in the planning, monitoring, decision making, management, report writing; all of those are resources needed, and are provided from within Manya Krobo. The important thing is not to undervalue those non-cash resources but to put a fair market value on them including the time and effort spent by the implementing committee and the executive committee in charge of the OVC project.

"We've been struggling all these years trying to raise these 1,065 children in fosterage but praised be to God we're enjoying enormous support in both cash and kind from members of the community. While we started on a small scale, little did we know that we would become the *Manyemie* (mothers) and hope to so many needy kids here in Manya Krobo traditional area!" Ironically, perhaps many of the caregivers on the Manya OVC project either no longer have any young children of their own or have just an average of two children themselves. This is because some had determined not to have more children they could not provide for. One caregiver said "I've to admit, this voluntary undertaking wasn't my original idea, and it was Manye's dream. It took a great deal of promptings to persuade me to take in the OVC." The Manya Krobo OVC project office situated in some of the rooms on the ground and first floors of an abandoned 18th century Basel Missionaries' wooden structure is used to receiving a stream of well-wishers. Churches and other religious-affiliated bodies bring bags of clothes, a local grains mill donates a few kilos of flour, neighbours present vegetables and other food stuff, some good Samaritan pays school fees for a couple of OVC, among other gestures of goodwill. Though Manya Krobo traditional area is home to a dozen or so aid organisations, so far this kind of support has come almost entirely from individual philanthropists and Ghanaian businesses.

Internally generated resources also refer to the creation of intangible results within the confines of the OVC project and Manya Krobo as whole. An intangible resource is an identifiable non-monetary asset without physical substance. It is simply the premium paid over and above the net value of the assets when calculating the value of the organisation. These resources either be touched or seen but nonetheless have value. There is no gainsaying that the Queen Mothers Association alongside the OVC project has been able to generate a fair market-based value that is gained logically and consistently rising in relation to their operating profile and processes over the years. Fair value is the amount for which a resource could be exchanged between knowledgeable and willing parties. Intangible assets include franchise rights, goodwill, non-compete agreements and researches, among others. Goodwill presumably reflects the value of things such as employee talent, market reputation and technology. These resources are one of the hardest items to put an actual value to hence be usually ignored if internally generated. This is why when it comes to valuing the OVC project; intangible assets

rarely have any relation to economic value. There is a common tendency for project leadership to under value these but it is very important to ensure that they are given a fair recognition of their worth during negotiations with other stakeholders and interested parties.

4.8.4.2 - Payment of MKQMA membership dues

Just as a number of social groups do, the Manya Krobo Queen Mothers Association (MKQMA) survives partly on resources mobilised from among its members. This is why MKQMA has levied membership dues payable on either a monthly or yearly basis. The membership year runs from January until December. The membership due is subject to change each year. The membership fee is not refundable upon membership termination. New or first time applicants must pay an initial one-time application fee before her membership is considered confirmed. This fee only applies to full memberships and varies according to position and role within the Association and community. A new member is invoiced when the member is joining MKQMA the initial one-time application fee, and is then only obliged to pay the per month pro-rated amount of the annual membership dues.

There are many reasons why MKQMA charges membership dues. Obviously, the funds are used to cover costs associated with MKQMA administrative activities like supplies for a project, rental on a space, provide transport for executive members or refreshments for meetings. It also serves as welfare fund from which distressed members are helped out according to laid down rules. MKQMA is responsible for setting, collection, distribution and management of these funds. These processes as well as accountability strictly follow a financial arrangement agreed on by members.

4.8.4.3 - The State

Government of Ghana supports the MKQMA OVC project with a variety of resources including the regular and fiscal budgetary expenditures of central, regional and district governments that can be regarded as a form of social protection. Social protection refers to state help given to those in need or at risk of hardship like OVC. It is a safety net meant to provide a minimum decent standard of living and designed to protect the vulnerable in society such as those affected by, for example, HIV/AIDS, low income,

family circumstances or age. Through the respective ministries, departments and agencies responsible for providing both goods and services, and ceded funds, the OVC project gets its fair share of the national kitty albeit inadequate. Besides inadequate provision, the main challenge is that the decisions to make these expenditures are done without any communication with the community or managers of projects as MKQMA OVC project. Decisions made by bureaucrats in faraway capital cities (national capital, regional capital or district capital) without the involvement of the communities are as bad a charity; they contribute to apathy, dependency, and the sustaining of poverty.

In March 2008, Ghana piloted a national social protection strategy focusing on what is termed Livelihood Empowerment against Poverty (LEAP) programme which is based on the Growth and Poverty Reduction Strategy II (GPRS II). The LEAP Programme is a social cash transfer programme which provides conditional cash and health insurance to extremely poor households. LEAP aims to create an all-inclusive and socially empowered society through the provision of sustainable mechanisms for the protection of persons living in extreme poverty, related vulnerability and exclusion. LEAP was designed to reach around 45,000 of the most vulnerable households (elderly persons, orphans, vulnerable children, and persons with severe disabilities who have no alternative means of meeting their subsistence needs and have limited productive capacity) in 80 districts. Eligibility is based on poverty and on having a household member who is an orphan or a vulnerable child (with emphasis on children affected by AIDS and children with severe disabilities), persons with severe disabilities, and the extremely poor above the age of 65. Households with one eligible beneficiary receive GH¢8 (US$5.70); those with two receive GH¢10 (USD7.10); those with three receive GH¢12 (USD8.50); and those with four or more beneficiaries get GH¢15 (USD10.70) as monthly allowances. The programme is fully funded from national tax revenues and is implemented by the Department of Social Welfare in the Ministry of Employment and Social Welfare in collaboration with the respective District assemblies. Apart from anecdotal stories, there is no evidence to show that LEAP has been beneficial, or has impacted families as expected during its design and the foster households are yet to ‘LEAP’ out of poverty in Manya Krobo. It was discovered during the research that among the 1,065 OVC in fosterage, only a three and half year old OVC boy receives benefit from the LEAP programme. There are numerous media reports of delays and

complains by beneficiaries of up to ten months of unpaid LEAP allowances. It may appear that either there is a lack of political will or appreciation of the LEAP programme.

Improving the quality of inclusive education in Manya Krobo by addressing known gaps to implementation offers OVC new opportunities to tap into their potential. In the context of HIV, education is a simpler question of ethics. To deny OVC basic education is to deny them the knowledge, life skills and ability to identify and avoid risk that might protect them and those around them from HIV. It is also to deny them the further skills that might allow them to build a future for themselves and their families, when poverty and a lack of education are strongly linked. One of the main barriers to access to education and gender discrimination is payment of school fees or tuition. To make good progress towards increasing access to education and narrowing gender gaps for OVC requires the abolition of school fees in basic education because it effectively addresses poverty. In 2006, Ghana abolished school fees nationwide in basic education and introduced a capitation grant for all basic schools. For the OVC enrolled in public basic schools in Manya Krobo area, the grant offers them the opportunity to narrowing gender gaps by substantially increasing basic education enrolment and retention rates. The national primary gender parity index (GPI) has improved from 0.93 to 0.95. The increase in enrolment was higher for girls than for boys, thus further narrowing gender gaps. A similar trend is observed in the poorest and most remote areas, confirming that abolishing school fees benefits the poor (World Bank, 2011). As is the case in many projects, the increase in enrolment has, however, led to a number of emerging challenges, including shortages of teachers (especially in remote areas like Upper Manya District), a shortage of school infrastructure, and implications for financing that could negatively affect the quality of teaching and learning, and thus learning outcomes (World Bank, 2011).

When children especially OVC in basic education attend school sessions on empty stomachs, they become easily distracted and have problems concentrating on their schoolwork. They become better students when their bodies are well nourished and healthy. The incentive of getting a meal also reduces absenteeism. Most importantly, performance improves and drop-out rates decreases. Providing a meal at school is a simple but concrete way to give poor children a chance to learn and thrive as well as sustained contribution to poverty reduction and stable food supply. The Ghana School

Feeding Programme was launched in September 2005. The programme aims at reducing hunger and malnutrition among the selected public primary school children, increasing school enrolment, attendance and retention in primary schools, and boosting domestic food production.

In the Upper Manya Krobo District, sixteen (16.84%) basic schools out of ninety five publicly owned basic schools have benefited from the National School Feeding Programme. Considering the poor living standard of the people, it is not the best to have the programme running in only sixteen schools out of ninety five. Similar number of schools in Lower Manya Krobo are benefitting from the scheme. In the meantime, new names of school deemed vulnerable had recently been submitted for consideration. From 2009, two new child educational welfare programmes have been introduced in basic education. These are the free distribution of school uniforms and exercise books. The government claim recently that 3-in-5 basic education pupils have benefitted from its free school uniform scheme has been received with mixed reactions. These free uniforms are given only to public basic schools that still wear the prescribed government uniform. Meanwhile many public basic schools that have missions affiliations use different school uniforms separate from the government prescribed one hence do not qualify to enjoy the free uniform. With respect to the exercise books distribution, there appears to be no known guidelines for distribution to school pupils. For these reasons, some have questioned the validity of the figure government has churned out.

It is not in dispute the commitment of government to contribute resources for the development of children in Ghana. Since OVC have special needs and that the normal fiscal and budgetary expenditures and projects might be inadequate in addressing these needs, the Queen Mothers in mobilising resources should seek to influence official decisions. While the MKQMA OVC project in doing fundraising do not have a lot of control over how such official decisions are made, they can contribute to change the impact. Firstly, by encouraging and assisting government officers to dialogue with the community in their influential role of broker. And secondly, by supporting and suggesting the development of policy papers in community development that support a governmental enabling environment in which central, regional and district plans are done only in response to the plans and priorities of the OVC in Manya Krobo.

4.8.4.4 - Civil Society groups

Assistance agencies come in several varieties. For any one community, the most common will be an international NGO, or a national NGO that is funded by an international one (NGO means non-governmental organisation; it usually implies a not-for-profit voluntary agency). Other outside agencies may be churches or their secular assistance departments, bilateral or multilateral projects. The International Red Cross claims it is not an NGO; it is an NGO. Increasingly the international sources of assistance are calling for community participation and sustainable development.

Again, your role can be one of broker, especially since foreign agencies are seldom well versed in local conditions and in opportunities for empowering communities by including them in decision making and developmental contributions.

4.8.4.5 - UU-UNO Every Child is Our Child Program

As efforts of varying degrees struggle to contain the AIDS crisis, a generation of children slips through the cracks as largely unwanted, uneducated, and at high risk of being infected. In support of the leading role of the Queen Mothers in community care, the Unitarian Universalist United Nations Office's 'Every Child is Our Child Program' (UU-UNO/ECOCP) came on board to strengthen and build on the existing traditional approach to orphan care, and seek to expand to a larger number of children who are affected by HIV/AIDS. It was an acknowledgement of the significant role of the Queen Mothers as traditional female leaders to care for the well being of children in their community when parents die or become too ill to look after their children. The most important gift, in the view of UU-UNO, humanity can give orphans is the chance to fulfil their own potential. UU-UNO's decision to help the orphans is a demonstration of their belief in them hence investing in their future through education while empowering them to see their own potential as limitless. By empowering through education, ECOC Program hopes the initiative will have long-lasting effects not just on the beneficiary students but on future generations, the region, and the world at large.

The ECOC Program began in 2005 following direct meeting between the Queen Mothers and UU-UNO ECOC Program officials. They learned and considered community issues, then jointly prioritised requirements. School fees and health care

were the highest priorities and so 61 boys and 45 girls in foster of 76 families from three communities were selected to benefit (Table 4.2). UU-UNO believes education is vital in preventing teenage pregnancies among girls which is a continuing problem. Education helps to rein in high rates of teenage pregnancies which are a result of early marriage, sexually active youth, lack of knowledge of reproductive health and lack of access to youth friendly reproductive health information and services. By this Every Child is Our Child Program, UU-UNO shares the burden of medical costs, food, clothing and miscellaneous expenses to provide comprehensive care for OVC.

UU-UNO observed that considering the high cost of living and inflation, many of the families who take in additional children are not able to provide the required school fees and access to sports, textbooks, school bags, uniforms, notebooks, stationary supplies and science resource centres. It is reasonable to assume that as a result, many orphans will never receive adequate care and support for schooling as these rights of the child are compromised by the effects of AIDS on families and society. Upon close examination of the occupational and income earning profiles of the caregivers in *Manya Krobo*, the statistics paint an alarming picture of uncertain the future for both the OVC and the project. Without doubt, virtually all the caregivers suffer concealed employment which is compounded by single parenting and aging problems.

Table 4.2 – Demographics of OVC and caregivers on UU-UNO Program

Category	Yokwenor	Okwenya	Asitey	Total (%)
OVC	35	29	42	**106 (100%)**
Male	20	16	25	61
Female	15	13	17	45
PRIMARY	21 (31.8%)	19 (28.8%)	26 (39.4%)	**66 (62.4%)**
Male	13	11	17	41
Female	8	8	9	25
JHS	14 (35%)	10 (25%)	16 (40%)	**40 (37.7%)**
Male	7	5	8	20
Female	7	5	8	20
CAREGIVERS	22	26	28	**76**
Male	5	2	8	15
Female	17	24	20	61

Source - Field Survey Data, March – May 2011.

Since all human beings have needs and the ability to satisfy such needs is crucial not just for survival but to live in dignity, the capacity to cater for others in need ought be enhanced. This ability is ultimately dependent on one's income earning source and how

such source is fulfilling and sustainable. Failure to meet a minimum and certain acceptable level of descent living greatly hinders one's progress in life. Therefore funding school fees was critical to providing the education required by this beneficiary crop of OVC. By this Every Child is Our Child Program, UU-UNO shares the burden of medical costs, food, clothing and miscellaneous expenses to provide comprehensive care for OVC. Based on the progress so far, this modest partnership in funding for OVC education forms a vital part in comprehensive care, and may hold promise for further replication in other parts. This partnership was formed with the knowledge that one of the most effective ways to fight poverty and the spread of HIV/AIDS is to increase access to education, especially for girls, and give the local community ownership of issues and of solutions. It is an example of a grassroots process of development that lies in combining community capacity and effective partnerships with outside organisations. It can help turn principles into action by fostering the hopes and dreams of children who have suffered from the devastating consequences of HIV/AIDS and socio-economic malaise.

4.8.4.6 –Transparency and accountability of operational resources

The MKQMA needs money to do its work. It is the responsibility of the association members to give the money and the leadership has the responsibility of using the money appropriately and accounting for it. The two responsibilities are equally important. Without money and resources, the basic mission of the group cannot be carried out. Without money, sponsorship and availability of resources, the association cannot build their resource centre for vocational training, skills transfers, cater for the OVC and carry out the numerous social services the Queen Mothers are involved in. Without money, they cannot organise, coordinate and liaise with all the groups and network members in an effective manner. Healthcare, feeding, clothing and education of the OVC cannot be supported to enable the OVC reach their full potential. For the caregivers, without money, they cannot continue maintain costs accruing on dwellings, provide food, afford education, and take care of health needs among others. Even ensuring that the OVC obtain the best quality of psychosocial support requires resources of some kind all of which can be translated into monetary values and

quantified for accounting purposes. Even integration as the core mission of the whole assignment can simply not be accomplished.

According to the leadership, the solution lies in the need for the association to plan how it carries out the tasks. They need to plan how to carry out the tasks such as regular home visits, identifying needy children, potential caregivers, dispute resolution and carrying out other numerous meetings with partners and stakeholders. How can, for instance, the association plan any programmes and execute them successfully if the financial support is not assured? They insist that without a system to ensure regular financial inflows, planning cannot be realistic and the association cannot do much. It is the responsibility of the group members as well as community members to give the money and the leadership has the responsibility of using the money appropriately and accounting for it. The two responsibilities are equally important to ensure continued and uninterrupted execution of decisions and plans. As a result, according to members, fundraising is not only undertaken in response to some powerful and emotional appeal, but is well planned to assure consistency. In order to prevent funds raised from being misapplied, siphoned or stolen, the leadership ought to ensure proper accounting. The members and leadership partnership in handling finances is very crucial for transparency and accountability. Anytime this partnership becomes weak and the members succumb to the leadership or the members put unnecessary impediments in the way, accountability suffers. Systems must be so developed that transparency is enhanced. The leadership described transparency systems that are put in place and allow to work. In their view, professionals are needed for the voluntary work but the more important criteria is their zeal for the work. Leadership must also commit and demonstrate to using available resources more effectively to avoid any criticism of the way they administer this liberal gift. “We are taking pains to what is right, not only in the eyes of men but also in the sight of the Lord”, the project director disclosed. She revealed that the following facts are noted which inspire them ‘to act with complete honesty’. They are aware that the community has enough resources to support the OVC work even from local people who appear as poor. The officials who handle the monies have been urged to live above board that nobody will have cause to be suspicious of the ways monies have been used. Integrity or honesty and zeal for the OVC work are very important traits that must be found in all officials who handle the group’s monies.

The association's leadership has a very crucial responsibility in ensuring that monies are not only raised for proposed projects, but are not wasted, or misapplied or stolen.

4.9 - Project management competence and implementation experience

In today's challenging times, nothing can't be taken for granted when it comes to any activity that involves social expenditures. Organisations like MKQMA seeking to successfully drive innovation and underpin social transformation primarily through the utilization of local resources, risk missing the mark unless a systemic and integrated view is taken of their intentions. There are many aspects involved in successful project and programme management such as hard work, experience, good teamwork, solid processes and work practices, having good tools with which to work, adopting and displaying the right behaviours. Successful project management is the one that achieves every milestone and is fully successful by every measure of cost, quality, timeliness, functionality and usability. In other words, it is the one that applies a methodical approach to planning and guiding project processes from start to finish. These processes are guided through five stages consisting of initiation, planning, executing, controlling, and closing.

Sustainability can give the work a better outlook. But, in a still fragile community like Manya Krobo, the project will only launch if it connects to organisational strategy. In managing a project, care must be taken to avoid having hands full with the day-to-day management of initiatives. It is difficult enough to keep a lid on all the tactical actions that are taking place, let alone plan for the future. We found that the project had just a single old desktop computer, a set of public address system and no permanent administrative staff. Occasionally, volunteers who join as interns manage the office as and when available. However, on most times we visited during the period of study field data collection; the office had not opened. Getting properly documented records on activities of the group is very difficult affair apparently because such records may not exist. In early April 2012, we were invited to observe the meeting session of the group at Odumase Krobo. Our first disappointment was lack of respect for time as the scheduled start time of 9:00am eventually began after 11:00am and worse still only nine members were in attendance. There was no prior meeting agenda hence issues were randomly put on the table and subsequently discussed without clear cut linkage to one another.

Besides, topics discussed focused largely on how to strengthen the internal working mechanisms of the association rather than how to enhance the care offer to the OVC. The good thing about this meeting which comes off every first Monday of each month is that it is designed to encourage participation. The members of MKQMA, who have interest in both the association and their respective communities, represent a cross-section of the Manya Krobo community. This broad-based democratic system supports the building of consensus with and to the approval of their constituents. This efficiency to date has largely been used to build up relationship and peace reserves to insulate the association and the subjects from any unexpected conflicts.

Nonetheless, the need for planning as a key element to project success must be cardinal objective. Despite all the daunting challenges confronting the management and implantation of the projects outlined previously, the Queen Mothers are unfazed and have vowed to keep faith with their intentions. Basically, the Queen Mothers have four projects namely: beads making, tie and dye batik production, soap manufacturing and organising Summer School for the OVC.

A bead is a type of jewel which is a small decorative object or round piece of material produced from a glass, plastic, or wood and pierced for stringing or threading. The beads have numerous significance and uses especially by women. Beads have been enjoyed by many for centuries.

They are treasured for their history. Bead as a small decorative piece of art is used for adornment and ritual natively. Beads have been favoured for their versatility, colour and the ease by which they can be polished to a wondrous shine. Beads have been used as currency during trade; symbolism, gifting during rituals and rites of passage, and as personal adornment to ward off evil spirits. Bead making project by the MKQMA typically seeks to teach OVC skills in income generating ventures while learning about local culture.

Figure 4.5 – Queen Mothers beads-making factory displaying samples of products

Source: Author, April 2012.

Krobo bead making is first documented in the 1920's, but the practice is believed to be much older. Krobo beads, also known as powder glass beads, are traditionally produced by using locally dug clay shaped to make moulds. Each mould holds a single bead. Then, finely ground glass is layered into the mould to form patterns. Once the mould is filled, it is fired in a wood burning kiln, also made of local clay. Beads can be pierced shortly after production to allow threading, or are produced in halves and fired together for a short time to fuse the two pieces. A glass slurry gaze can be used to decorate the beads. The structure pictured in Figure 4. 5 serves as the manufacturing base. It was constructed by the former US ambassador to Ghana, Pamela Bridgewater as her contribution to and recognition of the MKQMA project to empower OVC. However, as it can be seen from the photo in Figure 4.5, it appears to be in disuse or under utilise considering the overgrown weeds in front of the structure. The soap making, tie and dye batik venture and beads production appear to have economies of scale edge as both knowledge and raw materials for production are readily and easily available locally. However beyond these reasons, it is difficult to see how beneficial they have been to the sustainability of the group. The main challenge appears to me to be lack of market beyond their territory. Although admittedly Krobo beads for instance are very renowned, no deliberate plan has been implemented to market the products. As a result, it will be difficult to see how the OVC can depend on it in future.

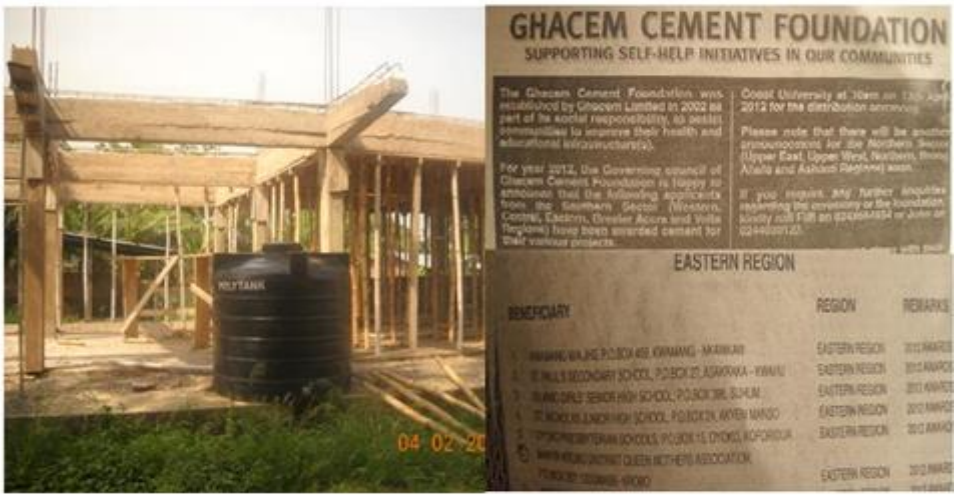
Though I found no evidence of this knowledge and use yet in Manya Krobo, the bead could prove to both aid and encourage women to adopt a more sensible approach to family planning. A type called CycleBeads has the potential to resolve contraception issues. CycleBeads are designed to educate and encourage women about their fertility and family planning responsibilities relying upon natural methods of contraception. These beads prompt women to think more logically about their sexual health and family planning rather than merely for adorning the body. This trend crossing boundaries is a concept the Queen Mothers can certainly tap from and expect to chalk success story as the young girls can easily adopt it and incorporate its reproductive health benefits. The potential is huge as it can be a point of reference to begin sex education and importantly HIV/AIDS knowledge transfer to both the OVC and women in Krobo territory and beyond.

The bankruptcy of the association's project management competence and programme implementation expertise is reflected in the state of affairs of its administration structure. The association has no permanent office after 14 years in existence. It used to be headquartered within the old Presbyterian mission building but was sent packing in 2011 and currently has only a single office as a temporary accommodation offered by Manya Krobo Foundation. They are however not lying idle. They are putting up a resource centre which is under construction. As can be seen from Figure 4.6, this project is almost at a standstill and the reason is not difficult to find. There is simply not enough resources to see it through. There is heavy reliance on donor support but because they have no control over its inflow, it is as when resources become available that they resume construction. The fate of the whole project is in the hands of generous donors and well wishers. Presently, the Godsway United Church Ghana organises annual voluntary support when they mobilise resources to continue erecting the resource centre. This mobilisation effort however appears to be not enough just as the pace of progress is also very slow. In early 2012, Ghacem Cement Foundation responded to the Queen Mothers plea and awarded them some bags of cement to assist with the project.

Insertion in Figure 4.6 shows the announcement nominating the Queen Mothers project for award of bags of cement as well as the stage of progress of the resource centre

construction. Ghacem Cement Foundation is the organ of Ghana Cement Company responsible for appraising requests from groups as part of her corporate social duties.

Figure 4.6 – The Queen Mothers' proposed Resource Centre project



Source: Author, April 2012.

Many corporate entities in Ghana had engaged or have been engaging in a variety of corporate social responsibility activities for various reasons. Corporate social responsibility in its broad meaning involves meeting the economic, legal, ethical and discretionary expectations that society has of organisations at a given point in time. A lot of reasons have been proffered as to why corporate bodies engage in corporate social responsibility. Some posit that it is for altruistic purposes, others claim that it a measure by which organisations secure social license. Another school of thought rejects the foregoing, arguing that corporate social responsibility is employed by organisations as a tool to fend off government interventions and interferences in their activities thereby gaining undue power and influence in the society. According to Ghana Cement Company, their sponsorship goes beyond philanthropic acts such as this donation to MKQMA's resource centre; it is part of their business to give to society by supporting self-help initiatives in various communities. While these philanthropic acts are very welcome, there is a cause for concern as it raises many questions about the project management expertise of the MKQMA leadership.

One such concern that readily comes to mind is the one that questions the ability of the MKQMA leadership is to achieve any milestone in respect of cost, quality, timeliness, functionality and usability of project implementation. The risks associated with the

external support suggest that it will be prudent for MKQMA to develop and explore more of its domestic resources to support project management and execution financing needs. Encouragingly, MKQMA has been using resources generated domestically for its development projects and this must be reinforced.

4.10 - Addressing the question of sustainability of MKQMA OVC project

If there is any question of paramount importance to stakeholders in respect of an OVC project, it has to be about the future of the programme. By the future, reference herein is made to relevance of content, direction, capacity, transition and the very survival of the project to continue serving the needs of OVC for the foreseeable future. The governance structure of MKQMA OVC project is designed to encourage participation. The Queen Mothers model though innovative suffers from absence of criteria for determining who can be a foster parent, lack of ceiling on number of children each foster parent can handle, unreliable source of funding, low level of spending and quality of care for children. The programme is not directed to younger children below the age of six years (Tuakli-Ghartey, 2003). To align with these local priorities implies a need for flexibility and adaptability in terms of the ways the Queen Mothers deliver services.

To meet these threats, the association has considered diverse adaptive strategies. The survey showed there were 396 foster families categorised into four groups namely; Queen Mothers, *akyeame,* family relations and benevolent citizens. This pattern of distribution is not by accident but an evolution based on lessons learned. There were a total of 196 children in households surveyed. The actual number of all children (regardless of background) per household was between a child (4.0%) and 12 children (2.0%) thus a mean of 4 children. This number is significant as it represents the total fertility rate in Ghana (Ghana Statistical Service, Ghana Health Service and ICF Macro, 2009). Total fertility rate refers to the total number of births a woman would have by the end of her childbearing period if she were to pass through those years bearing children at the currently observed age-specific fertility rates. This implies that barring other limitations arising out of the OVC conditions, caring for this number of children should not necessarily be burdensome. And with a mean age of about 13 years (12.7 years, SD – 4.3), bail out options are put in place, the current crop of caregivers should be able to handle the OVC in their care through transition.

To maintain their financial viability, the association relies to varying degree on membership monthly dues payments of GHC5.00 though such internally generated resources remain difficult. Considerable percentage of foster parents (88.0%) was unemployed, while just a tenth (12.0%) had formal employment. The overwhelming majority of foster parents stated informal income as their main source of household income (88.0%). No more than 12.0% of the foster parents named formal salary (pension – 4.0% and teaching – 8.0%) as their major source of household income and some (18.0%) mentioned donations chiefly by relatives as supplementary incomes. Petty trading (beads making, hawking items, marketing, stone crushing and crafts) constituted 44.0% of sources of household incomes. This kind of financing options clearly makes the project very vulnerable to uncertain future. In Table 4.3 we observe that the MKQMA has received support in the form of leadership training, capacity building (training and material support), financial resources, food and material support from various international NGOs, FBOs, the Ghana government and individuals.

Table 4.3 – List of partners supporting and funding MKQMA project

Names of development partners	Status	Area of support
Ghana AIDS Commission	National	Healthcare
Manya Krobo District Assemblies	Local	Governance
Catholic Relief Services	Religious	Nutrition/Education
FAO & Family Health International	International	Nutrition/Health
Hope International	International	Skills training
UN System Gender Programme	International	Capacity building
Rescue Mission	Religious	Education
Opportunities Industrialisation Centre (OIC)	International	Skills training
Toronto & United Way Ghana	Religious	Constructing Office
Uniterian Universalism-UN Offices	Religious	Education
USAID	International	Education/Health
PLAN Ghana	International	Nutrition/Education
University of Ghana (RIING)	Education	Education research
University of Calgary	Education	Education research
African Women Development Foundation	International	Capacity building

Source: Field Survey data, March to May 2011.

There is, therefore a clear need for the MKQMA programme to move away from inadequate, short-term funding and seek to provide longer term, more harmonised and predictable funding. This requires that the managers assure of delivery capacity in terms of planning, coordination and the actual delivery of inputs, cash, food, or goods to

people. In an attempt to respond and adapt to best practices, the association registered as a non-governmental organisation (NGO). Other aspects of the demographics that may have long-term implications for the project include sex, age, and marital status distribution of foster parents as well as lack of exit strategy to help maturing OVC transit smoothly. The sex distribution of the caregivers was in the main females (86.0%) with a ratio of almost nine females to one male (9:1). Overall mean age of foster parents was 54 years (Standard deviation –SD 11.5). Just about 4.0% were below 35 years while majority (54.0%) was in the 55-79 years age groups. Over a fifth (22.0%) of all caregivers were 65 years and above. The respondents who said they were head of household had a mean age of 56 while those who were not household heads mean age was 50 years. A little than a third of the OVC caregivers were either married or co-habited (36.0%), while nearly about two-thirds (62.0%) were either divorced/separated or widowed.

4.11 - Conclusion

While acknowledging the significant contribution of Manya Krobo Queen Mothers Association to help solve some of the problems confronting society, like the proverbial Oliver Twist, the orphans and vulnerable children are asking for more. There is more room for them for improvement. The MKQMA model offers innovative and culturally sensitive solution in supporting OVC to develop thus thwarting the negative consequences of HIV/AIDS and the problems of child neglect. Therefore the project helps in halting the transmission of generation to generation poverty. Further, it promotes a more efficient and equitable society by offering the OVC opportunities to play both a redistributive and a productive role as law-abiding citizens. MKQMA adaptive strategies however remain a work in progress and will be fragile trying to respond to increasing demands in the face of dwindling resources. Fundamentally, increased state-and or external funding framed to include opportunities to engage in and influence policy about the crucial role of traditional female leaders in social safety net intervention in fragile communities. Such a framework may be the viable option that could be considered with a view to sustaining and exporting the virtues of the model.

CHAPTER FIVE

THE EMPOWERMENT OF GROUPS AFFECTED BY HIV/AIDS

5.1 - Introduction

With 2015 in sight, there is little doubt that the Millennium Development Goal, target 7, which seeks to halt by 2015 and begin to reverse the spread of HIV/AIDS, would be missed by Ghana and many other developing countries. Regardless of where groups affected by HIV/AIDS live, as one looks to the future, can one see things improving for these affected groups over the next couple of years? Many countries have what is called social contract; a written or implied agreement between the state and people affected by HIV/AIDS that specifies the rights and duties of both sides. Generally, citizens are expected to abide by the laws of Ghana, to pay taxes, and to contribute toward a safe environment. The country in turn usually promise such things as adequate health care, quality education, protection against discrimination and stigma, provision of shelter, food, equality and economic security.

It cannot be denied that availability and accessibility of informal and formal social protection is crucial for successful prevention of social exclusion and measures that strengthen household or individual coping capacity (UNECA, 2009). Our world is a large quilt and its people are the fabric all joined together by a common thread of heritage. A child is an imitator and an adult is an initiator. The common thread between the generations is knowledge transfer through education on the importance of empowerment and to foster an appreciation of cultural diversity. The concept of empowerment involves the creation of a congenial environment for equipping the youth with knowledge, skills, attitudes, values and ethics. Provision of resources required to enable them contribute to the economic, social, and cultural advancement of themselves, their families, and the nation as a whole becomes a major responsibility of governments and other stakeholders. Consequently, youth empowerment involves the process of preparing young people to meet the challenges of adolescence and adulthood through series of activities, and experiences, which help and motivate them to become socially, morally, emotionally, physically, economically independent and cognitively competent (Ghana National Youth Policy, 2010).

The Ghana AIDS Commission was established in February 2002. One of the Commission's major aims among others is to act as a supra body that coordinates all AIDS-related activities to help increase awareness on HIV and AIDS in the country. Thus it has been working with stakeholders towards universal access and the attainment of health-related Millennium Development Goals four, five and six. The Commission is currently implementing the third phase of a five-year National HIV Strategic Plan that spans the period 2011 to 2015.

Beyond the coordination and creation of awareness at the board, however, what are the practical contributions of the Commission towards the well-being of people affected by HIV and AIDS in Ghana? How does the Commission help fight stigma against people affected, provide access to antiretroviral therapy and building the capacity OVC? What kind of crusade can the Commission embark on to bring real change in the lives of people affected by HIV and AIDS? How has Ghana AIDS Commission performed in those areas aimed at empowering affected groups? How does the situation appear today?

5.2 - The background to the social contract

The world was created in perfect harmony and each organism needs one another to sustain as well as maintain a perfect balance. As a group people have and possess the power to change the order of things for the better. More than three decades have passed since HIV/AIDS pandemic emerged as an enemy to progress and a health care danger. At the same time, nations faced a colossal challenge; an economic affliction of great proportions. The combination caused the world to suffer from the longest and one of the worst sustained afflictions and inflations in history. For decades that followed, humanity piled up deficit upon deficit, mortgaging the future of especially groups affected by HIV/AIDS and children yet unborn for the temporary convenience of the present. Increasing numbers of people were vulnerable to overburdened infrastructure, lack of economic opportunities, outmoded health systems, and stigmatization and discrimination of those affected. In fact within that period a third of the world's people lived in near total despair; lacking sanitation and clean water, exposed to the imminent effects of climate change, fuelling the spread of disease and possible pandemics as HIV/AIDS. To continue this long trend was to guarantee tremendous social, cultural,

political, economic, and health upheavals. As bleak as this outlook may have seemed, the world was not entirely pessimistic and so before the turn of the last century, humanity purposed to tackle eight serious challenges it identified as impeding the proper development of the world.

This proposition involved investing in development through a practical plan that brought together internationally agreed framework of 8 goals and 18 targets complemented by 48 technical indicators called the Millennium Development Goals (MDGs).

The road to tackling and harmonising HIV/AIDS-related activities and practices in Ghana has not been a smooth one as it was often fraught with lots of impediments and lack of clarity. It is imperative to point out that ordinarily, the state has an obligation to provide the needed interventions aimed at combating and containing HIV/AIDS and its ripple effects. Scaling-up such activities in low income countries like Ghana has, however, been hindered by resource constraints hence initiatives as the MDGs was a welcome relief. It necessarily obligated Ghana to see the imperative in developing her own programme framework and activities to address the vulnerability of young children and HIV/AIDS affected households within the context of service delivery and HIV control.

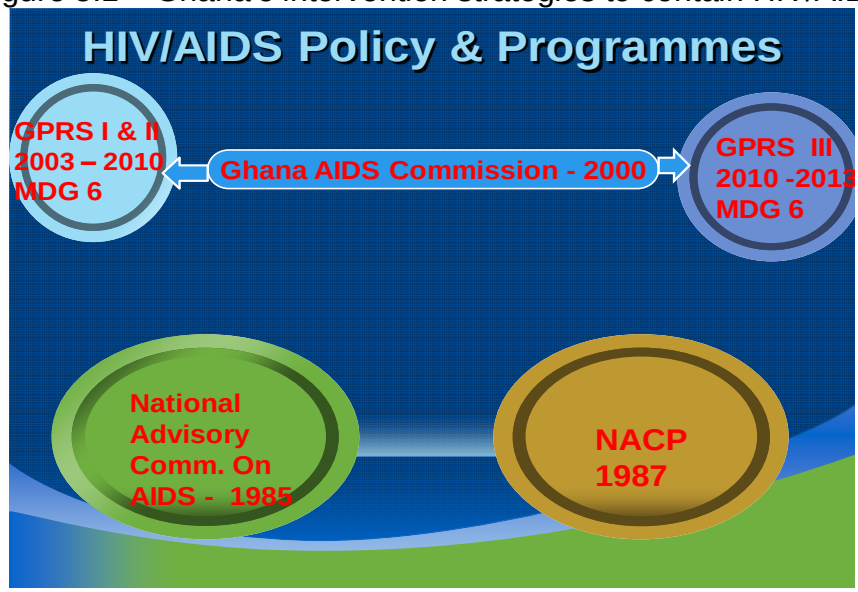
Thus Ghana being mandated under the MDG framework to recognise that HIV/AIDS affected households and especially children are vulnerable and require special protection appropriate to the age, level of maturity and individual needs started developing a formal child protective system in the country as a sequel. The trends in Ghana's HIV/AIDS and interventions including integration of MDG 6 revolve largely around the adoption of social marketing approach to influence behaviour change. The HIV/AIDS response in Ghana can be summed up as promoting policy, advocacy, and an enabling environment. Other responses are mitigating the social, cultural, legal, and economic impacts of HIV/AIDS by communicating prevention and behaviour change messages as well as providing treatment, care, and conducting HIV/AIDS research, surveillance, monitoring and evaluation.

Ghana's response to the threats posed by HIV/AIDS was initially medical; an approach informed by an international politics of funding which privileged prevention through behaviour change over integrated prevention-treatment efforts. The pretext was that prevention is a more cost-effective option in resource-poor setting as Ghana. Figure 5.1

shows a summary of the evolution and trend of Ghana's approach to dealing with the HIV/AIDS epidemic. Ghana had the National Advisory Commission on AIDS (1985) and National AIDS/STIs Control Programme (NACP, 1987). Ghana abandoned this approach in favour of an integrated one in 2000 as HIV/AIDS was seen as a developmental issue and a response to the MDG. This shift was precipitated by loss and gaps created by AIDS deaths within the productive sector. An apex body, Ghana AIDS Commission (GAC) was formed in September 2000 but ratified by parliament in 2002 and charged to provide leadership in the fight against HIV/AIDS (Ghana AIDS Commission, 2009). The MDGs necessitated synchronising interventions to meet the goals leading to drawing up of three successive medium term plans set within 2003-2013 timescale.

It may seem that the commitment of Ghana to tackle the epidemic appeared strong on paper as demonstrated by the various initiatives from the establishment of the AIDS Advisory Committee to Ghana AIDS Commission (GAC) and the OVC plan of action (Figure 5.1). The weaknesses were that these initiatives lacked the potency to holistically respond to the multifaceted nature of the epidemic until the establishment of the Ghana AIDS Commission.

Figure 5.1 – Ghana's intervention strategies to contain HIV/AIDS



Source: Author's construct, 2011.

The Ghana AIDS Commission was established as a supra-ministerial body with multi-sectoral representation in 2000. It membership consists of a chairperson (the president

of Ghana), a vice chairperson (the vice president of Ghana), a director general and 14 ministers of state. The membership also includes heads of 26 other national institutions. The sources of money for the discharge of the function of the commission include subvention from the government, donations and grants, and loans contracted and guaranteed by the government. The commission has power to make regulations; it may by legislative instrument make regulation on HIV/AIDS policy and generally to give effect to the provisions on the disease. It may also appoint committees consisting of member of the commission and non-members to perform any of it functions.

Their policy and programmatic response has a positive policy, advocacy and enabling socio-political environment for implementing a comprehensive multi-sectoral programme to combat the HIV epidemic. The Commission is tasked to formulate a national HIV/AIDS policy; to develop programmes for the implementation of the policy and direct and co-ordinate the programmes and activities in the fight against HIV/AIDS and to provide for related purpose. As a supra-body, its main object and function are outlined as to formulate comprehensive policies, strategies, and establish programme priorities. Further, to provide high level advocacy for HIV/AIDS prevention, control, effective leadership in the national planning, supervision and support of the HIV/AIDS programmes. Others include to expand and co-ordinate the national response to the HIV/AIDS by mobilizing, controlling and managing resources available for the achievement of its object and monitor their allocation and utilization.

Finally to foster linkages among stakeholder by promoting issues relating to research, documentation, dissemination on HIV/AIDS; and monitor and evaluate HIV/AIDS programme. The commission has instituted channels for consultations with stakeholders at the District, Area Council and Community levels. These include public fora and information dissemination and public education by the Information Services Department and National Commission for Civic Education. A number of initiatives have been undertaken to promote participation of other stakeholders especially NGOs, CBOs and the private sector in the development process at the decentralised stage like the districts. Several campaigns and publications on the causes and effects of HIV/AIDS have been organized by several NGOs and CBOs in the communities and in the schools. All of these efforts are aimed at ameliorating the high prevalence rate.

Though the OVC challenge is one of the top agendas of the commission, limited resources like expertise and personnel to drive hinder the national response. Consequently, commission partners many groups that seek to take up the HIV/AIDS challenge. Through various institutional arrangements such as the partnership forum, technical working groups and decentralised structures such as the regional and district AIDS committees, and district response management teams. The commission interacts with all stakeholders and receives input and feedback towards the HIV and AIDS response and modifies priorities and interventions. Thus where it deems as necessary for the effective implementation for its functions, the commission falls on others groups most especially at the decentralized phase of the district like Manya Krobo. For the MKQMA OVC programme to succeed, it is imperative that it be designed to intervene at the access points most appropriate for reaching OVC. This strategy should revolve around three levels of intervention of individuals (OVC and caregivers), support networks (household/ extended family/community) and systems (government and nongovernmental structures, donors, private sector). And these are the areas that the contributions of state agencies regarding provisions of health systems, VCT, laboratory tests, antiretroviral (ARV), clinical care, schools, tuition, financial resources, infrastructure, policy, legislation, capacity building and an experienced workforce are crucial. As part of its 10th anniversary celebrations and in recognition of the contribution of its partners, in February 2012, the Commission organised the first ever national HIV and AIDS fair to raise the level of awareness about the pandemic. The four-day fair which was themed, “A decade of active partnership-sustaining the National Response towards elimination of HIV and AIDS” brought together all stakeholders to exhibit and highlight what they have been doing individually (Figure 5.2). During the fair, the fight against HIV/AIDS discrimination hit home. PLWHA who hitherto had remained faceless have self –unveiled, removing their cover. They are determined to survive despite obvious challenges and societal imposed limitations by going public about the HIV status. It was inspiring to see persons living with HIV/AIDs boldly coming out to fight for their rights against discrimination and stigma. They rightfully sought answers to questions like, how can I pay for my drugs if you deprive me of my job simply because I am HIV positive? If you take away the roof over my head how do I survive out there? If I

cannot use your washroom, how do I ease myself? If even the church can throw me out, who will accept me?

Figure 5.2 - Ghana National HIV and AIDS Fair

Source: Author, February 22, 2012.

The agencies directly involve with the MKQMA OVC programme include Ministry of Women and Children's Affairs, Domestic Violence and Victims Support Unit of the Ghana Police, the two District Assemblies in Manya Krobo, Department of Social Welfare, District Health Management Team (DHMT) and Ghana Education Service (GES). On account of these, we consider the evidence as we shall take a cursory look at some of the ministries, departments, agencies, and their respective HIV/AIDS empowerment activities.

5.2.1 – Ministry of Women and Children's Affairs

Integral to the search for solution are issues of attitudes, beliefs and cultural practices which place men high above women and overlooking negative actions perpetuated against women is a total paradigm shift. The world recognises the challenges of women and with one powerful voice speaks out against it and promotes gender equality on 25th November every year by observing the International Day for the Elimination of Violence against Women. In Ghana, there are no legal barriers to both men and women aspiring to rise on the echelons of any profession. Indeed many women hold very high and respected public positions in the country presently including heads of the judiciary,

legislature, police, immigration, Commission on Human Rights and Administrative Justice (Ombudsman), and University of Cape Coast among a number of women who are ministers of state. There however exists some glass-ceiling within the customary and traditional environments that requires radical shift.

Realising the urgent need for a body to coordinate national response to gender inequality and promote the implementation of activities that address the rights of women and children, the government set up the Ministry of Women and Children's Affairs (MOWAC) in January 2001.

The ministry exists to promote the welfare of women and children in Ghana. It is the entity designated by government to initiate, coordinate and Monitor gender responsive issues. It is to ensure equal status for women and promote rights of children. The aims and objectives of the ministry are the formulation of gender and child specific development policies, guidelines, advocacy tools strategies and plans for implementation by MDAs, district assemblies, private sector agencies, NGOs, civil society groups, and other development partners. The ministry prepares national development plan and programmes for women and children in which all the desired objectives and functions of the ministry are programmed for implementation. It aims to ensure that development programmes for women and children are effectively implemented, through continuous monitoring and evaluation of the implementation process, making sure stipulated objectives are fulfilled.

The ministry has also carried out series of capacity building of stakeholders, including the media, religious bodies and MOWAC Staff on a number of issues affecting children and women.

Ghana like most developing and under developed countries is also going through the difficult parts of its socio-economic transformation but with a determination to achieve the best for her children. Ghana was an exemplary first country to ratify the UN Convention on the Rights of the Child. The Ministry faces both financial and human resource constraints in its gender equality promotion, Women’s empowerment and the survival, protection and development of the child. Specific challenges include socio-cultural constraints, behavioural and attitudinal changes within the cultural set-up, lack of sex-disaggregated data (gender data) to promote effective gender planning and evidence-based decision making on gender, women and children issues. Further,

enhancing an effective and stronger coalition with all stakeholders to accelerate the gender equality and women's empowerment agenda and ensuring that national, regional, sector and district annual resource allocation frameworks (budgets) adequately address gender equality and women empowerment issues.

It appears that the adoption of pragmatic strategies is what will help to achieve the best for the present generations of children in the country. The creation of the Ministry of Chieftaincy and Culture in 2006 to facilitate the development of the institution in order for it to take its rightful place in the governance of the nation largely demonstrates the relevance of the institution. Ghana has ratified a number of international charters and conventions that seek to promote an end to gender inequality. Beyond this, it is implementing a roadmap to steer programmes aimed at ensuring that women enjoy their fundamental human rights. The country's full commitment to the gender fight is demonstrated by ensuring that the necessary structures to see to the implementation of her obligations were effectively in place. The 1992 constitution of Ghana spells out fundamental human rights and freedoms for all citizens and specifically outlines rights to equality and freedom from discrimination. Such constitutional guarantee is however deemed rather notional than transformational. The ministry's approaches to its expected vision and core business appear to be moving at a slower pace than had been anticipated at the time of its creation feeding into the perception that it serves a mere political symbolism than anything else.

5.2.2 - Domestic Violence and Victims Support Unit of the Ghana Police Service (DOVVSU)

Its objective is towards advancing the status of women and the growth, survival and development of children. As a consequence, the Domestic Violence law was passed in February 2007 to usher in a new era and revitalized the hope of women and women advocacy groups. The Domestic Violence and Victim Support Unit (DOVVSU) of the Ghana Police Service was established and as of 2011 operates in all 11 Police regions and has 52 offices nationwide. This implies a presence in only a third of the districts in Ghana. Indeed, DOVVSU does not have office in any of the two districts in Manya Krobo area. This hampers handling of domestic violence cases especially those affecting the development of children like the OVC. Regardless of limited presence and

all the other challenges, DOVVSU is helping to address cases of abuse and violence against largely women, children and some men.

5.2.3 - Lower and Upper Manya Krobo District Assemblies

The structure of the District Assembly concept is built on various legal frameworks for local development in Ghana including the civil service Law, 1993 (PNDC Law 327), the National Development Planning (System) Law, 1994 (Acts 480) and the local government Law, 1993 (Act 462). All of these legal enactments place the District Assembly in the centre to reinforce the government's decentralisation process and participatory development. Thus the assembly, by law is the highest administrative and political body in the district. It is composed of two-thirds elected members while the remaining one-third of members is appointed by government. The members of parliament are ex-officio members.

Lower and Upper Manya Krobo have executive committees made up of varying members. They formulate and executive policies of the Assembly. The District Chief Executive representing the central governments chairs the committee. Upper and Lower Manya Krobo Assemblies each operates through seven sub-committees namely Finance and Administration, Social Service, Development, Works, Justice and Security, Environmental Management and Tourism.

The Social Services sub-committee principally deliberates on specific issues especially protection of children and women and recommends to the Executive Committee, which in turn presents them to the Assembly for ratification and adoption. The executive committee co-ordinators plans and programmes of sub-committees and oversees the smooth operation of the administration. The Assemblies by law are obligated to protect the welfare and promote the rights of children within its area of authority and shall ensure that within the district, governmental agencies liaise with each other in matters concerning children.

Area Councils and unit committees constituting smaller units of area of control within the assemblies, are pivotal in local level development as they ferry the Assembly and local community and act as the supreme points of development at the local levels. In Manya Krobo, through the Ghana AIDS Response Project (GARFUND), among whose

objectives include reducing AIDS impact on those already affected by HIV/AIDS, a range of OVC care activities were financed between 2005 and 2009.

There exists partnership between Manya Krobo District Assembly and Ghana AIDS Commission on one hand and MKQMA OVC project, Youth and Women Empowerment (YOWE) on the other for the implementation of Multi-sectoral HIV and AIDS Programme (MSHAP) funded HIV and AIDS programme in the Manya Krobo district. The agreement has produced a number of HIV and AIDS related projects that had already been implemented. Similar projects are being developed to strengthen the relationship.

5.2.4 - Department of Social Welfare (District Focal Persons on HIV/AIDS)

A provision of the Children's Act of 1998 sets out that the Social Welfare Department shall investigate cases of contravention of children's rights. Any person who contravenes a provision of the Act commits an offence and is liable on summary conviction to a fine or to a term of imprisonment or to both. Any person with information on child abuse or a child in need of care and protection shall report the matter to the Department of Social Welfare. When the Department receives a report of child abuse or endangerment and it is determined that the child is not in immediate danger, the matter is referred to a Child Panel, a non-judicial board charged with mediating matters concerning children. Section 30 of the Children's Act grants children the right to participate in decisions made by a Child Panel: A Child Panel shall permit a child to express his opinion and participate in any decision which affects the child's well being commensurate with the level of understanding of the child concerned.

If the investigation by the Department shows that the child has been abused or is in immediate need of care and protection, the Children's Act authorizes the removal of the child to a place of safety. When a child is removed, the child must be brought before a Family Tribunal within seven days. The Family Tribunal can then make a care order to determine the placement of the child or a supervision order setting out the terms under which a child may remain in the custody of his parent(s), guardian(s), or relative(s). Section 38 sets out the rights of the child at a Family Tribunal. These include "a right to legal representation," "a right to give an account and express an opinion at a Family Tribunal," and the right to appeal. Section 25 allows a child to apply for the discharge of a care or supervision order.

Although the Children's Act specifically entitles children to legal representation in front of a Family Tribunal in Section 38, in reality, not all children actually receive it. Legal representation for children is provided only at the request of the child, the child's parents or relatives, or persons interested in the matter and in Ghana, compensation for counsel must be paid by the parties, rather than the state. Still, though they may not receive legal representation, children in child protective proceedings are usually represented by probation officers of the Department of Social Welfare, which has among its functions the protection of children. During meetings with the District Focal Person on HIV/AIDS at the Department, it was revealed that her main functions include but not limited to home visits, family conflict resolution where minors welfare is at stake and helping place abandoned or neglected minors especially babies in foster care.

It was discovered that there was no special attention or care from the Department of Social Welfare for OVC in Manya Krobo though she bears the largest brunt of HIV infections in Ghana. Only one child currently benefits from the livelihoods empowerment against poverty (LEAP), 14 others have been nominated. Also, two OVC living with HIV access free antiretroviral medications. There are 16 and 7 schools on School Feeding in Upper and Lower respectively. The Social Services sub-committee of the assemblies charged to oversee child welfare matters were dysfunctional. Lower Manya operates with an interim management due to legal tussle over the status of Akuse and has denied the citizens right to elect assembly members. The Supreme Court gave its final verdict in July 2012. Akuse remained part of Lower Manya Krobo in the Eastern Region instead of Greater Accra Region. The Electoral Commission has just undertaken voter registration exercise in the Akuse Electoral area. It is however yet to conduct district assembly election in Lower Manya Krobo. According to the District Focal Person on HIV/AIDS, as a result of the absence of the sub-committee on Social Services, there is no budgetary support for coordinators hence quarterly reports have not been submitted by coordinators since June 2011. The assembly has stopped paying their stipends of GHC20.00 per quarter. This has serious implications for monitoring and evaluation which can also affect planning and intervention activities with respect to HIV/AIDS and OVC in the district.

5.2.5 - Districts Health Management Teams

Effective care to prevent mother-to-child transmission which comprises HIV testing, antiretroviral treatment and prophylaxis for mothers and babies, and safe infant feeding which can reduce the risk of a mother passing the virus to her baby to very large extent depends on the nature of the existing healthcare system. Clearly, the challenges are much greater in countries like Ghana where provision and uptake of maternal and child healthcare services is poor. A variety of social and economic factors can result in such situation. In Ghana, weak health systems and severe shortages of health workers hamper efforts to tackle common communicable diseases and provision of care for children including OVC. This peculiarity highlights the need to rethink how the health system works in situations as HIV/AIDS and associated conditions. The option Ghana adopted was to decentralise HIV services to the primary care and community levels and to consider shifting HIV related tasks from doctors to nurses or from nurses to community health workers.

Unlike many other African countries whose health systems have been heavily based on clinical medicine, Ghana has distinguished itself for its focus on public health concerns (Hiscock, 1995). The role of the ministry of health is policy formulation and oversight. A snapshot of the health system in Ghana shows that provision of health services and administration is the sole responsibility of the autonomous Ghana Health Service. GHS is governed by a 12-member Council called the Ghana Health Service Council. It basically functions to recommend and ensure implementation of health care delivery policies and programmes. Structurally, GHS is administrated and organised at three levels namely; national, regional and district. Functionally, GHS is organised at five levels as national, regional, district, sub-district and community. Decentralisation and health sector reform have ensured that services are integrated as one goes down the hierarchy of health structure from the national to the sub-district. The structure of delivery of services is that at the regional level, curative services are delivered at the regional hospitals and public health services by the District Health Management Team (DHMT) as well as the Public Health division of the regional hospital. The Regional Health Administration or Directorate provides supervision and management support to the districts and sub-districts within each region.

At the district level, curative services are provided by district hospitals many of which are mission or faith based. Public health services are provided by the DHMT and the Public Health unit of the district hospitals. The District Health Administration provides supervision and management support to their sub-districts. At the sub-district level both preventive and curative services are provided by the health centres as well as out-reach services to the communities within their catchment areas. Basic preventive and curative services for minor ailments are being addressed at the community and household level with the introduction of the Community-based health planning and services. The role played by the traditional birth attendants (TBAs) and the traditional healers is also recognized and monitored.

At the district level, the health centre has traditionally been the first point of contact between the formal health delivery system and the client. It is headed by a Medical Assistant and staffed with programme heads in the areas of midwifery, laboratory services, public health, environmental, and nutrition. Each health centre serves a population of approximately 20,000. They provide basic curative and preventive medicine for adults and children as well as reproductive health services. They also provide minor surgical services such as incision and drainage. They augment their service coverage with outreach services and refer severe and complicated conditions to appropriate levels.

These outreach services at the district level cover lay counsellors for HIV/ AIDS, quality training of in management of opportunistic infections and HIV related diseases, VCT/PMTCT counselling, counselling supervision in HIV/AIDS, HIV/AIDS counselling for lay counsellors, lactation management, home-based care in HIV/AIDS, and refresher training in community-based growth promotion as well as refresher training in VCT/PMTCT counselling. Availability of the provision of these services particularly at the three main hospitals in Manya Krobo greatly affords the OVC and their caregivers the opportunity to access them. As treatment of HIV/AIDS, tuberculosis as well as immunisation of children is free, orphans who are positive living benefit immensely from the services of the District Health Management team.

5.2.6 - Ghana Education Service

The Government of Ghana has implemented and will continue to implement a number of programmes in collaboration with stakeholders, which directly address the child labour issue. Prominent among these is the full implementation of the Free Compulsory Universal Basic Education (FCUBE) policy through free attendance at public basic schools to disengage children from child labour.

Other programmes include: the Skills Training and Employment Placement (STEP) and the Street Children component of the Community-Based Poverty Reduction Projects of Ministry of Manpower, Youth and Employment (MMYE); School Feeding, Early Childhood Development and the Skills Training and Apprenticeship Programmes by Ministry of Education, Science and Sports. The rest include: institution of awards schemes for teachers; sponsorship of teacher trainees and needy children; construction of educational infrastructure and various poverty reduction programmes. The Municipal, Metropolitan and District Assemblies are involved in the implementation of these programmes. In collaboration with the Ministry of Women and Children's Affairs, among several activities, the GES has organized visits and fora with community opinion leaders, chiefs, traditional rulers and queen mothers in those communities identified as sending' and receiving' communities, support in the form of school uniforms, cloth and micro finance for the mothers, and alternate livelihood skills training to empower mothers in the communities. The GES is liaising with a number of ministries, departments and agencies to ensure successful progress of Ghana school Feeding Programme. It also raises awareness of the continuing need for improvement in the quality of the education provided to Ghanaian children.

5.2.7 - Civil Society Groups

Many local, national, and international efforts struggle to contain the AIDS crisis in Ghana, mainly through medical assistance. Meanwhile, a generation of children has been slipping through the cracks: they remain largely unwanted, uneducated, and at high risk of being infected by the virus themselves. There is no social welfare system and no safety net for these Children. The most important gift we can give them is the chance to fulfil their own potential. We have helped the children by showing we believe

in them, investing in their future through education, while empowering them to see their own potential as limitless.

Civil Society plays a very important role in the development of the vulnerable and the excluded particularly children affected by HIV/AIDS in Manya Krobo. Participation by other stakeholders is manifested at the levels of information sharing, consultation, collaboration and empowerment. Their roles tend to ensure public ownership of development agenda. They achieve this by creating avenues for stakeholders and other parties with contributions to get involved in the whole process. This is very necessary and the effective way to generate true sustainability and public support for the development process.

5.3 - Social Marketing strategies

In Ghana, the MDGs are anchored and mainstreamed into three successive medium term national development plans spanning 2003-2013 through social marketing.

According to Academy of Educational Development (AED, 2011) social marketing is the use of commercial marketing techniques to persuade people to change their behaviour to improve their own lives. Professionals employ consumer research, policy strategies and product development to make change easier and more appealing for identified audiences. Social Marketing ideas are largely implemented in HIV/AIDS programming using communication for change. It is a programme that aims at improving the effectiveness and sustainability of behaviour change using communication (AED, 2011). This embraced engagement with social and donor partners using behaviour change health promotion concepts including policy, research, capacity building and use of mass media. When Ghana adopted the MDGs, she identified some key issues which needed to be addressed regarding integrating HIV/AIDS into the MDGs. It devised three successive development plans called Poverty Reduction Strategy Plans spanning 2003-2013 to capture these issues. These were advocacy and enabling environment, strategic planning, operational challenges, access to services, harmonisation and coordination of donor HIV/AIDS support. In 2003, HIV prevalence rate was 3.6%. The main HIV services provided by all stakeholders are clinical care, ART (since 2002), voluntary counselling and testing (VCT), early infant diagnosis, home-based care, post-

exposure prophylaxis, prevention of mother-to-child transmission, and strong media campaign on prevention.

Stop AIDS, Love Life was a national intervention originally launched in 2000. It was rolled out in phases to successfully address various audiences, improve and increase community-based communication approaches, and increase the quantities of and access to HIV and AIDS communication materials. Figure 5.3 depicts a poster campaign material titled 'ReachOut' which seeks to encourage people to show compassion to people living with HIV/AIDS. Its message is to teach how not one will contract the disease such as "you can't get HIV/AIDS by eating, working or living with people with HIV/AIDS". Also we see in the same figure campaign sticker largely for vehicles and doors featuring the open palm symbolising the power people have to take control of their lives by observing the ABC principle of AIDS prevention. Its title message says "stop AIDS and Love Life. Abstain or be faithful or condom use. The choice is in your hands".

Figure 5.3 – 'Stop AIDS & Love Life' sticker and 'ReachOut' campaign poster

Source: Health Communication Partnership (jhuccp.org/hcp), 2011.

Presently, the focus is on prevention of stigma as stigmatisation hinders disclosure and drives spread underground. Stigma remains the single most important barrier to public or societal action to visit their health facility to discuss possibility of testing and counselling for HIV. Even among those diagnosed positive, many are reluctant to seek medical treatment, which is readily available. It has interesting titles like one dubbed "who are you to judge" that presents characters of varied backgrounds disclosing their HIV status and urging others to voluntarily go for HIV test. Figure 6 is a poster material on shifting from a health-based approach to a social normative approach to HIV

prevention. Measurement of the impact of communicated messages by using data from a number of sources including two household surveys between 1996 and 2003 found that the campaign led to increase in protective behaviours nationally (Communication Impact, 2003). Concerning stigmatisation, the acceptance of people living with HIV and AIDS was 11 per cent for females and 19 per cent for males in 2008. There is the need to encourage people to accept the disease as an ordinary disease and do away with the stigmatisation. Under the national strategic plan, the commission intends to increase the acceptance to 50 per cent by 2015.

In pursuit of this objective the Commission in partnership with Network of Associations of Persons Living with HIV (NAP+ Ghana) and some civil society groups launched the "Heart-to-Heart Campaign" in December 2011. The campaign involves four people; Reverend John Amuzu, Mrs Lydia Amuzu, Joyce Dzidzor Mensah and Gifty Torkornu who are living with HIV and have become ambassadors for the campaign (Figure 5.4). The purpose of the concept is to provide a human face to those living with HIV and AIDS as well as to deepen the knowledge of Ghanaians on the virus.

Figure 5.4 – Heart to Heart campaign Ambassadors

Source: Daily Guide, December 22, 2011.

The objectives for the campaign, among others, include eliminating stigma and discrimination against people living with HIV and AIDS, to achieve a "zero discrimination" and ultimately a "zero infection" rate through the use of different channels of communication to enable people know what it takes to live with the virus and advocate HIV testing and counselling as a key to fighting the virus. Its other objectives included advocating for gender equality and active men involvement in HIV programmes, advocating for political commitment and advocacy for sustained resource mobilization for results. The stakeholders believe that to achieve the purpose of acceptance in the community; traditional leaders, the media and the ambassadors

should come together to help eliminate stigmatisation and discrimination against people living with HIV and AIDS in the country. This campaign has become necessary in view of the observed dichotomy between progress in the campaign against reduction in infection and increase in stigmatisation and discrimination against people living with the virus. This is attributed to people's low perception of personal risk and the need to take steps to avoid being infected. The HIV ambassadors share their life stories to touch the hearts of people in order to provoke accepting attitudes towards positive living people and advocating for HIV testing and counseling as the key to prevention. In this respect, Joyce Dzidzor Mensah discloses in the media messages disseminated that she had been living with the disease for the past four years and on antiretroviral therapy. According to her, the main motivation is to let people know that her son who is four years old is HIV negative thanks to prevention of mother to child transmission of HIV which starts with getting tested.

5.4 - Empowering those affected by HIV/AIDS

Any attempt to build the skills and self-esteem of the people affected by HIV/AIDS will be an exercise in futility if the stakeholders are unable to instil different opinions, values, beliefs and needs other than the affected groups' own. The ability of the stakeholders to exchange ideas, understand diverse perspectives, solve problems and successfully make the most of the talents of those affected by HIV/AIDS significantly determines how effective empowerment efforts reach. This involves any act by which the stakeholders give to or receive from those affected information about their needs, desires, perceptions, knowledge, or affective states. Such attempt helps them to understand their rights and responsibilities. It also allows them to discuss ways to respond to violations or abuses of their rights. Effective communication requires that the stakeholders are brief, succinct, organised, free of jargon and do not create resistance when stating point of view to those affected. Empowerment of the people affected is intended to arm them with basic survival or life skills comprising mental, physical and spiritual needs. It is intervention that enhances the capacity of those affected to identify, prioritise and address their long-term challenges. It flourishes on the principle that if actively involved and well facilitated, the groups affected will have capacity to identify structural cause of poverty and possible solution using both local and external

resources. This concept posits that underprivileged groups as PLWHA and OVC could be helped to unleash or unlock their power to use creative solutions in making life choices and decisions.

Regarding HIV/AIDS mental needs, the commission facilitates empowerment of people affected by relying on the support of various stakeholders to provide psychosocial support and care amongst children in their foster care. Through the commission and other partners, the people affected by HIV/AIDS are able to fight HIV/AIDS stigma, gender-based vulnerabilities and combat isolation through sharing, learning and protection. These efforts find meaning in communication rights which invoke spaces and resources in the people affected to be able to engage in transparent, informed and independent debate. They invoke unfettered access to information and knowledge essential to responsible egalitarianism, active citizenship and mutual accountability. They invoke political, social and cultural environments that encourage the free exchange of a diversity of creative ideas, knowledge and cultural products. The stakeholders also provide education, family tracking and mutual respect and help to promote integration among the family members. This capacity reflects and fulfils the need to ensure a diversity of cultural identities that together enhance and enrich the common good. Fulfilment of these mental needs boosts the self-esteem and confidence of the people affected to cope well in life in the long term.

The lack of physical needs of people affected by HIV/AIDS largely renders them vulnerable and has limited access to physical and economic support thus making them among the most vulnerable in the society. Physical needs consist of but not limited to nutritional requirement, health needs, shelter and personal protection. The commission addresses this empowerment gap by enhancing household food security for the families by building their competencies in income generating ventures as well as dole outs from Ghana AIDS Response Fund or fundraising. This includes growing of foods and engaging in bead-making and batik fabrics (that is tie and dye) and petty trading. Families have been supported with bead making and selling to generate extra income to supplement the scanty resources available to the household. Vocational training accompanied by small start-up kits for the trainees including schooling are essential reintegration activities that aim at supporting the neediest with school fees and other learning materials. The health seeking behaviour of the people affected by HIV/AIDS is

far more important empowerment tool than anything else. The cost of antiretroviral treatment in Ghana is virtually free except administrative cost for which PLWHA are encouraged to register with the national health insurance scheme. There are however other constraints in the provision of needs of the people affected by HIV/AIDS. The most significant factors which could potentially constrict their ability to engage in most physically demanding economic activities to provide for their needs and those of their families as well as fuel the spread of HIV infection have been singled out by the Millennium Development Goal 6 target 7.

Since its establishment, the Commission has been working with multiple and diverse stakeholders and partners, towards universal access and the attainment of the health-related Millennium Development Goals- MDG 4, 5 and 6 and it is currently implementing the third five-year National HIV Strategic Plan (NSP 2011-2015). The main focus of the NSP is to direct the implementation of a national response to HIV and AIDS. This plan intends to target programmes at the key sources of new HIV infections and to address the underlying factors fuelling the epidemic. For Ghana to halve new HIV infections by 2015, reduction of new infections among young people will be essential for breaking the trajectory of the AIDS epidemic. Ghana uses an evidence and researched-based approach to identify most-at-risk groups, understand their needs, and develop targeted interventions based on these results. It takes into consideration the challenges that Ghana faces in addressing the HIV and AIDS epidemic which is a developmental issue. This helps to address the need for the development of an operational plan which will outline specific evidence informed interventions to reduce new infections among young people.

One important objective is the Commission's goal to empower women and vulnerable groups to reduce vulnerability and provide care and support for OVC and other persons affected by AIDS. It is recognition of the need to develop and operationalise laws and policies to protect the rights of PLWHA, meet the challenges posed by stigma and discrimination, as well as new demands involved in expanding prevention, treatment, care and support. Advocacy and social mobilization will constitute important tools in addressing socio-cultural issues such as eliminating stigma and discrimination against PLWHA and improving the rights and status of women, orphans and other vulnerable persons. There is the evidence to believe that this recognition was borne out of the

MDG 6 target 7 which realistically provide clearly defined three technical indicators for measuring progress.

The MDG 6 target 7 specifically outlines practical investment strategies and approaches to empowering HIV/AIDS affected people, while presenting an operational framework that allows even the poorest countries such as Ghana to achieve the goal by 2015.

MDG 6 and target complemented by indicators 18 to 20 that specifically seek to address the problem of HIV/AIDS. In this statement are found the definition and basis for the empowerment of groups affected by HIV/AIDS. Goal 6 seeks to combat HIV/AIDS, Malaria and other diseases with target 7 specifically seeking to have halted by 2015 and begun to reverse the spread of HIV/AIDS. The operational approaches are outlined in the following three indicators.

5.4.1 - HIV prevalence among pregnant women aged 15-24 years

The prevalence should be less than 1.5%. About half of all new HIV cases are among people 24 years of age or younger. In generalized epidemics, the infection rate for pregnant women is similar to the overall rate for the adult population. Therefore, the indicator is a measure of the spread of the epidemic. Pregnant women are chosen for clinical surveillance, not because of gender issues, but because they offer a unique opportunity to monitor HIV/AIDS.

Each of the 170 districts in Ghana as well as all major government health centres has focal persons and VCT centres. Their role is to strengthen the capacity of decision-makers, opinion leaders to advocate in support of the programmes and activities that influence positive behaviour change. Total need for ART is expected to increase from 88,473 in 2009 to 111,908 by 2015 whilst the demand for ART in children would decline as a risk of PTMCT is reduced through an effective strategy. An estimated 20,313 AIDS deaths have been recorded with 2,566 being children but this is projected to decline from 15,732 to 11,907 annual deaths by 2015. Regrettably, new infections among 15 years and above will increase from 22,177 in 2009 to 24,299 by 2015 (NACP and GHS, 2010). Provision of prevention of PTMCT services has been increasing annually since being introduced in 2002 for example ARVs rose from only 12.6% in 2006 to 28.0% in 2008 while percentage of HIV-infected people receiving ARVs was 15% at the end of 2007 (Ghana AIDS Commission, 2009). Provision of ARV drugs in Ghana is free of

charge but beneficiaries are expected to pay a token as administrative cost. This sometimes serves as obstacle leading to break in ARV regimen and possible concern for drug resistance.

From Table 5.1, it is apparent that Ghana has not yet achieved this MDG 6 indicator. The percentage of HIV prevalence among population aged 15-24 years was 1.8% while the percentage of HIV incidence rate among the population aged 15-49 years old was 0.15% in 2008. Unfortunately, the reclining HIV prevalence in Ghana's young population witnessed over subsequent years was reversed in the 2011. Prevalence among young persons aged between 15- 24 years which is used as a proxy for new infections was 1.7% as against 1.5% in 2010.

2008 GDHS results indicate that individuals are generally supportive in providing a caring environment as 77% would be willing to care for a family member sick with AIDS in their home. On disclosure, 53.5% would not want to keep secret that a family member has HIV but only 17.5% have ever tested for HIV (Ghana Statistical Service, Ghana Health Service and ICF Macro, 2009).

5.4.2 - Condom use rate of the contraceptive prevalence rate

Among contraceptive methods, only condoms are effective in preventing HIV transmission. The condom use rate is used to monitor progress towards halting and reversing the spread of HIV/AIDS. Since the condom use rate is only measured amongst women in union, it is supplemented by an indicator on condom use in high-risk situations [indicator 2a] and an indicator on HIV/AIDS knowledge [indicator 2b]. Indicator 2c {contraceptive prevalence rate} is also useful in tracking progress in other health, gender and poverty goals. Such indicators give a better picture of the proportion of the population that engages in relatively high risk partnerships and that is therefore more likely to be exposed to the sexual networks within which HIV can circulate.

5.4.2.1 - Condom use at last high-risk sex

This is the percentage of young people ages 15–24 reporting the use of a condom during sexual intercourse with a non-regular sexual partner in the last 12 months. Consistent use of condoms in non-regular sexual partnerships substantially reduces the risk of sexual HIV transmission. The indicator is considered adequate to address the

target since it is assumed that if consistent use rises, use at last high-risk sex will also increase.

5.4.2.2 - Percentage of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS

This indicator is defined as the percentage of population aged 15-24 who correctly identify the two major ways of preventing the sexual transmission of HIV [using condoms and limiting sex to one faithful, uninfected partner], who reject the two most common local misconceptions about HIV transmission, and who know that a healthy-looking person can transmit HIV. However, since there are currently not a sufficient number of surveys to be able to calculate the indicator as defined above, UNICEF, in collaboration with UNAIDS and WHO, produced two proxy indicators that represent two components of the actual indicator. They are the following: [a] percentage of women and men 15-24 who know that a person can protect herself from HIV infection by "consistent use of condom"; [b] percentage of women and men 15-24 who know a healthy-looking person can transmit HIV.

5.4.2.3 - Contraceptive prevalence rate

This is the percentage of women who are practising, or whose sexual partners are practising, any form of contraception. It is usually reported for women ages 15–49 in marital or consensual unions. Contraceptive methods include condoms, female and male sterilization, injectable and oral hormones, intrauterine devices, diaphragms, spermicides and natural family planning. The indicator is useful in tracking progress towards health, gender and poverty goals. It also serves as a proxy measure of access to reproductive health services that are essential for meeting many of the goals, especially the child and maternity mortality and HIV/AIDS goals.

Evidence from Communication Impact study in Ghana (2003) shows that among sexually active men, condom use at last sex increased from 13% in 1998 to 24% in 2001. Among sexually active women, condom use at last sex increased from 4% to 12% during that period. While only 10% of male non-TV-viewers used a condom at last sex, 34% of men with high campaign exposure had done so. Among sexually active women, 4% of female non-TV-viewers reported using a condom at last sex, compared

to 22% of women with high campaign exposure. Trends in condom sales and distribution offered further evidence of the effect of the campaign on condom use.

The number of condoms sold during the two years following the campaign (34.8 million) was almost double that sold during the two years prior to the campaign (18.8 million). The 2008 GDHS tried to ascertain the effectiveness of communicated messages by asking about knowledge of HIV/AIDS prevention by condom use (79.0%), by staying faithful to one partner (86.5%), and abstinence (80.5%). On the contrary, among women and men who reported having had higher-risk intercourse only 25.0% and 45.0% respectively reported using a condom (Ghana Statistical Service, Ghana Health Service and ICF Macro, 2009). Although condom use increased, age at first sex and multiple partnerships were largely unchanged by the campaign among the population at large. This lack of change in sexual behaviour may have been due to the relatively late age of sexual debut and the relatively low level of multiple partnerships in Ghana. The data in Table 5.1 shows condom use and general contraceptive use in remains relatively low among population aged 15 -24 years.

Table 5.1 – Progress report on MDG 6 Target 7 indicators

Indicator	**Year (2008)**
HIV prevalence among population aged 15-24 years (%)	1.8
AIDS deaths	19,000
HIV incidence rate, 15-49 years old (%)	0.15
Condom use at the last high-risk sex	
Among 15-24 years old, women (%)	28.2
Among 15-24 years old, men (%)	46.4
Condom use to overall contraceptive use among currently married women 15-49 years old (%)	10.2
Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS	
Men	34.2
Women	28.3
Ratio of school attendance rate of orphans to school attendance rate of non-orphans aged 10- 14 years	
Ratio of school attendance rate of orphans to school attendance rate of non orphans	0.76
School attendance rate of orphans aged 10-14 whose parents are alive and who live with at least one parent	67 88
AIDS orphans (one or both parents)	150,000

Source: Ghana Demographic & Health Survey (2008)/Unstats – Millennium Indicators, 2011.

Reported faithfulness, however, did increase among married men with high exposure to the campaign as compared to those with no exposure (Communication Impact, 2003). Only one in ten (10.2%) people use condom as a percentage of overall contraceptive use among currently married women aged 15 – 49 years old. About 28% of women aged 15 -24 years either used condom at the last high-risk sex or has comprehensive correct knowledge of HIV/AIDS. Regrettably, the high usage of condom at the last high-risk sex by men (46.4%) aged 15 -24 years old fell to 34.2% when it came to exhibiting comprehensive correct knowledge of HIV/AIDS.

5.4.3 - Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years

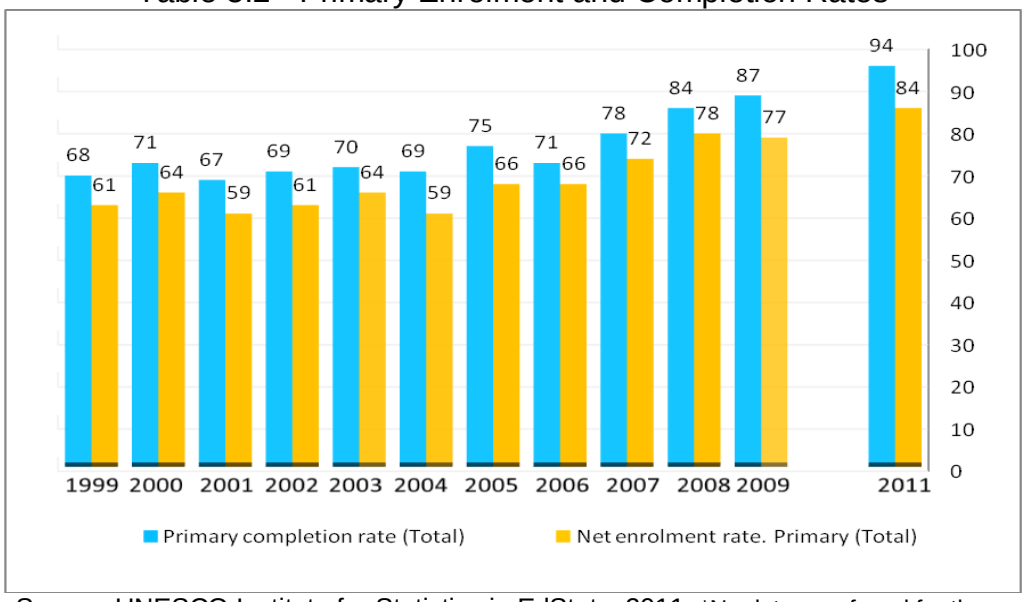
The number of children orphaned by HIV/AIDS is the estimated number of children who have lost their mother, father or both parents to AIDS before age 15. In practice, the impact of the AIDS epidemic on orphans is measured through the ratio of orphans to non-orphans who are in school. HIV/AIDS is claiming the lives of ever-growing numbers of adults just when they are forming families and bringing up children. As a result, orphan prevalence is rising steadily in many countries, while fewer relatives within the prime adult ages mean that orphaned children face an increasingly uncertain future. In sub-Saharan Africa, only 60 per cent of orphans who lost both parents attend school as compared with 71 per cent of those with both parents still living. It is important, therefore, to monitor the extent to which AIDS support programmes succeed in securing educational opportunities for orphaned children.

Over the years, the right of children, especially orphans and girls to education has been gravely violated consequently denying them of a life of dignity as adults. This condition may put some of orphans in a situation where they may have to work in order to earn income to support other younger family members thereby compromising the opportunity to acquire skills. This can have a disruptive effect on their future development and ability to live as responsible and normal citizens. Children may miss out on school enrolment, have their schooling interrupted or perform poorly in school as a result of their situation. This is due to the lack of funds for school fees, uniforms and school aids, as well as due to emotional distress, disintegration of a household. This can also trigger the onset of the gender imbalance in education as 33.9 percent of adult women in Ghana have

reached a secondary or higher level of education, compared to 83.1 percent of their male (World Bank, 2011). It is against this backdrop that the MDG 6 target 7 indicator 20 focuses on children orphaned including those caused by AIDS related conditions. Orphans do not receive the needed attention they deserve in the society which the framers of MDG believe should change. The rights of orphans to quality education imply a responsibility or duty on the society to protect, respect, promote and fulfil what is justly due them like a right to library facilities, appropriate training and all.

Table 5.2 shows that the percentages of both total primary school net enrolment and total primary school completion rates have been growing progressively since 2006 with marginal increase in the of total primary completion rate. Prior to this period, the growth had been uneven.

Table 5.2 - Primary Enrolment and Completion Rates



Source: UNESCO Institute for Statistics in EdStats, 2011. *No data was found for the year 2010.

When taking in tandem with the ratio of school attendance rate of orphans to school attendance rate of non-orphans aged 10 – 14 years as captured in Table 5.1, it means Ghana is doing fairly well. A rate of 67% is well above the average rate of 60% that prevails in sub-Saharan Africa for orphans 88% for non-orphans. Nonetheless a ratio of 0.76 should be a cause for concern as the observed data indicate a widening of the gap of inequalities in educational opportunities for the two set of children. It is important, therefore, to put in mechanisms that ensure AIDS support programmes succeed in securing educational opportunities for orphaned children.Ghana as a country that

ratified the rights of the child ahead of all others, there is need to reflect on indicator to see if Ghana is failing or living up to expectation. Studies suggest that the impact of orphanhood on a child's education is closely interlinked with other factors such as poverty. For example, a multi-country study released in 2010 found that orphanhood itself was not directly associated with lower school attendance (when measuring school attendance orphans are defined as children who have lost both parents while non orphans are defined as children both of whose parents are alive). Instead, other factors such as greater household wealth were more likely to result in increased school attendance for both orphans and non orphans. However, the loss of a productive family member is likely to be a financial burden and might push a family into poverty, increasing the likelihood that a child orphaned by AIDS will miss out on school. Moreover, most orphans and their caregivers still do not receive any type of external support in the form of healthcare, nutrition, or psychosocial support.16 Ensuring that households where a child has been orphaned by AIDS receive external care and support is therefore essential to ensure that the increasing number of AIDS orphans attend school.

Figures released in 2010 revealed that in most countries in sub-Saharan Africa the gap between school attendance by orphans and non-orphans has narrowed although progress varies across the region. Despite this, orphans, particularly those from poorer households still remain less likely to attend school compared to non orphans.

The success of meeting the MDGs includes the fact that Ghana has a government committed towards educational initiatives. In 2005, the government removed school fees for primary education, bolstering school attendance rates. A part of the free and compulsory universal basic education (FCUBE) proposals by the Education Reform Review Committee in 2004 included that four and five year olds' two year preschool education is both free and compulsory. Although, due to the increase of students, the educational budget and resources are strained, creating barriers to the achievement of the MDGs. The education sector requires more schools, funding for direct and indirect educational costs and trained teachers (Government of Ghana and UNICEF, 2006). The challenge is in providing quality education for all (Reimers, et al., 2006).

5.5 – Ghana AIDS Commission and empowerment of the OVC in Manya Krobo

The NFS became effective on 8th May 2002 with seed amount of US $25 Million from the International Development Association (IDA) credit and £20 million department for international development (DFID) capacity building support for the establishment of the Ghana AIDS response fund (GARFUND). IDA is the World Bank's fund that supports anti-poverty programmes in developing countries with long-term, no interest loans. Disbursement of the funds started on 25th June 2002 to enable the implementation of a balanced, diversified multi-sector response, engaging all relevant initiatives and expand contributions to engage the civil society in the fight against AIDS. And to finance eligible partner activities to ensure a rapid scaling up of HIV prevention and care activities in all regions of Ghana and at all administrative levels. The project disbursement components comprising $18.9m for prevention and care services, $2.4m for strengthening public/private (institutions for HIV/AIDS Control), $1.0m for knowledge management and $2.7m for project management.

These were consistent with the World Bank country assistant strategy to provide support to the health sector and to address the spread of HIV/AIDS through a multi-sector approach. The objectives which were originally determined prior to the establishment of Ghana AIDS Commission were neither revised nor varied to meet Ghana's specific needs. The project was developed before the secretariat was completely established and practically all concerned with its development disappeared before implementation.

The intervention areas or response focused on prevention of new transmission, support and care for PLWHAs, creating an enabling environment, decentralised implementation structures and undertake research, monitoring and evaluation. The component was designed to operate through three windows: Window A for the public sector, Window B for non public sector organisations, and Window C for small community-based organisations (CBO). A total number of 3,026 sub-projects were funded in various areas of interventions through four calls for proposals. About 82% of those subprojects were fully completed. Major areas of GARFUND interventions include HIV/AIDS in the workplace programmes, advocacy and counselling, condom promotion, information, education and communication and peer education. Other areas were behaviour change

promotion for commercial sex workers, voluntary, counselling and testing (VCT), and care and support for PLWHA and OVC (IEG-World Bank, 2007; Amoa, 2005).

In the area of care and support, 35% of the 110 districts have organised care for AIDS orphans and 50% have conducted community-based care for PLWHAs. The project also provided support to several organisations for the benefit of 17,500 orphans and vulnerable children (OVC). Besides, through a parallel funding mechanism, DFID supported training and technical assistance to beneficiaries. Care and support was a new and important focus of training for civil society organizations to improve the quality of life of PLWHA and OVC. Several training sessions focused on strengthening local capacity in the areas of care and support. A psycho-sociological course intended to strengthen the capacity of master training counsellors was organized. Training needs assessment activities were carried out with greater involvement of PLWHAs and scaled up their involvement in the implementation of the national response. This was coupled with peer counselling and education activities for PLHWA as well as similar regional activities. Nine regional PLWHA networks were created and strengthened by capacity building programmes supported by GARFUND and other partners in the areas of programme coordination and management.

GARFUND supported the Queen Mother's community foster programme for children affected by HIV/AIDS in Manya Krobo traditional during the first phase. Findings of a 2004 review in IEG-World Bank report (2007) indicated that it supported a total of 600 children, including those whose parent(s) die or become too ill to care for them. About 10 percent of foster parents subcontracted the care of their foster children to persons who were unknown to the programme manager of the Queen Mothers Association and therefore unsupervised. Feeding costs were calculated on the basis of three meals, but most children ate only twice a day and foster children from Upper Manya were found to be less well nourished overall. Only 52 percent of foster children were in school at the time of the study because GARFUND support had not been received for 2004. The health needs of the orphans were poorly addressed, with only two of the children tested for HIV and none of the children receiving vitamins, malaria prevention treatment or insecticide treated bed nets for sleeping. Only four seropositive orphans had been taken to a health facility in the year of the study. Yet, foster parents claimed an average of US$15 in health expenditures per child per month. The psychosocial needs were found

not to be adequately addressed for many of the children who suffer from anxiety, depression, discrimination and stigmatization, although orphans were found to be better integrated into their foster families than those in other programmes with less stigmatization and discrimination within the community. Over 80 percent of children were related to their foster parents. Nevertheless, about two-thirds of 50 orphans interviewed reported being subjected to emotional abuse, 24 percent to physical abuse, 10 percent to neglect, and 4 percent to sexual abuse. Other forms of maltreatment were reported by foster children, including denial of food, insults and beatings. Over 80 percent were found to be engaged in income generating activities, ranging from daily hawking of wares to hard labour (crushing stones in a quarry), 44 percent of whom were under 15 years old. There were no formal selection criteria for foster parents or foster children and no limits on the number of foster children per household, with some foster parents caring for as many as six children, netting considerably more than the average household income in the district. Only 25 percent of parents had been trained in the care and support of PLWHA. The Manya Krobo District Social Welfare office was found to be inadequately staffed and under-resourced, with just two field officers, already overstretched with a wide range of responsibilities, and lacking basic training in the care of orphans and vulnerable children, and in HIV counselling and care. Neither did this office have the basic infrastructure and logistics to carry out its critical role of counselling, oversight and supervision.

During the field data collection for this study, it was found that in the past, some NGOs like Family Health International and Opportunities Industrialization Center (OIC) were funded from GARFUND to sponsor the skills training for 110 selected OVC up to 2005. The beneficiaries should have at least completed basic education, between ages 17 to 20 years and can read and write. The skills areas are dress-making, carpentry and joinery, hair-dressing, auto mechanics, electronics and electrical. The duration for apprenticeship is two years. The cost for apprentice is GHS300.00 in addition to a stipend of GHS1.00 for each day the OVC. Presently, only ten OVC comprising 6 females and 4 males are benefitting from this facility. Among these 6 are from Lower and 4 from Upper Manya Krobo are undergoing apprenticeship at OIC with funding from Ghana AIDS Commission.

GARFUND significantly strengthened the breadth and depth of the national response. Ghana achieved near universal awareness yet low level of appreciation of personal risk at the end of the first phase. On the whole 27 indicators were used to monitor activities and extent of progress through GARFUND support and showed that the following are some of the impact and outcomes. AIDS education in schools helped to train 5370 teachers in life-skills based HIV/AIDS education and taught HIV/AIDS education in the 2002-2003 academic year. Prevention of mother to child transmission (PMTCT) services started in 2003 at two sites in Manya Krobo where the mother and baby were put on Nevirapine. There were some 436 treatments (Amoa, 2005). Since then, more sites have been established across the country, bringing the total number of sites to 85 and now available at almost all public health centres. It also promoted voluntary counselling and testing (VCT) which started in 2003 with 4 centres, then 90 and nearly all public health centres having at least one staff trained as a councillor providing specialised HIV counselling and testing services free or at affordable rates (Amoa, 2005).

Through GARFUND, 4 NGOs in 2002 and 19 NGOs in 2003 providing home-based care and support services to people living with HIV/AIDS received financial support. Home based care and support includes counselling, food, clothing, nutritional supplementation, palliative care, treatment, other psychosocial and material assistance. Significantly, a number of NGOs including MKQMA received financial assistance for giving care and support to OVC. Care and support includes food, school fees, counselling, nutritional supplementation etc to OVC. 2002, 8 NGOs were supported and in 2003, 55 NGOs were supported. During the first phase, GARFUND supported 22 organisations with funding totalling over $500,000 to provide care to benefit over 3000 OVC by providing school fees, uniform, meals and health care. Ghana considers age group 5-12 as window of hope leading to implementation of programmes for school aged children. It supported youth peer educations communication programme in schools and HIV/AIDS programmes are now mainstreamed in school curricula. The maxim is that prevention is cheaper than treatment. People living with HIV/AIDS were also supported through network associations. The challenge is how to sustain these initiatives (Amoa, 2005).

The national level-sectoral response indicated that by 2003 42% of Ghanaian sector ministries have HIV & AIDS work plans in place with corresponding budgets. It also showed significant improvement in both district response initiative and community level response. By 2005, all the regions and districts had at least a trained HIV/AIDS Focal Person.

Despite these achievements, several shortcomings hampered smooth implementation of activities including insufficient targeting of high risk groups, less priority for areas with higher HIV prevalence receiving relatively low funding while disproportionately high amounts of funds were allocated to general population awareness raising. The inability of ministries to provide the required counterpart fund as well as low commitment toward HIV/AIDS prevention and care in some ministries resulted in inadequate staffing and lack of operational resources for their HIV/AIDS secretariats. Moreso slow disbursement of funds due to lengthy processes for approval, insufficient information on district referral systems between home-based and institution-based care, and number of institutionalised NGOs umbrella organisations resulted in low level of funds disbursed in support of smaller civil society organisations.

IEG-World Bank (2007) assessors using conclusions based on triangulation of evidence from many sources rated the performance of Ghana AIDS Commission as the implementing agency as moderately satisfactory and in its role of coordinator and manager of the national multisectoral HIV/AIDS effort as moderately unsatisfactory. Table 5.3 has the summary ratings of the damning conclusions on objectives to reduce the spread of HIV infection, impact of AIDS on those infected and their families, and overall OVC project as modest, negligible and unsatisfactory. The report rated the project overall unsatisfactory. This assessment however appeared to be too simplistic. For instance, about awareness, surely they should have appreciated the difference between being aware of something and knowing what it means or its implications.

Table 5.3 - Summary IEG Ratings by Objective

Development Objective	Relevance	Efficacy	Efficiency	Outcome
Reduce the spread of HIV infection	Modest	Modest	Negligible	Unsatisfactory
Reduce the impact of AIDS on those infected	Modest	Modest	Negligible	Unsatisfactory
Overall OVC project				Unsatisfactory

Source: IEG-World Bank, 2007.

What the project was tasked to tackle was the implications of the knowledge of HIV/AIDS hence it seemed overoptimistic to expect massive behaviour change in a three year life of a project. Thus the NSF II covering 2006–2010 set targets for reducing new HIV infections, address service delivery issues and individual and societal vulnerability, and promote the establishment of a multisectoral, multidisciplinary approach to HIV/AIDS programmes. The current plan spanning 2011-2015 has four strategic objectives. Create an enabling environment for interventions through focused advocacy and community engagement to address barriers to effective interventions and reduce vulnerability, stigma and discrimination. Strengthen coordination among stakeholders and enhance organisational capacity to effectively deliver comprehensive services. Strengthen the evidence base and monitoring systems and to promote the generation of strategic information to improve programming and inform key stakeholders and decision makers.

Going forward with the lessons and challenges learned from phase one, NSF II covering 2006–2010 had targets aimed at reducing new HIV infections, address service delivery issues and individual and societal vulnerability, and promote the establishment of a multisectoral, multidisciplinary approach to HIV/AIDS programmes. This meant the Ghana AIDS Commission took ownership of the new project and regrettably eliminated the objective to empower groups affected by HIV/AIDS. Thus funding to the Queen Mothers OVC project was cut at the end of 2005. This had serious implications for both the Queen Mothers and OVC.

With dwindling inflow of external resources following the reduction funding from the Global Fund, the current plan spanning 2011-2015 has four strategic objectives taking cognizance of their ability to sustain the project financially. Create an enabling environment for interventions through focused advocacy and community engagement to address barriers to effective interventions and reduce vulnerability, stigma and discrimination. Strengthen coordination among stakeholders and enhance organisational capacity to effectively deliver comprehensive services. Strengthen the evidence base and monitoring systems and to promote the generation of strategic information to improve programming and inform key stakeholders and decision makers.

Although one cannot prove that the favourable trend changes in the Ghana epidemic and relatively enablement of PLWHA and OVC are attributable solely or even mainly to

the work done with the GARFUND by Ghana AIDS commission, it cannot be proved that it has made no contribution either.

5.6 – Addressing the research question

We posed the question 'how does the environment (cultural milieu) define women's response to the evolving concept of care and support for OVC?' at the section dealing with the research problem (i. Research problem). Fostering of orphans by relatives is well attuned to the prevailing Manya Krobo socio-cultural milieu than many other options. Interventions such as home visits to monitor the well-being of the child and to raise awareness of OVC needs help the Queen Mothers to meet OVC's needs for living in family-like setting in social environment where there is no institutional care. This intervention addresses OVC risks specific to orphans in Manya Krobo and reinforces the existing traditional coping strategies instead of replacing it. This factor has its own advantages which are being exploited by the Queen Mothers as women are noted for being ingenious, resourceful and resilient to such social shocks as incapacitation and death of family members. For instance alternative care types like orphanages are deemed relatively more expensive to run and are also believed to be less culturally appropriate. In the view of the Queen Mothers to allow the OVC to be put in any other form of care or even given up for adoption is tantamount to reneging on their roles as community mothers. It will also spell the doom for disconnecting the area and the OVC in the near future. There would not be any heritage transfer.

The Manya Queen Mothers initiative combines the two basic patterns of orphan care namely voluntary and crisis-led fostering. Voluntary fosterage pertains to arrangements between biological and foster caregivers to raise the child, but is not a formal adoption, while crisis-led fostering occurs in response to the death of a biological parent or a major shock. Cultural norms in Manya Krobo which make the woman the first custodian of children have largely determined the Queen Mothers efforts at fostering the children in their communities.

There is an urgent need for a coordinated intervention to reduce the effect of the piecemeal nature of the Queen Mothers ongoing efforts to address the HIV/AIDS and subsequent OVC crisis must be reiterated in the light of the enormity of high HIV prevalence in Manya. To sustain and encourage the Queen Mothers' initiative, it is

necessary that direct and indirect subsidies are made available to the foster families in Manya Krobo area.

5.7 – Hypotheses: T-test and Goodness of Fit Test

A hypothesis is a speculative idea or explanation of a phenomenon. Evidence or data such as the one for this study which was collected in an unbiased manner as possible can be mathematically tested to either prove it or disprove it. Hypothesis testing is a statistical method which tells if there is sufficient data to draw a conclusion, given a certain level of significance. Hypothesis validates a conclusion that a reasonable explanation seems to fit circumstances or events thereby increasing the level of confidence with which certain decisions are made or inferred with high degree of certainty.

There exist several types of tests that can be employed in testing a hypothesis. It is however imperative to know what is being tested. To truly test the hypotheses posed at the beginning of the study, inter alia:

H1-Intra-household neglect in terms of high malnutrition and reduced access to attention and care;

H2- Low access to health services and high burden of disease; and

H3- Alienation and exploitative survival strategies such as high school drop-out rate and engaging in work detrimental to proper growth due to lack of care and protection,

there was the must to compare the results from the study data. Two types of statistical tests were selected for this purpose. These are T-test and Goodness of fit test. In cases where the analysis involves comparing means which is continuous, the T-test which procedure tests whether the mean of a single variable differs from a specified constant become the method of choice. The Chi-Square Test procedure tabulates a variable into categories and computes a chi-square statistic. This goodness-of-fit test compares the observed and expected frequencies in each category to test either that all categories contain the same proportion of values or that each category contains a user-specified proportion of values. This is most suitable in situations where data has one variable but several proportions such that analysis require nonparametric test.

H1 - Intra-household neglect in terms of high malnutrition and reduced access to attention and care

Table 5.4 – Testing hypothesis one

One-Sample Statistics

Activity	N	Mean	Std. Deviation	Std. Error Mean
Number of meals eaten	100	2.64	0.522619664	0.052261966

Activity	Test Value = 3					
	t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
Number of meals eaten	-6.888375	99	5.2669E-10	-0.36	-0.46369908	-0.2563

Care and attention Chi Square Test

Category	Observed N	Expected N	Residual
Unhappy	15	50	-35.0
Happy	85	50	35.0
Total	100		

Test Statistics

	Unhappy Happy
Chi-Square	49.000a.
df	1
Asymp. Sig.	0.000

Care and attention Chi Square Test

Conflict between OVC and biological child	Observed N	Expected N	Residual
Yes	36	50	-14.0
No	64	50	14.0
Total	100		

Test Statistics

	Yes No
Chi-Square	7.840a.
df	1
Asymp. Sig.	0.005

a. 0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 50.0.

Source: Field data, March – May, 2011.

We sampled one hundred OVC and evaluated whether the OVC eat three square meals a day which every child is expected to enjoy to achieve normal development. The data was analysed using a T-test. The null hypothesis was rejected, t value = -6.89, P value ≤ 0.05. Some OVC do not eat three meals.

Further, we sampled one hundred OVC and evaluated whether the number of OVC who feel unhappy or engage in conflict with the biological children (15; 36) was equal to the number of OVC who feel happy or do not engage in conflict (85; 64). The data was analysed using a chi square goodness of fit test. The null hypothesis was rejected,

X^2 (1) = 49.00; 7.40, P value ≥ 0.05. More than half of the OVC also feel happy and do not engage in conflict. This means the OVC are receiving enough attention and care but poor nutrition.

H2- Low access to health services and high burden of disease; and

H3- Alienation and exploitative survival strategies such as high school drop-out rate and engaging in work detrimental to proper growth due to lack of care and protection.

Table 5.6 – Testing Hypotheses two and three

Access to health and burden of disease Chi Square Test				**Test Statistics**	
	Observed N	**Expected N**	**Residual**		Access to Health
Category					
Never ill	21	50	-29.0	Chi-Square	33.640a.
Fell sick	79	50	29.0	df	1
Total	100			Asymp. Sig.	0.000

Alienation & exploitative survival chi square test				**Test Statistics**	
	Observed N	**Expected N**	**Residual**		OVC currently in school
OVC currently in school					
Yes	8	50	-42.0	Chi-Square	70.560a.
No	92	50	42.0	df	1
Total	100			Asymp. Sig.	0.000

	Observed N	**Expected N**	**Residual**		OVC earning income
OVC earning income					
No	84	50	-34.0	Chi-Square	46.240a.
Yes	16	50	34.0	df	1
Total	100			Asymp. Sig.	0.000

a. 0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 50.0.

Source: Field data, March – May 2011.

Again, we sampled one hundred OVC and evaluated whether the disease burden and access to health services among OVC (79) was equal to the number of OVC who were

never ill (21). The data was analysed using a chi square goodness of fit test. The null hypothesis was rejected, X^2 (1) = 33.64, P value ≤ 0.05. More than half of the OVC suffer from one kind of disease burden or the other.

On the question of alienation, school enrolment variable was tested and the null hypothesis was rejected. Similarly on the matter of exploitative survival strategies, child labour via a proxy of working to earn income variable was tested and the null hypothesis was rejected. The OVC generally enjoy good care and protection albeit less ideally.

5.8 - Gaps in HIV/AIDS programmatic interventions

While the National Strategic Plan was intended to address the underlying factors fuelling the epidemic among young people, the implementation of the operational plan viewed as essential for breaking the trajectory of the AIDS epidemic has brought to the fore numerous bottlenecks. The Ghana AIDS Commission and UNFPA own situational assessment report (2011) revealed some critical areas of concern to be addressed.

Gaps in HIV prevention programmes identified so far include inadequate resource mobilization, short gestation period of programmes, low of partnership, low of integration and access to information, gate keeping and access to services. Negative attitudes of some health personnel hinder access to vital services especially by young people.

Policy and legal environment also present some implementation challenges. Here also gaps exist in policy like lack of coordination of various policies and inadequate/lack of implementation strategies where they exist. Further, there appears to be a lack of focus and strategies to address HIV for all identified sub groups in the policies such as low literate and illiterate youth in artisanal work and apprenticeship. Moreover, adolescent reproductive health policy is dated and needs revision, lack of operation plan for the Youth Policy 2010, and lack of National Operational Plan on HIV for the youth.

Furthermore, the various sub-groups of people and stakeholders suffer from participation for lack of technical capacity. This relates to the general quality of programmes which cover many groups but more work needs to be done especially in implementation. The biggest gaps in participation of people have to with stigma, little interest in involvement, difficulty in reaching unregistered organized and unorganized groups, and not outreaching youth through new media, for instance, facebook and

twitter. The gaps in technical capacities of stakeholders are inadequate capacity building for officer in key MDAs and lack of synergies/networking. The gaps in coordinating the national response include poor or no collaboration between key national institutions, and conflicting policies across sectors due to poor collaboration between government institutions.

5.9 - Going Forward

On the basis of these gaps outlined, building capacity with the view of developing evidence-based action plan to empower people to protect themselves from HIV as well as providing care and support offer the best option of empowerment going forward. A UNICEF (2004) framework for the protection, care and support of orphans and vulnerable children living in a world with HIV and AIDS is hereby put forward as an alternative. The framework outlines goals, principles, strategies, programming guidance and key indicators of assessment. It provides a policy and programmatic basis designed to assess how OVC stakeholders are progressing with implementation including the measure of the amount of effort put into place. At the *Framework*'s core are five strategies:

1. Strengthen the capacity of families to protect and care for orphans and vulnerable children by prolonging the lives of parents and providing economic, psychosocial and other support;
2. Mobilize and support community-based responses;
3. Ensure access for orphans and vulnerable children to essential services, including education, health care, birth registration and others;
4. Ensure that governments protect the most vulnerable children through improved policy and legislation and by channelling resources to families and communities;
5. Raise awareness at all levels through advocacy and social mobilization to create a supportive environment for children and families affected by HIV/AIDS.

In order to achieve and implement these core strategies, '5 pillars' of priority action areas have been identified as requirement to create an enabling environment for an appropriate scaled-up response. The '5 pillars' are:

(a) Conducting a participatory situation analysis of OVC (i.e. whether MKQMA has investigated the situation of orphans and other children made vulnerable by HIV/AIDS and, if so, the nature of that research);

(b) Reviewing policies and legislation affecting OVC (i.e. the contribution of MKQMA to Ghana's OVC national plan of action and policy and whether MKQMA has reviewed and updated the relevant legal framework relating to the OVC situation in Manya Krobo);

(c) Establishing coordinating mechanisms for OVC activities (i.e. whether action for OVC is being coordinated and the nature of that coordination within Manya Krobo area);

(d) Holding annual stakeholders' meetings to review progress (i.e. the extent to which key stakeholders are involved in planning interventions for OVC).

(e) Establish a monitoring and evaluation system (i.e. whether monitoring and evaluation is being conducted holistically into the situation of OVC and into programmes including availability of resources addressing their needs).

These executable priority actions attempt to find an objective measure by identifying specific strengths, weaknesses, gaps and the change in efforts over time.

5.10 - Conclusion

While not dismissing originality of initiatives and contributions made by HIV/AIDS state institutions and other stakeholders under the umbrella of Ghana AIDS Commission for carrying out these activities, one can also not discount the fact that pressure arising out of obligations from international treaties is also a driving force. While appropriately acknowledging Ghana AIDS Commission for championing issues of people affected by HIV/AIDS in Ghana, the evidence suggests that there is still room for improvement as far as execution of the commission's mandate is concerned hence the imperative for it to do more. Ghana must as a matter of urgency take advantage of the current constitutional review process to amend identified gaps in laws or perhaps promulgate an integrated HIV/AIDS law that would integrate and decentralise HIV/AIDS activities to the community levels with the appropriate resource mobilization mechanism to serve the needs of the country. Above all, the public must be sensitised to create the necessary ownership drive as well as an imperative to empathise with people affected

by HIV/AIDS. It is therefore necessary for government and stakeholders like parents, communities, churches and others responsible for the provision of better conditions of living for people affected by HIV/AIDS especially orphaned children to act now to enable them enjoy their right to live in dignity and secured future.

CHAPTER SIX

SUMMARY: FINDINGS, RECOMMENDATIONS AND CONCLUSIONS

6.1 - Introduction

The preceding five chapters represent the measures applied in achieving outcome details for analysis and interpretations of the HIV/AIDS generation nexus findings that deals with core competence and sustainability of a community-based organisation to provide for HIV/AIDS orphaned children and other vulnerable children. It highlights problem statement, study objectives, hypothesis and factors influencing the selection of Manya Krobo as the study area. The whole dissertation is divided up into two with first part treating the research methods and literature review including conceptual framework. The remaining section provides an evaluation of the role of traditional women rulers and other civil society groups on managing psychosocial and health care needs of OVC.

Chapter one provides assessment as well as evaluation of how the literature has been presented on OVC foster care including health and geography, social exclusion, vulnerability, gender, care and caregiving and social support. This chapter sums up with the concept of social integration in the era of HIV/AIDS which results in the adoption of the empowerment conceptual framework. The next chapter draw round how the research process has been realised in coming up with outcomes. Moreover, validation of instrumentation being applied has been duly examined in this chapter that posited reliability and validity of findings.

Chapter three presents certain profile and opinion of the participants involved in the research study. In order to analyse the data gathered from the survey, various statistical tools appropriate for each question item was computed and applied to interpretation and discussion. Both chapters four and five examined the complexities surrounding feminisation of OVC care, psychosocial support, empowerment and questions of sustainability as lifecycle practice resulting in appropriate forms of collaboration occurring between various stakeholders led by the Queen Mothers.

This research has been driven by the need to discover how this novelty project of traditional women leaders strives to maintain sustainable competitive advantage

through innovation while struggling to preserve all the essential elements of the local culture. In line with this, in this final chapter we present the summary of findings as an outcome of conclusions drawn on literature review and empirical research according to each individual research objective as stated. This is quickly followed by rational explanations linked to the summary of main claims as well as suggestions for future research and practical application. Something about the scope and limitations of this research brings down the curtain on this study.

6.2 - Research Objectives

There is no gainsaying of new interdependence paradigm that permeates every facet of society from the household, family, community, nations, across ages and between genders. However a supposed shared world in time and space is plagued by differentials in access to resources resulting in vulnerability to exclusion from life's opportunities to a large section of society. A careful review of world events shows that in spite of advancement in science and medicine, we still live in turbulent times. Since 1981, the HIV disease has being inflicting its heavy tolls on the living conditions of many people; individually and collectively. Regrettably, due to the link between the disease and poverty, many of the people affected by the scourge are often rendered powerless to act on their own to support and provide for their needs. OVC require safety net from the society to realise their full potential. Manya Krobo in south-east Ghana is one area hardest hit by a combination of high HIV prevalence, poverty and government support of only 7.4% for all OVC including 160,000 AIDS orphans. Women leaders (Queen Mothers) invoke the traditional extended family support system to intervene. 'HIV /AIDS Generation Nexus: Gender and Provision of Safety net for Orphans and Vulnerable Children (OVC)' was therefore chosen as a study, so that positive learning points could be disseminated throughout wider society.

It specifically aimed to investigate the social, economic, psychosocial conditions, experiences and prospects for stakeholders and the enterprise. The framework is based on a set of empirically derived propositions related to the design and management of collaborative support networks for disadvantaged children. The study used the empowerment framework as building blocks in analysing efforts to provide educational and economic opportunity to tap the potential of these OVC children to become

contributing, law-abiding citizens of Ghana. The model contains continuum of capacity building issues ranging from Agency, Relations to Structure.

6.3 - Summary of main results

A single disease appears unlikely to be the cause of the OVC problem in Manya Krobo traditional area since several children of varied backgrounds are also affected but the emergence of HIV/AIDS is very likely to have triggered or aggravated a chain of negative outcomes. Thus though not all of the children in the MKQMA safety net project were rendered vulnerable by the HIV/AIDS epidemic, the disease is the prime suspect. Manya Krobo traditional area is arguably the most vulnerable region to increasing HIV prevalence given the historical, social, cultural and economic factors that put large segment of the population living below or near the poverty line (Anarfi, 1990; Agyei-Mensah, 2001; Sauvé et al., 2002; Atobrah, 2004). This view is supported by the evidence that the increase in OVC number coincides with the high HIV prevalence in the Manya Krobo traditional which began in the late 1980s. The increase in OVC number appears to grow in magnitude with the size of the HIV prevalence in the area.

The magnitude of the large numbers of children in foster care underscores the apparent incredible density of HIV/AIDS orphans and other vulnerable children in Manya Krobo traditional area. The effect on the overall dependency burden is hard to predict. We can point with concern to what happened elsewhere with similar dependency burdens experiencing overwhelming and profound fallout. Some Sub-Saharan African countries with high HIV prevalence have experienced reduction in the sizes of working-aged populations and high old-aged dependency ratios with implications for household compositions including fertility schedules and the ratio between generations.

This study paints a stark picture of the real damage that the HIV/AIDS pandemic is causing to children, families, homes, indigenous communities and economies. This trend certainly further aggravates the state of the weak welfare system in an area with little provision of governmental support to people especially the elderly and children. It is therefore it worrying that so many caregivers struggle to share health-related information with OVC. Caregivers have a responsibility to give OVC information that makes sense. That way, OVC will be better empowered to manage their own health

conditions and make the positive lifestyle choices that lead to better health and wellbeing.

As the HIV/AIDS pandemic does not respect geographical zones, peoples, beliefs, or status and with no sign of abating or hope to find a cure anytime soon, resolution of any AIDS-related crisis in various places around the world can assist their local constituency and coordinate the appropriate response to provide a global solution to the problem. MKQMA OVC project is designed to facilitate local responses addressing OVC safety and security to assist in promoting prompt and effective resolution to HIV/AIDS OVC crisis. Other traditional leaders and women groups in particular can benefit from MKQMA's expertise by exchanging ideas and practices. This can assist any new group in avoiding the pitfalls encountered by MKQMA, enabling them to become effective quickly.

The study findings show that 1,065 AIDS orphaned and other vulnerable children have been placed in households, integrated and empowered with competencies that will enable them to fend for themselves as well as care for other siblings in the future. The key interventions include provision of shelter, clothing, healthcare, psychosocial support, food, education and life skills. The programme's overall goal to better the lot of children at risk of falling through shocks, preventing stigma and discrimination, and connecting local culture among generations as contribution to community development is laudable. In spite of these gains, however, much work remains to be done as price escalations in food staples, healthcare, education, general cost of living, poor caregiver communication skills, low incomes, high OVC population growth and the large dependency burden is a serious and growing concern.

The study findings show that the MKQMA safety net project ensures development through pragmatic leadership, positive management and institutional capacity building. It also brings out one of the key characteristics of effective leadership being offered by the Manya Queen Mothers; servant leadership. They connect and stay at basic level with the people constantly. Their ability to relate to their people and the needs of especially underprivileged children allows them to see and feel for these less fortunate people thereby intervening to prevent a bad situation from becoming worse. The MKQMA fostering system shows effective collaboration and coordination to offer choice, dignity and empowerment to the underprivileged. The MKQMA provides a visible and

transparent mechanism for coordination and collaboration between the caregivers and other entities in regard to MKQMA's governance, risk and administration functions. Coordination involves the organization of the stakeholders including parastatal and civil society groups to accomplish the important objectives of the project including generation nexus. By designing guidelines, the project provides appropriate communications connectivity which offers effective avenue or platform to all team members to know what they need to know to do so. Teams whose members lack this knowledge are prone to various kinds of predictable collaboration problems. These functions involve tasks that require frequent discussions and lobbying which need thoughtfulness and careful considerations.

The studying findings show demonstration of qualities of transformational leadership by the Queen Mothers. A transformational leader is an agent of change and one who brings about change for the better. There is no doubt that they did not stick to the *status quo* but were proactive to see ahead of all others the need to act on the OVC situation in the communities in order to trigger events for change in Manya Krobo traditional area.

While it is very clear that the structure of the MKQMA OVC foster care system seeks to build local capacity to meet local needs, the project does not have a viable exit strategy for children aging out of the fosterage. Given that Manya Krobo traditional area has exceptional concerns including a high prevalence of HIV/AIDS, increasing poverty and typically an environment of funding constraints, life in and out of foster care must be carefully crafted into a strategy that creates a system of partial self-sustainability over time to give both OVC children and MKQMA project hope and a future.

Protection of OVC in their own home is the best strategy for ensuring that the children grow and develop appropriate to the norms in Manya Krobo. It strengthens the protection and care, the economic coping capacities and enhances the capacity of OVC within their families and communities to respond to their psychosocial needs. To date, regrettably, little has been programmed on effective succession planning; particularly patriarchal ideologies of succession and inheritance, high social tolerance for violence and stigmatisation, factors that increase the vulnerability of OVC. Further, practical skills acquisition level presently offered by the project leaves much to be desired.

The study found that the MKQMA intervention links HIV/AIDS prevention activities, care and support for PLWHA with efforts to support OVC as well as focus on the most

vulnerable children in general and not only those orphaned by AIDS. It does not however pay particular attention to addressing gender discrimination (feminisation of care) to ensure the full involvement of males and the young. The prevailing situation involves chiefly elderly women caregivers as part of the solution. These factors directly have linkages to employment and income generating capacities of caregivers to provide for OVC needs as well as deprivation of OVC from exposure to the full socialisation process due to the absence of men in the home.

The existing state institutional mechanisms for monitoring interventions are too weak as protective legislative frameworks put in place appear to exist only on paper. Legal and law enforcement systems, enforcement capacity for protection of women and children's rights do not reflect best practice case.

6.4 - Summary of Main Claims

It is an indisputable fact that human beings, particularly children constitute Ghana's most valuable resource base. Substantial investment in children has been made in the Manya Krobo traditional area resulting in marked progress in many areas over the past decades. The advent of HIV/AIDS has brought its own new challenges such as increasing poverty, sickness and dead parents, positive living children, single and double orphans, lack of opportunities and other indirect burdens which are clearly exacerbating the traditional extended family safety net. Despite marked strides through policy and programmatic response, the area continues to grapple with challenging care service delivery needs which still lag behind targets. This gives cause for concern about the ability to tap the potential of OVC in ways which will not severely hamper the development of their educational and economic opportunity to become contributing and law-abiding citizens. The unreliable sources of and very low-incomes of caregivers many of whom are weak and elderly make the area one of the most vulnerable regions to price spikes. This could push more foster families already living on or close to the poverty line into extreme poverty and can be a disincentive to prospective volunteers and a drawback for project growth and sustainability. Though the Livelihood Empowerment against poverty (LEAP) programme costs just GH¢10 (€4.65) per vulnerable family monthly, a seemingly modest outlay that, at scale, has nonetheless failed to find favour with austerity-minded Ghana government.

The Manya Krobo Queen Mothers Association OVC project typifies good local ingenuity in design and delivery of care services for very vulnerable children thus challenging the idea that traditional women leaders are zombies and incapable of confronting local problems. It has improved local institutional and community capacity to positively respond to the effects of HIV/AIDS particularly children affected. Siblings orphaned or rendered vulnerable as a result of socio-economic factors are kept together in one home/community and the home-based concept gives the children a sense of belonging and ownership. It enhances rapid OVC integration into mainstream activities thereby empowering them to be self-confident and perception of full citizenship status. The project illustrates that OVC children need more than immediate interventions but also long term interventions that essentially equip them with life skills through empowerment. It is a conduit for an intergenerational heritage transfer in Manya Krobo traditional area that positively contributes to sustainable local and national development. There is no gainsaying the willingness and best effort of the Queen Mothers to ensure the OVC project continues to lift needy children out of poverty and giving a future. The road ahead however appears to present much more challenging heights especially surmounting funding constraints and building human capacity to wane the project from relying solely on volunteers. It appears from the study results that additional education and raising capacity regarding the current rules around child protection is needed for Social Welfare staff, District Assembly Social Services sub-committee members, and caregivers attempting to obtain custody of OVC children. What is needed is the self belief that what men can do, women can do even better and that if the mind can conceive and the heart can believe, and scientific approach is applied, then the dream is still possible to attain.

6.5 - Recommendations about future work

Based on the findings of the study, the following recommendations are made for sustainable development of communities in Manya Krobo traditional area and the wider Ghanaian community as a whole.

- Since sustainable development, including creating an enabling environment, is the goal of both the Manya Krobo Queen Mothers OVC project and HIV/AIDS

National Strategic Framework; improving service delivery and mitigating the impact on affected individuals has to genuinely be implemented.

- There should be a purposeful broadening of the development and promotion of skills training by incorporating the *Local Enterprises* and *Skills Development Programme* (LESDEP) for OVC aged 13 years and above (inclusive eligible caregivers) to facilitate transition of OVC while ensuring livelihood empowerment sustainability.
- All OVC intended programmes (namely: National Plan of Action for OVC 2010, National Policy Guidelines on OVC of 2005, National Youth Policy of 2010, and the Children's Act of 1998) should be rigorously enforced in order to regulate effectively the activities of community-based groups like MKQMA OVC project. It should aim to remind OVC managers of their responsibilities especially to provide for the rights of the child, maintenance and adoption, regulate child labour and apprenticeship.
- Government should encourage gender mainstreaming and induction of young mature adults into OVC care by fully implementing the National Gender and Children's Policy to enable them to provide for OVC while effecting long term gender balance. The District authorities must adopt a comprehensive prevention strategy that spans health promotion campaigns, government regulation, family communication and counselling for foster families.
- A greater share of the *Livelihood Empowerment against Poverty* (LEAP) Programme and royalties should be given to Lower and Upper District Assemblies for onward disbursement to the Queen Mothers and caregivers towards OVC development. Moreover, to avoid misappropriation and embezzlement of funds, there must be regular and efficient auditing of the District Assemblies' funds.
- Avenues should be created so that local inhabitants, relevant state agencies and civil society groups can meet with the leadership of the MKQMA regularly to discuss and solve HIV/AIDS problems and OVC psychosocial and stigma predicaments in the locality.
- Given indications of continued and increased need, it is imperative that operators of the MKQMA OVC project develop an effective process of and improve the

understanding on guidelines for exit strategy as a sustainability plan which has inherent benefits irrespective of timing and context.

- As one of the major aims of the project is to empower both caregivers and OVC, they are expected to make informed decisions on the presumption that they fully understand the information being given to them. Caregivers must be involved in the development of and process of sharing information with OVC to make sure they provide relevant and clear information.

6.6 - Implications of the study

The findings of this study are important in the formulation of research policies regarding HIV/AIDS orphaned and other vulnerable children for particularly local communities, civil society groups especially CBOs and government decision makers.

In particular, this study will be of use to social service providers in planning, implementing, monitoring and evaluating effective service delivery to the AIDS orphaned and other vulnerable children.

Further, this study will be critical to academic studies as basis for formulating theory on studies of AIDS orphaned and other vulnerable children as it offers a clear understanding of the underlying causes and practical aspects of the OVC care and support burden.

6.7 - Contribution to knowledge

The evidence on the contributions of communities to the well-being and upbringing of children living in environments severely affected by HIV/AIDS has been building over the last few years. Most of the evidence to date had been on the weak aging grandparents, child-headed households and orphanages. The study stands out because it sheds new light on wholly community home-based care arrangement facilitated by traditional women rulers whereby a single OVC is not put in an orphanage. The study further stands out for successfully using a combination of quantitative and qualitative methods to portray OVC situation and the fact that it was one of the first that was able to examine roles of benefactor, caregiver and OVC generations involved in OVC care process comprising the.

6.8 - Limitations

The study was limited by the relatively short period of field research activity during data collection which may have obscured a number of care practices among participants that could have profound implications. Since the results were from self-reported opinions and cross-section study questionnaires, it was not entirely possible to crosscheck the results conclusively from this study.

More studies, probably longitudinal in nature, will be needed to replicate the findings and focus more on sustaining the project by developing empowerment conditions such as building life skills, identifying viable state resourcing alternatives and exit strategies. Studies that measure OVC care with activity monitors instead of questionnaires will also help build the evidence base. All these studies will further inform us of the exact relationship between OVC fosterage living conditions and building HIV/AIDS generation nexus, which ultimately will result in better OVC child welfare recommendations like we already have for empowering benefactors, caregivers and OVC generations.

6.9 - Self-Reflection

A Ghanaian proverb advises that 'a successor does not sit and go to sleep under a tree whose fruit his or her precursor has eaten and died from.' That the fact that we had to endure serious challenges in accomplishing this research, does not imply prospective students embarking on similar assignment in future need to necessarily face the same difficulties. The truth is knowledge has to be improved, challenged, and increased constantly, or it vanishes and can best be attained through sharing of experience. After all, it is said that from the quiet reflection will come even more effective action. It is our desire that other students do not benefit from just our contribution to knowledge but also gain useful insights from things we would do differently if I had to do this dissertation again.

The most important point to underscore here that any study involving HIV/AIDS and its aftermaths is a sensitive topic thus disclosure of highly personal and confidential information such as getting to know who is positive living and orphaned by AIDS requires a lot of tact. When conducting research of this nature in an environment which appears to suffer from research fatigue, it is highly advisable that the researcher

establishes rapport with the people who make major decisions. It is also imperative that ambiguity in language both written and verbal is avoided as much as practicable. This helps build trust and open up respondents to facilitate the flow of needed information. The essential element here is knowledge of hazards of this type of research such as confidentiality and the need to protect respondents and researchers alike. In view of the sensitivity attached to the subject matter of HIV/AIDS, due respect for the rights of all participants should be of utmost concern.

Study till old, live till old, and there is still three-tenths studying left to do. The researcher must endeavour to acquaint him or herself with the traditions and customs of the area and observe them accordingly. Although there are some basic codes of conduct that can serve as helpful guidelines for respectful behaviour, there are an immense variety of gestures and non-verbal communications that vary in meaning from one locale to another. It is worthy, for example, to be aware of some local gestures that may be considered offensive or, in some cases, even obscene. One known cultural trait prevailing in a specific setting should thus not be considered synonymous with another area. This calls for deeper understanding of behaviours and attitudes not only at the superficial level but in its practical sense. This will enhance proper and accurate interpretations of observed phenomenon.

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APPENDIX A:

COPY OF A LETTER FOR PERMISSION TO CONDUCT SURVEY

Department of Geography
University of Minho
Guimarães, Portugal
February 1, 2011

The Programme Manager
Manya Krobo Queen Mothers Association OVC Project
Odumase Krobo, Ghana

Dear *Manye* Esther Kpabitey Nartekie,

PERMISSION TO CONDUCT SURVEY

I am currently undertaking an academic study examining the living conditions of orphans and other vulnerable children (OVC) and adaptive strategies of communities where they live. This survey will provide insights that will allow bettering understanding the role of female traditional rulers in care programming.

As the Programme Manager of the Manya Krobo Queen Mothers OVC safety net project, I am seeking your kind permission to allow me to collect data from among a section of your members, foster parents and OVC in the months of April and May, 2011.

The survey may take up to 30 minutes to complete and consists mainly of questions where the respondents check one or more boxes. There are also some questions where interviewees will be asked to provide either written or oral comments. Respondents can feel free to write or give their comments in one of English, *Krobo* or *Akan* languages.

It may seem that I am asking for a significant amount of your group's time, but please remember that this survey encompasses a very important part of the study. Please note that all responses are anonymous and confidential, and will be reviewed only by myself. No information will be collected that can identify individual responses.

Your kind permission will help contribute to improving academic understanding of the Manya Krobo Queen Mothers OVC project and hopefully help shape positive public opinion of your project needs.

Thank you very much for your time.

Sincerely,

Kojo Gyabaah
(Researcher)

APPENDIX B:

COPY OF A SET OF QUESTIONS FOR CAREGIVERS

CAREGIVER SURVEY QUESTIONNAIRE

1 QUESTIONNAIRE IDENTIFICATION NUMBER |___|___|___|
2 Town: _____
3 House /Centre:_____

4 DATE INTERVIEW: __/ ____ / _____

My name is… I'm working on an academic project vulnerable children. I am interviewing people here in order to find out about the situation facing families who have children under the age of 18.

I am going to ask you some very personal questions. It is about help for less privileged children in this community. Your answers are completely confidential. Your name will not be written on this form, and will never be used in connection with any of the information you tell me. However, your honest answers to these questions will help get better understanding of the circumstances that many people are living with.

Section 1: Introductory

No.	Questions and filters	Coding categories	Skip to

QXX	*How are you and your family?*		
Section 2: Household Economic Status			
Q1	Are you the head of this household?	YES NO DON'T KNOW NO RESPONSE	1 0 88 99
Q2	How many children 24 years of age and below live in this household?	WRITE NUMBER	[____]
Q3	How many people in this household earned money from regular employment in the past 30 days?	Number of people **(Can be 0)** DON'T KNOW NO RESPONSE	[____] 88 99
Q4	How many people in this household earned money from piece work in the past 30 days?	Number of people **(Can be 0)** DON'T KNOW NO RESPONSE	[____] 88 99
Q5	How much money was earned by all members of this household in the past 30 days?	WRITE AMOUNT **(Can be 0)** DON'T KNOW NO RESPONSE	|__ __| 88 99
Q6	How much money did this household receive from sources other than through working in the past 30 days?	WRITE AMOUNT **(Can be 0)** DON'T KNOW NO RESPONSE	|__ __| 88 99
Q7	What are all the sources of the income earned in the past 30 days? *(Probe to find out the type of work done and ask about "Pension" and "Relatives".)*	No sources of income Beads making Hawking items Marketeering Stone crushing House girl/boy Agriculture Fishing mongering Crafts Teaching Pension Relatives Other : _____ DON'T KNOW NO RESPONSE	0 1 2 3 4 5 6 7 10 11 12 13 14 88 99
Q8	How much money was spent on health care in the past 30 days? *(WRITE AMOUNT for each item **(Can be 0)** next to each item)*	Off-the-counter drugs Prescription drugs Payment for NHIS Herbal drugs (convert gifts to monetary value)_____ DON'T KNOW NO RESPONSE	[____] [____] [____] [____] [____] 88 99

Q9	How much money was spent on the children's education since the beginning of this school year? *(Write AMOUNT for each item **(Can be 0)** next to each item)*	School fees PTA fees Uniforms Books Pencils/pens Other supplies Transportation to and from school DON'T KNOW NO RESPONSE	[____] [____] [____] [____] [____] [____] [____] 88 99
Q10	Do you financially support other children who do not live in this household?	Yes 1 No 0 DON'T KNOW 88 NO RESPONSE 99	K **Skip to Q12**
Q11	How much money do you spend on these other children? *(Responses can NOT be zero.)*	Monthly Quarterly Annually DON'T KNOW NO RESPONSE	[____] [____] [____] 88 99
Q12	Yesterday, how many meals did the family eat?	WRITE AMOUNT **(Can be 0)** [____] DON'T KNOW 88 NO RESPONSE 99	K ***(If 0, skip to Q14)***
Q13	What did you eat for those meals yesterday?	_____ _____ *(list all food eaten)* DON'T KNOW 88 NO RESPONSE 99	
Q14	Do you own or rent this house?	Own 1 Rent 0 DON'T KNOW 88 NO RESPONSE 99	
Q15	Do you own any other property?	YES 1 NO 0 DON'T KNOW 88 NO	

		RESPONSE 99	

Section 3 Relationships in Household

For each child living in the household gather the information in the following 2 charts.
For Q16 identify the child's relationship to the head of household using the following list and corresponding codes to report responses.

CODE Response

1 Child
2 Brother or Sister
3 Grandchild
4 Nephew/Niece
5 Cousin
6 Neighbour
7 Step-child
10 Brother or Sister IN-LAW
11 Other *(Specify in the box next to the child.)*
88 DON'T KNOW
99 NO RESPONSE

ID	Q17	Q18	Q19	Q20	Q21	Q22	Q23	Q24	Q25
	Gender	Age	Relationship to Head of Household	Is mother still alive? Yes 1 No 0	Is father still alive? Yes 1 No0	Does this child earn money for the household? Yes 1 No 0	Length of time in house	# of Previous homes (If no other households skip to Q26)	Reasons for moving
C1									
C2									
C3									
C4									
C5									
C6									
C7									

Section 4 Children's Education Experience

ID	Q26	Q27	Q28	Q29	Q30	Q31	Q32	Q33	Q34
	Ever been in School **Yes 1** **No 0** K **(if NO skip to Q34)**	**Currently in School YES 1 NO 0** K ***(if NO, skip to Q32)***	**Attending which?** **Government** **Or Private**	**Current grade level**	**Since starting school, have you been absent from school for more than one term** **Yes 1** **No 0** K ***(If no skip***	**Reason for absence** K ***(Skip to Q35)***	**Last grade successfully completed**	**Length of time since last attended school**	**Reasons for not attending school**

					to Q34)				
C1									
C2									
C3									
C4									
C5									
C6									
C7									

Section 5 Psycho-social issues

Q35	How happy are the children you have taken in, compared to other children their same age?	Happy, Happier 4 The same, sometimes happy, sometimes not 3 Somewhat unhappy, less happy 2 Very unhappy, sad 1 DON'T KNOW 99 NO RESPONSE 88	
Q36	What do children do for fun?	Y Football, other sports, physical activity N 1 Non-physical games, dolls 0 1 Being with friends, talking 0 1 Being with family 0 1 Being cared for by guardian 0 1 Eating, food 0 1 Dance, music, drama 0 1 Having, getting new clothes 0 1 Going to/doing well in school 0 1 Reading 0 1 Crafts, weaving, art 0 1 Nothing 0 1 Other _____ 0 1 DON'T KNOW 0 88 NO RESPONSE 99	
Q37	Are there any conflicts between the foster and biological children?	YES NO 1 YES NO 0 DON'T KNOW 88 NO RESPONSE 99	

Q38	Who do they have these conflicts with?	Y N Their brothers and sisters 0 1 Other children in the household 0 1 Neighbourhood children 0 1 Their school mates 0 1 Other _____ 0 1 DON'T KNOW 88 NO RESPONSE 99	
Q39	What are the common causes for these conflicts?	Y N House work 1 0 Jealousy 1 0 Fighting over meals 1 0 Wanting attention 1 0 Ownership of clothes 1 0 Ownership of household items 1 0 Other _____ 1 0 DON'T KNOW 1 0 NO RESPONSE 88 99	
Q40	How well do foster and other children get along?	Very Well 3 Somewhat well 2 Somewhat poorly 1 Very poorly 0 DON'T KNOW 88 NO RESPONSE 99	
Q41	With whom do the children you have taken in usually talk with when they are worried or have a problem?	Y N The guardian 1 0 The guardian's husband/wife/relative 1 0 Step-, Foster-siblings 1 0 Their own brothers or sisters 1 0 Friends, Cousins, other children 1 0 Some other adult relative not living with them 1 0 School Teacher 1 0 Clergyman 1 0 No one, keeps to him or herself 1 0 Other _____ 1 0 DON'T KNOW 88 NO RESPONSE 99	
Q42	(***Ask only if one or more parents have deceased. If both parents are alive, skip to Q46***) Do OVCs know what caused their parent (s)' death?	YES 1 NO 0 DON'T KNOW 88 NO RESPONSE 99	
	Have you ever talked about the death of the parent(s)?	YES 1 NO 0 DON'T KNOW 88	

Q43		NO RESPONSE 99	
Q44	How often do you talk about their deceased parent(s)?	Daily 5 Weekly 4 Monthly 3 Every few months 2 Only one time 1 Other _____ 0 DON'T KNOW 88 NO RESPONSE 99	
Q45	Did the illness of the OVC's parent(s) include any of the following conditions?	Y N Unexplained weight loss 1 0 Eating disorders or loss of appetite 1 0 Persistent skin rashes 1 0 Herpes 1 0 Recurrent Diarrhoea 1 0 Pneumonia 1 0 TB 1 0 Thrush 1 0 Other _____ 1 0 DON'T KNOW 1 0 NO RESPONSE 1 0 88 99	
Q46	How has the illness or death of the parent(s) effected daily life (circumstances, etc.) if at all? *(DO NOT read the list. Circle 1 if item is mentioned. Probe: "Anything else?")*	Y N Their school attendance has declined/stopped 1 0 Their grades have worsened 1 0 They do more housework or field work 1 0 They have to take care of smaller children 1 0 They have to take care of a living parent 1 0 We have less food/money as a family 1 0 It has not effected their life circumstances 1 0 Other _____ 1 0 DON'T KNOW 0 NO RESPONSE 88 99	
Q47	What is difficult about living with another family? *(DO NOT READ LIST. CIRCLE 1 IF MENTIONED)*	Y N It gets hard financially 1 0 There is less food to go around 1 0 Some children can't go to school 1 0 I have no time to rest 1 0 Too much pressure 1 0 Other _____ 1 0 DON'T KNOW 0 88	

		NO RESPONSE 99	
Q48	Has the OVC experienced any of the following health/behaviour challenges in the past six months?	Y N Malaria 1 Diarrhoea 0 1 Fear of the opposite sex 0 1 Lying 0 1 Pregnancy /Sexually Transmitted infections 0 1 Bed-wetting and thumb sucking 0 1 Stealing 0 1 Other _____ 0 1 DON'T KNOW 0 NO RESPONSE 88 99	
Q49	What kind of help/support do you need? *(DO NOT READ LIST. CIRCLE 1 IF MENTIONED. If they say "Money" probe to find out what they would use the money for.)*	Y N Medical Care 1 Food 0 1 Support for the children's school fees 0 1 Clothing 0 1 Someone to talk with 0 1 Someone to watch kids for me from time to 0 1 time Training or education 0 1 Other _____ 0 1 DON'T KNOW 0 NO RESPONSE 88 99	
Q50	How often does the OVC cry during the course of a normal day, over something small or nothing at all, scary dreams or nightmares?	Often 3 Sometimes 2 On rare occasions 1 Never 0 DON'T KNOW 88 NO RESPONSE 99	
Q51	How often does the OVC feel unhappy, worried or sad, prefer to be alone, or fight/bully/attack or become angry?	Often 3 Sometimes 2 On rare occasions 1 Never 0 DON'T KNOW 88 NO RESPONSE 99	
		Often 3 Sometimes 2	

Q52	How often does the OVC refuse or resist going school, or act disobediently either at home or school?	On rare occasions Never DON'T KNOW NO RESPONSE	1 0 88 99	
Q53	How often does the OVC refuse to eat meals, go to bed, feel like running away or ever run away?	Often Sometimes On rare occasions Never DON'T KNOW NO RESPONSE	3 2 1 0 88 99	
QQ54	In the past 6 months have you received any kinds of services or assistance?	YES NO DON'T KNOW NO RESPONSE	1 0 88 99	
Q55	If yes, what was the nature of assistance or service received?	Medical Care Food Support for the children's education Clothing Emotional support/Counselling Financial assistance Training or education Other _____ DON'T KNOW NO RESPONSE	7 6 5 4 3 2 1 0 88 99	
Q56	Have you ever heard of Ghana AIDS Commission?	YES NO DON'T KNOW NO RESPONSE	1 0 88 99	
Q57	Please tell me the names of all the organisations that you know about who provide assistance to orphans and vulnerable children.	_____ _____ DON'T KNOW NO RESPONSE	 88 99	
Section 6: Background Characteristics				
Q58	SEX OF RESPONDENT	MALE FEMALE	1 2	
Q59	How old Are you?	Age in years DON'T KNOW *NO RESPONSE*	[_|__] 88 99	
Q60	What is the highest level of school you completed: primary, secondary or	Primary JHS SHS Higher	1 2 3 4	

	higher? **CIRCLE ONE**	None DON'T KNOW NO RESPONSE	0 88 99	
Q61	What is your marital status?	Single married Divorced Separated Widowed Co-habitation DON'T KNOW NO RESPONSE	0 1 2 3 4 5 88 99	
Q62	How old were you when you first married?	Age in years DON'T KNOW NO RESPONSE	[_|__] 88 99	
Q63	What religion are you? **CIRCLE ONE**	NO RELIGION Christian Muslim Traditional Other---------- DON'T KNOW NO RESPONSE	0 1 2 3 4 88 99	
Q64	What ethnic group do you belong?	Krobo Ga-Adangbe Akan Ewe Other---------- DON'T KNOW NO RESPONSE	1 2 3 4 5 88 99	

APPENDIX C:

COPY OF A SET OF QUESTIONS FOR OVC CHILD RESPONDENTS

OVC CHILD SURVEY QUESTIONNAIRE

1 QUESTIONNAIRE IDENTIFICATION NUMBER |___|___|___|
2 Town: _____
3 House /Centre:_____

4 DATE INTERVIEW: __/ ____ / _____

I'm working on an academic project vulnerable children. I am interviewing people in order to find out about the situation facing families who have children under the age of 18.

I am going to ask you some very personal questions. It is about help for less privileged children in this community. Your answers are completely confidential. Your name will not be written on this form, and will never be used in connection with any of the information you tell me. However, your honest answers to these questions will help get better understanding of the circumstances that many people are living with.

Section 1: Introductory

No.	Questions and filters	Coding categories	Skip to
QXX	*How are you and your family?*		
Section 2: Household Economic Status			

Q1	Are you the head of this household?	YES NO DON'T KNOW NO RESPONSE	1 0 88 99
Q2	How many children 24 years of age and below live in this household?	WRITE NUMBER	[____]
Q3	Yesterday, how many meals did the family eat?	WRITE AMOUNT **(Can be 0)** [____] DON'T KNOW 88 NO RESPONSE 99	K ***(If 0, skip to Q5)***
Q4	What did you eat for those meals yesterday?	_____ _____ *(list all food eaten)* DON'T KNOW 88 NO RESPONSE 99	
Q5	Do you own or rent this house?	Own 1 Rent 0 DON'T KNOW 88 NO RESPONSE 99	
Q6	Do you own any other property?	YES 1 NO 0 DON'T KNOW 88 NO RESPONSE 99	
Section 3 Relationships in Household			

For each child living in the household gather the information in the following 2 charts.
For Q9 identify the child's relationship to the head of household using the following list and corresponding codes to report responses.

CODE Response

1 Parent
2 Brother or Sister

3 Grandparent
4 Uncle/Auntie
5 Cousin
6 Neighbour
7 Step-parent
10 Brother or Sister IN-LAW
11 Other *(Specify in the box next to the child.)*
88 DON'T KNOW
99 NO RESPONSE

ID	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14	Q15
	Gender	Age	Relationship to Guardian	Is mother still alive? Yes 1 No 0	Is father still alive? Yes 1 No0	Do you earn money for the household? Yes 1 No 0	Length of time in house	# of Previous homes (If no other households skip to Q16)	Reasons for moving
C									

Section 5 Children's Education Experience

ID	Q16	Q17	Q18	Q19	Q20	Q21	Q22	Q23	Q24
	Ever been in School Yes 1 No 0 K (if NO skip to Q21**)**	Currently in School YES 1 NO 0 K *(if NO, skip to Q21*)	Attending which? Government Or Private	Current grade level	Since starting school, have you been absent from school for more than one term Yes 1 No 0 K *(If no skip to Q25)*	Reason for absence	Last grade successfully completed	Length of time since last attended school	Reasons for not attending school
C									

Section 4 Psycho-social issues

Q25	How happy are you compared to other children your age?	Happy, Happier 4 The same, sometimes happy, sometimes not 3 Somewhat unhappy, less happy 2 Very unhappy, sad 1 DON'T KNOW 99 NO RESPONSE 88	

Q26	What do you do for fun?	activity games, dolls	Football, other sports, physical Non-physical Being with friends, talking Being with family Being cared for by guardian Eating, food Dance, music, drama Having, getting new clothes Going to/doing well in school Reading Crafts, weaving, art Nothing Other _____ DON'T KNOW NO RESPONSE	1 2 3 4 5 6 7 8 9 10 11 12 13 88 99	
Q27	Are there any conflicts between you and your guardian's children?		YES . NO DON'T KNOW NO RESPONSE	1 0 88 99	
Q28	Who do you have these conflicts with?	sisters in the household children mates	My brothers and Other children Neighbourhood My school Other _____ DON'T KNOW NO RESPONSE	1 2 3 4 5 88 99	
Q29	What are the common causes for these conflicts?		House work Jealousy Fighting over meals Wanting attention Ownership of clothes Ownership of household items Other _____ DON'T KNOW NO RESPONSE	1 2 3 4 5 6 7 88 99	
Q30	How well do you get along with other children?		Very Well Somewhat well Somewhat poorly Very poorly DON'T KNOW NO RESPONSE	3 2 1 0 88 99	

Q31	With whom do you usually talk with when you are worried or have a problem?	My guardian 1 My guardian's husband/wife/relative 2 Step-, Foster-siblings 3 My own brothers or sisters 4 Friends, Cousins, other children 5 Some other adult relative not living with me 6 School Teacher 7 Clergyman 8 No one, keeps to myself 9 Other _____ 10 DON'T KNOW 88 NO RESPONSE 99	
Q32	***(Ask only if one or more parents have deceased. If both parents are alive, skip to Q46)*** Do you know what happened to your parent (s)?	YES 1 NO 0 DON'T KNOW 88 NO RESPONSE 99	
Q33	Has your guardian ever talked about your parent(s)?	YES 1 NO 0 DON'T KNOW 88 NO RESPONSE 99	
Q34	How often does your guardian talk to about your parent(s)?	Daily 5 Weekly 4 Monthly 3 Every few months 2 Only one time 1 Other _____ 0 DON'T KNOW 88 NO RESPONSE 99	
Q35	Did the illness of your parent(s) include any of the following conditions?	Unexplained weight loss 1 Eating disorders or loss of appetite 2 Persistent skin rashes 3 Herpes 4 Recurrent Diarrhoea 5 Pneumonia 6 TB 7 Thrush 8 Other _____ 9 DON'T KNOW 88 NO RESPONSE 99	

Q36	How has the illness or death of the parent(s) effected daily life (circumstances, etc.) if at all? *(DO NOT read the list. Circle 1 if item is mentioned. Probe: "Anything else?")*	My school attendance has declined/stopped My grades have worsened I do more housework or field work I have to take care of smaller children I have to take care of a living parent We have less food/money as a family It has not effected their life circumstances Other _____ DON'T KNOW NO RESPONSE	1 2 3 4 5 6 7 8 88 99	
Q37	What is difficult about living with another family? *(DO NOT READ LIST. CIRCLE 1 IF MENTIONED)*	It gets hard financially There is less food to go around I can't go to school I have no time to rest Too much pressure Other _____ DON'T KNOW NO RESPONSE	1 2 3 4 5 6 88 99	
Q38	Have you experienced any of the following health/behaviour challenges in the past six months?	Malaria Diarrhoea Fear of the opposite sex Lying Pregnancy /Sexually Transmitted infections Bed-wetting and thumb sucking Stealing Other _____ DON'T KNOW NO RESPONSE	1 2 3 4 5 6 7 8 88 99	
Q39	What kind of help/support do you need? *(DO NOT READ LIST. CIRCLE 1 IF MENTIONED. If they say "Money" probe to find out what they would use the money for.)*	Medical Care Food Support for the children's school fees Clothing Someone to talk with Someone to help me from time to time Training or education Other _____ DON'T KNOW NO RESPONSE	1 2 3 4 5 6 7 8 88 99	
		Often Sometimes	3 2	

Q40	How often do you cry during the course of a normal day, over something small or nothing at all, scary dreams or nightmares?	On rare occasions 1 Never 0 DON'T KNOW 88 NO RESPONSE 99	
Q41	How often do you feel unhappy, worried or sad, prefer to be alone, or fight/bully/attack or become angry?	Often 3 Sometimes 2 On rare occasions 1 Never 0 DON'T KNOW 88 NO RESPONSE 99	
Q42	How often do you refuse or resist going school, or act disobediently either at home or school?	Often 3 Sometimes 2 On rare occasions 1 Never 0 DON'T KNOW 88 NO RESPONSE 99	
Q43	How often do you refuse to eat meals, go to bed, feel like running away or ever run away?	Often 3 Sometimes 2 On rare occasions 1 Never 0 DON'T KNOW 88 NO RESPONSE 99	
Q44	In the past six months have you received any kinds of services or assistance?	YES 1 NO 0 DON'T KNOW 88 NO RESPONSE 99	
Q45	If yes, what was the nature of assistance or service received?	Medical Care 7 Food 6 Support for education 5 Clothing 4 Emotional support/Counselling 3 Financial assistance 2 Training or education 1 Other _____ 0 DON'T KNOW 88 NO RESPONSE 99	
Q46	Have you ever heard of Ghana AIDS Commission?	YES 1 NO 0 DON'T KNOW 88 NO RESPONSE 99	

Q47	Please tell me the names of all the organisations that you know about who provide assistance to orphans and vulnerable children.	_____ _____ DON'T KNOW NO RESPONSE	 88 99	

Section 6: Background Characteristics

Q48	SEX OF RESPONDENT	MALE FEMALE	1 2	
Q49	How old Are you?	Age in years DON'T KNOW *NO RESPONSE*	[_|__] 88 99	
Q50	What is the highest level of school you completed: primary, secondary or higher? **CIRCLE ONE**	Primary JHS SHS Higher None DON'T KNOW NO RESPONSE	1 2 3 4 0 88 99	
Q51	What is your marital status?	Single married Divorced Separated Widowed Co-habitation DON'T KNOW NO RESPONSE	0 1 2 3 4 5 88 99	
Q53	What religion are you? **CIRCLE ONE**	NO RELIGION Christian Muslim Traditional Other---------- DON'T KNOW NO RESPONSE	0 1 2 3 4 88 99	
Q54	What ethnic group do you belong?	Krobo Ga-Adangbe Akan Ewe Other---------- DON'T KNOW NO RESPONSE	1 2 3 4 5 88 99	

APPENDIX D:

A COPY OF FOCUS GROUP DISCUSSION INSTRUMENT

No.	Category / Activity	Details	**Remarks**

Focus Group Discussion Instrument

A	Town / Centre	_____ Respondent 1 _____ Respondent2 _____ Respondent 3 _____ Respondent4 _____ Respondent 5	_____ _____ _____ _____ _____
B	Grade / Position of Respondent	_____ Respondent 1 _____ Respondent2 _____ Respondent3 _____ Respondent4 _____ Respondent 5	_____ _____ _____ _____ _____
C	Group (Same sex groups ONLY)	#Males____ #Females__	_____ _____
D	FGD Leader	_____	_____
E	FGD Assistant	_____	_____
F	Date and Time	Date: Start Time___	**Finish Time**_____ **Total Time**___
G	Cooperation	1 High_____	**2 Medium** _____ **3 Low** ___
H	Date of Note Rewriting	_____	_____
I	Date of Final Check	_____	_____
J	**Date Entered**	_____	_____