A Study of Child-Related Policies, Services and the Needs of Orphans in Malawi

Esmie Tamanda Vilili Kainja

Submitted in accordance with the requirements for the Degree of PhD

The University of Leeds
School of Medicine

Leeds Institute of Health Sciences

Nuffield Centre for International Health and Development

October 2012

The candidate confirms that the work submitted is her own and that appropriate credit has been given where reference has been made to the work of others.

This copy has been supplied on the understanding that it is copyright material and that no quotation from the thesis may be published without proper acknowledgement.

The right of Esmie Tamanda Vilili Kainja to be identified as author of this work has been asserted by her in accordance with the UK Copyright, Designs and Patents Act 1988.

© 2012 The University of Leeds and Esmie Tamanda Vilili Kainja

DEDICATION

Praise, Glory, Honour and Power be to our God, who created heavens and the earth; The Father of our Lord Jesus Christ. The God of Abraham, who keeps His promises: the God of Daniel, who seals the mouth of the lions; the revealer of deep mysteries. Indeed! You are the lifter of my head; the God who answers prayer; God who exalts the humble and humiliates the proud. This thesis was made possible with the help of God, whose truth is in the Holy Living Bible. Surely! surely! Wisdom and power belongs to God (Daniel 2 verse 20-23).

The thesis is dedicated to our three children, Linda, Martin and Paul. It will stand as a living testimony to what God can do to those who work hard and persevere in life, to achieve their goals and aspirations.

To Bambo Milanzi, my father and his beautiful wife, Anambewe, thank you very much for showing me the way to education. I still believe in your words of wisdom, ‘Work hard in school, because no one will ever take away your educational qualification from you. It is your shield’.

ACKNOWLEDGEMENTS

This thesis would not have been possible without the support and guidance of my supervisors: Professor Darren Shickle, Dr. Cathy Brennan, Dr. Reinhard Huss and Professor John Walley. I am truly grateful to them. I sincerely appreciate their patience, encouragement and support during the challenging times.

I also wish to thank Malawi Government for securing my PhD Scholarship through the Commonwealth Association and for providing leave of absence to facilitate my career advancement. I am indebted to the Commonwealth and British Council staff who were very supportive throughout the entire period of study.

I would like to express my heartfelt appreciation to my family, especially my husband Samuel, particularly for coming to UK to take care of our children and manage the home- I will always cherish this gesture. I also thank our children, Paul, Martin and Linda for enduring my postponed motherly care as I spent more time in the library than at home. Indeed staying away from Malawi bound us together as never before.

I wish to thank the staff of the Nuffield Centre for International Health and Development and the University of Leeds for hosting my research project and particularly, Dr. Liz Glidewell, my Postgraduate Tutor. I would also like to thank my fellow PhD students in room G.02 and many friends, too numerous to mention for various contributions. I wish to acknowledge the following people who read my work: Dr. Rosemary Morgan, Dr. Tonia Frame, Dr. E. Chabwera, Dr. Ruth Mwandira, Dr. Virginia Pasanje, Ms Amanda Edmondson, Mrs Theresa Munyombwe, Mrs Gwen Jacques and Mrs Farzanah Pezandeh. To Tonia, all I can say is you are a true and reliable friend. Your commitment and endurance was my inspiration. I am indebted to John Braine for proofreading the entire thesis. Thank you all for being supportive.

To the orphans and caregivers who shared their traumatic experiences of illness, death and vulnerability, I wish to state that without your openness and courage, this work would not have been compiled. It is my hope and prayer that this work will contribute towards improvement of your lives. Appreciation goes to the Malawi policy makers and service providers for sharing their perspectives and for supporting the orphans.

Above all, Glory and Honour be to God who gave me wisdom and knowledge for the PhD (Daniel 1: 17)

ABSTRACT

Introduction: Due to HIV/AIDS epidemic, Malawi experienced a proliferation of orphans. These orphans are experiencing difficulties in meeting the basic necessities of daily life. Hence, donors have increased funding, Government has developed new policies for children and orphans and many civil society organisations are providing services to orphans. However, there is a paucity of research to establish the responsiveness of these initiatives to the needs of orphans.

Purpose: The aim of this thesis was to assess how child-related policies and service delivery were responding to the needs of orphans. The research was designed to identify weaknesses and strengths in service delivery and policy design with the intention of proposing strategies and making recommendations to better address the needs of orphans.

Methods: In 2010, 72 in-depth interviews were conducted in Blantyre and Lilongwe districts in Malawi. These comprised of 16 orphans aged 13-16 years, 12 caregivers, 12 national service providers and 13 policy makers. In addition, 12 interviews were conducted with participants playing both policy and service provision roles. Seven focus group discussions were conducted with district and community service providers. Government policies were also reviewed. Data were analysed using framework analysis.

Findings: Food was found to be the most critical need among orphans, followed by financial security for meeting needs autonomously. Child-related polices did not fully guide service implementation due to weak policy coordination, lack of alignment between structures stipulated in policy and structures used in for policy implementation, poor policy design and limited participation of service users and stakeholders in policy development and implementation. Non-comprehensive services, poor service integration, inequitable service delivery, inaccessible services and insufficient resources were found to undermine service responsiveness to orphans' needs.

Recommendations: To improve orphan related policies and service delivery, policies and services should focus on improving service coordination, resource mobilisation and policy design. Donors and non-governmental organisations should operate within Government plans, priorities and implementation structures. Services should prioritise food and household income generation strategies.

TABLE OF CONTENT

DEDICATION ii
ACKNOWLEDGEMENTS iii
ABSTRACT iv
ABBREVIATIONS xiv
GLOSSARY OF WORDS xvi
Chapter 1 – Introduction and Contextual Background 1
1.1 Introduction 1
1.2 Contextual Background 3
1.2.1 Politics and Policy Environment 3
1.2.2 Economic Situation 8
1.2.3 Food Security 9
1.2.4 Gender and Cultural Context 10
1.2.5 Health Services 11
1.2.6 Education Services 13
1.2.7 HIV/AIDS 14
1.2.8 Research Aim and Focus 16
Chapter 2 – Orphan Concept, Living Arrangements and Orphan Care in Malawi 18
2.1 Prevalence 18
2.2 Orphan Concept and Factors that Influence Orphan Definitions 21
2.3 Orphans Living Arrangements 23
2.3.1 Surviving Biological Parent 23
2.3.2 Grandparent Caregiver 24
2.3.3 Child Headed Households. 25
2.4 Orphan care Response in Malawi 26
Chapter 3 – Needs of orphans: Theory and Literature 30
3.1 Orphans Needs: Sub-Saharan Africa 30
3.1.1 Food Need 31
3.1.2 Educational Need 36
3.1.3 Health Need 40
3.1.4 Psychosocial Need 43
3.1.5 Economic and Material Needs 44

3.1.6 The Need for Protection..47

3.2 Orphan's Needs by Living Arrangement..49

3.3 Relationship between the Needs..51

3.4 Gaps in the Literature 52

3.5 Proposed Theory of Needs: Maslow's Human Motivation Theory 53

3.5.1 Physiological Needs 54

3.5.2 Safety Needs 54

3.5.3 Love and Belonging..55

3.5.4 Self Esteem and esteem by others 55

3.5.5 Self-Actualisation 55

3.6 Reeve's human motivation theory 56

3.7 UNICEF's Classification of Needs and the Link with Maslow's Theory .57

3.8 Application of Maslow's Theory: Limitations & Strengths 58

Chapter 4 – Policy and Service Provision: Theory and Literature 61

4.1 Policy Analysis Theories 61

4.1.1 Health policy analysis framework 62

4.1.2 Policy Implementation theories 65

4.2 Service provision Framework: Quality of Care Frameworks 67

4.2.1 Quality of Care Framework Concepts.......................................67

4.2.2 Frameworks for assessing Quality of care.................................69

4.2.3 Proposed Framework for Evaluating Policies and Quality of Service for Orphans 73

4.3 Justification for excluding policy analysis framework 75

4.4 Service provision to orphans in Sub-Saharan Africa 75

4.4.1 Comprehensive services 75

4.4.2 Service Accessibility and Equity..83

4.4.3 Coordination and Continuity of Service Delivery.......................89

4.4.4 Service Efficiency 92

4.5 Chapter summary 94

Chapter 5 – Research Methodology 96

5.1 Study Approach 96

5.1.1 Qualitative Approach..96

5.1.2 Evaluation Research 97

5.1.3 Sensitive Research 99

5.1.4 Principal Researcher's Position 100

5.2 Study Design 101

5.3 Research Methods and Rationale 104

5.3.1 In-depth Interviews 104

5.3.2 Focus Group Discussions 104

5.3.3 Document Review 105

5.4 Field Work Processes and Procedure 107

5.4.1 Sampling and Recruiting of Participants 107

5.4.2 Document Selection and Accessing 121

5.4.3 Data Collection Techniques and Procedures 125

5.5 Ethical Considerations 134

5.5.1 Ethical Approval 134

5.5.2 Informed Consent 134

5.5.3 Confidentiality and Anonymity 135

5.5.4 Protection from harm 136

5.5.5 Gaining Access to Community Participants 136

5.6 Data analysis 137

5.6.1 Qualitative data analysis 137

5.6.2 Framework Approach to Data Analysis 138

5.6.3 Document Analysis 141

5.7 Research Quality and Rigor 142

5.7.1 Audit trail 142

5.7.2 Triangulation 142

5.7.3 Credibility Checking 143

5.7.4 Quality and Training of the Research Team 143

5.7.5 Respondent Validation (Member Checking) 143

5.7.6 Reflexivity 144

5.7.7 Literature Search Strategy 145

5.8 Chapter summary 148

Chapter 6 – Results: The Reported Needs of Orphans 149

6.1 Physiological needs 149

6.1.1 The need for Life Sustenance 149

6.2 The Need for Safety 153

6.2.1 The Need for Good Health 153

6.2.2 The Need for Security of Body 154
6.2.3 Security of Property 156
6.2.4 Security of Finances 157
6.2.5 Security of work (child labour) 157
6.3 Need for Love and Belonging 159
6.4 Need for Esteem 161
6.5 The Need for Self-actualisation 162
6.6 Hierarchy of Needs 163
6.7 Relationships between needs 165
6.8 Strategies for meeting needs 167
6.8.1 Ganyu 168
6.8.2 Early Sexual Relationships 168
6.8.3 Selling off Domestic Assets 169
6.8.4 Harvesting Premature Maize 169
6.9 Factors affecting Orphans and Caregivers Needs 170
6.9.1 Household Composition 170
6.9.2 Decline in community assistance 170
6.9.3 Gender and Living Arrangement 173
6.9.4 Culture 176
6.9.5 Lack of parental support 177
6.10 Chapter summary 177
Chapter 7 – Results: Service Delivery to Orphans 178
7.1 Comprehensive Services 178
7.1.1 Failure to Address Whole Household Needs 180
7.1.2 Insufficient Resources and Donor Over-Dependence 180
7.1.3 Lack of Access to Services 182
7.2 Service Coordination and Collaboration 183
7.2.1 Poor Service Coordination 184
7.3 Service Accessibility 189
7.3.1 Distance and Structural Barriers to Service Access 189
7.3.2 Financial Barriers to Service Access 192
7.3.3 Service Timeliness 193
7.4 Service Effectiveness 193
7.5 Service Equity 195

7.5.1 Need-Based Equitable Services 195
7.5.2 Lack of needs assessment skills 196
7.5.3 Consequences of Corruption 197
7.6 Service Efficiency 198
7.6.1 Capacity Building and Technical Competence 200
7.6.2 Access to Information 202
7.7 Service Acceptability 204
7.7.1 Service Users Preferences 204
7.8 Service Continuity 207
7.9 Summary of Characteristics of Quality of Services 208
7.10 Chapter Summary 210
Chapter 8 – Policy Influence on Service Delivery 211
8.1 Policy for Coordination 211
8.1.1 Adherence to Collaboration Roles 211
8.1.2 Resource Sharing Agreement 214
8.1.4 Lack of Alignment to Coordination and Implementation Structures 217
8.1.5 Limited Multi-Sector Connectedness 220
8.1.6 Inconsistent Policy content 221
8.2 Policy Comprehensiveness 222
8.2.1 Absence of Essential Policies and Guidelines 223
8.2.2 Holistic Policy Strategies 225
8.3 Limited Access to Policy Information 227
8.4 Inequitable policy design and service distribution 227
8.5 Other Factors that influence policy 230
8.5.1 Participation in Policy Development and Implementation 230
8.5.2 Policy Monitoring and Evaluation 232
8.5.3 Feasibility of Implementing Policies 233
8.5.4 Contextual Factors 234
8.6 Chapter Summary 234
Chapter 9 – Discussion of Findings, Recommendations and Conclusion 236
Discussion of Findings, Recommendations and Conclusion 236
9.1 Discussion of Results in Relation to Literature 236
9.1.1 Needs Based Approach 236

9.1.2 Comprehensiveness....244
9.1.3 Equity....245
9.1.4 Coordination and Collaboration....246
9.1.5 Empowerment....251
9.1.6 Resource Capacity....256
9.1.7 Policy and Practice....258
9.2 Discussion of Methodology....261
9.2.1. Strength of Study Methodology Design and Framework....261
9.2.2 Limitations of study methodology design and framework....263
9.3 Modification of conceptual framework....264
9.4 Recommendations of study....266
9.4.1 Recommendations to Policy Makers....266
9.4.2 Recommendations to Multi-sector service providers....269
9.4.3 Recommendations for further research....270
9.5 Thesis Conclusion....271

APPENDICES 288
Appendix A : Orphans Demographic and socioeconomic information 288
Appendix B : Caregivers Demographic and Socioeconomic Information 290
Appendix C: Information Sheet for District and Service Providers Focus Group Discussion. 291
Appendix D: Information sheet for Policy Makers and Service Providers...........293
Appendix E: Information Sheet for Orphans and Caregivers..............................295
Appendix H : Interview Guide for Orphans 13-16 years...................................298
Appendix I : Interview Guide for Policy makers 301
Appendix J : Interview Guide for Service Providers 303
Appendix K: Focus Group Guide for Community participants............................306
Appendix M : Ethical Approval from Nuffield Institute of International Health and Development, Leeds. 311
Appendix N : Ethics approval from Health Sciences Research Committee in Malawi...312
Appendix O: Informed Consent Form for Focus Group Discussions 313
Appendix P: Informed Consent Form for In-depth Interviews for policy makers and service providers 314
Appendix Q: Informed Consent Form for Child and Caregiver 315
Appendix R : Needs of orphans' codes adopted from Maslow's hierarchy of needs...316
Appendix S : Policy and Services Codes Based on the Conceptual Framework .317
Appendix T : Policy Document Analysis Template..318
Appendix U : List of Malawi Government Child-Related Policy Documents Reviewed 319
Appendix V : Linkage between service users needs, services and policies 321

List of Figures

Figure 1.1: Geographical Location of Malawi in Africa. 3

Figure 1.2: Service implementation structure and orphan care stakeholder relationship 7

Figure 1.3: Impacts of HIV/AIDS on the individual and society. 16

Figure 2.1: Projections of Global prevalence of Orphans by region 18

Figure 2.2: Estimated Trends of Orphans due to AIDS in Malawi from 1990-2010 . 19

Figure 3.1: Interrelationship among orphan needs and HIV/ AIDS in households ... 52

Figure 3.2: Maslow's hierarchy of needs. 53

Figure 3.3 : The link between Maslow's and UNICEF's needs classification............. 58

Figure 4.1: Proposed Conceptual Framework for Evaluating Quality of Orphan Care. 74

Figure 5.1: Research Design 106

Figure 5.2 : Flow chart for sampling process of orphans and caregivers 110

Figure 5.3 : Policy makers and service providers recruitment flow chart 114

Figure 5.4: District service provider's recruitment flow chart (FGD participants). 118

Figure 5.5 : Breakdown of research participants. 119

Figure 5.6 : Flow chart of policy selection. 123

Figure 5.7 : Stakeholders analysis outcome.. 124

Figure 6.1: Detrimental consequences of strategies for meeting orphan's needs. 167

Figure 7.1 : Interaction between elements of quality in service provision to orphans. 210

Figure 8.1: Normal and Deviated Service Implementation Structure in Malawi.... 219

Figure 9.1: Bronfenbrenner ecological theory & child development 243

List of Tables

Table 1.1: Socio-economic indicators of Malawi 8

Table 2.1: Prevalence of Orphans by Age in Malawi 19

Table 2.2: Child-related services for orphans and other children. 28

Table 4.1 : Policy Concepts.. 62

Table 4.2: Elements of quality of care by Maxwell and Health Services Research Group 70

Table 5.1: Alignment of research objectives, research questions, conceptual framework and methods. 102

Table 5.2: Sampling and recruitment of research participants. 108

Table 5.3 : Characteristics of orphans by age and gender. 111

Table 5.4 : Summary of characteristics of caregivers by age, gender and household size... 112

Table 5.5: Policy makers interviewed 115

Table 5.6: Service providers interviewed 116

Table 5.7 : Summary of policy makers profiles. 117

Table 5.8 : Characteristics of the case study area.. 121

Table 5.9 : Application of Maslow's classification of needs on orphans needs...... 127

Table 5.10 : Application of Conceptual Framework Elements. 128

Table 5.11 : Research participants and data collection methods. 133

Table 5.12 : Medline Literature Search Results. 147

Table 5.13 : Web of Knowledge literature search results.. 147

Table 7.1: Summary of Characteristics of quality in service provision to orphans. 209

ABBREVIATIONS

AIDS	Acquired Immune Deficiency
ANC	Ante Natal Clinic
ADC	Area Development Committee
ARV	Anti Retroviral Treatment
CBS	Community-Based Services
CHBC	Community Home Based Care
CONGOMA	Council for Non-Government Organisations
CSCQBE	Civic Society Centre for Quality Basic Education
CSO	Civil Society Organisation
DFID	Department for International Development
DHS	Demographic Health Survey
DOVCC	District OVC Committee
ECD	Early Childhood Development
EHP	Essential Health Package
FAO	Food and Agriculture Organisations
FBO	Faith Based Organisations
FGD	Focus Group Discussion
FPE	Free Primary Education
GDP	Gross Domestic Products
GFATM	Global Fund for AIDS, TB and Malaria
HIV	Human Immune deficiency Virus
ILO	International Labour Organisation
IMCI	Integrated Management of Childhood Illnesses
IMF	International Monetary Fund
MDHS	Malawi Demographic Health Survey
MEJN	Malawi Economic Justice Network
MICS	Multiple Indicator Cluster Survey
MoEST	Ministry of Education , Science and Technology
MoGCCS	Ministry of Gender, Children and Community Services
MoHP	Ministry of Health and Population
MTCT	Mother to Child Transmission

NAC	National AIDS Commission
NGO	Non-Government Organisation
NHS	National Health Service
NOVCP	National OVC Plan
NOVCSC	National OVC Steering Committee
NOVCTWG	National OVC Technical Working Group
NPA	National Plan of Action
NSO	National Statistics Office
OPC	Office of the President and Cabinet
OVC	Orphans and other Vulnerable Children
RAAAP	Rapid analysis, assessment and action plan
SWAp	Sector Wide Approach
UNAIDS	United Nations AIDS organisation
UNDP	United Nations Development Programme
UNESCO	United Nations Education and Scientific Organisation
UNICEF	United Nations Agency for Children
USAID	United States Agency for International Development
VCT	Voluntary Testing and Counselling
VDC	Village Development Committee
VOCC	Village Orphan Care Committee
WFP	World Food Programme
WHO	World Health Organisation
UNCRC	United Nations Conventions of the Rights of Children

GLOSSARY OF WORDS

Child	A person under the age of 18 years.
Child-headed Household	A family that is headed and managed by a person who is under the age of 18.
Child labour	Any activity that employs a child below the age of 14 years or that engages a child between the ages of 14 years and 17 years in a way that prevents the child from attending school, concentrating on school or negatively impacts on the health, social, cultural, psychological, moral, religious and related dimensions of the child's upbringing.
Child work	Child work is defined as acceptable work undertaken by a child of any age that does not interfere with the child's schooling, physical, moral, emotional or psychological development.
Community	A community is a grouping of people who share common purposes, interest and who can express their relationship through face-to-face communication as well as other means without much difficulty.
Double orphan	A child under 18 years whose father and mother are dead.
Family	A group of people affiliated by a common ancestry, affinity or co-residence.
Ganyu	Any piece of work that one does to earn some payment in cash or kind, commonly related to farming activities and include other domestic chores like washing clothes.
Household	A domestic unit consisting of people who live together in one house.
Maternal Orphan	A child under 18 years whose mother is dead.
Orphan	A child who has lost one or both parents because of death and is under the age of 18 years.
Paternal Orphan	A child under 18 years whose father is dead.
Vulnerable Child	A child who is under the age of 18, who has no able parents or guardian, who stays alone or with elderly parents or lives with other children or has no fixed place of abode and lacks access to health care, material support, education and has no shelter.
Wellbeing	A state of being happy, healthy or prosperous.

Chapter 1 – Introduction and Contextual Background

1.1 Introduction

The United Nations General Assembly on HIV/AIDS Declaration of 2001 formed the initial basis for global responses to the plight of orphans. The United Nations petitioned countries to scale up policy development activities, services programming and strengthen the family orphan care capacity (United Nations 2001).

'By 2003, develop and by 2005 implement national policies and strategies to build and strengthen governmental, family and community capacities to provide a supportive environment for orphans, girls and boys infected and affected by HIV/AIDS …urge donor countries, civil society as well as the private sector to complement national programmes to support … orphaned children.'(United Nations 2001:10).

Following this Declaration, Malawi became one of the 17 countries in Sub-Saharan Africa where UNICEF conducted rapid assessment, analysis and action planning (RAAAP) to assess the situation of orphans as a basis for response. RAAAP helped countries to develop policies, strategies and provided baseline data for orphan care problem response (UNICEF 2008c). For Malawi, the orphan response included the development of a National Plan of Action (NPA) for orphans and other vulnerable children (OVC) and scaling up the multi-sector orphan care service provision. This was done through promotion of community based orphan care services and increased donor funding.

Why did Malawi and other countries need external global support for assisting orphans? Several authors have suggested both demand and supply reasons. From the demand side, the capacity of communities and extended family support systems to absorb orphans was overwhelmed with unprecedented numbers of orphans and community networks were disintegrating (Foster 2002a; Foster, Deshmukh and Adams 2008; Nyambedha, Simiyu and Aagaard-Hansen 2001; Heymann and Kidmann 2008). As a result, the families' coping capacities were eroded and the quality of orphan care service declined because most of the orphan carers lacked resources, skills or orphan-care knowledge (Heymann and Kidmann 2008). Furthermore, chronic poverty in the

communities necessitated formal support to households through Government and NGO interventions (Foster, Deshmukh and Adams 2008; Hometruth 2009; Desmond 2007). Poverty has been exacerbated by HIV/AIDS demands, including caring of chronic sicknesses and payment of medical expenses (Desmond 2007), as explained in chapter 3, section 3.1.1.

From the supply side, some scholars suggested that donor orphan care support was imperative because no low-income country could raise the amount of money needed for supporting orphans, and if they did, other social services would suffer (McPherson 2008). Nevertheless, It has been argued that there is a mismatch between orphan care needs and donor response, in Sub-Saharan Africa, because resources from donors are less than what is needed for national full-scale response, particularly in high HIV communities (Hometruth 2009).

Some have argued that it is the Government's mandate to provide support to orphans to fulfil the commitments made under the United Nations Convention on the Rights of the Child (UNCRC) to provide social protection to vulnerable children (Foster 2010). The support provided to the orphans by the Malawi Government appears to be insufficient in quality and quantity (Malawi Government, 2004b, Heymann and Kidmann, 2008). The orphans' access to services was estimated to be less than 10 percent (National Statistical Office and UNICEF 2008).

In addition, some authors suggested that there was a growing need to conduct a comprehensive evaluation, to assess the full scale of orphans' needs in Malawi and how orphans are assisted (Malawi Government 2004b). Exisiting studies so far have lacked methodological rigour. RAAAP evaluation instruments were not standardised and were done in a haste to fulfil donor timeframe (Foster, Deshmukh and Adams 2008). The review of the NPA indicated that, while the Malawi Government developed a number of orphan care policies, orphan care coordination structures and monitoring systems, the quality of services was poor and the quantity of services was inadequate (Sibale and Nthambi 2008).

Furthermore, there was need for a rigorous process evaluation to document what was working or not working in Malawi (Munthali 2002; Sibale and Nthambi 2008; Malawi Government 2010c). Researchers and Malawi Government agreed that there was lack of summative and formative evaluation of orphans care services and that this was undermining the efforts to provide quality orphan care services (Malawi Government 2004b:25; Munthali 2002; Sibale and Nthambi 2008).

Evidence-informed policies and service delivery are essential for providing efficient and equitable orphan care services, especially in developing countries where resources are limited (Leatherman et al. 2010; Gyapong, Seby and Anakwah 2009). This research sought to conduct an evaluation of the multi-sector orphan care programme in Malawi, to contribute towards the improvement of orphan care services quality. The findings of this research may influence orphan care policies and programmes, not only in Malawi, but also in other countries in the Sub-Saharan African region which have similar political, economic, social context as Malawi.

1.2 Contextual Background

1.2.1 Politics and Policy Environment

Malawi is a land-locked country in Southern Africa and shares borders with Tanzania, Zambia and Mozambique as shown in figure 1.1.

Source: (www.worldatlas.com/webimage/countrys/africa/mw.htm)
Figure 1.1: Geographical Location of Malawi in Africa.

Since independence from the British Colonial Government in 1964, Malawi has been ruled by four leaders, namely Dr. Kamuzu Banda (1964-1994), Mr Bakili Muluzi (1994-2004), Dr. Bingu wa Mutharika's (2004-2012) and the current President Mrs Joyce Banda whose leadership commenced in April 2012, after the sudden death of Dr. Bingu wa Mutharika.

From 1964, when the country attained Independence, the country's leadership has been a hybrid of dictatorship and democracy. Theoretically, Walt (1994) suggested that democratic leadership provided room for people's wider participation in public policy development. For the health sector, it implied involvement of the public and private sector competing in service delivery. Whereas, autocratic leadership provides a closed leadership and participation in policy processes is restricted to the few (Walt 1994).

During the reign of Dr. Kamuzu Banda, the country experienced an oppressive and dictatorial political system (Kanchedzera 2003). The leadership implemented undemocratic policies which violated human rights, such as autonomous traditional legal system, granting limited space for civil societies and provided minimal participation in politics.

The second State President, Mr Bakili Muluzi's reign transformed the country's political landscape from autocratic to democratic orientation. The transformation from dictatorship into democratic leadership brought about institutional changes (Chirwa, Patel and Kanyongolo 2004). The formulation of a democratic constitution brought about freedom of association, freedom of speech and respect of human rights, including reproductive health rights (Khaila and Chibwana 2005). To increase space for public participation, decentralisation policy was developed, which resulted in central Government devolving power and allocation of resources to District Assemblies (Malawi Government 1998c). NGOs emerged as counter parts to the Government in the implementation of development policies and provision of checks and balances against Government excesses. They also played a big role in implementing welfare programmes to support poor households.

Dr. Bingu wa Muthalika's first term of office (2004-2009) was characterised by economic reform that stabilised the economy and achieved food security. His second term of office (2009-2012) was however characterised by autocratic leadership, poor governance, suppression of human rights and economic policies that undermined economic growth and donor confidence (Cammack, Kelsall and Booth 2010). The current President, Mrs Joyce Banda assumed office in a hostile atmosphere, after donors had frozen financial support to Malawi, due to undemocratic policies of Dr. Bingu wa Mutharika.

Some scholars have suggested the need to understand the power structure of society in order to understand better the policy processes. This is because policy is a product of the exercise of power, which determines what the state will do or not do for its people (March and Olsen 1997; Hill 2009).

Cromwell and Kyegombe (2005) argued that Malawi conformed to the classic description of a neo-patrimonial state. Under this type of regime, common in Africa, the formal bureaucratic system is 'subverted' and office holders, 'the political party and the elite' systematically appropriate public resources for their own use (Bird and Booth 2003). Political power and 'giving and granting of favours' is centralised around a single individual, or a small group of people with ultimate control over patronage networks, with little regard for the poor people (Cromwell and Kyegombe 2005).

There have been attempts to undermine patrimonialism in Malawi, but with little success. The IMF/World Bank's introduction of structural adjustment policies to eliminate the main source of state revenue and corruption, has not been very effective (Bird and Booth 2003). Some analysts have argued that instead of undermining patrimonialism, structural adjustment policies helped neo-patrimonialism to survive and adapt into a more oppressive form. This was because structural adjustment policies did not fully address the problem of patrimonialism (Cromwell and Kyegombe 2005; Bird and Booth 2003). In addition, Booth et al. (2006) argued that the relationship of donors and recipient Government was like a 'game' where donors had the resources to disburse but had poor understanding of the reality on the ground, while recipient Governments had different interests from the donors', and more

complete knowledge of the situation on the ground. This gave Governments an advantage to avoid or subvert any conditions that a donor imposed. Furthermore, the civil society efforts to undermine patrimonialism through exertion of pressure on Government to be accountable and transparent have not worked very well. This was because the organised civil society was too weak to hold government accountable to the public (Cammack 2004). It has been suggested that neo-patrimonialism has had negative consequences for Malawi. It undermined policy formulation and implementation processes through limited public participation in policy processes, diversion of massive public resources, through corruption and weak accountability (Cammack 2004).

1.2.1.1 Malawi service implementation structure and orphan care response

Service implementation in Malawi is composed of a combination of horizontal and vertical structures (Figure 1.2). The vertical structure represents the three main levels of the hierarchy, which include the national level (representing the headquarters of each organisation), the district assembly and the community level (village).

The horizontal level represents the multi-sector stakeholders that are represented at each level. This structure applies to all sectors, inclusive of the orphan care structure.

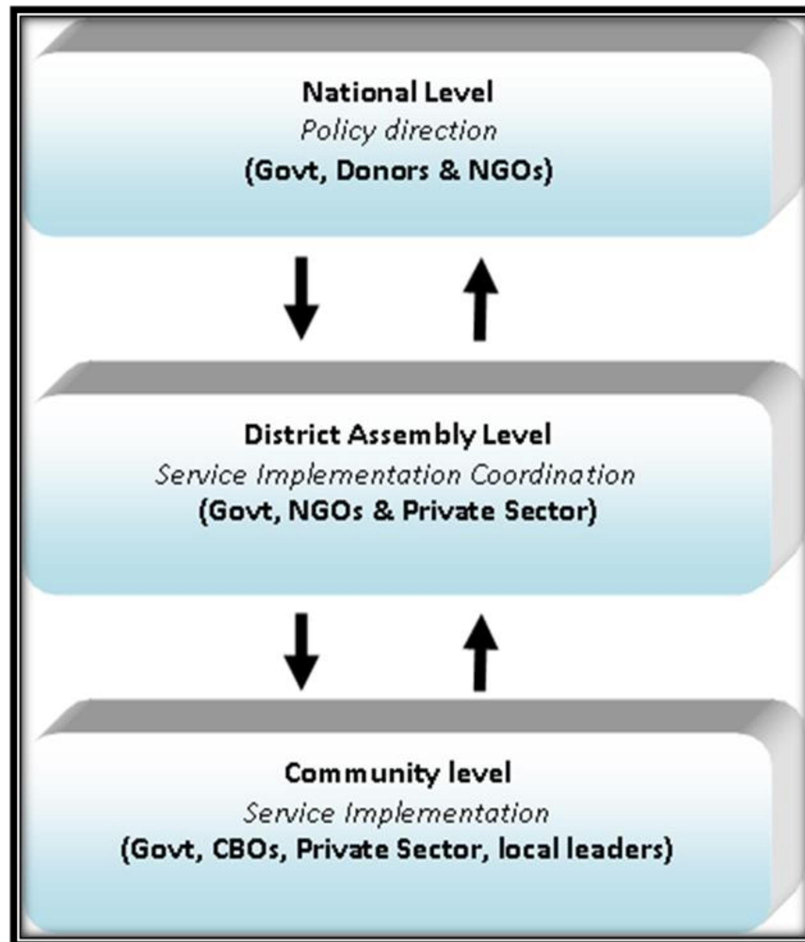


Figure 1.2: Service implementation structure and orphan care stakeholder relationship

Overall, the National level is responsible for policy development, monitoring and strategic planning for service delivery. The district assembly translates policy into practice. It makes by-laws for service implementation. The actual implementation of orphan care services is carried out at the community level. There are certain services that are provided at district headquarters but not found in the community, for example, the provision of Anti Retroviral Treatment (ART).

The Decentralisation policy stipulates that the District Assembly is responsible for implementing all policies. The assembly has a mandate to create area development committees (ADC) responsible for development work at the level of the traditional authority and village development committee (VDC) at village level. Sector specific sub-committees are formed within the VDC. All stakeholders, including Government Departments, private sector and NGOs implement services through the District Assembly which has an overall planning coordination responsibility for the district development plans.

1.2.2 Economic Situation

According to the United Nations Human Development Report (UNDP 2011), Malawi has a lower average human development index of 0.4 than the Sub-Saharan Africa at 0.463. The Human Development index, which takes into account education attainment, economic performance and life expectancy, ranked Malawi at number 171 out of 187 countries in the world. It is estimated that 40 percent of the Malawi population is in severe poverty. Table 1.1 shows the social-economic indicators for Malawi.

Table 1.1: Socio-economic indicators of Malawi

Indicator	Unit	Value		Year	Source
		Malawi	Africa		
Population	Million	15		2012	WHO
Pop. growth rate	%	2.8	2.4	2012	WHO
Urban population	%	20	38	2012	WHO
Rural population	%	80	62	2012	WHO
Total Fertility rate	per woman (15-49yrs)	6	4.8	2012	WHO
Gender inequality	Men/women ratio	0.59	0.61	2011	UNDP
HDI	Ratio	0.4	0.463	2011	UNDP
GDP per capita	$	850	2,437	2012	WHO
Poverty	%	52.4	-	2011	UNDP
Male primary enrolment	%	91	80	2012	WHO
Female primary enrolment	%	98	76	2012	WHO
Adult literacy	%	74	63	2012	WHO
Life expectancy	Years	54.2	54.4	2011	UNDP

Sources: (WHO 2012; UNDP 2011)

In Malawi, poverty is pervasive and it is reflected in low income, food insecurity, high malnutrition levels and high prevalence of disease (National Statistics Office 2004). Different factors have contributed to the weak economy of the country. Agriculture remains the primary economic activity, with export earning dominated by one commodity, tobacco. About 90 percent of the labour force is in agriculture, the remaining 10 percent is shared between industry and services (Malawi Government 2006d). Malawi's economy is vulnerable due to lack of diversity, making it difficult to

achieve sustainable economic growth (Claussen et al. 2006). The economic vision of the country is to transform Malawi from a predominantly importing and consuming country to a predominantly producing and exporting country. However, the pathway to long-term economic growth remains a big challenge for the resource-poor, landlocked and densely populated country (DFID 2011).

Malawi is, and has been, dependent on aid since independence in 1964 because of weak economic performance (Claussen et al. 2006). Budget support has ranged from 33 percent to 55 percent over the years (Claussen et al. 2006). About 70 percent of development budget of Malawi comes from donors (Chinsinga 2007). In spite of massive aid into Malawi to reduce poverty, aid effectiveness in reducing poverty has been low (Barnett et al. 2006).

In addition, over the years, aid and financial inflow appear to have depended on the quality of relationship between the Government and donors/international financial institutions. At times, the relationship between Government and donors has depended on governance and the human rights record of the reigning regime. There has been an established pattern in Malawi, so that whenever political leaders respected human rights, donor aid was sustained and when human rights were violated, aid was frozen (Green and Baden 1994; Cammack 2011).

This suggests that Malawi's economy is extremely vulnerable and the Government of Malawi can easily be manipulated by donors and international financial institutions through aid or loan conditionalities. Cammack (2011) described Malawi's economy as a roller coaster, referring to its oscillating character.

1.2.3 Food Security

Food security in Malawi is achieved when food is available in sufficient quantities, adequate quality and variety through production, trade and donations to meet demands of all Malawians at all times (Malawi Government 2006a). For the majority of Malawians, maize is the staple food and an indicator of food security.

Most of Malawi's agriculture is rain-fed, which makes domestic food availability vulnerable to rainfall variability. Malawi experienced severe food shortages precipitated by drought or heavy rains in 1992, 1994, 1997, 2001 and 2002. Poor weather conditions, high population growth rate and low maize productivity are major contributors to deteriorating food security in Malawi (Malawi Government 2000a). There has been food surplus only during the years when farm input subsidies have been available (Cromwell and Kyegombe 2005).

Poverty in Malawi appears to be associated with a growing population that is increasingly less dependent on subsistence agriculture and increasingly more dependent on off-farm incomes. The majority of rural people have less than a hectare of crop land, so they are unable to feed themselves for the whole year from their own production (Cammack et al. 2003).

During the period when people run out of food (from December to March), many rely on ‘ganyu’ (any piece of work that one does to earn some payment in cash or kind. See page xv) to purchase additional. Rural unemployment is high and labour wages are low (Bryceson 2006). With the majority of rural people chronically experiencing endemic food insecurity but with no reliable income for purchasing food, prospects for food self-sufficiency for the majority of the households in Malawi remains bleak.

1.2.4 Gender and Cultural Context

In Malawi, about 90 percent of the population practices matrilineal culture. The remaining 10 percent are of patrilineal culture. Under the matrilineal culture, children born in or outside marriage belong to female lineage. The responsibility of looking after the children rests with the wives' relatives. The wife’s brothers are guardians, helpers and defenders in all matters, under the leadership of the eldest brother (Kishindo 1994).

Traditionally, a husband is expected to live in the village of his wife until they divorce or the husband dies. A husband may be allowed to leave the village when there is shortage of land or there are frequent deaths of children or when there are conflicts between the husband and relatives of the wife, especially when he plans to re-marry

(Munthali 2002). As a result, under a matrilineal system, men do not feel obliged to make any investments as they feel that they will not live in that village forever. Furthermore, they do not feel they have an obligation to take care of their children. This puts women at a disadvantage. Therefore, women are usually overburdened to care for their families single-handedly, even when the husband is alive (White 2007).

Patrilineal culture is the opposite of the matrilineal culture. Mathambo and Doctor (2002) stated that under patrilineal culture, lineage is through the father's side. The wife lives in the husband's village and the relatives of the husband have the responsibility over the children. When the husband dies, the wife and children remain under the authority of the relatives of the husband. This authority extends to decisions about farming activities and the harvest. However, Phiri (1983) argued that traditional social systems in Malawi have been modified over the years by religious influences, HIV/AIDS, westernisation processes and interaction with other social systems, so that various versions of social systems are practiced.

White (2007) argued that in a patrilineal society, women assume an inferior position relative to men, as a result, decisions are mostly made by the men. To address this anomaly, Government developed the national gender policy in 2000 whose aim was to "mainstream gender in the national development process to enhance the participation of women, men, boys and girls for sustainable and equitable development for poverty eradication" (Malawi Government 2000a:5). Women are marginalised in social and economic activities so that their contribution to social-economic development of the country is hindered (Malawi Government 2006d; White 2007). Women are denied access to and control over food production inputs, land, bank credit, business and marketing training (Malawi Government 2000a). Women also have low education qualification than men and this restricts their access to valuable information (National Statistics Office 2010).

1.2.5 Health Services

Ministry of Health and Population (MoHP) is the main health service provider. Other health services providers include private non-government organisations. All

Government health facilities provide free health services, but private hospitals charge user fees. Delivery of health services takes place at three levels. These are primary level (through rural hospitals, outreach clinics, and community health care), secondary level (through district government and private hospitals) and at tertiary level, through referral hospitals. Health policy guidance and regulatory roles are provided by MoHP headquarters.

Malawi faces a Health workforce crisis exacerbated by high staff mortality caused by HIV/AIDS. This has created a reduction in the capacity to deliver health services, especially in rural areas where primary health care has been compromised. WHO (2012) indicated that Malawi has significantly lower number of physicians (0.2) than Africa (2.2) per 10,000 people. In addition, there are health services access inequalities associated with gender, location and level of education (WHO 2012). Furthermore, 80 percent of the health services were funded by donors in 2009, compared to only 10.2 percent foreign aid for Africa (WHO 2012).

In order to reform and improve the delivery of health services, the Malawi Government developed 'Essential Health Package' (EHP) policy. EHP policy was designed to prioritise 90 percent of the health problems responsible for morbidity and mortality in Malawi. The Malawi Government acknowledged that it was not possible to address all health needs because of limited resources (Malawi Government 2011). Under this package, the Malawi Government reaffirmed its commitment to provide essential health services free of charge.

Malawi Government and collaborating partners launched a Health Sector Wide Approach as a vehicle to deliver EHP (Gwatkin et al. 2006). Cassels (1995) described SWAp as a sustained partnership between donors and governments, with the aim of providing effective and equitable health services in a coherent manner through a programme of work with clear defined targets and performance evaluation processes. Health SWAp was developed as a solution for solving inefficiency and poor coordination in health service delivery (SWAP Support Group 2004).

Furthermore, MOHP encouraged District Health Officers to sign service level agreements with private hospitals to increase service access to EHP services. In this agreement, poor people could access private hospitals at the expense of the government. As of 2011, only 42 percent of the private hospitals had signed service level agreements (Malawi Government 2011).

World Bank described health sector SWAp achievement in improving health services delivery as 'modest' (Vaillancourt 2009). This suggested that there has been some progress towards improvement of health delivery, but there was more work to be done. The SWAp was not fully funded, with only 57 percent of its necessary budget raised (Bowie and Mwase 2009). Prospects for fully funding EHP are poor because the Malawi Government is unable to raise more resources due to a narrow tax base. Collaborating partners were also facing limitations of resources and prospects of raising additional funds through a social health insurance scheme are poor, due to a small formal sector (Bowie and Mwase 2009). This suggests that the health service demand will remain disproportionately higher than the health service supply, with expected overcrowding on one hand and poor quality of service on the other.

1.2.6 Education Services

The Malawian education system comprises four levels, namely pre-school education for children under 6 years, primary school education which takes 8 years, secondary education which last 4 years and tertiary education, which takes two to four years depending on the institution at which one enrols. Adult literacy classes are also organised to improve literacy and numerous skills among adults who missed primary education at their prime age (Malawi Government 2009c).

Ministry of Education in Malawi has experienced some major policy reforms. Many of these reforms have been triggered by the introduction and implementation of the free primary education (FPE), as a means of achieving universal education for all children. With introduction of FPE in 1994, enrolment increased by 55 percent. However, infrastructure and human resources (classrooms, teacher training facilities and staff housing) were grossly inadequate (CSCQBE 2008a).

Poor education outcomes for Malawi have been reported (CSCQBE 2008a). In 2008, school age-population of basic education (the 6-17 years age group) represented 37 percent of the national population. The net school enrolment for basic education in 2008 was 79 percent (Malawi Government 2009c). The fact that some children did not enrol for free primary education (21 percent) suggests that there were other hindrances to education-access other than school fees. Gains in net enrolment achieved through FPE, especially for girls, were eroded by high dropout rates caused by negative attitudes towards education, long distances to school, early pregnancies, lack of food in households and poverty (CSCQBE 2008a). Access to education was also hindered by location-based inequitable availability of schools that favoured urban, more than rural children (CSCQBE 2008a).

Furthermore, of those children who were enrolled in school, only 40 per cent reached standard four (CSCQBE 2008a). While enrolment was high at standard (year) one, only 35 percent of children complete a full course of primary education (Malawi Government 2009c). The education system was not effective with repetition rate of estimated at 25 percent. It took some children 14 years to complete primary education which is meant to take 8 years (UNDP 2008). At standard (year) 6, only 33.6 percent of the students attain basic English literacy skills while only 23.5 percent attain basic numeracy skills (SACMEQ 2011). This therefore suggests that access, retention and completion rates of primary education are unsatisfactory, due to a complex web of related factors around tradition, culture and poverty (CSCQBE 2008a:14).

1.2.7 HIV/AIDS

The first HIV case was reported in Malawi in 1985. HIV/AIDS prevalence in 2010 was 10.6 percent among 15-49 years age group, but this statistic masks gender disparity. Among women in the age group of 15-49 years, prevalence is 12.9 percent as compared to 8.1 percent for men in the same age group (National Statistics Office 2010). Overall, HIV/AIDS prevalence shows a declining trend over time since 2009.

There has also been a declining trend in the HIV mortality rate of both men and women (15-49 years). Mortality for women dropped from 11.6 percent in 2004 to 8.4

percent in 2010 while men mortality rate dropped from 10.5 percent in 2004 to 8.8 percent in 2010 (National Statistics Office 2010). These are positive results that suggest that the HIV/AIDS policy might have been effective in reducing new infections and mortality.

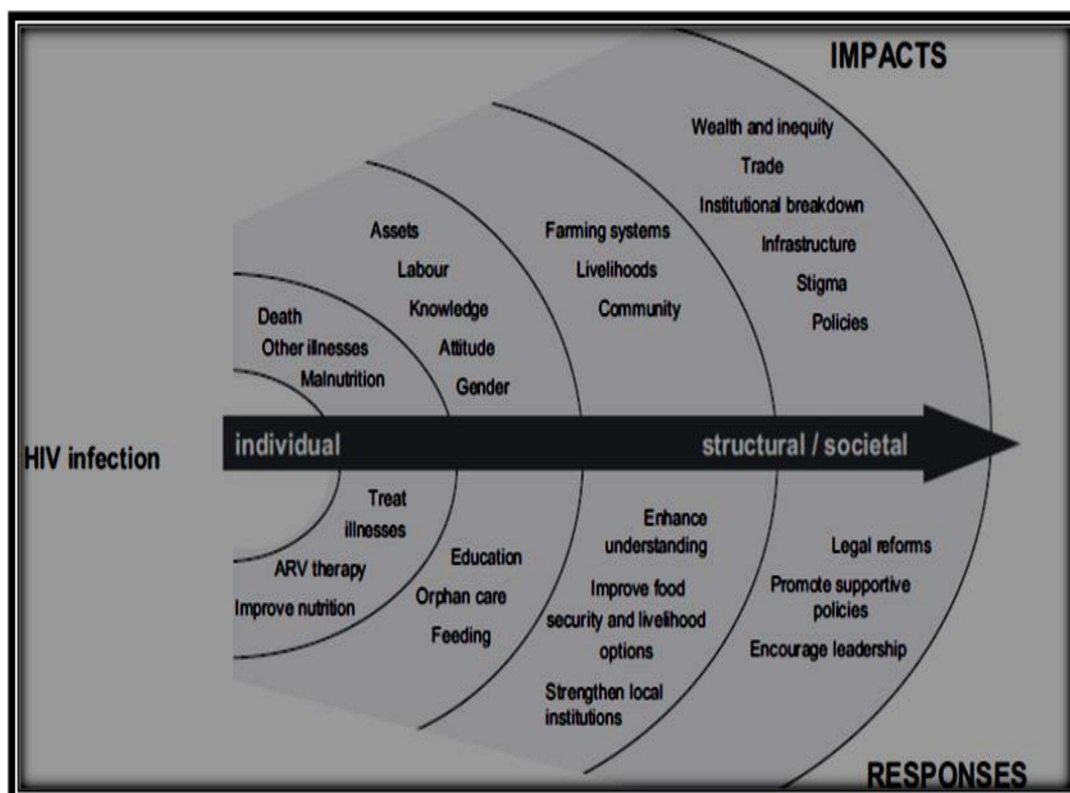
Malawi responded to the HIV/AIDS pandemic by developing the National AIDS Control Programme in 1988. This was to coordinate the national response to the epidemic. The Programme was superseded by National AIDS Commission in 2001. While Office of the President and Cabinet (OPC) coordinates HIV/AIDS and nutrition policies, the MoHP coordinates the implementation of HIV/AIDS Programmes in Malawi. The HIV/AIDS programme focus on HIV Counselling and Testing (HCT), Prevention of Mother to Child Transmission of HIV (PMTCT) and Antiretroviral Therapy (ART) (Malawi Government 2003b).

The National HIV/AIDS policy was developed and launched in 2003, (Malawi Government 2003). The policy goal was to reduce HIV infections and vulnerability, improve provision of HIV/AIDS treatment, care and support for people living with HIV and mitigate social-economic impact of HIV/AIDS. Malawi also adopted the global 'Three Ones' planning and management tool; one National Strategic Framework (NSF), one National Action Framework (NAF) and one National Monitoring and Evaluation Framework (NMEF) (UNICEF 2008a). This is a multi-sectoral, multi-stakeholder partnership with a single pool of funds which promotes coordination to avoid duplication of efforts and it aims to ensure efficient utilisation of resources. The goal of NSF is to reduce incidence of HIV and STI and improve the quality of life of those infected by HIV/AIDS. NAF seeks to prevent the spread of HIV infection, provide access to treatment for people living with AIDS and mitigate the health, socioeconomic and psychosocial impact of HIV/AIDS on individuals, families and communities.

While HIV/AIDS response has registered some progress, access to ART from clinics remain inequitable, with only 71 percent of the health facilities offering ART services by 2011 and 86 percent of the health facilities providing PMTCT (Malawi Government 2012).

Over the years, government funding has declined. In the years 2010-2011, 98 percent of the HIV/AIDS programmes were donor funded (Malawi Government 2012c). If donor funding dried up, the life of about 322,000 people currently on ART would be in danger (Malawi Government 2012c) .

Figure 1.3 shows the impact of HIV from an individual to the entire nation, as well as the relationship between impact and response. Impact of HIV/AIDS on society implies that the diverse effects of HIV/AIDS require integrated and coordinated policies, strategies and services. The link between individual's needs, services and general policies provide a broad picture for understanding the scope of this thesis whose objectives embrace service users, service providers and policy influence.



Source: (UNICEF 2005)
Figure 1.3: Impacts of HIV/AIDS on the individual and society.

1.2.8 Research Aim and Focus

The aim of this research was to assess how child-related policies and service delivery in Malawi were responding to the needs of orphans. This research has the following objectives and research questions;

Study Objectives

1. To explore and describe the nature of orphans' needs
2. To assess the extent to which child-related policies guided service implementation for orphans.
3. To examine how different service providers implemented orphan care services to address the needs of orphans
4. To propose strategies and recommendations for improving service delivery to orphans based on gaps between needs and service delivery.

Research Questions

1. What are the needs of orphans in Malawi?
2. How do selected child-related policies guide implementation of orphan care services?
3. How do multi-service providers from government and non-governmental organisations implement orphan care services and ensure quality?
4. What strategies emerge from the thesis and best practice in Sub Saharan Africa that can be recommended to improve policies and services for orphans in Malawi?

1.2.9 Outline of the Thesis Chapters

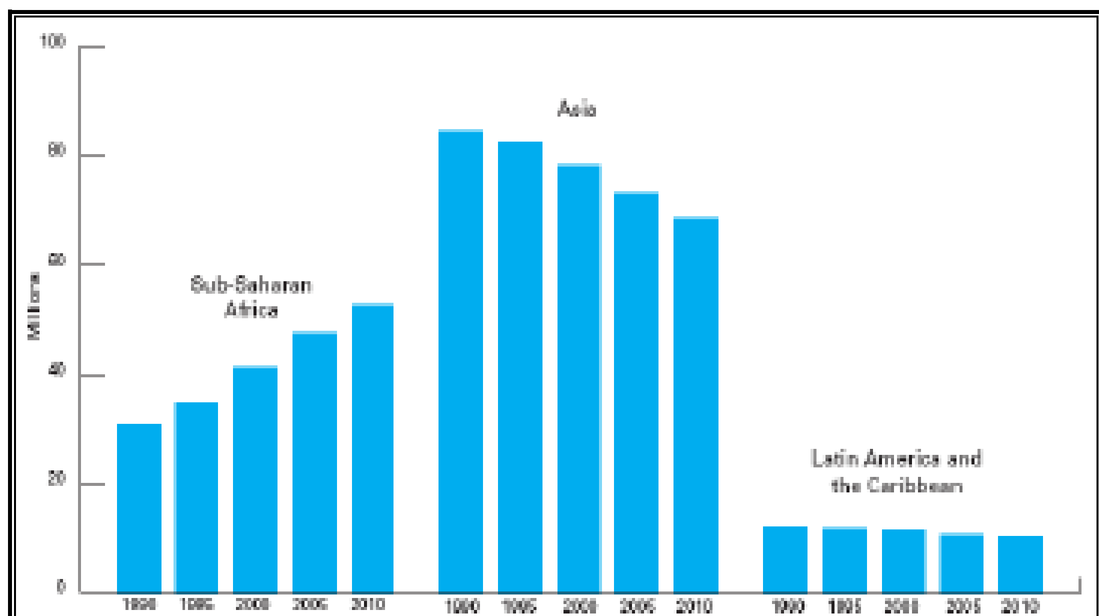
Chapters 1-4 provide the background information highlighting the challenges and circumstances under which orphans live and service provision takes place. The difference however is that chapter one focus on Malawi situation, whereas chapters 2 to 4 provide a review of the Sub-Saharan perspective. Chapter 5 describes the methodological issues based on literature review. Chapters 6 – 8 present results of needs, orphan care services and child-related policies analysis respectively. Discussion of results and recommendations are presented in Chapter 9.

Chapter 2 – Orphan Concept, Living Arrangements and Orphan Care in Malawi

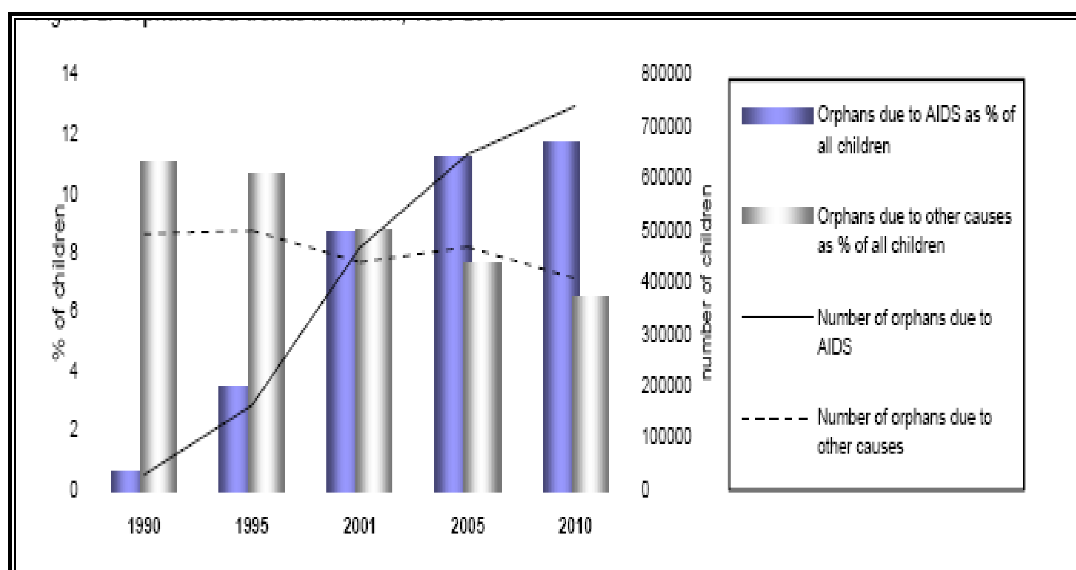
2.1 Prevalence

HIV/AIDS is considered to be the main contributing factor to increasing number of orphans (UNICEF 2004). Globally it is estimated that more than 16 million children under 18 have been orphaned by AIDS, of these, Sub-Saharan Africa has about 89 percent of AIDS orphans (UNAIDS 2010).

While the estimated number of orphans is either declining in Asia or not changing significantly over time in Latin America and the Caribbean, the number of orphans in Sub Saharan Africa is on the increase (Figure 2.1). The proportion of children orphaned by AIDS is estimated at 50 percent-80 percent of the total number of orphans in Sub-Saharan Africa (UNICEF 2008a).



Source: (UNAIDS, UNICEF and USAID 2002)
Figure 2.1: Projections of Global prevalence of Orphans by region



Source: (UNAIDS, UNICEF and USAID 2002)
Figure 2.2: Estimated Trends of Orphans due to AIDS in Malawi from 1990-2010

Malawi is estimated to have about 1 million orphans, representing 12 percent of the total population of children, about 50 percent of which are believed to be orphaned by HIV/AIDS (Malawi Government 2005). Figure 2.2 shows projected increasing trend of orphan prevalence in Malawi.

Table 2.1: Prevalence of Orphans by Age in Malawi

Age group	Both parents alive (%)	Only mother alive (%)	Only father alive (%)	Both parents dead (%)
0-4	96.4	2.6	0.7	**0.3**
5-9	87.8	7.5	2.5	**2.2**
10-14	78.5	11.6	4.4	**5.4**
15-17	73.7	13.5	5.0	**7.9**
0-17	**86.8**	**7.5**	**2.6**	**3.0**

Source: (National Statistics Office and UNICEF 2008)

Death of parents appear to have different effects on children, depending on the development stage of the child (Foster and Williamson 2000; Audemard 2006). Table 2.1 shows that the proportion of orphans increases with age for respective orphan categories in Malawi. This finding is consistent with the global finding reported by UNAIDS, UNICEF and USAID (2004), that 0-5 years age orphans were 12 percent , 6-11 age group orphans was 33 percent and 12-17 years age group orphans was 55 percent. Consistently, paternal orphans are the largest proportion (about 2-3 times maternal orphans proportion), followed by maternal and double orphans respectively (table 2.1).

Malawi is among the countries with high prevalence of orphans of more than 10 percent of all children in Southern Africa. Other countries include Botswana, Swaziland, South Africa, Lesotho and Namibia.

It has been suggested that with slow change in risky sexual behaviour and limited access to antiretroviral drugs among HIV infected people, the number of orphans may continue to rise for some time (National Statistical Office and UNICEF 2008). This suggests that large orphan numbers are likely to present a long-term problem. A rising trend in orphan numbers is consistent with Foster and Williamson (2000) prediction, that because of the long incubation period of HIV, global orphan numbers will continue to rise for a long period of time.

The burden of orphan care is exacerbated by the countries' poor social services (National Statistical Office and UNICEF 2008; National Statistics Office 2004), gender inequities (UNDP 2011) and dire poverty (UNDP 2005; National Statistics Office 2004).

It seems that there is scanty information on estimates of paternal orphans while maternal orphans information is drawn from assessment of maternal deaths in general that are reported in national Demographic and Health Surveys (Foster and Williamson 2000). Failure to account for parental death may result in inaccuracy in estimating the number of orphans in a particular area. Orphan definitions which does not account for children who have lost their fathers may contribute up to 45-70 percent of underestimation of the number of orphans in a given area (Foster and

Williamson 2000). The definition of various orphan types may be a potential source of double counting because double orphans represent an overlap of orphans who have lost a mother and orphans who have lost a father (UNAIDS, UNICEF and USAID 2004).

2.2 Orphan Concept and Factors that Influence Orphan Definitions

The definition of the term orphan is important because it helps to quantify orphans in a given population and provides guidance for research, programming and policy direction (Sherr et al. 2008). The orphan concept appears to be difficult and challenging because there are variations in interpretation and implications of the term. This thesis defines an orphan as a child below the age of 18 who has lost one or both parents. This is consistent with the Malawi Government and UNICEF definitions (Malawi Government 2010c; UNAIDS, UNICE and USAID 2004).

Three types of orphans are recognised. Maternal orphans are children under age 18 whose mothers have died, paternal orphans are children under age 18 whose fathers have died and double orphans are children under 18 whose mothers and fathers have died (Sherr et al. 2008; UNAIDS, UNICEF and USAID 2004; Audemard 2006). Key issues that facilitate the understanding of the orphans' concept are as follows:

a) Child/Adult Threshold Age

Inconsistencies do exist in defining the cut-off point on the definition of an orphan. The commonly used cut off point is age 15 or 18 years. Smart (2003) suggested that probably the 18 years might have been derived from legal consideration, in countries that assume rights of a child to marry, vote, make a will and even give consent on issues affecting them. The age threshold of 15 years appear to be derived from data sources such as demographic and health surveys, that recognise that adulthood starts at 15 years of age because of it's linkage with reproductive age (UNAIDS, UNICEF and USAID 2004).

It has been argued that publications which define an orphan as a child under 15 years of age have grossly underestimated the number of orphans (UNAIDS, UNICEF and USAID 2004; Smart 2003; UNAIDS, UNICEF and USAID 2002). Foster and Williamson

(2000) suggested that the underestimation could be in the range of 25-35 percent. It may also be a cause of exclusion of some children from potential services in development programming.

b) Living Arrangement

Audemard (2006) classifies orphans by living arrangement, with emphasis on who is providing care to the child. The common documented living arrangements included the surviving parent and those fostered by relatives. In Sub-Saharan Africa, children are mostly fostered by relatives within the extended family even when parents are alive. Foster and Williamson (2000) argue that fostering of orphans has a great potential to influence underestimation of the number of orphans because extended family members may report orphans as their own children. More detailed information and forms of living arrangements are discussed in section 2.5.

c) Vulnerability of the Child

Within the United Nations, it seems there is an agreement to use the term orphan and other vulnerable children (OVC) as part of orphan definition (UNAIDS, UNICEF and USAID 2004). This has shaped orphan programming approach in Sub-Saharan Africa. The term OVC combines conditions of an orphan and other vulnerabilities, including sickness of a parent or adult caregiver in the home, a child who lives outside of a family or is living under poverty (UNICEF 2008a; UNAIDS, UNICEF and USAID 2004; Mishra and Assche 2008). However, there appears to be a debate in literature regarding the value of including vulnerability in orphan programming. Those who attach vulnerability to the term orphan tend to reflect the effects of HIV/AIDS that seem to threaten child's survival, well-being or development (UNAIDS, UNICEF and USAID 2004). Considering existing cultural and socioeconomic contexts variations between countries, non-standardisation of the definition of vulnerability was justifiable (UNICEF 2005). Furthermore, the inclusiveness of vulnerability provides the full and comprehensive picture of orphans' circumstances, because it focuses on poverty-related challenges and needs-based indicators (Audemard 2006; Sherr et al. 2008).

Authors who disqualify the inclusion of vulnerability from the orphan definition suggest that it brings about stigmatisation of the child because it may imply that the

child is infected with AIDS (Skinner et al. 2004; Smart 2003). Lack of a standardised definition of OVC is a major contributing factor in limiting understanding of the magnitude, vulnerabilities and needs of the OVC population. For instance, vulnerability may include a household's vulnerability, destitute status or disability (UNAIDS, UNICEF and USAID 2002). In many developing countries, vulnerability is associated with poverty (Ainsworth and Filmer 2002; Richter, Manegold and Pather 2004; Mishra and Assche 2008).

With the foregoing debate, it may be necessary for countries to include vulnerability of a child as part of a needs assessment of all children and not as part of a definition of an orphan. However, each country may need to prioritise areas of vulnerability for service programming to target interventions and for monitoring purposes. This would help to utilise the limited resources in a cost effective manner.

2.3 Orphans Living Arrangements

The following modes of care have been well documented and are discussed in this section: surviving single parent, grandparent, and child headed household. This section focuses on the effects of parental mortality on household structure and composition, in relation to provision of care to children. The discussion also focuses on the degree of vulnerability of children associated with the change of living arrangements and caregivers.

2.3.1 Surviving Biological Parent.

It has been consistently and overwhelmingly reported that more children live with mothers when their fathers die than with their fathers when the mothers die (Foster 2002a; Monasch, Boema and Ties 2004; Foster and Williamson 2000; Sherr et al. 2008). Monasch and Boema (2004) found out that in 40 Sub-Saharan countries, 75 percent of paternal orphans lived with their mother while 50 percent of maternal orphans lived with their father. The authors also found out that fewer girls (48 percent) who lost their mothers lived with their fathers than did boys (58 percent). However, the authors did not include orphans of 15 to 17 years age hence it is not possible to know the living arrangement patterns for this age group.

Similarly, in Malawi Pullum (2008) found out that when the father died, 56 percent of the orphans lived with the mother, while only 25 percent lived with the father when the mother died. Children Count (2005) also found that 69 percent of paternal orphans lived with the surviving mother and 27 percent of maternal orphans lived with the surviving father in Sub Saharan Africa. These findings suggest that surviving mothers may have a heavier orphan care burden than surviving fathers.

Richter and Desmond (2008) found that in South Africa while female caregivers had an average of 2 orphans per household, male caregivers had on average 1.6 orphans per household and child headed households had an average of 1.8 orphans.

2.3.2 Grandparent Caregiver

There is enough evidence to support the increasing role of grandparents taking care of orphans in Africa (Monasch and Boema, 2004; UNAIDS, UNICEF and USAID, 2004). Foster and Williamson (2000) found that grandparents were looking after about 50 percent of orphans in South Africa and 24 percent in Cameroon. UNICEF (2004) reported that in Eastern and Southern Africa mostly widowed grandparents cared for about 50 percent of orphans. Foster and Williamson (2000) found that in Zambia more grandparents (40 percent) looked after orphans than did young women (28 percent).

Foster et al. (1997b) describes the condition, where children go to their grandmother when the mother dies, as ‘skip-generation parenting'. Foster et al. (1997b) suggests that because grandparents are older and incapacitated, orphans cared for by older people can be more vulnerable to child labour than orphans in other living arrangements.

There are varied views on the care of orphans by relatives other than grandparents. In a study conducted by Foster et al. (1997b) in Zimbabwe, they found that about 88 percent of the households, aunties and uncles expressed reluctance to take orphans into their households. This was because they did not want to reduce standards of caring for their own children due to economic pressure originating from additional children. They were also afraid of contracting AIDS from the surviving children whose parents died of AIDS. In addition, they were afraid of bringing stigma into their home.

2.3.3 Child Headed Households.

There is sufficient evidence to support the observation that in places of high HIV prevalence, there has been an increase in child-headed households (Watts Hellen 2005; Adato et al. 2005; Plan 2008; Baquele 2004). However Richter and Sherr (2008) contend that despite escalation of orphan hood and adult mortality, child headed households are still a minority. In agreement, Children Count (2005) argued that child-headed household only surfaced as a temporary measure while arrangements to shift children to adults' households are being made.

Foster et al. (1997b) suggested that child headed households emerge because of death of both parents, unwillingness of relatives to foster orphans, death and sickness of relatives, capacity of older children to care for younger children, preference of children to live alone, fulfilment of wishes of a dying parent and inheritance of residence by surviving children.

A question has been raised whether the emergence of child headed and grandparent headed household's show that the extended family is failing to cope or it is adapting or adjusting to the changes. Literature provides adequate evidence of these divergent views on orphan and childcare (Chirwa 2002; Abebe 2007; Foster 2002b; Foster and Williamson 2000; Munthali 2002).

Some authors suggest that the increased roles that the community is playing to support orphans may suggest that the family is adapting (Hometruth 2009; Foster, Deshmukh and Adams 2008). Authors who hold the views that indeed families are adapting provide evidence of increased roles that the community is playing in supporting orphans. These include mobilising community support to meet needs of children, community provision of emotional support to counter the psychosocial effects of orphans and provide orphans with cultural and appropriate skills (Hometruth 2009; Foster, Deshmukh and Adams 2008). It is suggested that families and communities responded much more promptly to the demands of orphans in comparison with any external support to communities (Foster 2006b).

Authors who argue that the extended family is failing to accommodate orphans point out that the family and community child care systems are failing to cope with orphan care challenge as evidenced by their failure to absorb orphans, with a typical example of emergence of child headed households (Chirwa 2002; Abebe 2007). Consequently, orphans who are abandoned and end up on the streets (Foster 2002b; Foster and Williamson 2000).

2.4 Orphan care Response in Malawi

The Malawi Government coordinates the orphan care programme through the Ministry of Gender, Children and Community Services (MoGCCS). The Government's role in orphan care response include the formulation of OVC policies, mobilisation and coordination of orphan care stakeholders for the provision of care and support services for HIV/AIDS affected and infected households. The Government also facilitates the review of legal instruments for protecting the rights of OVC and developing operational structures and committees for orphan care programmes. The implementation of orphan care programme is facilitated by the National Plan of Action (NPA). The NPA had six objectives namely to enhance orphan access to essential services, strengthen family and community capacity to care for orphans, protect OVC through improved policy and legislation, improve the capacity of service providers to deliver orphan care services, raise awareness of the public on the plight and rights of OVC and continuous orphan care progress monitoring and evaluation (Malawi Government 2005).

Following the policy guidelines, the MoGCCS facilitated the formation of orphan care policy and technical committees. The national OVC steering committee (NOVCSC) has the responsibility of providing policy guidance and supervisory service in support of the implementation of the OVC NPA, while the NOVCTWG guides service implementation level.

The NOVCSC membership includes Principle Secretaries of Government Ministries, Country Directors, Representatives of International and local NGOs, United Nations agencies and donor agencies. The policy level orphan care committee (NOVCSC) is chaired by the Principal Secretary for MoGCCS. Child Development Department, in the

MoGCCS is the secretariat of both policy level (NOVCSC) and the service technical advisory level (NOVCTWG). The policy orphan care level (NOVCSC) is assisted by a national OVC technical working group (NOVCTWG) made up of technical specialists from Government and NGOs. This committee is composed of Directors of relevant line Ministries, Programme Managers of International and local NGOs, Section Heads and Project Officers of United Nations agencies. The NOVCTWG is responsible for providing technical guidance to the NOVCSC.

Various committees service orphan care at different levels. The NOVCSC and the NOVCTWG operate at national level. At district assembly level, the district OVC committee (DOVCC) is comprised of Government District Officers (Health, Education, Agriculture, Labour, Judicial and others), the private sector and the NGOs. This committee is chaired by the District Assembly Chief Executive. The Social Welfare Officer is the secretary of the DOVCC. The role of this committee is to plan, coordinate and implements orphan care services for the whole district.

The third level is the community where the orphans live. At this level, the community/village orphan care committee (VOCC) are composed of CBOs, local leaders, caregivers and Government technical assistants from different line Ministries (child protection workers, health surveillance assistants, home farm assistants, community police and others). The child protection worker coordinates the technical activities at this level, under the guidance of the chief.

The role of the VOCC is to implement orphan care services, identify orphan care services beneficiaries, distribute material support to orphans, and provide orphan care services' progress reports to District Assembly through Social Welfare Staff. The higher-level personnel, from National and the district levels, are responsible for supporting the community service providers by building their capacity and supervising them. For example, the NGOs are expected to implement services in the community through the CBOs, which are members of VOCCs. Any direct service implementation in the community by the district or the national level is considered as a violation of orphan care structure.

Table 2.2: Child-related services for orphans and other children.

Sector	Type of services
Education	school fees, learning materials, school feeding, school health and community-based child care centres
Economic	income generating activities, cash transfer, vocational & life skills, economic empowerment training
Food & Nutrition	nutrition education, food production & dietary diversification services, micronutrient supplementation
Protection from abuse	child protection and participation services, gender based violence programme, access to juvenile justice
Psychosocial care	psychosocial training & counselling services
Health	community child care services, under five health, CHBC , VCT, ART, reproductive health, home-based care

Source: (Malawi Government 2004b; Malawi Government 2005; Malawi Government 2006b)

The multi-sector orphan care service providers implement child-related services in different sectors as shown in table 2.2 including education, economic, food and nutrition, protection from abuse and health.

Studies done in Malawi suggest that CSOs and CBOs seeking to provide responsive services to orphans face difficulties. James and Malunga (2006) conducted research to understand the development of Civil Society Organisations (CSOs) networks, and to assess the contribution of CSOs to poverty reduction. About 25 stakeholders from three CSOs were interviewed, with semi-structured interviews. The organisations that were interviewed included, Malawi Economic Justice Network (MEJN), Land Task Force and Civil Society Coalition for Quality Basic Education (CSCQBE). The findings suggested

that the CSOs had contributed towards raising the voice of the poor in policy decisions, and monitoring Government policy implementation. Furthermore, the findings suggested that CSOs have leadership problems, they failed to manage their members, they played multiple roles, lacked technical competence and failed to mobilise resources. This study however, lacked some critical information and methodological rigour. The study did not explain the criteria used to select the organisations. In fact, the sampled organisations were all big scale, urban-based with large donor support. Therefore, the organisations were not representative of the true nature of national CSOs in Malawi, since they left out the indigenous small scale CSOs.

In order to inform policy and institutional development, the Insitute for Policy Research and Social Empowerment (2007) conducted research to explore the extent of community based organisations response to HIV/AIDS pandemic. Focus group discussions and interviews were conducted with 26 CBOs. The findings identified factors that determined the success or failure of CBOs. The factors included, conflicting views on voluntarism, participation of community members, patronage (dependence on handouts), management, networking and financial sustainability. Furthermore, the research suggested that the work of CBOs was hampered by institutional factors including lack of operational guidelines and selfish motive for establishing CBOs.

Chapter 3 – Needs of orphans: Theory and Literature

A need has been defined as a 'condition within an individual that is essential and necessary for the maintenance of life, for nurturance of growth and wellbeing' (Reeve 2005:6). This chapter provides two perspectives of orphans' needs. First, the Sub-Saharan Africa literature primarily provides a descriptive classification of orphans' needs as guided by the UNICEF (2005). Second, the theoretical approach to needs based on Maslow's human motivation theory. Other theories of needs were also discussed in this chapter: Reeves and UNICEF classification of needs. The chapter also provides a link between Maslow's human motivation theory and the Sub-Saharan literature on orphan need. The rational for adopting Maslow's theory in this thesis to better understand the needs of orphans in Malawi is discussed.

According to UNICEF, children whose parents are dead encounter painful experiences (UNICEF 2005; United Nations 2001). They lack education, good health and economic and material items. They are also psychosocially affected and they need to be protected.

3.1 Orphans Needs: Sub-Saharan Africa

Malawi is within the Sub-Saharan Africa region. The Sub-Saharan African scope for assessing orphan needs was done to place the needs of orphans in Malawi in context with other orphans in other countries that face similar challenges. The orphans' needs have been discussed by comparing orphans' needs with those of non-orphans and by comparing needs within orphan types. Orphans' needs were also assessed in relation to their living-arrangement.

The needs of orphans seem to a great extent to be influenced by household dependency ratio (UNICEF 2004). Dependency ratio was defined as the sum of children under 18 and persons 60 years or older in a household divided by the number aged 18-59 years (UNICEF 2004). Dependency ratio signifies the proportion of household

productive capacity versus the number of people that need to be assisted or supported. High dependency ratio suggested that the households had more difficulties to provide the needs of the members than a lower dependency ratio household.

3.1.1 Food Need

In this section, lack of food or food insecurity, has been discussed in relation to mediating factors, coping mechanisms and potential consequences. The definition of food security was provided in chapter one, section 1.2.3. Research conducted in Sub-Saharan Africa suggests that orphans lack adequate food (Rivers, Silvestre and Mason 2004; Kimani-Murage et al. 2010; Greenbelt and Greenway 2007). A study was conducted in Blantyre Malawi, based on the Demographic Health Survey and Multi Cluster Indicator Survey (MICS) data sources (Rivers, Silvestre and Mason 2004) . The purpose of the study was to identify characteristics of food insecure households.

The findings showed that a large number of orphans (40 percent) lived in food insecure households, especially households with multiple orphans and/or orphans living with a chronically sick household member. Rivers et al. (2010) repeated the study six years later in the same location. Further, they found that households with multiple orphans were 2.42 to 6.87 times more vulnerable to food insecurity than non-orphans' households. These studies might suggest that being an orphan was not the only factor associated with food insecurity, but the number of orphans and household size were other important factors.

Kimani-Murage et al. (2010) analysed data from a World Bank project to explore food security situation of orphans living in urban slums of Korogocho and Viwandani in Kenya. The research sample size contained 2404 children aged 6-14 years, comprising equal numbers of orphans and non-orphans. The orphans were matched by age, gender and location. The findings indicated that orphans were more vulnerable to food need than non-orphans were. Among the orphans, paternal orphans were more food insecure than other orphans. Male orphans were more food insecure than female orphans.

It has been suggested that lack of food resulted in reduced food quality (Hall et al. 2010). Studies done in Nigeria (Enwereji 2007) and Ethiopia (Hall et al. 2010) suggested that orphans were more likely to eat less nutritious food than did non-orphans. Hall et al. (2010) analysed a national data set of 7752 orphans and non-orphans, to explore the health and nutrition needs of orphaned school children, aged 7-17 years. Orphans were less likely to eat breakfast and a fruit than non-orphans were.

Similarly, Enwereji (2007) reported that 61 percent of orphans had their diet consisting of mainly carbohydrates which included cassava, yams, plantains and potatoes. Orphans rarely ate meat protein or fruits. This was established through interviews with 120 orphans and 30 caregivers and the use of food recall diary assessment with orphans.

It has been suggested that not all households who adopted orphans, provided proper care to orphans In rural areas of Ingwavuma in Kwazulu-Natal, South Africa (Schroeder and Nichola 2006). These authors compared households that adopted orphans with those that did not adopt orphans. The findings suggested that the households that adopted orphans were food insecure.

3.1.1.1 Mediating factors for food need

It was suggested that HIV/AIDS and chronic illnesses increased the likelihood of orphan's household food insecurity. Indeed some scholars reported that orphans who lived in households that were affected by HIV/AIDS appear to have higher food insecurity risk than orphans living in household not affected by HIV/AIDS (Wagt and Connolly 2005; Greenbelt and Greenway 2007; Ngwira, Bota and Loevinsohn 2001). It has been established that HIV/AIDS exacerbate food insecurity by decreasing household labour supply in the food production processes (World Bank 1997; Yamano, Yayne and McNeil 2002). For some households, HIV/AIDS depleted household income through death of breadwinner, health care and death expenses (Ngwira, Bota and Loevinsohn 2001; Madhavan and Townsend 2007; Mohindra et al. 2010; Hadad and Gillespie 2001). In Nairobi, Kenya, Yamano, Yayne and McNeil (2002) found that

HIV/AIDS related death of the male head of household reduced household food production by 68 percent.

Similarly in urban Kenya, in Kisumu and Siaya, Ayieko (1997) found that orphans who lived in HIV/AIDS affected households were food insecure and sold assets during illness of parents, to generate some income. Food production labour was diverted to caring for the sick members of the household and household purchasing power declined due to the death of breadwinners.

Further, in Tanzania, a study found that food expenditure and food production among HIV/AIDS affected households declined by 32 percent and 25 percent, respectively (World Bank 1997). HIV/AIDS affected households invested in short term economic activities. Members of households with orphans were also excluded from social networks because of stigma and discrimination (Ngwira, Bota and Loevinsohn 2001).

Caregivers caring capacity appear to cause food shortage among some orphans. Wagt and Connolly (2005) argued that food insecurity and poor nutrition status of orphans affected by HIV/AIDS, may be caused by lack of caregivers caring capacity. This was because sometimes foster parents did not have knowledge and skills for looking after orphans. Funkquist, Ericksson and Muula (2007) found that orphans had difficulties finding food due to caring-related factors in Thyolo district, Malawi. Orphans who headed a household reported having no means of finding food, because they had no guardians to provide food. On the other hand, there were some orphans who lived in food secure households but their guardians and relatives denied them food (Funkquist, Ericksson and Muula 2007).

There is an apparent gender dimension of food need. Some researchers found that HIV/AIDS related reduction of food production had a gender dimension (Donovan et al. 2003). The authors found that when the father was ill, 42 percent of the households had poor diet, but when the mother was ill, only 34 percent of the households had poor diet. The findings were based on a household survey that sought to find the effects of prime-age mortality and morbidity on households that were affected by HIV/AIDS in Rwanda.

3.1.1.2 Coping mechanisms

Households with orphans reported different strategies for finding food. Maxwell and Cardwell (2008) described a Food Security Coping Strategy Index that is used to measure frequency and severity of food insecurity. According to their experience, most of the households adopt the following strategies to cope with food shortages; consuming cheaper foods, borrowing money for buying food, reducing the number of people eating from home (send children to eat at the neighbours' house) or reducing number of meals per day.

Kaschula (2011b) suggested that coordinated social networks could help food insecure household from high poverty and high HIV/AIDS affected areas. This was established through mixed methods and observation research that was done in Kwazulu-Natal, in South Africa. The results showed that households that had severe food insecurity survived the hunger period, through food donations from social networks in the form of cereals, legumes, fruits and fish from relatives and friends. Similarly, in Nigeria, Enwereji (2007) reported that communities used pot-logging to cope with food insecurity. Pot logging was a system where food and other items donated to orphans were brought to one central point, where orphans accessed them according to their need.

In addition, in South Africa, it was established that wild foods helped to provide nutrition to HIV/AIDS infected and food insecure households that had orphans (Kaschula 2011a). Challe, Niehof and Struik (2011) reported that orphans from child-headed household collected and sold wild orchid tubers, to find money for buying food throughout the year. However, this was merely a survival strategy that did not help them to meet other financial needs.

3.1.1.3 Consequences of food need

Potential negative consequences of food insecurity, leading to malnourished orphans have been documented (Panpanich et al. 1999; Greenbelt and Greenway 2007). Panpanich et al. (1999) compared the nutrition status of under-five orphans and non-orphans in Blantyre district of Malawi, using anthropometric measures of children and

interviews with caregivers. The orphans were drawn from orphanages and villages, while all non-orphans were from the villages. More orphans than non-orphans were found to be under-nourished, especially those from orphanages. The findings showed that 54.8 percent of orphans from orphanages, 33.3 percent orphans from the village and 30 percent of non-orphans were undernourished.

The orphans were found to be more likely to have poor growth than the non-orphans. More orphans were stunted than non-orphans, about 64 percent of orphans and 46.4 percent of non-orphans. Furthermore, in Kenya, Sala (2009) found that 29 percent of orphans from fostered homes had malnutrition because of poor diet. Often they had one meal in a day.

In addition, in Zimbabwe Watts et al. (2007) conducted a quantitative data analysis of 31, 672 children aged 0-17 years (6,753 aged under 5 years). Findings showed that less than five years old orphans and vulnerable children were more likely than non-vulnerable children to be stunted and underweight. However, it was unclear how the author defined vulnerability in the study. Vulnerability has different meanings, which include living with chronic sick parents and having low income, poverty, among others (UNICEF 2005).

According to studies in Botwana and Malawi, orphans under five years were more likely to be undernourished (Miller et al. 2007a; Pullum 2008). Using demographic health survey and UNICEF MICS data in Malawi, Pullum (2008) found that double orphans under 5 years were much more likely than non-orphans to be stunted, underweight and wasted. However, Greenbelt and Greenway (2007) argued that studies that are conducted to establish the nutrition status of orphans do not show the whole picture of orphans situation because often they use national quantitative data sources. This data sources include only orphans aged less than 5 years of age accounting for only 12 percent of orphans' population, leaving out 88 percent of orphans.

3.1.2 Educational Need

Since the United Nations Children Rights Commission, education is recognised as a human right need for every child, including orphans, for fulfilling their dreams and aspirations (UNAIDS and UNICEF 2004; Boler and Carroll 2003; USAID and Catholic Relief Services 2008). UNAIDS and UNICEF (2004) and USAID and Catholic Relief Services (2008) suggest that orphans who access quality primary education have a chance of a better future life. This is because children who can read, write and acquire numerous skills have a solid foundation for continued learning for their entire life and achieve their potential. However, myriad studies that were conducted in Sub-Saharan Africa suggested that orphans struggle to access education and they appear to have a number of poorer education outcomes than non-orphans.

3.1.2.1 School enrolment

Low school enrolment problems exist among orphans. Analysis of national representative data suggest that orphans in Sub-Saharan Africa are less likely to enrol in school than non-orphans (Case, Paxson and Ableidinger 2004; Evans and Maguel 2007; Guarcello et al. 2004; Sharma 2005). Evans and Miguel (2007) conducted a five year longitudinal assessment of 20,000 primary school children, to assess the effects of parental HIV/AIDS death, on children in Kenya. The findings suggested that maternal orphans were less likely to enrol in school than the other children.

Enrolment comparisons between pre-parental death and post-parental death periods showed that there was poorer school enrolment during the post parental death period than the pre-parental death. This study underscores the significance of the longitudinal, rather than the cross-sectional, methodology for capturing educational enrolment patterns among orphans. However, these studies appear to be rare in Sub-Saharan Africa (Munthali 2002). This means future studies in Sub-Saharan Africa should endeavour to increase educational longitudinal studies.

Besides, using household survey data from 10 countries in Sub-Saharan Africa, Guarcello et al. (2004) explored the relationship between orphans' school enrolment and child labour. The findings showed that orphans from 9 out of 10 countries were

less likely to enrol in school. Orphan status was the key factor for not enrolling in school. Additionally, Case, Paxson and Ableidinger (2004) analysed data from 19 demographic health surveys in Sub-Saharan Africa. The research also found that maternal orphans and double orphans were less likely to enrol in primary school.

Different reasons have been highlighted in literature for orphans low school enrolment. Case, Paxson and Ableidinger (2004) and Evans and Miguel (2007) attributed orphans' failure to enrol in school, to loss of income from the death of the father. Ueyama (2007) found that orphans, particularly, paternal orphans and double orphans were found to be less likely to enrol in school than other children were because they came from poor households and the household head had no education.

Further, Sharma (2005) and Ayieko (1997) found that orphans failed to enrol in school because of caregivers' attitudes, child labour and lack of psychosocial services to assist the stigmatised orphans. Some caregivers were not willing to invest in the education of orphans, because they felt that educational future benefits would not accrue to them (Sharma 2005; Ayieko 1997). Instead, the caregivers expected the orphans to engage in extensive domestic chores. Guarcello et al. (2004) also found that child labour contributed to orphans' low school enrolment. Orphans from 5 out of 10 countries that were studied were at risk of engaging in child labour in a form of paid work.

3.1.2.2 School attendance and school drop-out

In Sub-Saharan Africa, there seems to be sufficient evidence to suggest that orphans, were more likely to have poor school attendance (absenteeism) and to drop out of school (Operario et al. 2008; Isolde et al. 2009; Oleke et al. 2007; Funkquist, Ericksson and Muula 2007). Oleke et al. (2007) analysed household survey data of 2337 sample size in Uganda, to explore educational needs of orphans affected by HIV/AIDS. The findings suggested that orphans were more likely to be absent from school or drop out of school.

Additionally, Isolde et al. (2009) found that in Zimbabwe, double orphans and maternal orphaned girls (aged 15-19 years) had higher school dropout rates than non-

orphans of the same age. Double orphans also had lower school attendance rates than other children. Using a case study in Lesotho, Nyabanyaba (2009) also found that orphans were more likely to drop out of school than non-orphans.

In South Africa, Operario et al. (2008) found that 23 percent of orphans did not complete school although it was free compulsory education system. This suggested that school fees might not be the only factor causing orphans to drop out of school as compulsory education allowed children to finish secondary education by 16 years old. Both maternal and paternal orphans were less likely to complete their education than non-orphans were. This was based on analysis of a national representative survey data of 10,452 children aged 16-24.

A number of reasons contributed to the situation including lack of food, particularly breakfast and no food at school, child labour, lack of school uniform and lack of good clothes. Teachers were forced to send orphans home because they were dressed in shabby clothes. Further, Funkquist, Ericksson and Muula (2007) and Bennell (2005) reported that orphans had poor school attendance because they lacked food, clothes and soap for washing their clothes.

Robson and Kanyanta (2007) suggested that orphans dropped school because of increased economic stress, changes in household structure and increased domestic responsibilities. The findings were obtained from a qualitative study done in Copper Belt, in Zambia using focus group discussions with orphans, teachers and document review.

Gender has been reported to have a bearing on orphan's educational outcomes. Two studies that were conducted in rural Zimbabwe suggested that women play a key role in promoting education of orphans (Nyamukapa, Foster and Gregson 2003; Nyamukapa and Gregson 2005). In the first study, Nyamukapa, Foster and Gregson (2003) found that orphans failed to complete school when their mothers died, but the death of the father had no effect on orphans' education. The study also found that a disproportionately high number of orphans were living in elderly female-headed and child headed households.

In the follow-up study, Nyamukapa and Gregson (2005) found that maternal orphans had lower primary completion rates than other orphans. Lower rate of school completion was caused by lack of support from fathers, due to negative influence of stepmothers and lack of welfare support. In addition, high level of completion among paternal orphans was attributed to the contribution of female-headed households, where the orphans were fostered. The two studies might reflect limited education support provided by surviving fathers and extended families in rural areas. Indeed, (Munthali 2002), suggested that surviving fathers seemed to provide limited support to orphans.

3.1.2.3 School attainment

Using a quantitative regression analysis in Kenya, Ueyama (2007) found that double orphans were less likely to progress to high school grades. Maternal orphans, older than 12 years, had difficulties progressing to higher grades. Similarly, Isolde et al. (2009) found that maternal orphans and double orphans did not attain form four certificates.

A number of reasons have been highlighted for orphans' poorer school attainment compared to non-orphans (Oleke et al. 2007; Funkquist, Ericksson and Muula 2007; Ueyama 2007). Oleke et al. (2007) found that orphans in Kenya had poor education attainment for a number of reasons. Orphans were not able to do assignments because they lacked learning materials, such as mathematical instruments or exercise books. Orphans also had low school attainment because of lack of school fees and lack of counselling when they were stigmatised because of their status. Indeed Isolde et al. (2009) found that when orphans were assisted with school fees, they completed school and attained the form four certificates.

Kasirye and Hisali (2010) found that HIV/AIDS orphans, particularly those from poor households were 3 years behind their appropriate education grade. The findings were drawn from analysis of Ugandan household survey among orphans aged 6-17 years.

In addition, Funkquist, Ericksson and Muula (2007) found that in Malawi, poor performance among orphans was associated with poor diet and lack of food, which

distracted orphans' concentration in class. The effect of food on education of orphans has been highlighted in section 3.1.2.2.

Further, Bennell (2005) found that 70 percent of primary school children had repeated a class because of irregular attendance and poor quality of schooling. Repetition was higher among orphan girls than orphan boys, suggesting a gender dimension to school performance. Isolde et al. (2009) also found that orphans failed to attain form four certificates because they had higher dropout rates than other children.

Furthermore Kimani, Kodero and Misigo (2009) found that although orphans from households or institutions had low self-esteem, orphaned children from institutions showed positive correlation between self-esteem and academic performance. This was because the institutions adopted strategies for promoting positive altitudes which gave orphans a feeling of being loved and cared for. In contrast, orphans who lived in the households were exposed to child labour and often were absent from school, attending to sick people. This finding underscores the significance of positive nurturing and caring of orphans on their education outcomes.

3.1.3 Health Need

Researchers in Sub-Saharan Africa suggested that orphans could have worse health outcomes, compared to non-orphans, for a variety of reasons. First, orphans appear to have higher risk of HIV/AIDS infection (Palermo and Peterman 2009; Robertson, Gregson and Garnett 2010; Operario et al. 2007; Miller, 2007; Robertson et al. 2010). Miller (2007) conducted a systematic literature review, to explore the living conditions of orphans from highly HIV/AIDS impacted areas in Sub-Saharan Africa. The findings indicated that orphans' HIV/AIDS risk originates from biological infection from mother to child. Similarly in Malawi, mortality among the under five years orphans was higher for mothers, who were HIV positive, than mothers who were HIV negative (Crampin et al. 2003). It was suggested that HIV/AIDS infection from mother to child was one of the highest causes of increased mortality among orphans and other vulnerable children under the age of five years in Sub-Saharan Africa (Crampin et al. 2003; Miller et al. 2007).

Apart from infant orphans, Pascoe et al. (2010) found that in Zimbabwe, older male and female orphans had a higher risk of contracting HIV/AIDS. The quantitative study recruited 6791, secondary school children from rural areas. Blood testing was done to establish HIV status. About 60 percent of those with HIV/AIDS were orphans. Orphans were found to have come from poorer households than did other children. Orphans who had lost both parents had higher risk of HIV/AIDS infection, experienced sex early, had experienced forced sex and were less likely to use condoms than were other children.

Similarly, Operario et al. (2011) found that both male and female orphans were exposed to higher HIV/AIDS risk through sex than non-orphans were. This finding was based on 10 systematic studies. Indeed, these two studies may be commended for validating the sero-status of HIV/AIDS among the orphans. Many studies tend to use chronic illness as a proxy indicator of HIV/AIDS death of parents.

Consistently, many studies suggest that in Sub-Saharan Africa, female orphans had a higher likelihood of becoming infected with HIV/AIDS than female non-orphans (Palermo and Peterman 2009; Birdthistle et al. 2008). Birdthistle et al. (2008) observed that that the prevalence of HIV/AIDS among girls was higher among orphans than non-orphans. Maternal and double-orphaned girls were most likely to initiate sex early, and to have had multiple sex partners. Maternal girl orphans were least likely to have used a condom at first sex. This was established through a random cross-sectional survey in 2004 from a sample of 1283 aged of 15 to 19-year-old living in a high-density suburb of Harare, Zimbabwe.

In Uganda, Ssewamala et al. (2010) found that access to economic assets was an effective strategy for reducing risky sexual behaviour among HIV-orphaned girls. This finding emerged from a random controlled 10 months trial among AIDS orphaned adolescent girls from rural Uganda. The sample had 133 control group cases and 127 treatment group cases. The treatment group had access to savings accounts, training workshops and mentoring programme. Both groups had access to counselling and school supplies. The findings indicated a reduction in sexual risk-taking behaviour

among the treatment group after controlling for socio-demographic factors, parental communication and peer pressure.

Second, there is a connection between material need and health need (Enwereji 2007) (Operario et al. 2008; Isolde et al. 2009; Oleke et al. 2007; Funkquist, Ericksson and Muula 2007). Enwereji (2007) suggested that poor health among orphans was caused by living in poor housing conditions. In Nigeria, about 58 percent of orphans reported having lived in conditions that were characterised by poor sanitary environment which included overgrown grass surrounding the houses, lack of toilets, dilapidated houses and lack of proper kitchens. As a result, orphans suffered various forms of illnesses that resulted in hospital admission. The common illnesses were malaria, fever, malnutrition, diarrhoea and injuries.

Third, lack of access to health services may exacerbate orphan's poor health status (Muhwezi, Muhangi and Mugumya 2009; UNAIDS and UNICEF 2004). Muhwezi, Muhangi and Mugumya (2009) conducted a cross-sectional unmatched case control study of 98 orphans from an area in Uganda with NGO health services support and 98 orphans from a non-supported area. The authors found that fever, skin diseases and diarrhoea were common sicknesses among orphans. Orphans from areas that had no NGO support had higher prevalence of diarrhoea (85.7 percent) compared to 14.3 percent from the supported areas. About 20 percent of orphans from the supported area had skin diseases, compared to 80 percent from the non-supported areas.

Many caregivers accessed medicine from the village in the supported areas because the NGO provided home-based care while few caregivers from unsupported areas took their children to health centres, and few bought drugs from shops. This study may imply that service provision that is closer to users may be more responsive to the needs of service users and effective in addressing the needs of orphans. However, this study did not explain the geographical location of the control group, nor how they controlled the orphans from accessing other health assistance, for instance, through school health services.

3.1.4 Psychosocial Need

There is evidence that some orphans suffer from psychosocial distress. Through a 2004 national survey among 5321 orphans aged 12-17 years in Zimbabwe, Nyamukapa et al. (2008) found that for both gender, all orphan types displayed more severe distress than non-orphans. Psychological distress was measured using Rand Mental Health and Becks Depression Test.

A 4-year longitudinal study was conducted in South Africa to determine psychological problems associated with AIDS-orphaned children (Cluver and Gardener 2012). In this study, a national representative sample of 1021 children was followed from 2005 to 2009. A standardised scale was used to measure depression. Using regression analysis and controlling for baseline mental health, type of bereavement and socioeconomic factors, they found that being orphaned by AIDS was associated with depression and anxiety. This study may imply the need to identify the specific cause of psychological distress, because not all orphans had this association. Hence, psychosocial services might need to target those who are affected by the problem.

There are multiple factors affecting HIV orphan's emotional and behavioural wellbeing. According to Cluver and Gardner (2007) the factors that affect orphans included bereavement, dysfunctional family, lack of social support, poverty, stigma, abuse and loss of access to education. These were results of a qualitative study, using semi-structured interviews and focus group discussions among orphans, caregivers and social care professionals in Cape Town, South Africa.

The research may be commended for using qualitative methods that allow respondents to express their experiences, because most studies use quantitative methods. In addition, the approach provided orphans to share their views, by drawing pictures and writing about their feelings, instead of caregivers reporting on behalf of the children (Ngwira, Bota and Loevinsohn 2001).

In Malawi, it has been reported that children face grief and anxiety as they watch their parents deteriorate through sickness and eventually die (Cook, Sandra and Alaistair 1999). Children become vulnerable because they lack the support of adults who could

talk to orphans about sickness and death (Wood, Chase and Aggleton 2006). Further, it has been noted that failure to address psychosocial issues of orphans may lead to long-term complications for the child's well-being. This may include, poor mental health, illiteracy, poverty, child labour, exploitation and the risk of HIV infection (Foster 2003).

3.1.5 Economic and Material Needs

Economic need was to do with lack of overall finances in orphan households while material need depicted lack of tangible material or physical items by the orphans or the household.

3.1.5.1 Economic need

It appears that orphans lived in lower income households than did non-orphans. In Nairobi, Yamano and Jayne (2005) analysed two household surveys, conducted between 1997 and 2000, in high HIV prevalence in Kisume and Siaya, in Kenya, to assess economic status of orphans. The study found that death of a father was associated with a reduction in household income, because of reduced cultivated land, reduction in production of cash crops and off-farm businesses.

Besides, a quantitative study was conducted in Malawi to identify social-economic status and vulnerability factors of households, through a nation-wide Integrated Household Survey that contained both orphans and non-orphans (Malawi Government 2006b). Findings indicated that chronic illness had a double impact on the household income. First, income declined because labour was diverted from productive activities to care services of the sick persons. Secondly, there were expenses incurred directly to provide nurturing and care. Orphans from chronically ill households therefore experienced a decline in income and they lived in deprivation. The authors concluded that the inverse relationship between resources demand and supply drove households and poor communities into chronic financial instability (Malawi Government 2006b). The study also found that death of a father was associated with land loss of 1.5 times more than land loss due to death of a mother (Malawi Government 2006d).

3.1.5.2 Material needs

There is evidence that support the views that orphans lacked material things, including shelter, clothing and other items. Sala (2009) carried out a mixed study in Kibera, Kenya to examine the quality of life among fostered orphans. They found that orphans from 90 percent of the households lacked adequate shelter. On average, six people lived in small crowded houses among the orphans. Further, some studies suggest that double orphans lacked clothes, shelter and beddings more than did other types of orphans (Mogotlane et al. 2010; Dalen, Nakitende and Musisi 2009).

Ayieko (1997) found that the reasons why orphans lacked housing and household assets were due to cultural, legal and age factors. The study found that, in Kenya, orphans lived in dilapidated houses that were left by the parents. Culturally, if the deceased parents were not married through customary law, the houses were not repaired. In addition, the orphans often lost assets because they were ignorant of legal procedures for safeguarding deceased estate, while other orphans had their property taken by relatives.

The consequences of lack of shelter, clothes and beddings among orphans varied between the studies. Mogotlane et al. (2010) and Funkquist, Ericksson and Muula (2007) found that lack of clothes and books often prevented orphans from going to school. Dalen, Nakitende and Musisi (2009) through narratives and observations of 43 household heads of double orphans in Uganda found that lack of food and clothes had psychological effected on orphans. The orphans felt ignored, excluded from the community and eventually dropped out of school. The negative effects of psychosocial needs of orphans on their education were highlighted in section 3.1.2.1. Further, Sala (2009) found that orphans who lived in small crowded houses suffered from respiratory infections including pneumonia, coughing and cold.

3.1.5.3 Strategies for coping with economic/financial and material need

Scholars have highlighted different strategies adopted by orphans to satisfy financial need (Munthali 2002; Monasch and Boema 2004; Foppena 1996). Studies done in Malawi suggested that when parents died, a bulk of orphans were fostered by the

extended family members particularly the grandparents (Munthali and Ali 2000; Mastwijk 2000). However, due to lack of income, orphans engaged in economic activities for example selling of charcoal and food items.

In some instances, the remaining parent arranged early marriages for girls. These measures taken by some families to cope with the economic effects of HIV/AIDS had serious repercussions on children, such as early marriage for girls at the expense of schooling (Foppena 1996; Cook, Sandra and Alaistair 1999; Munthali and Ali 2000; Mastwijk 2000). Furthermore, households that lost parents to HIV/AIDS failed to cultivate the whole garden, due to reduced labour. This resulted in declining crop yields (Munthali and Ali 2000). Other orphans were cared for by the community through community-based organisations.

Additionally, Monasch and Boema (2004) reported a migration of surviving mothers, with their children, from rural to urban areas, in search of better income opportunities. These strategies, which were meant to address orphans' problems, appear to have driven them into further vulnerability. More detailed information regarding the results of economic effects on orphans are discussed in the next section. Furthermore, Yamano, Yayne and McNeil (2002) reported that in response to declining income resulting from parental death, some daughters were married off to gain some income through dowry payment.

In contrast, Tamasane and Head (2012) found that in Free State, South Africa, orphans, fostered by grandparents, coped with material needs better than those fostered by other relatives. This was because, apart from receiving grants from Government, grandparents had a pension. Orphans from all fostered households had problems with access to education, and with access to meals. Although all caregivers received child and fostering grants, the grants were not sufficient to cover all orphans' needs.

Donahue (1998) grouped family strategies, for addressing financial insecurity into three categories of increasing vulnerability. These categories were reversible strategies, disposal of productive assets and destitute strategies. Reversible strategies

that were cited included reducing expenditure patterns and seeking relief from others. Destitute strategies included breaking up families and prostitution.

Overall, orphans seem to lack finances or income and material items, and use different strategies to address those needs. However, the strategies used to cope with their needs increased orphans' vulnerability hence the need for supportive services.

3.1.6 The Need for Protection.

Several cases in Malawi provide evidence that various forms of child abuse do occur among orphans and non-orphans. These abuses include rape, prostitution, child labour and child trafficking, particularly for females (Malawi Government 2004b; Government 2007b; Phiri 2007). The limitations of some of these studies were that they were based on unpublished literature; hence their quality was not established.

There appears to be evidence that orphans in Sub-Saharan Africa, may be exposed to more abuse than non-orphans (Kang et al. 2009; Robertson, Gregson and Garnett 2010; Foster and Williamson 2000; Cluver et al. 2011). Based on a 4-year quantitative longitudinal study from 2005-2009, Cluver et al. (2011) found that in Cape Town, South Africa, AIDS, orphan-hood and parental sickness determined an orphan's risk to emotional and physical abuse.

Similarly, two separate quantitative studies that assessed 10 demographic health surveys in Sub-Saharan Africa, among 15-17 years children, found that, indeed, orphans were at risk of starting sex early, early pregnancy and early marriage (Palermo and Peterman 2009; Robertson, Gregson and Garnett 2010).

Mkandawire (2011), using mixed method in Malawi, found that orphans were less likely to undertake voluntary HIV tests, started sex at an early age and engaged in high-risk sexual behaviour than non-orphans. Female orphans were less likely to use condoms.

Researchers are reporting an increase in the number of girls at risk of sexual abuse, including rape and sexual assault (Cluver et al. 2011; Birdthistle et al. 2011). Kang et al. (2009) conducted a quantitative regression analysis of 2000 HIV/AIDS positive girls,

aged 16-19 years in peri-urban areas of Zimbabwe, to explore the reproductive needs of girl orphans. The findings suggested that both maternal and paternal orphans lacked protection from sexual abuse.

However, Kang et al. (2009) suggested that there were different patterns in the nature of needs between paternal and maternal orphaned girls. Maternal orphans were likely to be found in child- headed households, to be sexually active, to have STI, to have been pregnant and to be infected with HIV. On the other hand, paternal orphans were more likely to be homeless and be out of school. The study suggests the need to conduct thorough needs assessments, to identify the variations of need within orphan types and address them accordingly.

There seems to be a gender dimension on the need for protection between boys and girls. Using a qualitative study based on interviews and FGDs with orphans and non-orphans, Mmari et al. (2006) compared the risky sexual behaviour between boy and girl orphans in Tanzania. The research suggested that more girl orphans engaged in unsafe sex than did the other children. While girls consistently felt that being in school or earning income was a protective factor against risky sexual behaviour, earning some income was perceived as a risk factor for boys, because it increased their temptation to engage in transactional sex. Girl orphans engaged in sex because they lacked food, clothes and because the caregivers did not provide adequate supervision or guidance.

Further, it has been suggested that orphans engage in harmful and unsafe coping mechanisms, which create the need for protection. It has been reported that orphans engage in child labour, in the form of paid work, as well as domestic chores more than non-orphans (Enwereji 2007; Ayieko 1997). Enwereji (2007) reported that In Nigeria, often orphans were fostered within the extended family, but that caregivers made orphans work strenuously. The orphans did paid work outside the home, in the garden and domestic chores.

The orphans described the work as slavery, hence this posed a threat to the orphans' health and development. In addition, Ayieko (1997) found that, in Kenya, both boys and girls were involved in domestic child labour. Girls assumed maternal roles, to

provide care for the younger siblings and they worked in the gardens as young as 9 years old. Male orphans assumed paternal, income earning roles.

However, Miller (2007) suggested that capturing of child labour data appears to be difficult. Hence, the full extent of the child labour problem may be more serious than reported. This was because often orphan caregivers hide information about child labour and a lot of domestic work was not considered as child labour, hence remain undocumented.

3.2 Orphan's Needs by Living Arrangement

This section summarises the differences between the orphans' needs based on living arrangement or main caregiver. This was one of the research questions to better explore the differences between the needs. As discussed in section 3.1, dependency ratio, appear to be the main contributing factor that determines the caregiver's capacity to support orphans. UNICEF (2004) suggested that families that hosted orphans had a higher dependency ratio (1.8) than families not keeping orphans (1.5). It appeared that the social-economic situation in particular households was a by-product of the dependency ratio.

Consistently, paternal orphans, who lived with surviving mothers, had high dependency ratio. They were more likely to be poorer than maternal orphans who lived with their fathers. High dependence ratio translated into limited financial resources within a household, and stressful care giving, especially for female-headed caregivers compared to male caregivers (UNICEF 2004). Similarly in Malawi, Pullum (2008) found that paternal orphans lived in relatively poor households with the surviving mother, consisting of a larger number of people than in the households with maternal orphans.

Foster et al. (1997a) suggest that orphans cared by older people could be more vulnerable to child labour, because grandparents are old so unable to work. Grandparents' physical capacity may hinder them from providing adequate and quality orphan care. As discussed in chapter two (section 2.3.2), it was estimated that 50 percent of orphans lived with their grandparents. This suggests that grandparents in

Sub-Saharan Africa could be bearing the heaviest burden of orphan care. This also suggests that a large proportion of orphans may be vulnerable.

Child-headed households had problems looking after their siblings because of poverty. Littrell et al. (2011) analysed quantitative data of 1219 caregivers in Malawi. The authors found that care giving increased stress and poor health among child caregivers. Orphan caregivers had worst health and emotional stress compared to adult caregivers. Lack of income and food insecurity was the major sources of problem.

Kuhanen et al. (2008) argued that child-headed households, keeping orphans, were struggling to run their households because they lacked experience and were unemployed. These households depended on handouts from relatives, neighbours and faith organisations for basic needs such as food, clothes and shelter for their survival.

Further, Foster (2004a) suggested that although child-headed households were a minority, and therefore in danger of being ignored, they deserved the much needed support, because of their critical vulnerability and poor living conditions.

Faced with limited resources, caregivers appear to make preferences and prioritised assistance to orphans, depending on the strength of their relationship to the child (Case, Paxson and Ableidinger 2004; Beegle et al. 2009). The observed relationship between assistance to orphans and the closeness of relationship between an orphan and a caregiver appear to be consistent with the Hamilton's rule. Hamilton's rule suggests that altruistic relationship between individuals depends on genetic closeness of the two (West et al. 2002). This suggests that the quality of care given to an orphan will correlate with biological connectedness of the orphan to the caregiver. This is consistent with the observation that grandparent caregivers were looking after as much as 50 percent of orphans in Sub Saharan Africa as discussed in section 2.3.2

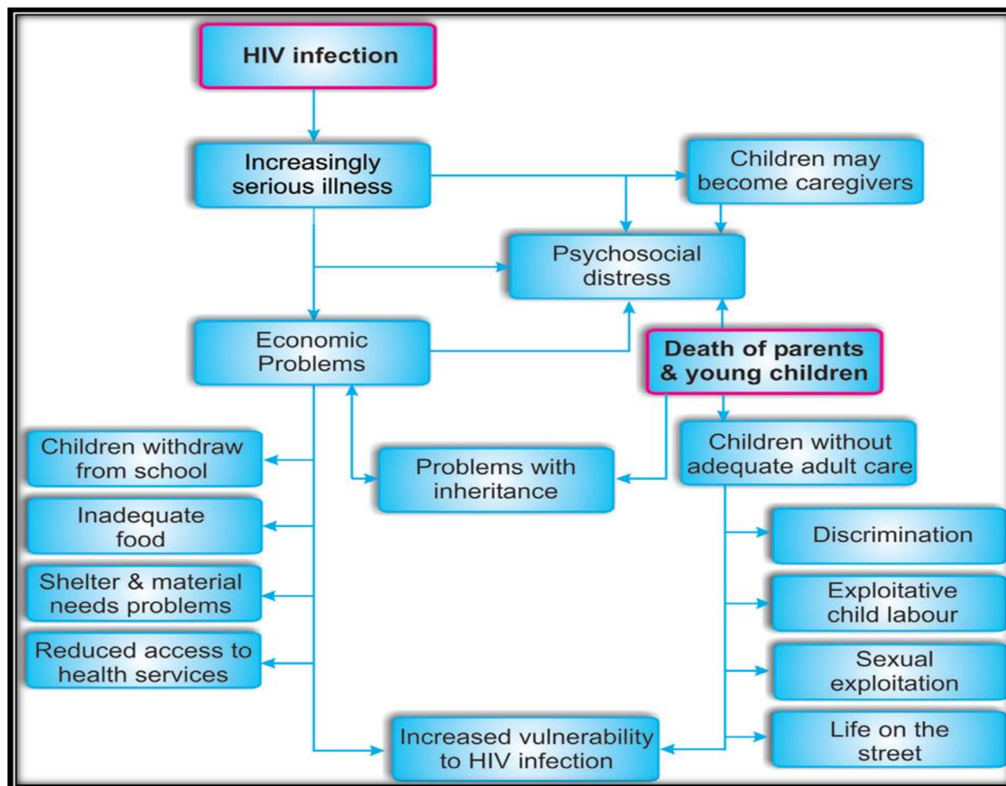
Similar findings were reported by (Nyabanyaba 2009). Nonetheless, it may be difficult to assess further the effect of the Hamilton rule, because there is scanty literature on other extended family caregivers other than grandparents (Foster 2004a; Foster et al. 1997b).

Indeed, Parker and Short (2009) found that in Lesotho, orphaned children who lived with their grandparents were more likely to enrol in school than those who lived with other relatives. Further, the findings suggested that living with grandparents or living with surviving mothers improved likelihood of orphans' school enrolment equally. The study therefore underscores the significance of fostering of orphans by close relatives.

3.3 Relationship between the Needs

Following extensive experience with orphan care in high HIV/AIDS prevalence in sub-Saharan Africa, Foster and Williamson (2000) identified extensive needs of orphans and how they related to each other, as shown in figure 3.1. Other studies done in Sub-Saharan Africa also show relationships between orphans' needs.

Greenbelt and Greenway (2007) suggested that lack of food caused low school enrolment among orphans. This observation was similar to findings of evaluation studies of World Food Programme elsewhere (Ahmed et al. 2007). Other studies suggested that death of parents deprives orphans of a secure environment and increase the risk of poor health, including infection to HIV/AIDS (Robertson, Gregson and Garnett 2010; Operario et al. 2007). In Uganda, Oleke et al. (2007) found that a relationship existed between economic and educational needs. The needs of orphans, identified by Foster and Williamson (2000) and other scholars, suggest the need for provision of comprehensive services for orphans (UNICEF 2005).



Source: (Foster and Williamson 2000)
Figure 3.1: Interrelationship among orphan needs and HIV/ AIDS in households

3.4 Gaps in the Literature

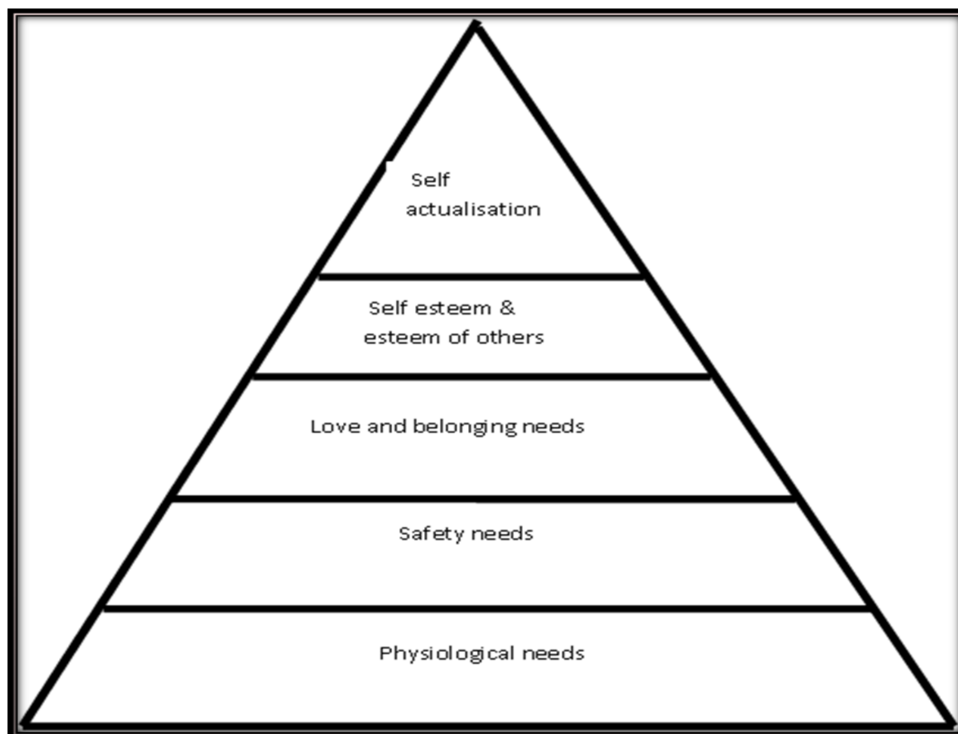
The review of Sub-Saharan literature on the need of orphans highlights a number of gaps. More research seems to focus on food, education and health needs. On the protection of orphans, studied seem to focus more on sexual protection than the other aspects of protection including physical and protection from child labour. Selected studies looked at the material need and psychosocial needs. Studies also tend to look at individual or few needs within one study. The comprehensive approach to understanding needs taken in this study seems to be rare. The implication for this approach is discussed in chapter 9.

The majority of studies in Sub-Saharan Africa on the needs of orphans tend to utilise quantitative methods, using national representative studies. The limitations and implications of such methods have been documented (Foster and Williamson 2000). This research makes a link between the needs of orphans, policies and services through process evaluation. This was a long-term gap in the implementation of orphan-care programme in Malawi, as reported in chapter 1. Further, this thesis has

adopted a theoretical approach to better understanding the needs as well as the responsiveness of policies and services to orphan's needs.

3.5 Proposed Theory of Needs: Maslow's Human Motivation Theory

Need was the starting point of Maslow's human motivation theory (Maslow 1954). Maslow (1954) claimed that needs could be arranged in a hierarchy of five levels, ranging from the lowest physiological needs, safety needs, belonging and love needs, self-esteem needs and the highest level needs of self-actualisation (Figure 3.2).



Source: (Maslow 1954)
Figure 3.2: Maslow's hierarchy of needs.

Later scholars reviewed and validated Maslow's human motivation theory (Arkes and Garseke 1982; Reeve 2005; Hollyford and Whiddett 1999). The hierarchy of needs was based on the principle of pre-potency, which states that when the lower need is fairly gratified, the person focuses attention on higher needs (Maslow 1954 1987a). This process was well described by Arkes and Garseke (1982:125) as 'chronological gratification' of needs. The basic lower needs were biologically necessary while the higher needs were necessary for psychological growth. This thesis used Maslow's

human motivation theory, for the classification of needs and understanding of the behaviour of orphans in relation to the needs of orphans. The theory states that a need creates a drive for human behaviour. Thus, when people have a need, it motivates them to take action that will enable them to satisfy the need.

3.5.1 Physiological Needs

Physiological needs are the lowest on the hierarchy of needs and are a deficient physiological condition (Reeve 2005). The concept of need as a motivator is based on the concept of homeostasis, which is the body's mechanism for maintaining an equilibrium state (Maslow 1987a). In this way, the human body regulates its internal conditions to maintain health and its functions. Thirst and appetite are regarded as indicators of physiological needs; hence people drink and eat food to satisfy thirst and hunger to survive.

Other physiological needs such as clothes and shelter help to maintain body temperature. Maslow (1954) stated that unmet physiological needs are life-threatening; hence they motivate behaviour that seeks to satisfy these needs. Lack of food and water are immediately life threatening, and lack of shelter and clothes normally become life threatening in the medium term. Exceptionally, under extreme conditions, coldness and rain can be dangerous in the short term for street children.

3.5.2 Safety Needs

Maslow claimed that if physiological needs were gratified, then safety needs became pronounced. Safety needs comprise need for security, stability, protection and freedom from fear, anxiety and chaos (Maslow 1954). Maslow argued that people felt unsafe when life was endangered. Maslow claimed that the motivation for safety was activated during emergencies such as war, natural catastrophe, societal and economic disorder, including breakdown of authority (Maslow 1954; Maslow 1987).

Maslow suggested that children were affected when they lived in environments which appeared to be unstructured, unorganised or disrupted with injustice, inconsistency, unfairness or disrupted routines (Maslow 1987b; Arkes and Garseke 1982).

3.5.3 Love and Belonging

Maslow suggested that the need for love manifested, as people expressed a drive for affectionate relationships with other people. It's satisfaction depended on a two-way relationship of giving and receiving of love (Maslow 1954; Maslow 1987). Maslow (1987b) argued that children were likely to display negative psychological effects when they were moved away from their homes, friends or neighbours. For Maslow, belonging to a family, clan, class or neighbourhood played a significant role in children's development. When the need for love was not met, children felt socially deprived, depressed, frustrated, rejected and lonely (Maslow 1987b; Arkes and Garseke 1982). These effects seem to be consistent with psychosocial needs of orphans, caused by loss of parents, described earlier in section 3.1.4.

3.5.4 Self Esteem and esteem by others

Maslow described two sources of esteem. These were self-esteem and esteem by others. Self-esteem was dependant on how an individual valued themselves. It consisted of strength, achievement, adequacy, competency, confidence, independency and freedom of the person (Maslow 1954; Maslow 1987). Esteem by others manifested through how other people expressed your value including reputation and prestige. Thus, one may need status, fame, dominance, recognition, attention or importance in order to satisfy esteem needs (Maslow 1987b; Arkes and Garseke 1982). Failure to satisfy esteem needs caused feelings of inferiority and helplessness, and could lead to depression (Arkes and Garseke 1982).

3.5.5 Self-Actualisation

Maslow defined self-actualisation as 'what humans *can* be they *must* be' (Maslow 1987b:22). It means 'People must be true to their own nature: people feel self-fulfilment when their full potential becomes actualised' (Maslow 1987b:22). Self-actualisation was seen as a psychological growth (Maslow 1987b). Maslow argued that the need for self-actualisation could not be attained unless the other four needs in the hierarchy were satisfied. Hollyford and Whiddett (2002) and Hollyford and Whiddett

(1999) argued that the gratification of self-actualisation need could vary from person to person and may never be completely attained, because the need was infinite.

Maslow's human motivation theory was relevant in this thesis. The theory was incorporated to better understand the needs of orphans from behaviour point of view. Studies conducted so far in Sub-Saharan Africa mostly use UNICEF classification of needs. As stated in chapter one, no orphan care studies in Sub-Saharan Africa adopted a theoretical approach to needs. Maslow's human motivation theory helped to understand the link between the needs of orphans and the responsiveness of services to the needs.

The next two sections describe two theories of needs that were reviewed and considered in this thesis. Their limitations were also highlighted.

3.6 Reeve's human motivation theory

Reeve's theory of need was a further modification of Maslow's hierarchy of need. Reeve (2005) proposes three classifications of needs as physiological, psychological and social needs. Reeve agreed with Maslow that physiological needs were biologically induced. He however differed from Maslow when he claimed that failure to satisfy the need has psychological consequences.

Reeve (2005) claimed that needs have the capacity to develop into a positive-negative continuum. That is, when a need is satisfied, there is growth and development. When a need is neglected, it creates deficiency and deprivation such as biological and psychological disruption. Reeve suggested that social needs were acquired from the social environment in which one grows. Reeves did not distinguish social needs from psychosocial needs. He claimed that there was a 'subtle difference' between the two Reeve (2005:103). Competence was seen as a psychological need for a person to seek out and make an effort to master or challenge situations (Reeve 2005:116). Relatedness was explained as one's capacity to establish relationships and close bonds with other people (Reeve 2005:124).

Overlapping social and psychological needs were difficult to apply in practice in this study. Reeve described an engagement motivation model for dealing with psychological aspects. The model claims that a person must develop relationships to interact with a social context. This is where social cultural factors interplay with a person.

Like Maslow, Reeve developed an organismic psychological theory, which demonstrates a two-way interaction between a person and society. The author argued that three major needs constitute psychological needs namely need for autonomy, competence and relatedness. These vary in different environments. Reeve defined autonomy as people's ability to make choices or decisions with flexibility (Reeve 2005:115).

3.7 UNICEF's Classification of Needs and the Link with Maslow's Theory

As discussed in chapter 3, section 3.1, UNICEF classified the needs of children as the need for food, good health, education, psychological, protection and the need for economic and material support. These were discussed from 3.1.1 to 3.1.6. Figure 3.3 shows the link between Maslow's and UNICEF's classification of needs. There appears to be a clear linkage between UNICEF's classification of needs and the three levels of Maslow's classification of needs namely physiological needs, security needs and the need for love and belonging. A weak link between self-actualisation needs with education need exists. There seems to be no apparent link between esteem needs in Maslow's classification and UNICEF's classification of needs.

UNICEF classification of needs was considered to be narrow and inadequate to assess the needs of orphans because it was merely descriptive. UNICEF described the mediation factors, coping strategies when the needs were not met and the consequences of unmet needs on the lives of orphans. Furthermore, advantages of using Maslow's human motivation theory have been presented in section 3.8

Figure 3.3 : The link between Maslow's and UNICEF's needs classification.

3.8 Application of Maslow's Theory: Limitations & Strengths

Some critics argue that the hierarchy pattern of needs, with a priority on lower needs, imply an individualistic approach to need (Hollyford and Whiddett 2002; Hollyford and Whiddett 1999). Maslow's choice of five needs, and the nature of the ranking, was not considered to be scientific nor scholarly grounded (Rowan 1999; Neher 1991). This is because the methods of enquiry used did not appear to be based on systematic

observations, nor on experimental data. Maslow did not explain the rationale for the pattern of the hierarchy, therefore, the theory assumed to be Maslow's personal values and beliefs (Neher 1991). In addition, the theory also fails to address the observation that some needs remain motivators, even when they have been satisfied, for example eating (Hollyford and Whiddett 1999). Further Maslow was not explicit about cognitive need. Maslow (1987b) suggested that cognitive motivations, such as the need for education, have been overlooked, because they were not considered as important in a clinically dominated field.

What appears to be the major contested concept of Maslow's human motivation theory from literature was the assertion that there is a hierarchy of needs. Despite the critics, this thesis uses the hierarchy of needs to understand how orphans prioritise their needs. Apparently, the criticisms of Maslow's human motivation theory do not dispute the assertions that needs motivate behaviour. In this thesis, Maslow's human motivation theory was applied to show how needs motivated behaviour. Maslow's human motivation theory facilitated the understanding of how the unmet needs of orphans' and caregivers' influenced their behaviour, towards solving or addressing their needs. Therefore, the behaviour of orphans is a verifiable indicator of need. In addition, the persistent behaviour of orphans towards addressing certain needs would help to identify priority needs. In return, that facilitated assessment of whether service providers were responding to priority needs of orphans. This was very important in this thesis, whose aim was to assess service responsiveness to the needs of orphans.

Besides, the theory made specific reference to children's needs and their consequences on the children's well-being, if the needs were not satisfied. This may assist service providers to plan for future preventive services, and provide better strategies for assisting orphans. The findings of the application of Maslow's classification of needs and orphans' behaviour in relation to relative to needs are reported in chapter six.

Further, this chapter looked at the ethnocentrism of Maslow's theory. According to the Oxford dictionary ethnocentrism refers to the use of one's cultural norms as a universal yardstick to make generalizations about other peoples' cultures and customs.

This therefore underscores the fact that culture is different and depends on the context in which one lives. This thesis recognises the ethnocentricism of Maslow's human behaviour theory because the theory is based on a western culture.

Cianci and Gambrel (2003) and Hofstede (1984) suggested that western culture was individualistic hence more self-centred while non-western cultures were collective and tended to value more collective views as opposed to the need for freedom and individuality. Besides, hierarchy of needs may depend on age, individual differences or social-economic status of the individual (Goebel and Brown 1981; Heylighen 1992). For example, Maslow's work was based on elite children while orphans in this study came from poor households. Furthermore, Maslow developed this theory in the 20th century, while this study worked with 21st century orphans. Ultimately, Maslow's work did not have orphans in mind. In this thesis, the orphans pursued education as a standalone need. At the same time, orphans demonstrated the existence of interdependence between education and food need.

3.8 Summary of the chapter

This chapter described the Sub-Saharan Africa literature on the needs of orphans. Maslow's human motivation theory was chosen to inform the thesis because of its appropriateness to fulfilment of the objectives of the thesis. The rationale for the choice of Maslow's theory, the link between Maslow's and UNICEF's classification of needs has been discussed.

Chapter 4 – Policy and Service Provision: Theory and Literature

As stated in chapter one, the aim of this thesis is to explore the responsiveness of policies and services to the needs of orphans. This chapter describes the literature and the theoretical approach to understanding policy and service delivery to orphans. Policy analysis theories are discussed first. Service delivery responsiveness was informed by the framework of quality of care adapted from Maxwell (1992) and the Health Services Research Group (1992). The literature review was informed by the framework of quality of care.

4.1 Policy Analysis Theories

Buse, Mays and Walt (2005) and Walt and Gilson (1994) argued that the concept of policy had diverse interpretations, therefore difficult to define. Table 4.1 provides various definitions of policy, all of which have elements deemed relevant for this research. Policies are made at many levels; local or central Government or multinational level. Policies are made both in the private and the public sectors. This thesis focuses on the public or the Government policies. Policy is complex because it involves a web of decision makers who are expected to produce action.

Sometimes policy translates into more than one decision; policies may result in non-decision and inaction. Sometimes policy may mean action without decision. In this thesis, these dimensions of policy and their application are further discussed in chapter 9, section 9.1.7. Walt (1994) suggested that policy involves a decision to act on a particular problem, as well as subsequent decisions concerning its implementation and enforcement. Apart from policy content, policy involves roles of the Government and the non-Government organisations. This thesis focuses on Government policies which include visions, objectives, decisions, strategies, targets, plans, guidelines and directives.

Table 4.1 : Policy Concepts

Policy-related Definitions	**Sources**
Policy is defined as 'broad statements of goals, objectives and means by a group of decision makers who create a framework for activity'.	Buse, Mays and Walt (2005:5)
Policy is a series of 'practices, statements, regulations and laws' resulting from decisions on how things should be done.	Barker (1996:8)
Policy denotes a course of action that is intended or not intended in the process of implementation and administration.	Parson (1995:13)
Policy is a course of action or inaction rather than specific decisions or actions.	Heclo (1972:85) Hogwood and Gunn (1984 :14)
Policy as decision taken by government to guide and translate aspirations into actions.	Malawi Government (2008c)

4.1.1 Health policy analysis framework

Walt and Gilson (1994:355) framework, known as the 'health policy triangle' is a highly simplified model of an extremely complex set of interrelationships of policy influencing factors. It has four categories: process, context, actors and content.

i) Policy Process

The policy process "refers to the way in which policies are initiated, developed or formulated, negotiated, communicated, implemented and evaluated" (Buse, Mays and Walt 2005:13). Within the literature, there are four common stages of policy

process (Porter and Hicks 1998; Buse, Mays and Walt 2005; Barker 1996). It has been argued that these stages should be viewed as a 'policy cycle', not like a straight line. This is because, usually after the evaluation stage, policies are changed, terminated or new ones are introduced (Porter and Hicks 1998).

Some scholars refer to this approach as "stages model" because the processes do not actually represent what happens, but is a theoretical device that provides a "useful conceptual disaggregation of the complex and varied policy process into manageable segments" (Jenkins-Smith and Sabatier 1993). These four policy processes include:

Problem Identification and Issue Recognition: how issues get or do not get onto the agenda (agenda-setting).

Policy Formation: who is involved in the formation of policies, how policies are developed and decided upon and how they are communicated.

Policy Implementation: the process of executing and operationalising the policies.

Policy Evaluation: This is done to explore policy outcome and impact after implementation of policy.

ii) Policy Context

Context refers to systemic factors both internal and external, which may have an effect on policy (Buse, Mays and Walt 2005). Analysis of the context in which they are made is significant for understanding how policies change and identify factors that may influence policy outcomes. According to Leichter (1979) , four contextual factors that influence policy are situational, structural, cultural and International or exogenous factors. Leichter (1979) argued that there were virtually unlimited factors that influence what government decides to do or not do. Situational factors are impermanent, transient, less repetitive, distinctive conditions such as war, drought or political instability, which may have an effect on policy.

Structural factors are less transient, relatively unchanging elements such as economic structure, the political system, demographic features or technological advances. Cultural factors include values and beliefs on issues surrounding gender, religion or ethnic minorities. For example, the involvement of the minority groups in policy

making processes. International or exogenous factors deal with the role and influence of international agreements and treaties or the role and influence of international donor policies on organizations.

iii) Policy actors

Buse, Mays and Walt (2005) define actors as individuals, organisations or even the state and their actions that affect policy. Actors influence policy at different levels: local, national or international. Actors influence policies using their power, which consists of wealth, personality, level of access to knowledge or authority (Buse, Mays and Walt 2005). The major categories of actors that are key in this study include Government, non-state actors or non-government organisations, the International organisations and community-based organisations.

Central to government function is the making of policies and laws by bureaucrats and coordination of policy implementation (Walt 1994). Foster, Deshmukh and Adams (2008) argued that 'national governments are the lead and appropriate authority to set ground rules for effective collaboration and interaction between international institutional and local communities and not through piecemeal negotiations among individual actors. Stakeholder alignment is critical to deliver outcomes for children' (Foster, Deshmukh and Adams 2008:21).

International or intergovernmental organisations include those whose membership, finance and field of operation involve three or more member countries. They make up the highest level that influences national policies (Walt 1994). While developing countries may gain sovereign control over policy, their policies are being decided externally by International organisations (Walt 1994). For example, there are a number of UN organisations that have direct influence on children. These include UNICEF, WHO, ILO, FAO, WHO and UNESCO.

Non-state actors are voluntary bodies who do not assume government roles (Walt 1994) . They are referred to with different names such as interest groups, civil society organisations or non-governmental organisations that may influence policy but may not seek formal political power (Buse, Mays and Walt 2005). Some are local, normally called grassroots development organisations; others are international. Walt (1994)

argued that some civil societies may bend government policies towards their narrow perspectives, making policy implementation stand still.

IV) Policy content

Policy agenda is a list of subjects or problems which policy makers are paying serious attention to, at any given time (Kingdom 1984:3). It is synonymous with policy content. Buse, Mays and Walt (2005:21) argued that power, vested in some groups of people, controls what goes or does not go into the policy content 'agenda' or during policy formulation or policy change. Power is defined as the ability by individuals or organisations to influence and control others or resources.

It has been argued that the individuals' and organisations' power and legitimacy is reflected in their ability to participate in policy process. These are influenced by moral, technical or political factors (World Health Organisation 2007). An actor's power and legitimacy may vary according to whether or not an actor holds a level of authority within the organization (Buse, Mays and Walt 2005).

4.1.2 Policy Implementation theories

i) Bottom-up and top down approaches to service implementation

Bottom-up approach views policy implementers as active participants, who inform policy upwards. Unlike in top-down implementation, where implementers as seen as passive recipients, bottom up implementation allows implementers to interact with the policy processes and are at liberty to engage in policy bargains and conflict (Walt 1994). The major criticism of the top-down approach over the bottom-up approach is that it assumes that implementation will 'take place as planned by policy makers and disregards the roles of actors at the level of implementation, described as 'street level bureaucrats' (Parson 1995:467).

Walt (1994) argued that there is inconsistence between policy content and policy practice. She suggested that policy implementation should take into account behaviour, attitudes, interpretation and copying strategies of street level professionals. Conversely, the bottom-up approach gains credit by emphasising the relationship between policy makers and policy deliverers. Indeed, Parson (1995)

argued that street level implementers have a discretion on how to apply the policy. Hence, professionals, such as teachers, doctors, planners, social workers, ought to control service delivery.

ii) Policy-action theory

Barrett and Fudge as cited in Parson (1995) built upon the weaknesses of top-down and bottom-up approaches to policy implementation, on the ground of 'oversimplifying complexities of implementation'. They argued that policy implementation is better understood as a 'continuum of interaction and negotiation over time between those who put policy into effect and those whose action implementation depends upon' (Parson 1995:471-2). The model emphasises that the success of policy depends on the power dynamics of policy enactors and policy implementers, their interests, motivations and behaviour.

Thus policy should be seen as an evolutionary process which produces potentialities and principles which change and adapt practice (Parson 1995). Arguably, implementation should not be seen as a 'chain of command' but as how organisations face 'realities' on the ground, and how organisations 'interact with less powerful or more powerful organisations to reach their goals (Parson 1995:173).

iii) Policy coordination

Horwath and Morrison (2007) described coordination as a formalised working relationship, where organisations do not apply sanctions for non-compliance. Easton's theory of 1972, cited in Barker (1996:24), described policy as a system whose function hinges on coordination of its components. Central to the systems approach is the analysis of policy organisational relationships and influences that take place within policy interaction processes. Organisations involved in policy processes operate within the organisation's structures to make decisions about the policies.

Parson (1995) argued that systems thinking theory explains the coordination and controlling mechanism of implementation processes. Systems analysis in policy implementation suggests that the sequence of activities, which include inputs, outputs

and information flow determine the success of a project or service delivery. Environmental influences such as social, political, economic and historic factors interact with the policy system. Systems thinking help to identify necessary interactions and actions that occur.

iv) Decentralisation

Once policy planners transfer policy to district implementers, its success depends on the capacity for the decentralised system to mobilise, control or retain resources, competent personnel, rules and effective regulations (Walt 1994). Decentralisation has comparative advantage over central level managers, because of the proximity to the local needs and challenges. However, decentralisation is not immune to implementation bottlenecks that drag policy implementation. Often, there is a narrow participation of local government in policy making and central planners fail to plan for decentralised activities within decentralised values, technology and geography (Grindle and Thomas 1991).

Conflicting interest and competition for access to scarce resources between central policy planners and the district implementers exist. As a result, district implementers fail to adjust policy programs, when they are faced with daily challenges and realities (Walt 1994; Grindle and Thomas 1991). For instance, central level may retain control over resources. This may set tight control over budget expenditure which may compromise the quality of service delivery (Grindle and Thomas 1991).

4.2 Service provision Framework: Quality of Care Frameworks

4.2.1 Quality of Care Framework Concepts

The framework of quality of care was used to assess quality of policies and services to orphans. There are many definitions of quality of care with no consensus, because different cultures and institutions have different perceptions of what is considered good (Shaw and Kalo 2002). The definition of quality “depends on who is assessing, the values used, by what standards it is evaluated” (Ovretveit 1998:229). Several quality of care definitions have been advanced as follows:

- *Quality of care is the 'degree to which health services are likely to meet the desired outcome of individuals and populations and are consistent with current professional knowledge'* (Institute of Medicine 1990:1).
- *"Quality health services has been defined as organising resources in the most effective way to meet the health needs of those most in need to ensure safety, prevention and care, with minimum waste and high level requirements" (WHO 2008a:4).*
- *"Health service quality has been defined as meeting the health needs of those most in need at the lowest cost and within regulations'' (Ovretveit 1998:231).*
- *The quality of a health system was defined as the level of attainment of health system's goal for health improvement and responsiveness to legitimate expectations of population (Evans et al. 2001).*

The definition by the Institute of Medicine was appreciated for its focus on meeting the needs or the outcome perspective. The service providers' point of view appeared to be narrow, in the sense that quality seemed to depend mainly on professional knowledge of the service provider. It left out experience of health providers and other elements, which were crucial for orphans' service delivery. The definition of care by Ovretveit (1992) appeared to be narrow, as they are mainly interested in maintaining efficiency in the utilisation of resources during service delivery. It focuses on the most vulnerable clients, leaving other people who are also in need.

This thesis adopts the definition of health care by (Evans et al. 2001; WHO 2008a). This was because Evans et al. (2001) looks at health as a system. This definition suggests a broader scope that goes beyond health and may include other determinants of health, where other needs of orphans can fit in. By including service responsiveness, the authors took into account the interaction between service provider and service user.

This was very relevant for this thesis, which sought to explore the responsiveness of orphan care services to the needs of service users. Apart from efficiency of services, the definition by WHO included 'high level quality requirements' which may embrace the other elements of quality of care, such as effectiveness, equity and others. Looking

at health care as a system also provided room for integration of health with other sectors. This related well with Malawi's multi-sector orphan care service delivery system and its coordination challenges. Therefore, the key feature of the definition of quality of services to orphans is the ability of the complex multi-sector orphan care system to provide services that are responsive to the needs of orphans.

4.2.2 Frameworks for assessing Quality of care

Various theories and frameworks for measuring quality in health care exist. Four frameworks were considered, namely Donabedian (1988), Maxwell (1992), the Health Services Research Group (1992) and a WHO multi-dimensional consisting of different scholars and organisations WHO (2008b).

a) Donabedian (1988) argued that care can be accessed from three categories, namely structures, processes and outcomes. The author described *structure* as the institution or setting in which care is provided as well as management of the institution. *Process* is seen as a two-way transaction, whereby practitioners on the one hand diagnose and provide treatment, while a patient seeks and receives care. *Outcome* refers to the effect of care on the patient, such as health status and perception of the care provided.

b) Maxwell (1992) provides six multi-dimension framework for assessing quality of care. Maxwell used the following elements to assess quality of care: effectiveness, efficiency, acceptability, accessibility, equity and relevance.

c) The Health Services Research Group (1992), as shown in Table 4.1, is another multi-dimensional framework similar to Maxwell with the two additional elements of coordination and comprehensiveness.

Another set of multi-dimensional frameworks of quality of care was compiled by WHO (2008b). This included other elements of quality of care which were considered relevant for this thesis. It incorporated frameworks from the Council of Europe developed in 1999, NHS in 1997, Institute of Medicine in 2001, Donabedian in 1988 and World Health Organisation in (WHO 2008b).

This study adopted complementary evaluation elements from Maxwell (1992) and the Health Services Research Group (1992) frameworks. Therefore, this thesis applied eight elements of quality comprising six elements from Maxwell's framework (effectiveness, efficiency, acceptability, accessibility, equity and relevance), with two additional elements from Health Services Research framework (coordination and comprehensiveness). Table 4.1 shows the complementary framework of quality of care from Maxwell and Health Services Research Group.

Table 4.2: Elements of quality of care by Maxwell and Health Services Research Group

Elements of quality of care	Maxwell	Health Services Research Group
Effectiveness	√	√
Efficiency	√	√
Acceptability	√	√
Accessibility	√	√
Equity	√	
Relevance	√	
Coordination & continuity		√
Comprehensiveness		√

The justification for the choice of the complementary elements is outlined as follows:

- The Donabedian framework was deemed inappropriate because the framework requires inclusion of all the three elements of quality that constitute the framework, namely structure, process and outcome, applied in a linear fashion (Donabedian 1988). While process and outcome were applicable to this study, quality assessment of structures though applicable, was deemed beyond the scope of the study.

- Maxwell's elements of quality were found to be very relevant for the study. They have been successfully used in evaluation studies (Ovretveit 1998) and in assessment studies of users' perceptions of quality of maternity care (Hirst 1999). Maxwell's framework of quality of care alone was deemed insufficient for this thesis, because it did not include coordination and comprehensiveness. These seemed to be important factors identified from the orphan care programme and from the literature review. Hence, the Health Service Research Group framework was relevant, because of the coordination and comprehensiveness elements. There are many orphan care service providers in Malawi, who offer a wide range of social services, using different delivery approaches (Malawi Government 2004b). Coordination and comprehensive elements of Health Service Research Group framework complemented Maxwell's framework.
- The multi-dimensional framework by WHO, which contains several frameworks, was dropped, because it was found to be too overly complex for the study. It also contains some elements which were already included from Maxwell's framework. Other elements in the framework were not applicable to the study.

Definitions of eight elements of quality of care that were used in the thesis are presented in Box 4.1.

Box 4.1: Definitions of elements of care used in this thesis

Coordination is a process where different elements of complex activities and organisations are brought into efficient relationships, where they can work together effectively to deliver services to users (King and Meyer 2005).

Comprehensive care is the extent to which there is a range of services provided that is broad enough in scope and depth to meet the users' multiple needs (Klassen et al. 2010a).

Efficiency is measuring of what resources are used in providing services, and what services produce (Phillips, Palfrey and Thomas 1994).

Effectiveness is the capacity of the delivered service to produce the desired outcome on the service user, as well as serving the needs with appropriate services (Phillips, Palfrey and Thomas 1994; Aday et al. 1933).

Accessibility is the ability by people to access goods and services provided by the organisations in respect to challenges of distance, timeliness, transport, social and finances (Phillips, Palfrey and Thomas 1994).

Equity is the extent to which equal needs are served with equal services or unequal needs are served with unequal services, taking into account gender, geographical, socioeconomic and age differences (Maxwell 1992; Phillips, Palfrey and Thomas 1994)

Acceptability/client centred is when a service is provided in a socially acceptable manner according to users' values, preferences and culture. It is client driven (WHO 2008b).

Continuity is when a service continues to be provided whenever it is needed, without major disruptions (Health Services Research Group 1992).

4.2.3 Proposed Framework for Evaluating Policies and Quality of Service for Orphans

This research has adopted a quality of health care framework and has applied it to the orphan care services delivery, because health care and orphan care services both seek to address human needs. Klassen et al. (2010b) argued that quality frameworks, with several elements, were found to be useful and adaptable in different circumstances and settings of care.

Figure 4.1 portrays the conceptual framework, adapted from Maxwell and Health Research Services Group, used in this study. Four elements of quality, namely accessibility, equity, coordination and comprehensiveness were relevant and applicable for assessing the child-related policies. All eight elements of quality of care were deemed relevant and applicable for assessing the responsiveness of services to orphans' needs.

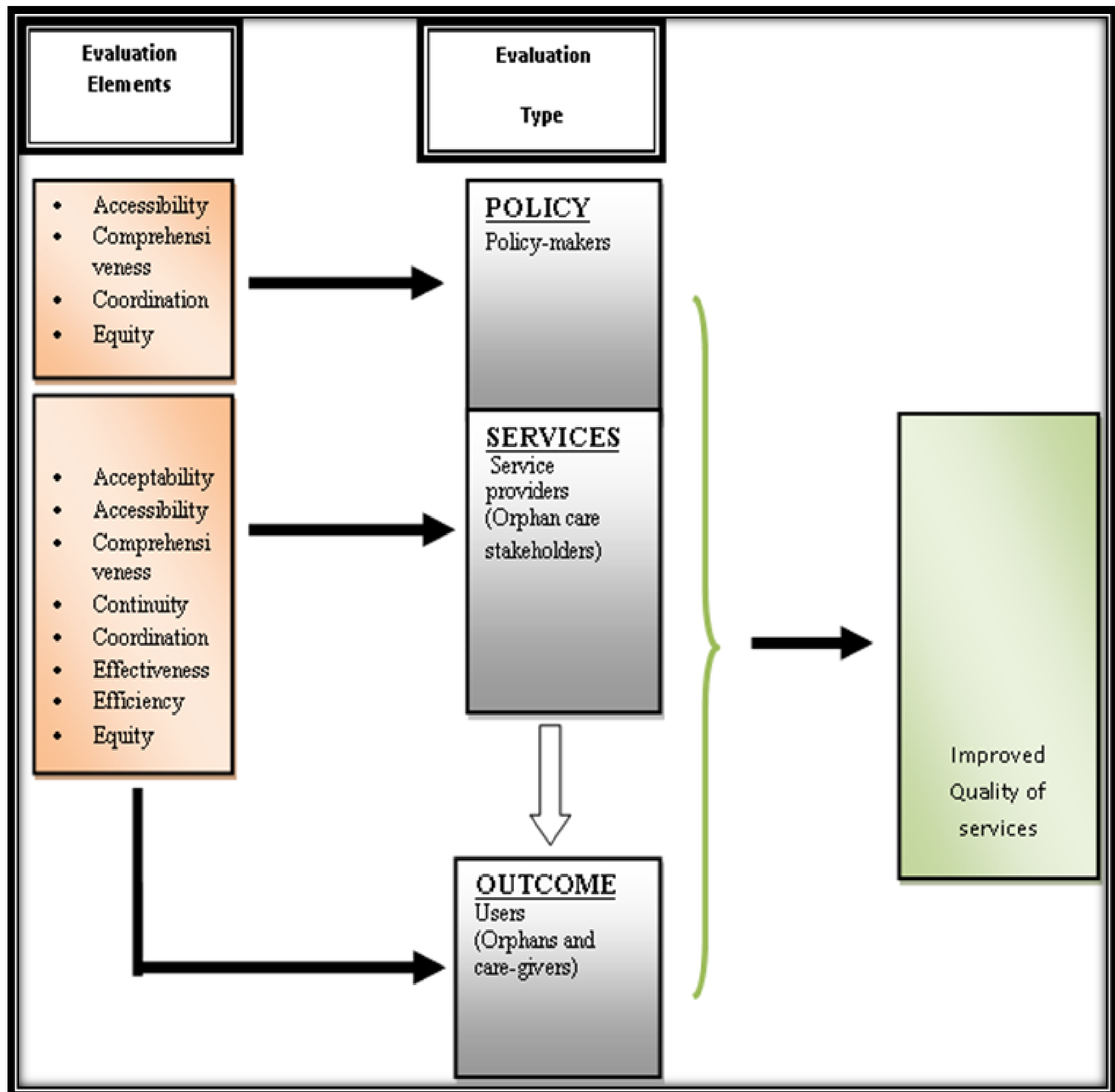


Figure 4.1: Proposed Conceptual Framework for Evaluating Quality of Orphan Care.

Source: Author

Quality of care was used to assess services' delivery process. On a smaller scale, it included assessment of outcome measures through service users' perception of quality. Process evaluation was deemed important, because it provides a feedback to planners and managers who seek to improve service quality (Ovretveit 1998). Evaluation of outcome assessed perception of users on the service (Ovretveit 1992b). Process evaluation explored what led to the outcome. Therefore it provided feedback for the service providers on how to improve the quality of service.

The application of the elements of quality of care in orphan care service delivery assessment is presented in chapter 5, table 5.10.

4.3 Justification for excluding policy analysis framework

This thesis did not use policy analysis frameworks because, to a large extent, policy analysis frameworks highlight policy formulation processes (Walt and Gilson, 1994). This was not considered a priority for this thesis. It would have diverted the direction of the thesis. Since this thesis was evaluation research, the elements of care were considered appropriate for identification of strengths and weaknesses of policies; with the aim of eliciting outcomes for improving policies and services.

This thesis was evaluating the policies that were already developed. The contents of the policy triangle framework (actors, context and content) were the subject or components of policy that were being evaluated. Since this research was evaluating the policy implementation process through service delivery, theories of policy implementation were used in the discussion of this thesis in chapter 9, section 9.1.4, 9.1.5, 9.1.6 and 9.1.7.

4.4 Service provision to orphans in Sub-Saharan Africa

Literature on orphan care services available in Sub-Saharan Africa did not cover all the eight elements of quality of care used in this thesis. The following six elements of quality of service provision were found: comprehensiveness, coordination, continuity, accessibility, equity, and efficiency. The orphan care literature indicates an interaction between the elements of quality of care.

4.4.1 Comprehensive services

The literature in Sub-Saharan Africa provided evidence of both provision of comprehensive services and lack of comprehensive services to orphans. Scholars provide evidence that comprehensive services worked when they used the following strategies in service implementation to orphans: community-based services, family focused services and provision of cash transfers, as discussed below. Comprehensiveness was related to coordination of services.

4.4.1.1 Community based services

Community-based organisations/service providers were described as grassroots organisations, managed by members on behalf of the community (Hulme and Edwards 1997). There is sufficient evidence that community-based interventions have great capacity to provide comprehensive services (National Statistics Office 2005; Foster 2004a; Foster 2002b; Brook and Clearly 1996; Narayan et al. 2000). Community members and faith-based organisations provided orphan care services in communities. Orphans access services from the community-based initiatives through community-based organisations, schools, faith-based organisations and home/family based interventions (Foster, Deshmukh and Adams 2008).

A number of studies have shown that community-based services appear to possess certain attributes that promote a culture of helping vulnerable households, including orphans, with comprehensive services (Foster 2002b; Foster 2006b; Brook and Clearly 1996; Narayan et al. 2000). Communities appear to bind people together because they hold similar cultural traditions and values, and are responsive to people's priorities (Attawell, Chitty and Purvis 2005; Narayan *et al*. 2000).

Narayan et al. (2000:143) described community-based organisations as being 'Deeply rooted in local culture, indigenous organisations may sponsor celebrations, rituals, and festivals that bring joy and give meaning to people's lives. Culturally, community members hold a reciprocity principle that perceived helping another person as a safety net and insurance policy against future need' (Foster 2002b). As a result, community members feel that, 'What has befallen me today will befall you tomorrow' (Foster 2002b:11). Therefore, members of the community feel obliged to assist households in need.

In addition communities appear to have a self-reliant characteristic, which helps to mobilise local communities to assist households with difficulties (Foster 2006a). Community-led initiatives serve better the needs of orphans because they adapt, and respond to the changing needs of children (Foster, Deshmukh and Adams 2008). These characteristics make communities willing to mobilise different forms of help for

orphans, in forms of labour, help the sick, and donate food, clothing and cash from community income generating activities.

The World Bank conducted research in 23 countries to explore the dimensions of need in poor households. The findings from this research described and recognised community care support as informal family support systems (Brook and Clearly 1996). From the World Bank perspective, community care was described as an immediate social and institutional context for household relationships, that includes neighbourhood, village or wider geographical network of kin or family that provide a wide range of material and non-material support to households in need (Brook and Clearly 1996).

In addition, it has been argued that communities responded promptly to the diverse demands of orphans affected by HIV/AIDS than formal organisation (Foster 2006b). The World Bank and University of Dar-es-Salaam (1993) found that communities supported seven groups of orphans in Kagera, Tanzania, with education assistance, food and clothing, prior to formal service providers' response.

Skovdal et al. (2010) suggest that community mobilisation could raise funds for supporting orphaned households locally to meet their different needs. Skovdal et al. (2010) interviewed 300 orphaned children and 110 adults who participated in a community-based capital cash transfer initiative in Kenya. The findings suggested that communities gave orphans economic, political and social support. Its success was attributed to availability of community resources from extended family, friends, neighbours, schools and community groups.

Further, the community capacity-building programme helped to build community competency for mobilising local cash transfer. The capacity-building programme included raising awareness of orphans' care needs awareness, skills development, assets building and building partnerships.

Furthermore, Lee et al. (2002) provide evidence that in Zimbabwe, a faith-based community service provider, locally known as FOCU, provided comprehensive services to families hosting orphans and children under stress. The evaluation was carried out

by in-house staff, FOCU coordinators, through meetings and workshops, interviews with donors, Government departments closely linked with the programme and participatory workshops with field staff and beneficiaries. FOCU maintained good ethics in handling HIV patients and promoted use of local resources.

The findings suggested that a broad spectrum of services was delivered to 6500 orphaned children in 2000 households. The services included psychosocial, food, beddings, home- based treatment and sex-education services. FOCU promoted low-cost investments, transparency and accountability. Community mobilisation involved participation of leaders who supervised the volunteers frequently. Sustainability of donor-driven activities was promoted by engaging in self-help fund raising activities. Volunteers visited the households regularly. They provided a wide range of service to the families.

After each visit, volunteers submitted reports to their supervisors. The volunteers were committed to their work because they were given small incentives in the forms of clothing, maize seed at planting time and a small cash gifts equivalent of £3 during Christmas season. Further, FOCU was managed by Family AIDS Caring Trust that employed a wide range of well coordinated stakeholders from Government departments, International and local NGOs (Lee et al. 2002).

However, the programs failed to adopt a child-centred approach. This was because volunteers worked directly with the caregiver. They did not consult the orphans, so that the orphans did not share their emotional needs of stress. In addition, the volunteer participation reflected gender imbalance (Lee et al. 2002). In providing care and support to orphans, FOCU utilised more widows and women (94 percent) than men (6 percent), because men considered cooking, childcare and care for the sick as feminine roles. As a result, the few males who participated in the programmes played supervisory roles.

Furthermore, while acknowledging the achievements of FOCU, the report seemed to fall short of quality and rigour. The objectivity of the project evaluation may be questioned because self-evaluation by project staff could tempt them to overlook

shortcomings of the project or exaggerate their achievements to give a good impression to the donors. The study did not assess the long-term benefits of the programme, due to limited time. The sample size for participants in the study was not included in the report.

Notwithstanding the above, Fischer (2005) argued that faith-based organisations seem to provide services that produce better outcomes than secular services, because they are motivated by their faith. Overall, there is need to assess the effectiveness of their services and their capacity to conduct research to evaluate effectively the impact of their services, since most of their documentation appears to be descriptive.

Community-based service provision appears to have some weaknesses and limitations, which compromised service effectiveness, comprehensiveness and service standards. These are presented later in this chapter under service efficiency in section 4.2.4.

4.4.1.2 Providing holistic family centred services

Literature evidence suggests that service providers that adopt family centred services have great potential to address the wider needs of the family, beyond the client's (orphan) needs (Wakhweya 2008; Loewenson et al. 2008; International 2006). Wakhweya (2008) conducted a literature-based study to assess existing formal and informal approaches to a family support model for orphans and families affected by AIDS. A three-pronged methodology was used in the study: systematic review of peer reviewed studies, web-based literature search and interviews with program officers and specialists from local and international organisations.

Wakhweya (2008:25) reported that family centred interventions provided a

> "Continuum of care that include the following for adults and children: primary health care including HIV/AIDS prevention; educational support; food security and nutrition; shelter support; psychosocial counselling and support; spiritual support; child protection…to abuse and neglected orphans…household economic strengthening and legal support."

In addition, Help Age International (2006) suggested that in resource-poor countries, it is a morally imperative responsibility of service providers to care for all who are devastated by HIV /AIDS, to ensure that orphans and their carers are not forgotten. The author contends against service providers who do not serve the needs beyond the orphans. In addition, Help Age International (2006) suggested that Government should address diverse needs of family members including psychosocial needs, protect the rights of old caregivers and involve service users.

Further, Loewenson et al. (2008) suggested that in Zimbabwe, comprehensive services were feasible when service users were involved in service delivery. The aim of the study was to identify the needs of orphans, available services and to assess adequacy of the services. The study used a three-staged research methodology using literature review, participatory action research with district implementers and interviews with district and national key informants. They found that participation of service users helped to address psychosocial problems of caregivers and different needs of orphans and other children in the household.

4.4.1.3 Provision of cash transfer

Assessments that were made in different parts of the world consistently provided evidence that cash transfers provided comprehensive services to families with orphans, and vulnerable households affected by AIDS, by providing means (cash) of addressing wide coverage of needs (Desmond 2007; Adato and Bassett 2007; Namibia NGO Forum 2009; Cecchini and Madariaga 2011; World Bank 2009).

Adato and Bassett (2007) argued that principally, cash transfer offers multiple benefits. It serves preventive, protective, promotional and transformational functions to orphans and other vulnerable children. Based on a literature review that was conducted in developing countries, including Sub-Saharan Africa, Adato (2008) found that unconditional transfers provided for basic needs of adults and children such as for food, clothing and school expenses. Apart from addressing basic needs, cash transfer simultaneously promoted investment in human capital and increased women's autonomy.

A mixed method study was used to assess the impact of cash transfer in Namibia, locally known as Basic Income Grant project (BIG), among vulnerable households with orphans and other children(Namibia NGO Forum 2009). The study used base-line and follow-up evaluation surveys, as well as interviews with key informants, and case studies. The findings suggested that cash transfer helped families with orphans to address multiple needs. Cash transfer helped families to pay for school fees, buy nutritious food, and provided households with capital to engage in income-generating activities, such as brick making, baking and dressmaking. Further, the assessment showed that about 90 percent of households paid school fees. As a result, school dropout fell by 40 percent. Child malnutrition was reduced by 42 percent. The police reported that the crime rate reduced by 42 percent in the community. Similar findings were also reported by (World Bank 2009; Miller 2007).

It has been noted that cash transfer, while improving the demand side of service, does not improve the supply-side of service, in terms of improving service quality (Cecchini and Madariaga 2011). This suggests that other strategies are required to address the service supply side of service (World Bank 2009; DFID 2011). Further, cash transfer has been reported to depend heavily on donor resources; hence, its sustainability in low-income countries is yet to be explored.

4.4.1.4 Lack of comprehensive services

It appeared that sometimes service providers failed to provide comprehensive services to orphans. Heymann and Kidmann (2008) used mixed methods to explore availability of services from Government and communities for orphans in Malawi and Botswana. Interviews were held with HIV/AIDS related staff, volunteers, caregivers and community leaders in the countries. The findings suggested that the services from Government were insufficient, therefore did not address all the needs of orphans and their households.

In Malawi, the orphans received food but they also needed food production inputs. Primary school- going children did not access adequate education nor emotional support, compared to preschool children (Heymann and Kidmann 2008). In the

absence of support from the Government, the communities provided some assistance, but the assistance was very small compared to the magnitude of needs (Heymann and Kidmann 2008). In Botswana, the Government reached only a third of the households who fostered orphans; community members provided very little support.

Furthermore, UNICEF and the World Food Programme conducted assessments to establish the significance of integrating food-related projects (Greenbelt and Greenway 2007). The findings indicated that the project failed to improve food security because it did not provide comprehensive services and only provided a single dose of food. The authors suggested that comprehensive food services should mean moving beyond food access and should include agricultural farm inputs, food utilisation, mainstreaming food services, with livelihood support, skills training and safety-net programming to ensure continuum of care.

The provision of comprehensive services failed because of poor coordination to provide integrated services by the multi-sector service providers, and lack of mechanisms for sustaining benefits of the project. The authors further argue that comprehensive services cannot survive without effective coordination and sustained partnerships. 'We all need to build programming that is long-range, multi-sectoral and seamlessly integrated. But we are still trapped by funding silos, sectoral boundaries and bureaucracy' (Greenbelt and Greenway 2007:20).

Nyambedha, Simiyu and Aagaard-Hansen (2001) reported that, lack of Government support towards community-based initiatives, contributed towards failure to address comprehensive needs of orphans among the Ruo people living in the Bondo district in Kenya. The aim of the study was to assess the existing support systems for orphans, and inform policy and health planning on the needs of orphans. The assessment used mixed methods to collect data from 100 caregivers and 5 orphans, who were followed up for 6 months. The study population had high HIV prevalence of between 30-39 percent among adults, resulting in an increased number of orphans.

The findings indicated that there was no formal Government service delivery system for supporting orphans in the area. The community-based organisations found in the

area were organised by women who were economically handicapped. As a result, they were able to support only the bereaved family and the orphans during the time of funeral, with mostly food. The community-based organisations were overwhelmed with the increased responsibilities for orphans. About 20 percent of the households could not access adequate health services. The people had to negotiate for credit health services from mission hospitals.

This study is commended for employing a variety of data-collection techniques to capture rich data. The methods consisted of data collection, including narratives, focus group discussions, participant observation, in-depth interviews, longitudinal household monitoring, survey and analysis of secondary data. The study participants were very inclusive, involving orphans, caregivers, community key-informants such as teachers, local leaders and volunteers. However, the number of orphans was small and information regarding the type of orphans was missing.

4.4.2 Service Accessibility and Equity

The evidence from literature in this section indicates a close interaction between access and equitable services. In addition, the two elements interacted with the coordination element. The studies in this section provided evidence that service access and equity sometimes worked, but in other situations they did not.

A study that was conducted in Malawi, Zimbabwe and Kenya, provided both positive and negative evidence of orphans' access to education services (Kendall and O'Gara (2007). On one side, Kendall and O'Gara (2007) suggested that access to education service was negatively affected by poor coordination, cost of services, distances and lack of preparedness by service providers to provide necessary services.

Kendall and O'Gara (2007) conducted a comparative study to assess the strategies adopted to increase service access between schools and communities, to children in high AIDS-affected areas. Three case study approaches were used to collect data: In Malawi children were consulted from schools, through 80 interviews with teachers, parents, NGOs and district personnel. In Zimbabwe, interviews were conducted with out of schools youths from three rural CBOs, document review and observation. In

Kenya, FGD, community mapping and household surveys, involving 900 community members, were conducted.

The study found that school fees were one of the factors that hindered orphans from accessing education. In addition, with the introduction of free primary education, schools were poorly prepared to harness the increased capacity of learners. In Malawi and Zimbabwe, although the community responded positively by sending many children to schools, the schools were overwhelmed with large numbers of pupils, because the schools had inadequate classrooms, teachers and other support systems. Teachers perceived schools to be institutions not capable of providing support to meet the needs of vulnerable children. The teachers were not trained to handle HIV lessons. School curriculum did not cover psychosocial and sexual health issues. Some pupils could not attend regular classes because they had to attend to sick siblings, they could not afford uniform nor school supplies and the schools were too far away.

Conversely, in Kenya, good coordination of services between service providers contributed to making school accessible through collaborated service resources. Some services were offered by USAID through local NGOs. In the community, young children affected by AIDS accessed early learning and stimulation through preschools, churches, homes and private schools. With the free primary education, many children accessed school, while the community mobilised resources and bought books and school materials.

The programme provided transport for children to access a health facility when they fell ill. Kendall and O'Gara (2007) highlighted two elements that contributed to the success of the programme in Kenya. First, the cooperation of NGO, in schools, health facilities and the community. Second, the financial support from International NGO to the local NGO. Financial support was used to pay school fees for orphans, stipends for volunteers and primary health care user fees. However, such heavy reliance on donor funding does not promote sustainability of community initiatives (Foster, Deshmukh and Adams 2008). The service provider could have initiated or promoted service users to use local long-term strategies, alongside donor support.

This study may be criticised for failing to use standardised methods in data collection. This is because various methods adopted could have limitations that may not complement well with a study of different settings. Probably qualitative methods would have been ideal because of their flexibility, considering the nature of study, which involved service users and service providers from different organisations.

Additionally, Nyabanyaba (2009) provided evidence of lack of access and lack of equitable services. The study was conducted in Lesotho, to explore the extent to which schools helped orphans to access learning and to promote school retention. The findings suggested that long distances to school and contributory costs, prevented orphaned children from accessing schools. Schools were found to be inequitably accessed because more schools were situated in urban than rural areas.

As a result, access rate was 68 percent in urban and 7 percent in rural areas. The schools in mountainous areas were poorly resourced and charging higher school fees than those with in non-mountain areas. Education scholarship was offered to double orphans only, ignoring other orphans who were equally in need of school support.

It has been suggested that user fees in health service delivery diminish service accessibility as well as equity. This was because the poor cannot afford to pay for services (Amone et al. 2005; Gilson and Mills 1995). Therefore, many African countries have abandoned or reduced user fees in the health sector (Ridde and Morestin 2010; Lagarde and Palmer 2011; Gilson and Mills 1995).

Ridde and Morestin (2010) used a systematic literature search in selected African countries of Ghana, Uganda, Kenya, South Africa and Madagascar. They found that abolition of user fees increased the utilisation of services and health service user satisfaction. Furthermore, the findings showed that user fees did not necessarily improve the quality of services, because of poor planning and corruption. Lagarde and Palmer (2011) suggested that when user fees were complemented with quality improvement strategies, use of health services improved.

Further, it has been suggested that efforts made to improve service access and reach more orphans and other children with school health services, resulted in the provision

of inequitable services. Guyatt (2003) compared the cost of providing de-worming treatment to school pupils, including orphans between community/household-based and school-based initiatives. Findings indicated that while providing services through schools made the services accessible and cost effective, it undermined equitable distribution of de-worming treatment to pupils, compared to the village approach in Ghana and Tanzania.

The report suggested that school-based service delivery had two comparative advantages over community-based service delivery. The cost was reduced, by using the existing school system to distribute de-worming treatment, and the training of teachers using their own channels of communication, compared to organising a few available health personnel to go round the community. Guyatt (2003) suggests that offering school-based de-worming treatment was a 10-fold more cost effective than using mobile teams in the community.

The limitation of a school-based service delivery system was that it left out orphans who were out of school. Unfortunately, out of school children were reported to be more susceptible to infections than those in school (Hussein et al. 1966). It may further be argued that the cost effectiveness of school- based service delivery was amplified, because it did not factor in the contribution of the external coordinating committee, who supported the implementation processes from the United Kingdom. Apparently school health programmes have been supported by UNICEF and other donors (Guyatt 2003). Hence, the sustainability of implementing the programme, without donor support, was indeed very questionable.

There was evidence for provision of equitable services, where those with more needs were provided with more services. Gelli, Meir and Espejo (2007) suggested that girls may require different, and more strategies in schools, to close gender education enrolment disparities. This was because more girls than boys drop out of school in higher grades. The aim of the study was to find out if school feeding increased girls' school enrolment.

Using a data sample of 4175 children from 32 countries, the study found that provision of schools meals increased enrolment by 28 percent for girls and 22 percent for boys in the first year of the programme among standard 1-5 pupils. With additional take-home rations for girls, apart from on-site school feeding, girls' dropout rate in higher grade reduced by additional 30 percent. The findings further suggest that equitable access to education to both genders could be improved by appropriate interventions targeting girls.

There are a number of issues that may risk the rigour of the study. The information was collected retrospectively. Reliability of information or data collected retrospectively may result in either under-reporting or over-reporting, due to recall bias, considering that the data was collected over a long period of time (Hessey and Hussey 1997). The author did not report why older primary school pupils were not included in the study, realising that the dropout rate increases with age.

Furthermore, Ntata (2007) suggested that there was inequity in the distribution of ARV by health service providers, on the basis of age, gender and geographical location in Malawi. HIV policy advocates universal access to HIV services in Malawi (Malawi Government 2002b). In 2004, with assistance from the Global Fund on Tuberculosis, malaria and HIV and AIDs, the Malawi Government launched a programme of providing free ARV. Out of one million people who were infected with HIV virus, only 34 percent of the 170,000 eligible people accessed ARV treatment.

Ntata (2007) conducted research in Malawi to assess equity factors in the distribution of ARV drugs. Equity was defined as equal opportunity of access to ARV, based on the assessment of vulnerability to illness and infection. Hence, equitable access to ARV meant no discrimination to access, based on sex, age, residence or social economic status. Qualitative data collection methods used included consultation meetings with key stakeholders, document review, key informants' interviews and community led FGDs.

The findings indicated that more women than men accessed ARV, because more men than women were reluctant to go for prerequisite voluntary HIV testing. Older and

married women were more willing to be tested for HIV than younger girls were. About 90 percent adults above 15 years accessed ARV; only 7 percent were children (Ntata 2007). Children's access was constrained by ethical, practical considerations and absence of provision by the Global Fund program. More people in urban areas accessed ARV than those in rural areas.

The factors that influenced equity in distribution of ARV included policy limitations, operational management and socio-economic factors. Specifically, lack of medical personnel, lack of access to information in rural areas, where 85 percent of the population lives, distance challenges to access health facilities and inadequate community support groups influenced equitable access to services.

The study indicated some limitations on rigour. The policy factors were not elaborated. The assessment did not review the actual policy documents on equity. The author acknowledged that, due to unavailability of documents, it was not possible to review some documents. Overall, considering that only qualitative data collection methods were used, the basis for calculating percentages of coverage in the results may be questioned. It can be speculated that the author might have supplemented the results with some quantitative data sources, but this was not acknowledged in the study.

Overall, there appears to be a lack of consensus in the literature on whether services should target orphans and other vulnerable children and their households, or whether services should be given to children universally. Some authors suggest that service response that is based on orphan status should be discouraged. This is because the approach promotes discrimination and inequitable distribution of resources among children (Ainsworth and Filmer 2002).

This was established in research conducted in 28 countries in Africa and Latin America that suggested that sub-Saharan Africa had the lowest school enrolment rates compared to Latin America. The author cited interventions, such as provision of textbooks, uniform, school fees, medical care or supplementary feeding as universal needs that non-orphans need as much as orphans do. In addition, some authors, who implemented conditional cash transfer, suggested that targeting should be avoided

because service providers incurred high administrative costs for managing and monitoring the service delivery (Cecchini and Madariaga 2011).

On the other hand, Miller (2007) suggested that there may be a need to target households with orphans, because often Government and other stakeholders may not usually have sufficient resources to cover everyone who needs the services. Indeed, there appears to be a tension between the need to provide equitable services and the reality of resource limitation to provide universal services. From these studies, it may be speculated that, whether services should be target orphans or not may depend on several factors including thorough needs assessment and availability of resources.

4.4.3 Coordination and Continuity of Service Delivery

Sikosana and Dlamini (1995:53) described integrated health services as a process of 'bringing together common functions within and between organisations to solve common problems, develop commitment to shared vision and goals, as well as using common technologies and resources to achieve common goals.' Integrated service delivery was described as important for ensuring continuity of services to orphans. Hometruth (2009) said that provision of integrated services through schools and communities, may serve as an effective avenue for reaching orphans with comprehensive services. This corresponds with the discussion in section 4.2.1.

In Sub-Saharan Africa, 13 Eastern and Southern countries adopted schools as a 'platform for delivering integrated services' through a UNICEF supported 'Learning Plus' initiative (Hometruth 2009). The integrated health and school support package included a feeding programme and health interventions, such as vaccination, micronutrient supplementations, de-worming treatment and HIV prevention.

Furthermore, UNICEF (2008) provided evidence of a successful integrated school and health programme, that adopted schools as centres of child care and support for almost all schools in Swaziland. The study showed that collaboration roles between Government and donors, and the involvement of community members, contributed towards the success of the programme. Donors funded the construction of more schools to reduce classroom congestion, the schools mobilised the communities,

parents helped in the construction of school kitchens and transporting clean water to schools.

On the contrary, Attawell, Chitty and Purvis (2005) suggested that sometimes coordination did not work in service delivery, because of various factors. They included leadership, communication and structural factors that undermined inter-organisation coordination and hampered implementation of integrated service delivery in Tanzania. This was established in an assessment of six regional USAID- led Tumaini NGO Alliance projects that managed 23 grants in five regions of Tanzania, to provide integrated home-based health care to people living with AIDS, and to orphans and vulnerable children.

Myriad factors contributed to the coordination failure between service providers. Much as the Tumaini Alliance had established good working relationships and networks between the partners, it did not agree on administrative and technical roles and responsibilities. It had poor organisational structure, poor communication and lack of consultative leadership. The donor was in a hurry to start implementing services early, prior to setting up effective leadership structure. It had a weak district decentralisation capacity to coordinate the multi-sector HIV/AIDS committee, to monitor and supervise program activities, because the link between national organisations and district programs was weak.

Lack of integrated home-based care resulted in lack of comprehensive services therefore, did not improve the quality of life of children infected and affected by AIDS. The services did not address OVC needs for psychosocial support, bereavement counselling, legal advice, vocation training, economic strengthening, HIV/AIDS prevention nor treatment and child protection' (Attawell, Chitty and Purvis 2005).

In addition, Rosenberg, Hartwig and Merson (2008) provided evidence of coordination of service delivery systems that worked well or that did not work well. An evaluation study was conducted to explore the role of collaboration between Government and NGOs and its contribution to the continuity/sustainability of community-based organisations. The study was done in five countries of Southern Africa which included

Botswana, Lesotho, Namibia, South Africa and Swaziland (Rosenberg, Hartwig and Merson 2008). Nine projects funded by a United Kingdom based NGO, implemented different projects in the community, local NGOs, and research institutions and Governments.

The research focussed on the collaboration and government roles regarding the sustainability of the projects. Sustainability was described as 'the continuation of activities and benefits achieved during the project after the donor funding has ceased' (Rosenberg, Hartwig and Merson 2008:52). Rosenberg, Hartwig and Merson (2008) found mixed outcomes in the assessment of coordination between Government and NGOs in service delivery to orphans.

The findings suggested that coordinated services resulted in complementary service provision, when NGOs administered grants and food rations, while the Government conducted the training on the utilisation of the services (Rosenberg, Hartwig and Merson 2008). On the contrary, the findings indicated that there was conflict between Government and FBOs when an NGO decided to take over a Government fundamental role of fostering and adoption of children. Faith-based organisations shunned Government funds to guard against compromising their faith values. Duplication of roles existed in service delivery due to parallel implementation structures.

It was further noted that, while NGOs were good at advocating orphans' rights, Government played a crucial role providing policy direction, leadership, operating structures and mentoring (Rosenberg, Hartwig and Merson 2008). As a result, nine of the projects established sustainability strategies with government. The limitation in this research was lack of consensus on the parameters for defining sustainability during the evaluation. Lack of standardised definition might imply use of diverse indicators, which might affect the results.

Nshakira and Taylor (2008) suggested that poor coordination caused inefficiency in service delivery. Hence, it may not always be lack of resources that undermines service responsiveness, but poor coordination among service providers. This was because resources were sufficient for implementing services but because of poor coordination,

resources did not reach communities where orphans lived. The study was based on qualitative methods using interview and policy document reviews, to assess orphans' ability to access resources and support.

This study provided an illuminating experience that demonstrates the interplay of three levels of service providers who financed service delivery. These were donors, the national NGOs and Government. The project employed three sources for channelling funds to the community.

Firstly, small repeated grants from donors (described as 'pipelines') given to community groups from organisations and individuals. Secondly, NGOs established projects and directly implemented services (described as 'watering canes'). Thirdly, large amounts of resources were channelled through multiple channels to scale up services called 'rainstorm'.

The findings suggested that sufficiency of finances did not necessarily improve service responsiveness. Poor coordination and lack of monitoring of services resulted in overlap, duplication and failure to reach many orphans in the communities. As a result, the majority of vulnerable households, up to 75 percent, were not assisted. They had to depend on community and social networks for help.

4.4.4 Service Efficiency

First, service inefficiency was caused by service provider insufficient technical and management capacity by service providers (Narayan et al. 2000). The World Bank commissioned a study to assess the impact of formal and informal institutional services in improving well being of poor households, including households that hosted orphans in 58 countries in Sub-Saharan Africa (Narayan et al. 2000). The study used qualitative and rural participatory methods to collect data from NGO programme coordinators, as well as from poor men and women. Experienced researchers, from different academic and research institutions in different countries of study, carried out the research. Different themes were allocated to the World Bank regions.

The findings from the institution capacity thematic group suggested that, while the NGOs were delivering basic services to the poor and using a bottom-up approach, NGOs had myriad capacity limitations and had inefficient service delivery practices. The NGOs were weak in the areas of leadership, finance management, planning skills, monitoring and evaluation. They depended solely on donor aid, therefore worked as ‘contractors rather than community catalysts’ (Narayan et al. 2000:137). The NGO had corrupt practices and were not transparent with donor aid.

In addition, Edwards (1996) argued that NGOs’ work appeared to fall below donors' expectations in service delivery performance and accountability. Donors had anticipated that NGOs would perform much better than Government institutions (Edwards 1996). NGO services were less cost-effective than Government’s. As a result, the services were on a small scale, inequitable, less effective and less sustainable than Government services.

It was argued that NGOs often failed to account for their activities. They tended to have multiple accountability demands to donors, Government and the people they served. Accountability was defined as ‘the means by which individuals and organisations reported to a recognised authority and were held responsible for their actions’ (Hulme and Edwards 1997:8).

Further, lack of institutional capacity by CBS providers resulted in delivery of inefficient services to orphans. It has been argued that, despite willingness of CBOs to provide support and services to orphans, their efforts were hindered by lack of knowledge, skills and poor management of volunteers (Foster 2004b; Foster 2002a; Foster, Deshmukh and Adams 2008; Munthali 2002; Attawell, Chitty and Purvis 2005).

In addition, Miller, Maxton and Kathryn (2008) found that, due to lack of institutional capacity, there was health outcome disparity in orphan-based health service centres in Botswana. The study attributed the findings to insufficient human personnel and low allocation of funding towards children and orphans' activities by Government and donors. The health services system had insufficient ARV treatment. The social welfare system lacked capacity to implement policies.

Second, service efficiency was caused by poor financial management capacity by service providers. Studies that assessed performance and impact of increased funding on service provision to orphans, and other vulnerable children in Sub-Saharan Africa, suggest a diminished impact with increased funding from UNICEF and other International donors. This was due to increased capacity and coordination limitations (Foster 2005a; Foster, Deshmukh and Adams 2008; Edstorm and MacGregory 2011).

The authors noted a number of limitations that occur when donors bypass national structures and work with communities. For example, with increased donor funding, 'briefcase CBOs'[1] emerged, pretending to be legitimate community-led responses to orphan-care problems. As a result, bogus CBOs diverted resources away from orphan care.

Existence of bogus CBOs increases the risk of donor support withdrawal from communities. Services are at risk of being reduced, interrupted or discontinued (Edstorm and MacGregory 2011). There appears to be little documentation and lack of transparency by local NGOs on the proportion of aid that reaches the children affected by AIDS (Lee et al. 2002; Foster 2002a).

Foster, Deshmukh and Adams (2008) argued that effective management of community interventions was achievable, if the national Governments, responsible for welfare of orphans, developed an effective resource-tracking mechanism and a coordinated accountability framework for service providers. This should focus on policy guidelines, mapping of needs of orphans and their families and participatory monitoring of community interventions (Foster, Deshmukh and Adams 2008).

4.5 Chapter summary

Elements from the framework of quality of care helped to assess the quality of orphan care documented in through Sub-Saharan Africa literature. The Sub-Saharan literature on service provision to orphans, suggested the existence of both strengths and

---

[1] Briefcase CBOs or NGOs are those that have no operating office. They pretend to undertake projects to support vulnerable people, but their intention is to steal funds from donors. In other words, they are bogus.

weaknesses in the orphan care service delivery system. While the quality of care framework suggested that elements of quality of care were independent, the literature suggested that some inter-relatedness between the elements of quality of care existed.

Chapter 5 – Research Methodology

The chapters thus far, have provided thesis contextual and policy environment background information (chapter one and two) and the theoretical literature on both the needs of orphans and service delivery in Sub-Saharan Africa (Chapters three and four). Chapter five discusses the methodological approaches, procedures and consideration that were undertaken to address the objectives and research questions that were set in chapter one, section 1.2.8. The aim of the research is to assess how child-related policies and services respond to the needs of orphans in Malawi.

5.1 Study Approach

5.1.1 Qualitative Approach

In essence, this thesis assessed the quality of orphan care in Malawi. This thesis is therefore an evaluation qualitative research. This type of research is central to policy related investigations and seeks to identify factors for the success or failure of policy and service delivery and explore the roles of organisations in service delivery (Ritchie and Lewis 2003). The qualitative inquiry is consistent with the nature of research questions which this thesis sought to address namely 'what', 'how' and 'why' (Green and Thorogood 2009; Lacey and Puff 2007). Holstein and Gubrium (1995) suggested that a qualitative method is an active and reliable process because the interviewee and interviewer interact and collaboratively build up, receive and interpret information in a social context. Qualitative research was regarded as a tool for learning about people's feelings, thoughts and experiences (Rubin and Rubin 1995; Rubin and Rubin 2005). In this thesis, lived experiences of orphans were captured through direct interactions with orphans and those involved in their care.

Evaluative qualitative research have been successfully applied in process and outcome evaluation to assess the contribution/consequences of services and policies of a range of organisations in service provision (Ritchie and Lewis 2003; Patton 2002). Indeed, in

Malawi there is evidence of the application of qualitative methods in orphans related studies (Munthali 2002; Sibale and Nthambi 2008; Chirwa 2002). The difference, however, is that previous studies looked at one or few needs of orphans, which is different to the comprehensive approach to needs of orphans taken in this thesis. The pros and cons of applying this comprenhsive approach are discussed in the final chapter of the thesis.

A pluralistic inquiry approach which was adopted for this qualitative research, involved the use of multiple data collection methods and techniques (Chamberlain et al. 2011). It has been suggested that a pluralistic inquiry offers a number of benefits in qualitative research. Chamberlain et al. (2011) argued that combining methods helps to build creativity and innovation in research, widen the scope and depth of research, promotes reflexivity and intensifies the relationship between the researcher and the participant. In addition, Coyle (2010) suggests that diversity of methods maximise the interpretation of data. Pluralism allows triangulation of data which can enhance the validity of research findings (Frost and Nolas 2011). According Green and Thorogood (2009), multiple methods within a project appear to be a matter of common sense and good practice particularly when they address distinct research questions. Hence, the pluralistic research design lends to qualitative research robustness and comprehensiveness.

5.1.2 Evaluation Research

Evaluation is defined as making a 'comparative assessment of the value of what is being evaluated or interventions, using systematically collected and analysed data for purposes of making informed decisions or understanding causal mechanisms or generate principles or to take action (Ovretveit 1998). The need to evaluate policies ought to be considered as an imperative action and not a luxury (Hometruth 2009) because we live in a world of 'uncertainties and imperfect administration' (Hogwood and Gunn 1984 :219). There is a growing eagerness for evidence-based policy to spot 'what works' and to ascertain the value for the resources that were invested in service delivery (Foster, Deshmukh and Adams 2008). Policy goals need to be tracked to ensure that they respond to needs of stakeholders (Barker 1996). It has been

suggested that policy evaluation may sometimes be avoided as it seems to threaten 'people's stake'; policy implementation takes place in an 'action setting,' involving politicians who protect their reputation, public servants who might want to protect their careers and clients who receive benefits (Hogwood and Gunn 1984:227)**.** For some, evaluation is a costly business which many organisations would wish to do away with; it may bring about results that require change and that are in conflict with interest of policy initiators (Clarke and Rao 2004).

Nonetheless, there is a growing need to evaluate family support services. Family services are defined as any service which Government/local authorities have a duty to provide for the promotion of welfare of children in need (Statham 2000). Methodological challenges for evaluating family services have been reported (Statham 2000; Hometruth 2009; Cheetham et al. 1992). The quality of data may depend on accessing the right information and involving participants at local and central level, which could at times be difficult to achieve (Cheetham et al. 1992; Hogwood and Gunn 1984). Sometimes the interval between implementation of service and the assessment of outcome may be shortened due to donor demands and fail to measure realistic impact (Statham 2000). Realising that implementation of services has vested interests from various groups, including service users, policy makers, researchers and local government, conflicts may emerge regarding which outcome should be measured (Statham 2000). Cheetham et al. (1992) has argued that research that attempts to evaluate service effectiveness should include the context of implementation and employ a variety of methods because multi-agency implementers use different procedures and time scales.

Various types of service evaluations exist. This thesis takes cognisance of widely documented and fundamental formative and summative evaluations (Clarke 2005; Patton 1990; Cheetham et al. 1992; Ovretveit 1998). Formative evaluation is undertaken to provide information for programme or service improvement and tends to focus on perceptions of programme planners, practitioners and participants (Clarke 2005; Cheetham *et al*.1992; Patton 1986). Summative evaluation is undertaken to assess the overall effectiveness of a programme or services with the aim of deciding whether to continue or terminate the service (Clarke 2005).

Another way of defining evaluation is by focussing on the object being assessed and three types have been documented: process, outcome and output evaluations (Leger, Schnieden and Walsworth-Bell 1992; Statham 2000; Cheetham et al. 1992). Process evaluation measures the way services have been delivered, how they were set up, and how the principles are translated into action (Statham 2000). Output evaluation measures the products of service, such as the number of families being served and training conducted (Statham 2000). Outcome evaluation assesses the impact of the service on those who receive it; either short or long term effects (Statham 2000). Evaluation of outcome measures users' perception of the service (Ovretveit 1992a). In research, output and outcome measures appear to be closely linked. However Cheetham et al. (1992) makes a clear distinction between the two where output is connected to performance indicators or quality of what is provided and outcome measures effects of service provision or impact indicators.

This thesis is mainly concerned with formative evaluation because it explores how different organisations implemented services with the purpose of improving quality of service delivery and the lives of orphans. To a smaller extent, by asking the user's perceptions about services, the thesis is also assessing outcome. Process and outcome evaluations are important because they provide feedback to planners and managers who seek to improve service (Ovretveit 1998). Indeed, process evaluation of a service is deemed necessary and timely for Malawi because it is envisaged that the findings from this thesis will help to understand how service providers are implementing orphan care services.

5.1.3 Sensitive Research

Sensitivity of research relates to the topic having potential negative consequences or implications either directly or indirectly to the participants and also topics with some threatening elements (Renzetti and Lee 1993; Liamputong 2007). There are many factors that make this research sensitive. First, it 'intrudes into private lives and delves into some deep personal experiences of orphans and caregivers (Renzetti and Lee 1993:7). Orphans and caregivers were expressing bereavement since orphan status is due to death of parents, which can trigger high emotions such as stress and grief. In

addition, the link between HIV and death of parents can be socially stigmatizing for orphans and caregivers. Orphans and caregivers disclosing their poor social, economic and other personal information may be a cause of some discomfort.

Second, this thesis was classified as sensitive research because it deals with vulnerable groups of people (Liamputong 2007). Vulnerable groups of people are described as those who are disadvantaged, marginalised, impoverished, discriminated and exposed to factors that diminish their autonomy and marginalise their lives (Liamputong 2007). Vulnerable groups are sometimes categorised as a hidden population that is hard to reach in research and assumes that their lives are confronted with peculiar experiences (Liamputong 2007). This thesis contains a broad spectrum of people that form a vulnerable group consisting of children, women, the elderly, the chronically ill, economically and educationally disadvantaged and HIV affected households (Liamputong 2007).

5.1.4 Principal Researcher's Position

My position in the Ministry of Gender, Children and Community services is a Deputy Director of Child Development. This is a senior policy position and my main roles include providing the professional advice to Programme Officers in Child Development, managing and coordination the National OVC Steering Committee through the OVC management, resource mobilisation and promoting collaboration with OVC stakeholders. My job has a direct effect in the research because the position gives me authority to put into action the outcome of the research. The policy position also facilitated easy access to contact and interview donors and NGOs senior policy makers from the donors and the NGOs. My position gave me prior understanding of issues and authority to influence change. Accessing senior policy makers increased the possibility of accessing reliable information directly from decision makers. These senior policy makers are presented in section 5.4.1 and table 5.7.

5.2 Study Design

This thesis is based on one qualitative study that utilised different data collection methods including in-depth interviews, focus group discussions (FGD) and policy document review. This approach was taken to explore a holistic picture of needs, policies and orphan care services. Table 5.1 shows the link between research objectives, specific research questions and the methods used. The study design was informed by two theoretical perspectives. The framework of quality of care on the evaluation of policies and services, as discussed in chapter four, section 4.2 and Maslow's human motivation theory as discussed in chapter three, section 3.5. The subsequent sections outline in detail research methods, fieldwork processes and procedures that were undertaken.

Table 5.1: Alignment of research objectives, research questions, conceptual framework and methods.

Objective	Research Questions	Conceptual framework/theory framework	Method
1. To explore the nature of orphans' needs	1a. What are the specific needs of orphans? 1b. In what way does the living arrangement of orphans influence their needs?	Maslow's human motivation theory Physiological, security, love & belonging, self-esteem and self-actualisation needs	1. In-depth Interviews with orphans and caregivers
2. To assess the extent to which child-related policies guided service implementation for orphans.	2a.Are needs of orphans adequately incorporated in child-related polices? 2b. In what way are child-related policies influencing service implementation?	Quality of care framework elements Access, coordination, Comprehensiveness and Equity	2a.In-depth interviews with multi-sector policy makers from National OVC Steering Committee 2b. Document review
3. To examine how different service providers implemented orphan care services to ensure that orphans receive quality services.	3a. What factors affect (enhance or inhibit) quality in service delivery? 3b. What are the perceptions of service users regarding service responsiveness to their needs	Quality of care framework elements Access, Acceptability, Equity, Effectiveness, Coordination, Comprehensiveness, Efficiency and Continuity	3a. In-depth interviews with National multi-sector service providers 3b.Focus group discussions with district assembly officers and community based service providers 3c.In-depth interviews with orphans and caregivers

Objective	Research Questions	Conceptual framework/theory framework	Method
4. To recommend appropriate strategies for improving service delivery to orphans based on gaps between needs and service delivery.	4a. What are the strengths and weaknesses in policy and service delivery? 4b. What strategies emerge from the thesis and best practice from Sub-Saharan Africa that can be recommended to improve policies and services for orphans in Malawi?	Maslow's human motivation theory Quality of care framework, 8 elements of quality of care	4a. Findings from Framework analysis of interviews and FGD and in-depth interviews 4b. Findings from Framework analysis of document analysis 4c. Lessons from Sub-Saharan literature

5.3 Research Methods and Rationale

5.3.1 In-depth Interviews

An interview is a conversation between interviewer and interviewee which helps to collect information about people's understanding of events and experiences (Hansen 2006; Legard, Lewis and Ward 2003; Marshall and Rossman 2006). Interviews have been applied extensively in policy programme evaluations seeking opinions, experiences, expectations, processes and outcomes among programme participants (Denscombe 2007). Further, interviews have the capacity to elicit complex information from multiple service implementers in an interactive manner (Stephens 2007; Denscombe 2007; Ritchie and Spencer 1994; Patton 2002). In-depth interviews capture information and knowledge with depth, in a flexible, interactive and generative manner (Legard, Keegan and Ward 2003). An in-depth interview allows interviewee sufficient time to develop their own accounts on issues they perceive as important (Green and Thorogood 2009). This therefore helps interviewee to sieve through information according to their choice. Likewise, the use of interview guide provides the interviewer the flexibility to control and focus on key areas of the subject matter. Since a discussion is interactive and generative, using probes has the capacity to bring about more knowledge from participants (Lewis and Ritchie 2003). In this thesis, participants' perceptions brought out their preferences on service delivery approaches and policies, as reported in chapters seven and eight respectively.

5.3.2 Focus Group Discussions

Focus group discussion (FGD) is a process where data is generated in a defined area of interest by interaction of group members through sharing of views and experiences (Finch and Lewis 2003; Barbour and Kitzinger 1999; Levers 2006). There is evidence that FGDs have been successfully used in program evaluation (Finch and Lewis 2003; Barbour and Kitzinger 1999; Morgan 1998; Levers 2006).

FGDs help to reflect both "collective as well as individual self identity, shared meaning that are an important part of the way in which people perceive, experience and understand the world around them" (Finch and Lewis 2003:172). In this thesis, FGD

allowed the participants, who came from respective organisations and formed a multi-sector service provision group to share their experiences from both their respective organisations and experiences from their participation in the multi-sector service provision group. For example, participants from Government health department shared their experiences as employees of Government department of health as well as members of a multi-sector service provision group. In addition, levels of service providers including community, district and national service providers provided rich consolidated information on service responsiveness to the needs of orphans.

FGDs helped to build consensus among shared views of research participants on certain concepts and approaches to service delivery (Denscombe 2007). FGDs elicit diverse views and if planned well, could be cost effective (Patton 2002). FGD appear to be spontaneous because they arise from a social context which allows participants to reveal their own frame of reference (Lewis and Ritchie 2003) and help to capture cultural issues. Since the discussion is held in a conversational matter, participants feel comfortable to share their experiences (Lewis and Ritchie 2003).

Despite the strengths of FGD, some have argued that the relationship in FDG may silence other participants, for example, women may be silenced by men (Krueger 1994) and service providers may sometimes speak things that please their organisation (Lewis and Ritchie 2003). Measures were taken during data collection to counteract these weaknesses as will be discussed in the fieldwork processes and procedures in section 5.4.

5.3.3 Document Review

Policy document review was undertaken to explore how Government guided service delivery. Documents are available for independent verification of data sources hence allow people to use them at their convenience (Lincoln and Guba 1985). Documents provide contextually rich and relevant source of information (Lincoln and Guba 1985) and help to track activities and events (Lewis and Ritchie 2003). They are relevant for policy studies as they provide data at the initial stage to guide the research process (Abbott, Shaw and Elston 2004). In this thesis, the initial review of policies provided information regarding what activities and services were available. However, it has

been argued that documents may give superficial aspects of reality and can provide complex information which may difficult to interpret and analyse (Abbott, Shaw and Elston 2004). In this thesis, the framework that informed the review of documents provided sufficient guidance to choose documents that were appropriate. The study design is provided in figure 5.1.

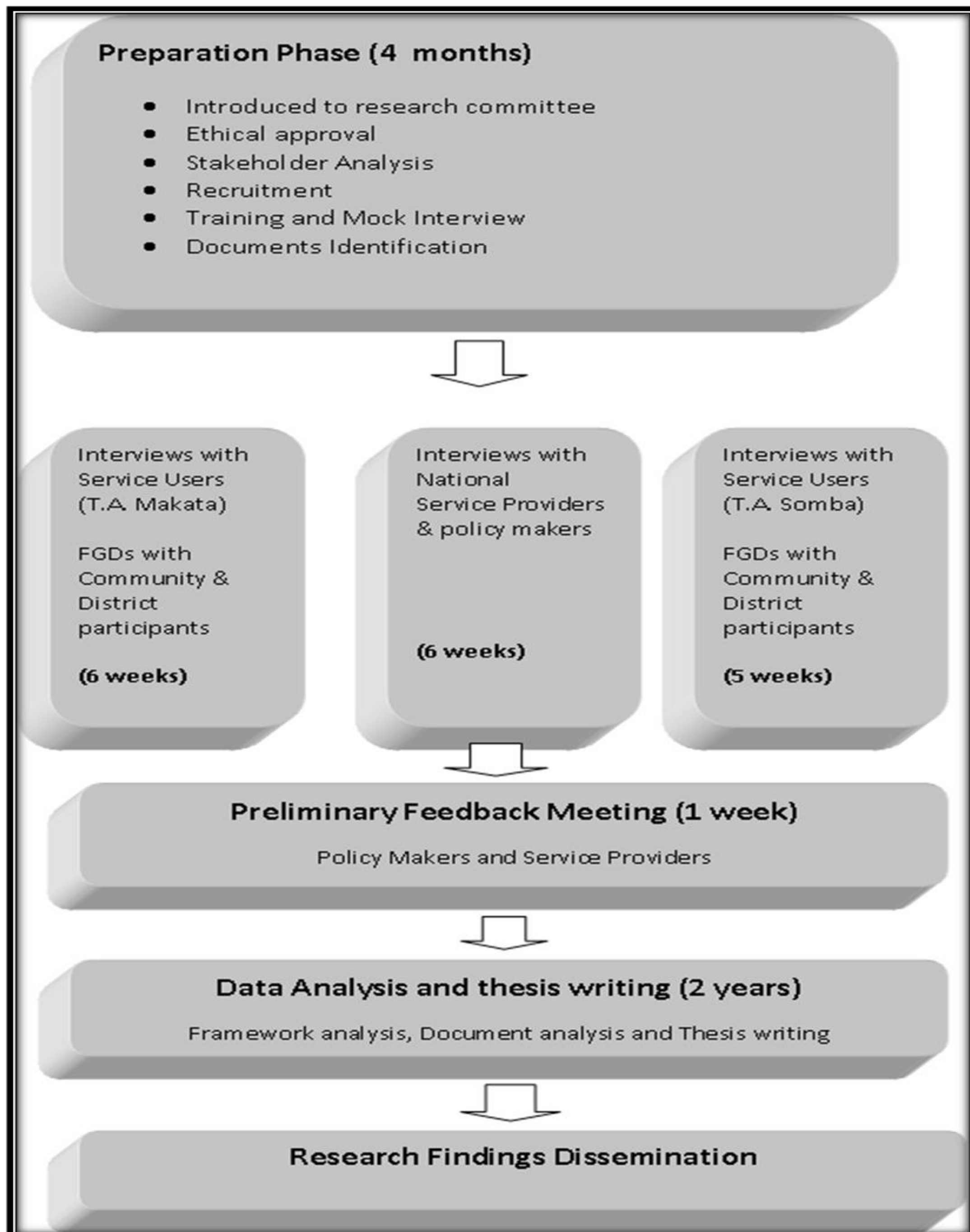


Figure 5.1: Research Design

5.4 Field Work Processes and Procedure

5.4.1 Sampling and Recruiting of Participants

All the participants were identified using purposeful sampling to select information-rich cases that had in-depth understanding of the topic and addressed the purpose of the research (Patton 2002). According to Palys (2008:1) purposive sampling is 'virtual synonymous with qualitative research'. Considering the diversity of research participants in this thesis (service users, service providers and policy makers), different types of purposeful sampling methods were applied.

Orphans and caregivers were recruited as service users and orphans were the main focus of the research. Maximum variation sampling was used to ensure that service users with diverse characteristics were recruited. Table 5.2 shows diversity in geographical coverage and study participants that provided a wide range of experiences (see figure 5.5). In addition, snowballing was also used to identify service users. This occurred mainly due to limited number of paternal caregivers and maternal orphans, as well as long distances to reach such participants. No effort was made to match related orphans and caregivers. However, due to scarcity of paternal caregivers, two paternal caregivers and maternal orphans came from same households. This opportunity helped to validate household information for consistency. Stakeholder sampling and maximum variation sampling were applied to service providers and policy makers. Stakeholder sampling was significant because it offered the context of evaluation and helped to identify the appropriate participants with diverse experience and from different backgrounds (Palys 2008). Maximum variation sampling helped to ensure diversity of service providers.

Table 5.2: Sampling and recruitment of research participants.

	Service Users	Service Providers			National Policy Makers
		Community Service providers	District Service providers	National Service providers	
Population	Orphans and caregivers from T.A. Makata & Somba	T.A. Makata & T.A. Somba Community Service Providers	Blantyre District Service Providers	National Service Providers	National orphan care policy makers
Sampling frame	Village register	District Social Welfare Register	Blantyre Orphan Care Committee	National OVC Technical Working Group	National OVC Steering Committee
Variables of participants	Age, sex, living arrangement, access to service	Involvement with service provision, registered with District Social Welfare Office, Member of village OVC	Registered with Blantyre orphan care committee, undertake orphan care roles	Service roles, membership to the NOVTWG, types of organisations	Policy roles, membership of NOVCSC
Identification of participants	Blantyre District Social Welfare Officers	Blantyre District Social Welfare Officers	Blantyre District OVC Committee	National OVCTWG	National OVC Steering Committee
Who recruited	Child Protection Workers & volunteers	Child Protection Officer	District Commissioner	Principal Secretary for MoGCCS	Principal Secretary for MoGCCS
Data collection method	In depth interviews	FGDs	FGDs	In-depth interviews	In depth interviews

Outlined in this section are the processes for sampling different groups of research participants, in a systematic manner. The strengths of the approach were that the sampling used dual approach. A formal sampling frame as well as use of local information, including the use of key informants such as the chiefs. This was done to

avoid selection or volunteer bias, if dependent on chief's choosing the participants. The use of registers was systematic, so it didn't depend on who the Chief liked or disliked. However, sometimes, the registers appeared to be incomplete and so the chief could identify someone that you could have missed. The chief's endorsement may also have provided reassurances that you are a legitimate person. Thus there were advantages in the triangulation of recruitment strategy.

a) Sampling of service users for In-depth interviews: Orphans and Caregivers

Service users were recruited using good communication and existing structures, as reflected in the figure 5.2, service users' flow chart. To access the orphans and caregivers in Blantyre district assembly, the Permanent Secretary wrote a letter to the District Commission, who also informed the chief in the area through a letter. This process opened access to the villages in the cited areas. The chief called for an orientation meeting to introduce the research to the potential participants from households with orphans. The child protection workers briefed the potential participants about the research during the meeting. The actual recruitment of service users was systematically done using a village register which had a list of all households with orphans and caregivers. The list of orphans was divided into three lists of types of orphans; paternal, maternal and double orphans. Recruiters went through thorough orientation, focusing on the research purpose. The recruitment of participants was guided by a recruitment checklist. However, it was not possible to interview orphans from difficult to reach areas considering the rain season and the terrain; hence some adjustments were done.

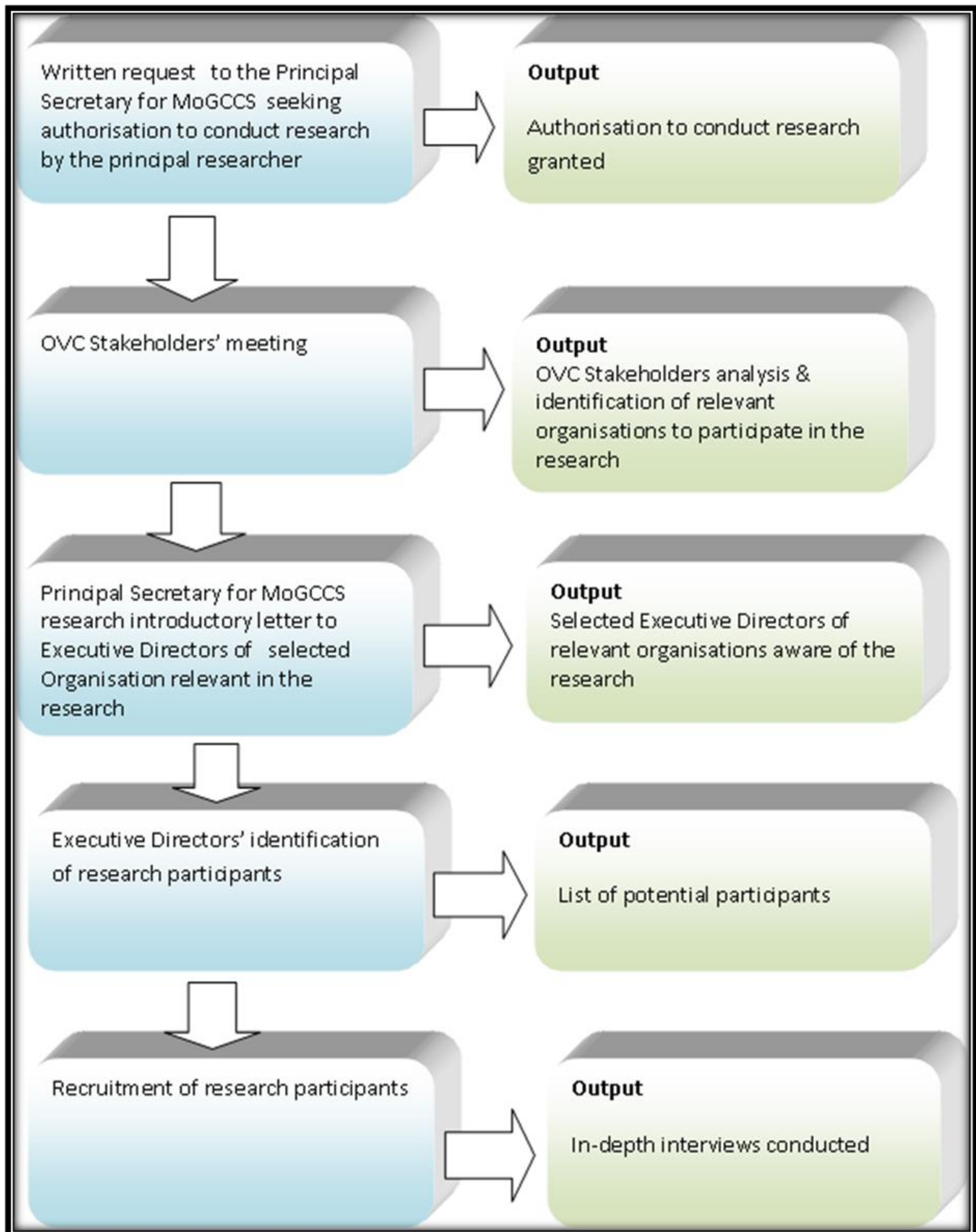


Figure 5.2 : Flow chart for sampling process of orphans and caregivers

During the sampling of orphans, gender, age and location of residents were considered. This was significant to compare the differences or variations of the needs of orphans during the analysis. A summary of orphans' characteristics is shown by gender and age in Table 5.3**.** Detailed information regarding the demographic information of orphans is provided in appendix A.

Table 5.3 : Characteristics of orphans by age and gender.

Age	Gender		Total
	Male	Female	
13		2	2
14	4	3	7
15		1	1
16	4	2	6
Total	8	8	16

Similarly, caregivers with diverse variations in age, socio-economic status and duration of caring for orphans were sampled from the village resister. Table 5.4 shows some of the demographic characteristics of caregivers. A detailed demographic information of caregivers is presented in appendix B.

Table 5.4 : Summary of characteristics of caregivers by age, gender and household size.

Caregiver	Age	Gender	No. of orphans in the household	Household size
1	62	male	4	5
2	43	female	6	7
3	69	female	7	10
4	47	female	4	5
5	50	male	1	2
6	61	male	2	5
7	52	male	1	2
8	34	female	8	11
9	70	female	4	6
10	38	female	4	5
11	61	female	11	16
12	61	female	2	3

The researcher's role in the recruitment process was limited to consultation on specific questions. Instead, participants were recruited by child protection workers to minimise selection bias. This was done to avoid making research participants especially service users feel coerced into the research, as the researcher held a senior policy level position with responsibility for children's issues, in the MoGCCS.

Sample size was determined by sample saturation, which is described as collecting information to the point that no new information was emerging from participants. Field summary reports were used to determine whether there was new information emerging or not.

An inclusion criterion was anyone who was an orphan or caregiver receiving services in the villages covered by the sample frame. Orphans who were married were excluded because according to Malawi culture once a person is married, they are considered to

be an adult because their roles change. Vividly, some had food shortage although they were married. Service users who were not receiving services were also excluded. During the field visit, I tried to interview those caregivers who did not receive any service. It was observed that it was difficult for them to answer the questions. This was because, the questions were framed in relation to the service they had received, to seek their perceptions about the service. However, those caregivers helped to understand why some households did not receive services even when they had food need.

B) Service providers and policy makers for In-depth Interviews

Policy makers and service providers were recruited through a similar process. The Principal researcher sought permission to do orphan care research through the Permanent Secretary for Gender, Children and Community Services before the fieldwork. The Principal researcher conducted stakeholder analysis to identify potential policy makers and service providers with the National OVC Technical Working Group and OVC management team. Then the Permanent Secretary for Gender, Children and Community Services, wrote a letter to different organisations to ask for nomination of potential participants, bearing policy and service delivery responsibilities. The research Information sheet was attached to the letters to guide the selection of the participants (appendix C, D and E). The actual recruitment was done on the day of the in-depth interview. Figure 5.3 shows the flow chart for the recruitment of policy makers and service providers.

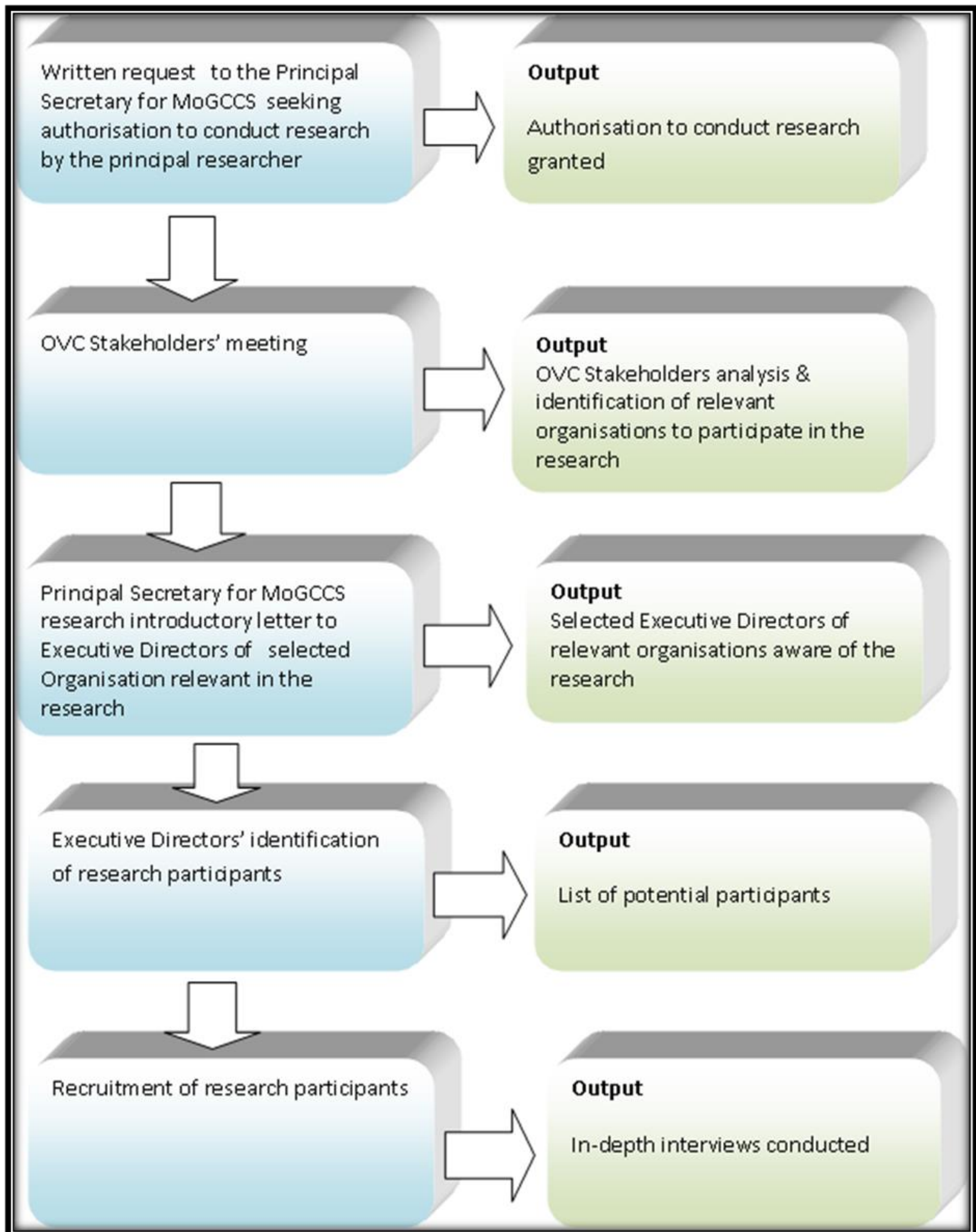


Figure 5.3 : Policy makers and service providers recruitment flow chart

Table 5.5: Policy makers interviewed

Respondent	Gender	Organisation	Organisation Type	NOVCSC membership	NOVCTWG membership
A	F	UNICEF	Donor	Yes	Yes
B	F	WHO	Donor	No	Yes
C	F	FAO	Donor	Yes	No
D	F	USAID	Donor	Yes	No
E	F	HIV Department	Government	Yes	Yes
F	M	Ministry of Health	Government	Yes	Yes
G	M	Ministry of Labour	Government	Yes	Yes
H*	M	High Court	Government	No	No
I	M	Ministry of Education	Government	Yes	Yes
J	M	Ministry of Economic Planning & Dev	Government	Yes	Yes
K	M	Ministry of Gender, Children and Community Services	Government	Yes	Yes
L	F	Law Commission	Government	No	Yes
M	F	Ministry of Agriculture	Government	Yes	Yes
N*	F	National AIDS Commission	NGO	Yes	Yes
O	M	Children NGO Coalition	NGO	No	No
P*	F	OXFAM	NGO	Yes	Yes

* Also interviewed about their service provision role

Data from national services providers and policy makers were drawn from Lilongwe district, the capital city of Malawi where Government ministries and NGOs headquarter offices are based. A few national service providers and policy makers came from Blantyre district. Policy makers were sampled from broad categories, including donors, Non-Government organisations (local and International) and from Government, as shown in table 5.5**.** Their link with the sampling frame or committee

Table 5.6: Service providers interviewed

Respondent	Gender	Organisation	Organisation Type	NOVCSC membership	NOVCTWG membership
A*	F	World Vision International	NGO	No	Yes
B*	F	PACT Malawi	NGO	Yes	Yes
C	M	CONSOLE home	NGO	No	Yes
D*	M	Eye of the Child	NGO	No	Yes
E	M	Ministry of Education	Government	No	Yes
F*	M	Ministry of Youth and Culture	Government	Yes	Yes
G*	M	Save the children	NGO	Yes	Yes
H	M	Ministry of Labour	Government	Yes	Yes
I	M	Ministry of Health	Government	Yes	Yes
K	M	Ministry of Gender and Child Development	Government	Yes	Yes
L*	M	NOVOC	NGO	No	Yes
M	M	NAPHAM	NGO	No	Yes
N*	M	Plan Malawi	NGO	No	Yes
O	M	High Court	Government	No	Yes
P*	M	Malawi Interfaith Association	NGO	No	Yes
Q*	M	Coalition on Child Rights	NGO	No	No
R	F	Coalition of women with HIV	NGO	No	No

*Also interviewed about their policy making role

they serve was also considered. This indicates that the sampling was very inclusive in the selection of participants. Service providers were sampled from Government and Non-Government organisations (table 5.5). Some participants were interviewed for both policy and service delivery roles. This is because only one name was selected by the nominating organisation.

The research sampled high level profile policy makers. As reflected in table 5.7**,** policy makers included mainly those with high managerial and decision making responsibilities from all the organisations, such as executive directors and senior managers with competence in policy decisions. A list of policy makers and service providers who interviewed is shown in appendix F and G respectively.

Table 5.7 : Summary of policy makers profiles.

Organisation Type	Position	
	Chief Executive	Director/Managers
NGO	1	2
Government	4	5
UN organisations/Donors	1	3
	6	10

C) District Service providers for FGD

The participants for FGD were recruited at two levels, district and community levels. The District Commissioner requested the Government departments to identify key participants from District OVC committee members. The Social Welfare Office assisted the identification of Social Welfare assistants and child protection workers for FGDS (Figure 5.4). Figure 5.5 presents the sampling break down which indicates the diverse categories of research participants.

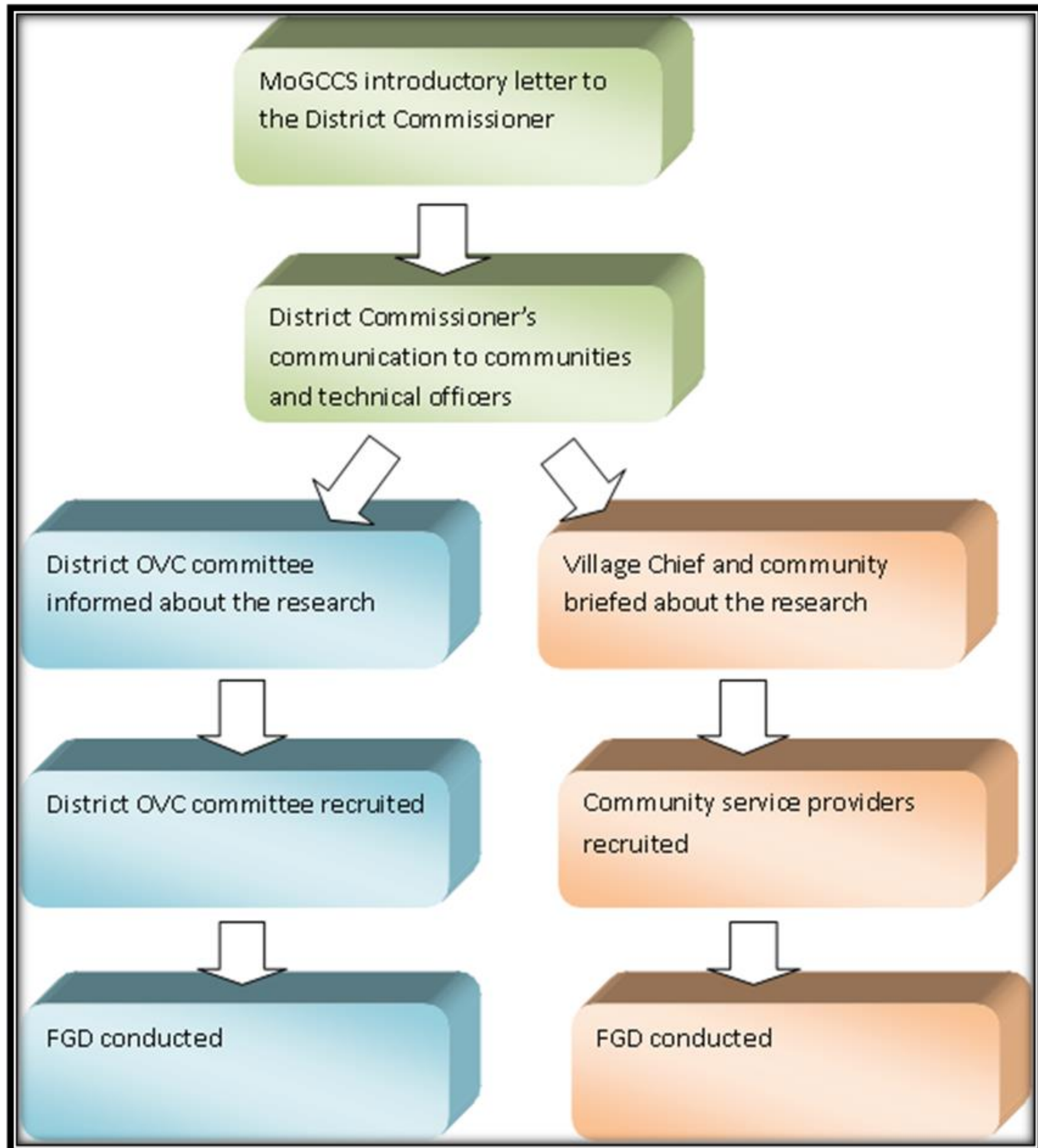


Figure 5.4: District service provider's recruitment flow chart (FGD participants).

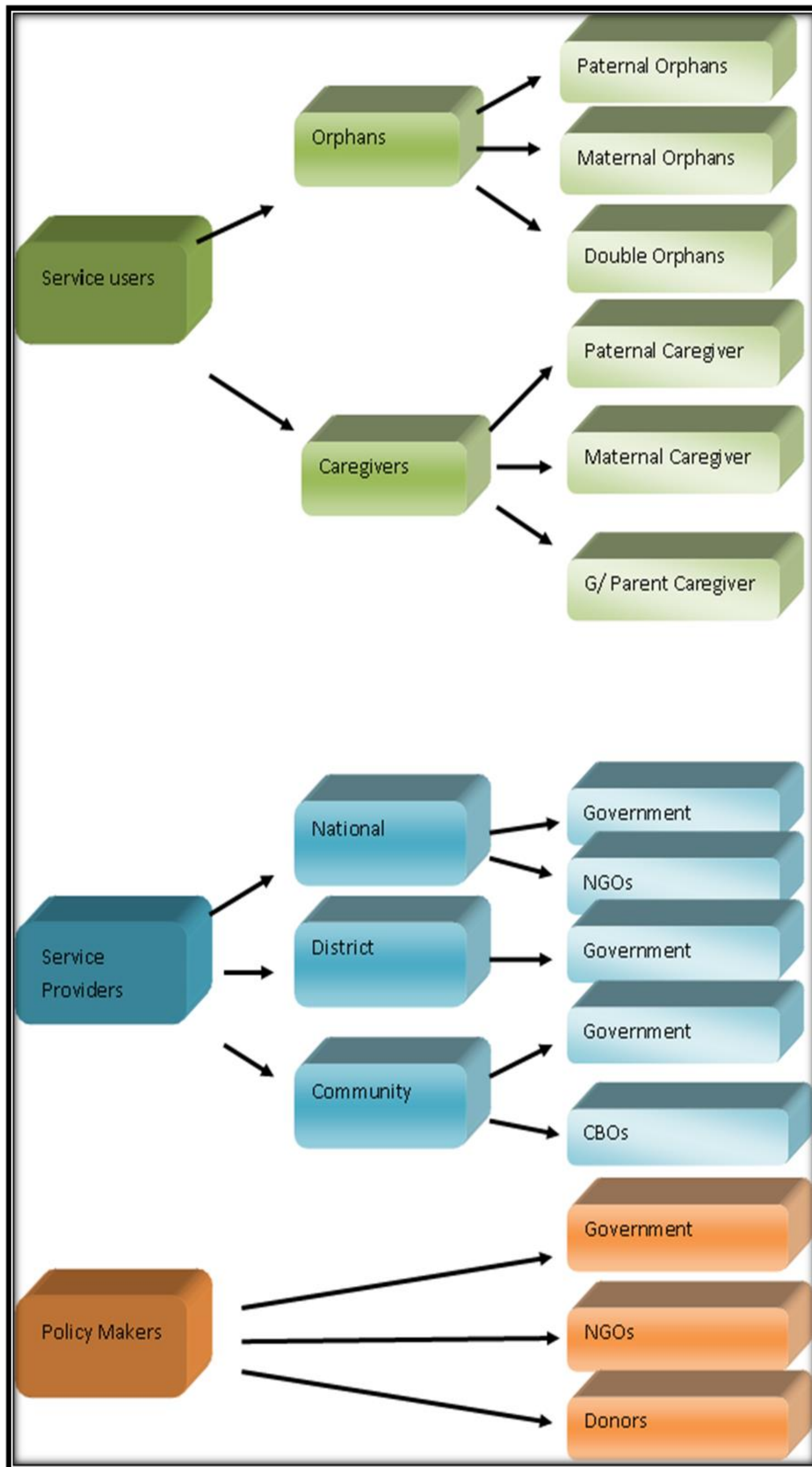


Figure 5.5 : Breakdown of research participants.

5.4.1.1 Choice of study setting

The research was conducted in Malawi. There were several factors that made Malawi a conducive environment for this project. Malawi government has a national policy on Orphans and other Vulnerable Children and other children related policies that address issues of orphans and also implements integrated orphan care services/programmes. The services are implemented by multiple partners, including government, nongovernmental organisations, community based organisation and faith based organisations guided by government policies. The high prevalence of orphans resulted from death of parents due to high percentage of HIV and AIDS infected adults, as reported in chapter one. Patton (2002) and Creswell (2008) suggested that pragmatic and evaluation research should be done in a naturalistic environment where the outcome of the research will be applied because participants explain their experiences in context.

Data from the national services providers and policy makers were drawn from Lilongwe district, the capital city of Malawi where government ministries and NGOs headquarter offices are based. Blantyre district was cited as the case study location to understand the needs of service users and from the user's point of view and from localised service providers.

Blantyre district has other characteristics that are fitting for the study. For instance, it features among the districts with the highest prevalence of orphans in Malawi (National Statistical Office and UNICEF 2008); the district is more accessible than other districts during rainy season when data was collected; the district offered diversity of orphan care arrangements for both typical rural and semi-urban communities making it feasible for comparing characteristics of two settings within the district. The research targeted users of services from rural communities where most of the interventions are implemented on the understanding that rural populations are comparatively poorer than urban dwellers (National Statistics Office 2005). In Malawi 85 percent of the population live in rural areas (National Statistical Office 2008). Two of the traditional authorities of Makata and Nsomba were selected from the District Social welfare areas

of operation for the study on the basis that multi-sector orphan care services were implemented in these areas.

Blantyre district provided the setting for sampling service users, and district and community service providers. Service users and community service providers were sampled from Blantyre rural. District service providers were based in the city. The differences in the characteristics of the two areas of study are presented in table 5.8.

Table 5.8 : Characteristics of the case study area.

Characteristics of case study site	Traditional Authority Makata	Traditional Authority Nsomba
Geographical differences	Typical rural area	Typical semi-urban with more squatter settlements
Demographic differences	Less densely population	More densely populated
Socioeconomic activities	Less market and business opportunities	More income activities opportunities and markets
Accessibility	More muddy roads & less accessible, some inaccessible terrain	Easier access roads and less inaccessible terrain

5.4.2 Document Selection and Accessing

The identification of documents evolved through systematic processes and stages. The first stage focused on selection of policy documents. This stage involved three steps.

The first step involved the identification of organisations associated with orphan care. These organisations included Government, International donor organisations and NGOs. For example UNICEF, WFP, WHO, USAID, DFID and FAO, OXFAM, Save the

Children and from International NGOs, Pact Malawi, Family Health International, Save the Children and World Vision.

The second step involved the identification of policy and service documents associated with orphan care issues. Policy documents included speeches, budgets, plans of actions, guidelines and the actual policies. Service documents included programmes, interventions, service guidelines and project documents.

In the third step, documents relevant to the study were identified as those that contained information about orphans, children affected/infected by HIV/AIDS, AIDS orphans, vulnerable children. During fieldwork, an initial reading of 124 documents was done to identify relevant documents for this research. This process helped with familiarisation of the existing orphan care organisations and their roles.

The second stage involved the process of developing a systematic approach to documents selection. This was done through OVC stakeholders meeting. The stakeholders meeting involved orphan care technical experts including members of the National OVC Technical Working Group, planners and experienced researchers from the University of Malawi. The document inclusion and exclusion criteria were developed together with orphan care experts in the MoGCCS, to focus on relevant documents for this study. The inclusion criteria included: Government policy documents, policies that addressed children, orphans, orphaned households or policy plans of action. The timeframe of the documents covered the period from 1995-2010.

The third stage involved systematic selection of documents using the inclusion and exclusion criteria developed during the OVC stakeholders meeting. A total of 33 documents were selected and reviewed. Government policy documents were considered priority documents because they guided national service delivery. All policy and service related documents from NGOs were excluded. Figure 5.6 shows policy documents selection flow chart. Outcomes of stakeholder analysis in relation to policy review process are presented in figure 5.7.

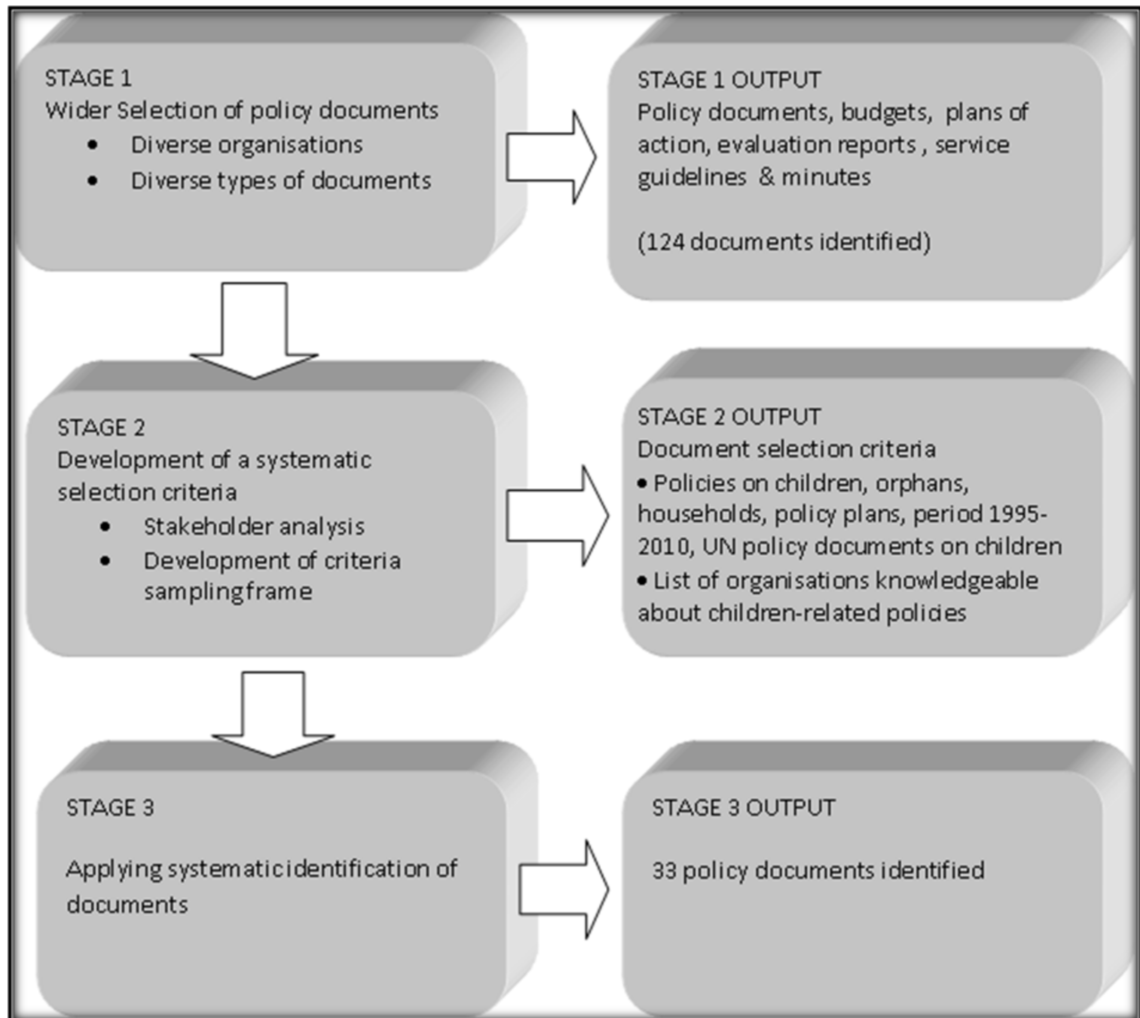
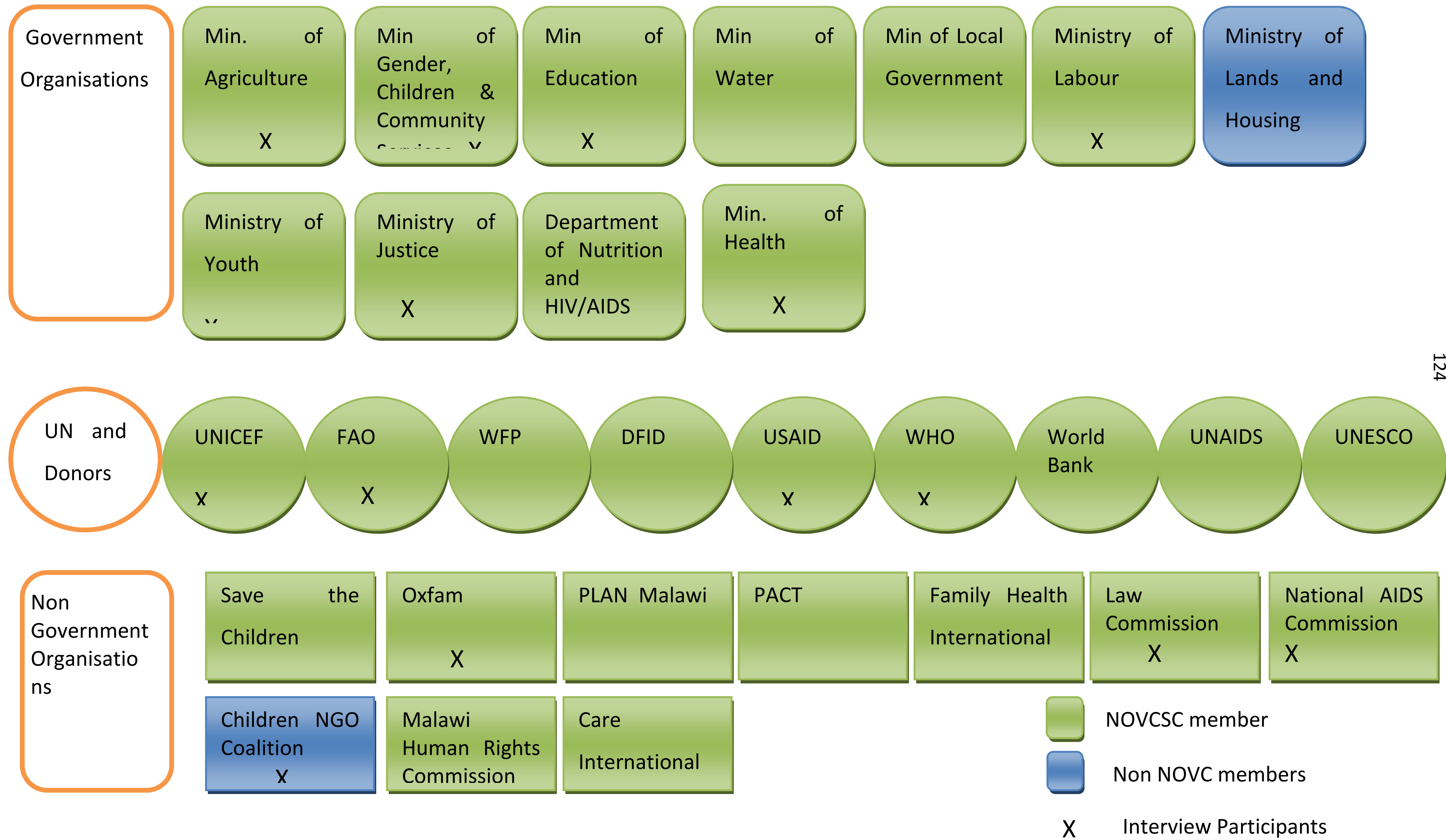


Figure 5.6 : Flow chart of policy selection.

One of the reasons for doing stakeholder analysis was to identify potential policy makers participants. A number of criterions were applied to identify these participants. Participants were drawn from three types including these categories: Government policy makers, UN and donors and NGOs. The other criterion was the sector the participant represented such as food, education, health and others. Then the roles the organisation played. Some participants were excluded if they played similar roles, for example World Food Programme was dropped because Food Agriculture Organisation was involved with food related functions. The majority of the participants

Figure 5.7 : Stakeholders analysis outcome



were members of the National OVC steering Committee, except a few as shown in Figure 5.7. For example, the Children NGO network was a newly formed organisation that was set up to coordinate NGOs at policy level, but was not a member of NOVCSC.

Some organisations were excluded if other members within the group or category were already represented. For example, within the category of International NGOs, FHI and Care International were excluded because OXFAM and Plan Malawi provided similar services to orphans. Some organisations were excluded if they did not belong to any of orphan care committees.

5.4.3 Data Collection Techniques and Procedures

5.4.3.1 Conducting In-depth Interviews

In-depth interview was the main data collection method and was applied to different participants to address different research objectives. In-depth interviews with service users explored objective 1: the nature of orphan's needs and their perception of service delivery. In-depth interviews conducted with policy makers addressed objective two, which sought to explore the influence of child related policies on orphan care service delivery. In-depth interviews with mainly national service providers addressed objective three whose aim was to assess quality of multi-sector service implementation.

The procedure for in-depth interview with all the participants included the following general pattern. Before the beginning of each interview, the participants introduced themselves and were reminded of the importance of giving consent and the key issues about the research in the information sheet. Demographic information was then collected. The interview or question guide was used throughout the interview. Simple and general questions were asked at the beginning to make the participants feel relaxed. Probes were used for exploring views, explanation or clarification of issues. Different interview guides were used for service users, service providers and policy makers, as well as interview guides for FGD with district and community service providers (appendices H, I, J and K). All question guides were translated into local

language. A sample of orphans questions guide translated into local language is presented in appendix L.

Before concluding the interviews, participants were asked to share their final views or ask questions before thanking them for their time. After the interviews and FGDs, a meeting was conducted with the research assistant to discuss the notes and form consensus on issues raised during the discussion related to content and methodology. Whenever possible, interview notes were summarised within the day of the interview.

This interview pattern was also used for interviewing caregivers. The purpose was to gather information regarding their caring experiences and the general information about the whole household. The interviews were guided by interview guide and probes were used throughout the discussions. All interviews were tape recorded using two digital voice recorders.

The interview topic guides (appendix H, I, J and K) were developed from two sources: the literature review and the conceptual frameworks. The literature review in chapter three provided the scope of needs and the effects of unmet needs on the lives of orphans and their households. The literature on service provision in Sub-Saharan Africa helped to develop the research questions and the themes. For example the roles of service providers and the policy makers and how the context influences both the policy and the service provision were sourced from the literature review in chapter four.

In addition, the Maslow theory of human behaviour guided the development of question guide for the interview with orphans and caregivers. The five level classifications of Maslow's needs helped to identify the themes of the types of needs. From the terms which Maslow used, I developed open questions under each theme to interpret Maslow's concept in line with orphans. Then I developed specific questions to align Maslow's needs with needs that were identified from literature. These were used as probes for orphans and caregivers' needs. Probes helped service users identify their areas of need. Table 5.9 shows how Maslow's theory helped to come up with questions and probes.

Table 5.9 : Application of Maslow's classification of needs on orphans needs.

Type of need	Guidelines for applying Maslow's theory to identify the needs of orphans	Specific Probes
Physiological needs	-Do orphans lack things that threaten their life such as food and safe water? -Do orphans lack physical and material things that can help them to maintain their body systems and body temperature?	The need for nutritious food and safe water The need for shelter and clothing
Security needs	-Do orphans have a need for good health? -Do orphans need any of these forms of security: emotional, physical and sexual?	The need for access to health services The need for protection from abuse
Love and belonging	-Do orphans need love and affection? -Do orphans feel lonely, isolated and lack friends?	The need for friendship
Esteem needs	-Do orphans value themselves, do they have self-respect? -Do orphans feel valued by others? Do they feel that they are important? Do they feel appreciated?	The need for recognition and acceptance
Need for self-actualisation	-Do orphans feel the need to fulfil/achieve something in life?	The need to fulfil one's aspirations e.g. education

The framework of quality of care guided the development of question guides on service delivery, using the elements of quality of care as adapted from literature (Maxwell 1992). See table 5.10.

Table 5.10 : Application of Conceptual Framework Elements.

Quality of service delivery	Guidelines on application of quality of Service & policy delivery
Accessibility	How do service providers identify and reach out to orphans? Are service users provided with assistance to overcome distance, timing, information and cost challenges? What factors affect accessibility in service provision?
Acceptability	Are services provided satisfying orphan's preferences, values and culture? In what ways are orphans involved in service provision decision process?
Effectiveness	Are appropriate and quality services delivered based on the needs of orphans? Are services improving orphan's outcome? What factors affect service delivery effectiveness
Equity	Are services provided fairly to orphans according to gender, age, socio-economic status and geographical location? What factors affect service delivery equity?
Efficiency	In what way does service delivery processes minimise wastage and control for corruption. Are resources coordinated to deliver integrated services? What factors affect service delivery efficiency?
Coordination	Are policy and service resources coordinated? Are roles of policy and service providers collaborated? Does effective communication take place among orphans care stakeholders? Are collaboration structures, committees functioning?
Comprehensiveness	Are services needed by orphans provided or not? Do service providers address diverse and variety aspects of each need? Does service delivery plan to achieve service user self-sufficiency?
Continuity	Are services implemented continually? Are services implemented on as a programme or on pilot basis? What factors affect service continuity

There were some variations in the manner in which interviews were conducted with service providers, orphans and policy makers as discussed below;

a) Interview techniques with children

Orphans were interviewed to gather their lived experiences, to learn how the children understand, interpret, negotiate and feel about their daily lives (Greene and Hill 2005). D'Cruz and Stagnitti (2008) recognised that children are social actors with morals, status, values and rights and are therefore capable of participating in research and can share their personal experience. In-depth interview was useful and appropriate for children because it allowed each child to express their individual experiences freely,

without being influenced by other children. Greene and Hill (2005) argued that data collection methods should suit children's level of understanding, interest, knowledge and location. Further, it has been suggested that data collection with children should encompass a variety of methods and techniques to stimulate and maintain interest of participants as part of child-focused research (Nyonator et al. 2005; Greene and Hill 2005). To ensure child friendly environment with the orphans, various techniques were employed to stimulate interest, reduce fatigue and promote discussion. Farga-Malet et al. (2010) suggested that pictures could be used as prompts or to facilitate communication of sensitive issues with children. They also recommended asking children what they already knew, for example every day routine activities, use of simple questions, use of open ended questions and use of non-verbal cues.

First, pictures of various scenarios of experiences and a range of services were presented throughout the interview as they served different purposes. For example, pictures as prompts were used at the beginning of a different theme. The pictures provided a wide variety of issues that might be important in the lives of orphans. The pictures covered aspects of the needs of orphans and the type of services orphans might receive.

The pictures were also used for facilitating recall of events and the scope of services that were provided by the service providers. At times orphans had forgotten or were unsure of what was classified as a service. This was understandable because culturally people in the community were also used to helping each other and sometimes source of help was not explained to orphans. Hence, pictures with different types of services reminded them the existing services and assisted orphans to identify the services they received. Orphans also reported services they were not receiving but wished they were receiving. An effort was made to provide balance of services themes to avoid bias, hence positive and negative aspects were provided. The pictures were also used alongside the interview guide to facilitate a discussion and release stress. During the interview, when orphans visibly expressed distress, talking about the pictures relaxed them so that they continued with the discussion with ease. This was consistent with ethical precaution to protect the child as discussed in section 5.5.4

In general, interviews with children used simple language and the interview questions were asked indirectly, first about other orphans in the area before addressing their issues. In addition, the orphans were asked how they spent their day to give them chance to share their experience like a story with limited disruptions. This was the opening question at the beginning of the interview. This approach helped the child to distance themselves from emotional feelings associated with the experiences, even when asked to compare such experiences with their own.

Orphans interview guide did not include questions related to policy issues, as the researcher assumed that they were more directly knowledgeable about services. However, it was surprising that orphans shared their perceptions about policies that affected them, as discussed in chapter eight.

The setting of interviews with orphans was determined by their choice as well as for their security and comfort. Many of the interviews were conducted in their homes and some were conducted in a community-meeting place like a church or school. Since the interviews were done in the afternoon after school, it was preferred to conduct the interviews at home for their comfort and safety. Interview with orphans took short time between 30 and 45 minutes. At the end of interview, orphans were given school materials to thank them for taking part in the interview. Giving children incentives has been suggested as a good protocol so long as it does not bribe participants (Greene and Hogan 2005).

Initially, I had planned to conduct interviews with orphans alone; however with the use of pictures I involved a research assistant who was taking notes and taking demographic information. The field work involved two research assistants. The other research assistant helped with transcribing of data.

b) Interview at organisation level with policy makers and service providers

In-depth interviews provided adequate time to capture information concerning policies and services from each respective organisation. In-depth interviews with policy makers took shorter time between one to one and half hours whereas those with service providers took between one and half to two hours. Policy makers preferred to

conduct the interviews in their offices while service providers were flexible. As a result, some interviews were held in offices while others in any public places, including hotels. Office environments created competing demands between the interview and office work. At times, it was difficult for interviewees to cut off completely from their daily work hence, there were sometimes disruptions.

The researcher played both the roles of a facilitator and taking notes during the in-depth interviews with policy makers and service providers. The interviews were conducted in an informal conversational manner using an interview guide throughout the interviews. Interview guide helped to save time, to decide in advance relevant information and to keep the discussion focussed. Despite using different question guides for policy makers and service providers, similar themes were covered across all participants to enable cross case analysis. Interviews were tape recorded to concentrate on the discussions.

5.4.3.2 Conducting Focus group discussion

Focus group discussions were held with community and district service providers to address objective number three. This method was found to be appropriate to capture both the individual organisation's activities as well as to capture information about coordination and collaboration networks.

FGDs were conducted by the researcher and a male assistant. The FGD opened with introduction of researchers and research participants and the purpose of the research. A circular seating arrangement was adopted to promote flow of communication. The researcher facilitated the establishment of ground rules for the FGD and obtained participants' consent. The research assistant obtained participants' demographic information. As the researcher, I facilitated the FGD using a question guide, continuously probed for more information, managed dominant and reticent participants, including participants' feelings and reflected on the information with reference to the research questions. The assistant researcher's role was to observe the flow of discussion, control digital voice recorders, observe non-verbal cues and take notes. The discussion was recorded using two audio recorders. FGD checklist was used

to guide FGD procedures. The discussions took between 1.5 to 2.5 hours. This was longer than the documented recommended time (Descombe 2007; Hennink 2007).

The discussions during FGD used similar probing techniques and skills as reported with the in-depth interviews. One focus group guide was used for district and community service providers to get a broader understanding of similar issues. However, there were some differences between the district and the community service providers FGDs.

The focus group discussion with the district orphan care committee consisted of six participants representing departments of Education, Health, Agriculture, Labour, Local Government and Social Welfare. The discussion took place in a conference room at the District Assembly and participants found this to be comfortable, since that was their usual place for meetings. To avoid a hierarchical relationship in FGDs in an effort to facilitate free discussion among participants, the District Commissioner was excluded from participating in the FGD. Instead, an in-depth interview was conducted with the district commissioner, focusing more on policy and management issues.

Community level FGDs aimed at finding out how services were implemented by the community multi-sector service providers at local setting. Each focus group discussion consisted of 6-8 participants and this was found to be convenient and facilitated the flow of communication so that all necessary components of service delivery were covered. FGDs took place in a neutral and comfortable place such as a school or a church, although two interviews took place at a CBO centre. These places provided undisturbed and familiar environment for the participants. The timing of the interview was agreed in advance considering that this was farming season. Most of the FGDs took place during the weekdays either in the morning or afternoon. Participants preferred to meet during weekdays because weekends were market days. Whenever necessary, participants were willing to adjust the timing. Local chiefs did not participate in FGDs because of their leadership roles. Instead, in-depth interviews were opted for local chiefs. The major problem with the community service providers was that there were too extreme types of participants, those who were dominating the discussions and those who were very quiet. The facilitator had to continuously control

the dominance and encourage quiet participants to contribute. Table 5.11 summarises the type of participants and the method that was used.

Table 5.11 : Research participants and data collection methods.

Type of participants	Method of inquiry
Orphans	In-depth interview
Caregivers	In-depth interview
National service providers	In-depth interview
National policy makers	In-depth interview
District & Community service providers	Focus group discussions
	In-depth interviews (Key selected community informants & Follow up)

5.4.3.3 Research Team and their Roles

The research team consisted of three people; me as a female principal researcher, and two male research assistants. My role in the research included designing the research protocol, developed research tools, facilitating all in-depth interviews and FGDs. After data collection, my role was analysing the data and writing the report of thesis. One research assistant travelled with me to the field when I collected data using FGDs with district and community service providers. His role was mainly writing interview notes during the interviews, taking demographic information and managing the sitting arrangement and observing any non-verbal communication. During the in-depth interviews with orphans, the research assistant also helped to take notes and to manage the presentation of pictures to orphans, which facilitated the discussions with orphans. The second research assistant helped with transcribing of data. The research assistants had no role in the analysis of data or writing of the thesis.

5.5 Ethical Considerations

Ethical issues were strictly observed during data collection, data analysis and presentation of findings in this research to respect the rights and dignity of the participants, to avoid harm to both participants and researchers and to ensure research credibility and integrity (Denscombe 2007).

5.5.1 Ethical Approval

Prior to starting the data collection, ethical approval was sought from the University of Leeds Institute of Health Sciences Ethical Committee (Appendix M) and Ministry of Health and Population through Medical Research Council of Malawi (Appendix N). However, there were some variations on the definitions and application of ethics from University of Leeds and Ministry of Health and Population in Malawi. While the Malawi Government had same ethical requirements for all children, United Kingdom applied adult ethical requirements for 17 years old children. This resulted in dropping orphans aged 17 years from the research to avoid applying two ethical requirements as per United Kingdom requirements. The approvals were obtained after four months from submission date. In addition, a permission letter was obtained from the Principal Secretary for the MoGCCS to access information from the service providers and policy makers. A permission letter from the Blantyre District Commissioner granted access to participants from the community.

5.5.2 Informed Consent

During recruitment, participants were informed about ethics protocols to help them make informed decision about participating in the research. Informed consents were collected from service providers, policy makers and service users (appendices O, P and Q). Before deciding to participate in the study, participants were provided with information sheet where the purpose of research, participant’s involvement and expectations were explained. To ensure voluntary participation, the right to withdraw before, during and after data collection if participants felt distressed or uncomfortable was discussed. Withdrawal meant that any information collected from participants could not be used in the study. No one withdrew from this study.

The idea of children providing consent in research has been a contentious concept in the literature (Coyle 2010; France 2004; Alderson, Sutcliffe and Curtis 2006; Goodenough et al. 2003). However, in this study consent for children age 13-16 was observed by combining consent of the child and their parent or caregiver where possible. In the absence of parents or caregivers, the local chief provided consent. This happened in two cases. There is evidence that gate keepers in the form of school or local authority may provide consent on behalf of parents (Greene and Hill 2005). The children in this study were given one to two weeks prior to the date of the interview to decide whether they wanted to take part in the study. The actual consent was taken on the date of the data collection, prior to commencing interviews. The information was read out from the information sheet in local language and children were asked to give consent verbally and this was audio taped. A copy of the information sheet is provided in appendix E and joint consent information for orphans and caregiver is shown in appendix Q.

5.5.3 Confidentiality and Anonymity

The participants were informed that the information they provided would be confidential and only used for purposes of this research. To maintain anonymity and confidentiality, different measures were taken. Transcripts used pseudonyms rather than participants' true identities and during data analysis, codes were used as participant identifiers. Participant demographic information and data were kept in separate files in the computer and were saved in a university computer under a password. The transcripts were kept in locked cabinet. During the reporting of findings, names of organisations were used in the quotations and not names of officers who provided the information. Wherever necessary, for sensitive issues, umbrella organisations were used instead of names of organisations. Handling confidential government policy issues and documents demands realisation of sensitivity and confidentiality to both researcher and policy participants.

Renzetti and Lee (1993) argue that sensitive research raises many concerns to the researcher which include technical, ethical, legal, methodological and political concerns. In addition to measures put in place by the researcher to protect

confidentiality, some participants made specific requests during data collection and the researcher observed these. For instance, one girl asked the male research assistant to go away and not to record her episode of a sexual relationship. As a result, no quotation was documented regarding that particular sexual experience.

5.5.4 Protection from harm

Finally, the researcher took precaution to ensure that the research process did not cause any harm and danger to participants, research assistant or researcher. As much as possible interviews in the community were done during daytime. Reliable transport was used and there was good communication, using cell phones among the research team. Since field work was done in remote areas, clear and safe places were used for discussions (Goodwin 2006). However, since the data was collected during rainy season when grass was tall, use of male research assistant and volunteers helped to give the researcher company and provide security. The participation of community police officer in the FGD also provided a safety precaution and their local office were made aware of our visits. Participation in a risk assessment course prior to fieldwork helped the researcher to become aware of and to deal with all issues of protection.

During the data collection period, we worked in close collaboration with the District Social Welfare Officer who is trained to provide counselling to distressed people. It was uncommon for adult male caregivers to express visibly their grief on the consequences of caring for orphans during interviews. However, the presence of the male research assistant helped to console the males because the involvement of the female researcher would culturally embarrass the males, since men are expected to be strong and to contain their emotions and challenges. Men's emotional reaction was interpreted as evidence of psychosocial needs or negative effects of the situation and challenges they faced.

5.5.5 Gaining Access to Community Participants

Culturally in Malawi, rural community leaders require some protocols and procedures to feel respected and to accept visitors. The following measures were followed. The chiefs were contacted with an introductory letter from the District Commissioner, briefed about the research, and asked to inform to their subjects about the research.

As a female researcher, my dressing code was adjusted to suit the rural poor community and their culture. For example, as a form of respect for the local tradition, I did not wear pairs of trousers and at times, I had to cover my hair to be accepted in some parts of the community. However, sitting arrangement was negotiated to allow men and women to feel equal and to promote fruitful FGD, as traditionally men would sit on chairs and women would sit on the floor if chairs were insufficient. According to Hennink (2007), such type of sitting arrangement create power imbalance and inhibit free participation.

5.6 Data analysis

5.6.1 Qualitative data analysis

Qualitative analysis has been described as a "process of transforming the collection of materials into writings that speak to the wider, outside audiences: with a goal to produce a coherent, focused analysis of some aspect of social life that has been observed, an analysis that is comprehensive to the readers who are not acquainted with the social world at issue" (Emerson, Fretz and Shaw 1995:143).

5.6.1.1 Data preparation and management

Initial analysis of data commenced during the fieldwork and involved daily management of data. Each day of the interview, the information was compiled in a summary sheet after conducting a debriefing meeting with the research assistant. The summary sheet was important because it highlighted themes and illuminated incidences about the interview which provided follow up issues and direction for the next interview.

5.6.1.2 Translation and transcription of interview

Interviews with service users and community service providers were conducted in the local language while interviews with national service providers and policy makers were done in English. Translating the data from Chichewa to English was avoided to prevent diluting the meanings of some concepts and local proverbs. However, a few transcripts were translated from Chichewa to English for the purpose of sharing the information

with the supervisors as part of independent development of coding skills as well as validation of my analysis. All quotations of local language used in this thesis were translated into English. Double translation was conducted by the researcher and a research assistant to compare meanings of some concepts for accuracy.

Verbatim transcribing started during data collection and continued after fieldwork. Transcribing was done after listening to the audio recordings and was conducted by a research assistant. Transcription was facilitated with the help of Express Scribe Software which helped to control the speed of playback of the recorded interviews.

5.6.2 Framework Approach to Data Analysis

Approaches to qualitative data analysis vary according to the main focus of study. Ethnographic accounts appear to describe details about individual's or groups' way of life (Creswell 2008). According to Hansen (2006), conversational analysis focus on the structure and interactions during conversation while grounded theory seek to generate a theory (Glaser and Strauss 1967). In this thesis, framework analysis was used to analyse the data collected through in-depth interviews, focus group discussions and document review (Ritchie 2003; Ritchie and Spencer 1994). Framework analysis is a ''matrix based analytical method which facilitates rigorous and transparent data management such that all the stages...can be systematically generated'' (Ritchie, Spencer and O'Connor 2003:220). In this thesis, framework analysis was a matter of 'contextualising' the approach 'explicitly generated for policy and practice-oriented research and in health and social science research by the National Centre for Social Research' (Green and Thorogood 2009). The analysis started with a deductive approach using the conceptual framework and later inductively, building the emerging themes from the data. The inductive analysis started from the data and helped to develop regular themes and patterns.

There are a number of reasons why framework analysis was considered appropriate for this study. Framework analysis was explicitly designed for applied policy research which seeks to provide information on the needs, outcomes and recommendations of studies (Ritchie and Spencer 1994; Lacey and Puff 2007; Pope, Ziebland and Mays 2000). The analysis allows for inclusion of 'priori as well as emergent concepts' which

helps to address diverse policy related issues (Lacey and Luff 2009:9). This analytical process is explicit, transparent and provides systematic and visible stages which show how results have emerged from the data (Pope, Ziebland and Mays 2000; Ritchie and Spencer 1994). As such, the process provides a documentary trail of the analysis process which may allow review of the process if needed (Lacey and Luff 2009).

Five stages of framework analysis were applied as outlined below (Ritchie and Spencer 1994; Ritchie, Spencer and O'Connor 2003; Lacey and Luff 2009).

(a) Familiarisation: “Getting immersed in the raw data by listening to tapes, reading transcripts, and studying observation notes and transcribing data” (Ritchie and Spencer 1994:178; Pope, Ziebland and Mays 2000). Familiarisation commenced during the time of data collection and compilation of field interview summaries. Two FGDs and six interview transcripts were used to get familiar with the data. I chose transcripts from each of the main components of the research, service users, service providers and policy makers and variation of participant’s types/groupings. This process helped to develop themes as well as attitudes, behaviours, motivations, or views (Ritchie, Spencer and O'Connor 2003).

(b) Identifying a thematic framework: The process of identifying key issues, themes and concepts by which the data can be referenced and examined (Pope, Ziebland and Mays 2000:116). This was guided by the priori issues, developed from two conceptual frameworks of Maslow’s classification of need and quality of care discussed in chapters three and four respectively. This process produced a coding index for labelling the “data into manageable chunks for subsequent retrieval and exploration” (Pope and Mays 2006:73).

(c) Indexing/coding: The process of applying the thematic framework to all data using the codes. Coding was a process of tagging text with codes to help classify the undigested and complex data from verbatim to make sense (Bazeley 2007; Patton 2002). Indexing was done using a computer programme, NVivo. In the computer programme, different terms were used.

The coding involved deductive and inductive approaches and went through a rigorous process. Deductively, the analysis used coding index developed in section 5.6.2 (b). For example, the initial codes of the needs of orphans and caregivers (appendix R) were drawn from the Maslow's hierarchy of needs. Likewise, the codes on policy and service implementation (appendix S) were drawn from the framework of quality of care. Additional codes that emerged from inductive data analysis through the process of data familiarisation were also used. For example, themes on factors affecting the needs or orphans including culture emerged from inductive data analysis. Two levels of themes/codes on the framework of quality of care were used. The main codes were the elements of quality of care and they were categorised further into the service sector they represented, like health, education and others. This was done to manage the data better.

(d) Charting: "The process of creating charts from main themes and sub-themes to bring similar content together for ease of reading across the data" (Ritchie and Spencer 1994:178; Pope, Ziebland and Mays 2000). The thematic framework or coding index helped to chart the data across themes and participants. Each theme once printed was charted into its own matrix for reading. Instead of assigning row to each participant or transcript, and a column to sub topic or sub theme (Ritchie, Spencer and O'Connor 2003), the participants were categorised by type. For example, service providers were categorised as community, district or national levels. Orphans and caregivers were likewise categorised as service users. This was done to compare the findings within and between the different groupings. The charting process was done manually on A3 size paper.

(e) Mapping and interpreting: With the guide of objectives and themes emerging from the data, the researcher looked for associations between themes and explanations for the findings (Pope, Ziebland and Mays 2000). Reading through the charts helped to establish further themes, patterns, similarities and differences. This meant that each element produced another set of sub-themes. For example out of quality of care element coordination, the sub-themes on communication, structures, connectedness and others emerged.

Findings from each method was compared or triangulated with another method. Cross case analysis was done by comparing findings from different groups of participants. For example, views of service providers were compared with views of service users. Patterns, themes and emerging relationships provided a basis for identifying major policy or service delivery strengths and weaknesses.

5.6.3 Document Analysis

Document review was done as a continuous process throughout the study duration. Policy document analysis was done manually because not all policies were in electronic format. The preliminary document analysis helped to identify the existing documents that guided the sampling process through understanding of the context of policy and service implementation.

The main review of documents was done concurrently with analysis of other qualitative data. The analysis focused more on content than context of documents. The context was collected to inform the content analysis and provided background information. The context information included date of producing document, objectives, year, and location of document, document beneficiaries.

The analysis of policies used four codes from the conceptual framework of quality of care namely coordination, accessibility, comprehensiveness, and equity (see section 4). Different colour codes helped to sort the data from the policy documents. Under each element, the data was coded further according to policy type themes. The sub-themes included food, education, protection, economic, health and psychosocial. The data was then charted on a piece of A3 paper; they represented various child related policies for example, education, health or food policies. The content that emerged from the sub-themes was assigned as rows, while each element of quality of care formed the columns. These were read and the findings were reported by comparing the themes from each category of policy. The findings focussed on identifying strengths (positive) and limitations (weaknesses) of policies. Direct quotations from documents were used as findings from the analysis. Policy analysis template is shown in appendix T.

5.7 Research Quality and Rigor

While there is controversy and variations in terminology on what constitute qualitative rigour, scholars form consensus on its significance in qualitative research (Lincoln and Guba 1985; Seale 1999; Whittemore, Chase and Mandle 2001; Golafshani 2003; Hansen 2006). It has been suggested that rigour should be applied throughout the process of undertaking research to ensure validity of design, process and findings (Meyrick 2006; Descombe 2007; Lincoln and Guba 1985). The following measures were taken to ensure rigour of the study; audit trailing, triangulation, respondent validation, credibility checking and reflexivity.

5.7.1 Audit trail

This thesis has been transparency about how the research was conducted from design, sampling of participants, data collection and data analysis (Meyrick 2006; Hansen 2006). The framework analysis also provided systematic stages of data analysis. The quotations used to support analysis help the reader to make sound interpretation of the data.

5.7.2 Triangulation

Triangulation has been defined as a “valid procedure where researchers search for convergence among multiple and different sources of information to form themes or categories in a study” (Creswell and Miller 2000:126). Triangulation involves application of different strategies, methods and analysis approaches in one study. (Hansen 2006:54; Golafshani 2003). In this thesis, two types of triangulation were used. First, triangulation of research methods (in-depth interview, FGD and document review) was used to get a fuller picture of the problem under study. This was because each method brought about its strength as discussed in section 5.3. Second, triangulation of data sources was used to increase vigorous approach to data analysis and to maximise the interpretation of the data; hence assist in getting broader understanding of the participants and the situation (Green and Thorogood; Guion, Diehl and McDonald 2011). For example, interview with orphans and caregivers provided a comprehensive picture of the individual orphans’ and their households’ needs. Likewise, different levels of service providers brought about broad base of

evidence, hence increased the confidence in the findings. The analysis also corroborated the interpretation of findings from different data sources.

5.7.3 Credibility Checking

During the initial qualitative data analysis, coding of data from transcripts was done with a fellow research student to check for uniformity, consistency in use of codes and to avoid subjectivity in the coding process (Barbour 2001). Coding variations were observed on types of needs of orphans particularly the needs for security, which had different categories. Double coding of the same transcript facilitated the process of refining the definitions of codes and resulted in the reduction of the number of codes. Hence providing explicit information about the methods used (Green and Thorogood). The research supervisors helped to refine the process of developing codes (Barbour 2001; Ritchie and Lewis 2003). Four different coding indices were attempted before reaching the final template.

5.7.4 Quality and Training of the Research Team

Three days training was conducted with research assistants responsible for facilitating focus group discussions and data transcribing. The two research assistants were of good quality drawn from University of Malawi, had Master's level education and were well experienced in social research. The training was guided by information from study protocol/design and focused on data collection methods, ethics and other methodological issues. During the training, pilot interviews and mock interviews helped to clear misunderstanding and assumptions about the research. The recruiting volunteers were also oriented about the research. During this process, data collection tools, like question guides and recruitment checklist were refined.

5.7.5 Respondent Validation (Member Checking)

Barbour (2001) suggested that respondent validation involves cross checking interim findings with respondents to refine the explanations as well as to address participants concerns. Respondent validation also improves quality of analysis when participants provide interpretation and challenge the findings (Hansen 2006). In addition, the

process helped to build consensus on issues raised between the researchers and the participants and to ascertain the confidentiality of participants about in relation to information that was provided (Green and Thorogood). After collecting qualitative data, the preliminary research findings from field summaries and a quick look at the transcripts were discussed with national service providers through a feedback meeting. The meeting helped to build consensus on critical findings and to clarify some themes. There were two areas of consensus. First, the need to scale up community based services as a more cost effective approach than organizing services from the national level. Second, the urgent need to improve coordination of policies, integrated services and coordinated resource mobilisation for orphan care programmes. However, there were other areas where participants wanted the research to focus on, which were beyond the scope of the research. For example, service providers wanted the research to facilitate the standardisation of orphan related definitions and to develop guidelines for separating what constituted child labour from child work.

5.7.6 Reflexivity

Mansfield (2006:1) described reflexivity as "an examination of the filters and lenses through which qualitative researchers explores, learn and understand how they influence research." Hence, reflexivity reminds a researcher to realise they are part of the social world they are researching and to be sensitive to the manner in which their personal perspectives may influence the research (Pope and Mays 2006; Hansen 2006). Therefore, being reflexive help researchers to be honest about their role and to question their assumptions (Hansen 2006).

Documenting and keeping a research journal (which contained thoughts, feelings, frustrations, highlights and emerging issues) helped me to document how the research evolved and to build memos which helped during data analysis (Bazeley 2007; Watt 2007). For example, initially I had planned to interview only NGO service providers at community level. During the field data collection time, I realised the need to incorporate Government community multi-sector service implementers in the study. Field memos also helped to understand and apply the proverbs, which participants used to get deeper insight from the data.

At the onset of the research, I realised the sensitivity of the research in relation to my own experience of loss and grief caused by HIV related deaths. A number of my relatives (uncle, aunt and cousins) died of HIV/AIDS and I had the responsibilities of supporting orphans. I realised the need to separate and control my own emotions, when interviewing visibly distressed orphans and caregivers. Learning how the orphans struggle to live has helped me to become emotionally strong and feel the need for being aggressive to do more to help through policy reform and improved orphan care service implementation.

In regards to my job, doing this research made me realise the difficulty of being honest and accept the weaknesses of my own organisation and its influence on policy. Before this research, it was normal to defend my organisation's performance at any cost. When one interviewee pointed out the weaknesses of my organisation, I felt challenged. As more evidence emerged from independent interviewees, a transition process took place within me as I abandoned my defensive attitude towards my organisation's faults and concentrated on capturing the perspectives of the interviewees. Without being reflexive and the need for being honest, my documentation of interviewees' negative perspectives of my organisation would have been biased.

Reflecting on the data collection (interviews and FGD), I discovered the limitations I contributed in the processes. For example, reading through the transcripts, I realise how I should have probed for more information. I also realised how my interview techniques improved over time and wished I had more time to repeat some interviews. I also reflected on how I got overwhelmed with the amount of data I collected from the field and wondering how I would analyse the data. I reflected on how the data increased during fieldwork and came up with strategies for effectively organising effectively the themes further according to their service type and policy type.

5.7.7 Literature Search Strategy

There is a lot of published literature on HIV/AIDS, orphans and vulnerable children worldwide. Literature search was therefore guided as follows;

1. Published peer-reviewed literature on orphans and vulnerable children from Sub-Sahara African Region.
2. Literature related to orphans and vulnerable children produced by academia, Malawi Government, Non-Government Organisations and International development organisation.

This thesis recognises the comprehensiveness and multidisciplinary nature of literature. Therefore several sources were used to compile a list of relevant documents namely, internet searches from published peer reviewed including Web of knowledge, ERIC and Medline electronic databases, networking with key orphan and other vulnerable children stakeholders and references cited in documents reviewed.

Web of Knowledge is recognised as a premier research platform in the fields of natural sciences, social sciences, Arts and Humanities. It provides access to multiple databases, cross-disciplinary search and independent exploration of specialised fields. Medline is a premier database in the fields of life sciences and biomedical fields. ERIC database is considered to be the primary database for social sector particularly education literature.

Published literature electronic search

Searches restricted access of literature published from 1990-2012, using English language and focusing on Sub-Saharan region where there has been high prevalence of HIV/AIDS and orphans.

For orphan needs articles, the following keywords were used ; food, nutrition, school fees, school uniform, user fees, education material, health, stigma, discrimination, sexual abuse, child labour, child abuse, cash transfer, social protection, social welfare, safety net, clothes, beddings, shelter, housing and shoes. The result of this search was further filtered to select only those articles that covered orphans or vulnerable children.

To find orphan service articles, the following keywords were used; service intervention, programmes, project, project activities or guidelines. Further, the

following words were used; coordination, collaboration, partnership, cooperation, access, barrier, equity, fair, efficiency, corruption, nepotism, bribe, effective, comprehensive, all-inclusive, holistic, acceptable, suitable and affordable. This number of articles was further filtered to select only those articles that covered orphans or vulnerable children.

Orphan policy articles were found by using the following keywords; orphan, orphan care intervention, orphan care guideline, orphan law, plans, plan of action or guidelines. Table 5.12 and 5.13 show literature search results from the web of knowledge and medline respectively.

Table 5.12 : Medline Literature Search Results.

Search theme	**Number of hits**	**Number of Relevant articles**
Orphan needs	151	83
Orphan services	29	22
Orphan policy	46	32
Total	**326**	**117**

Table 5.13 : Web of Knowledge literature search results.

Search theme	**Number of hits**	**Number of Relevant articles**
Orphan needs	288	157
Orphan services	129	19
Orphan policies	188	34
Total	**605**	**210**

Medline literature search results

Preliminary review of the articles showed that there was an overlap of articles both between Web of Knowledge and Medline databases (11 articles (4.8 percent)) and between the search themes. For the Medline articles found for the three themes, 57 (27.1 percent) articles were duplicates while 42 (35.9 percent) articles were Web of knowledge articles were duplicates. After removing duplicates from both Medline and Web of knowledge articles, the total number of relevant articles reviewed was 217.

ERIC database search results

A search of peer-reviewed scholarly journals was conducted. Search words used were orphan or vulnerable children. A total of 79 articles were identified. Relevant articles were identified as those that addressed African continent orphans and orphans needs (food, education, health, shelter, protection and orphan care services). A total of 21 articles were identified. Out of these, six were cited in this thesis.

Networking

Since some literature written about orphans and vulnerable children is not published in peer-reviewed journals, several key organisations were contacted to collect existing relevant documents. These included Government organisations, United Nations institutions, academia and Non Government Organisations.

5.8 Chapter summary

This chapter provided detailed description on how research methodology process addressed the research objectives and questions. Pluralistic qualitative method was used using in-depth interviews, FGD and document review. All data sources were analysed using framework analysis.

Chapter 6 – Results: The Reported Needs of Orphans

This chapter addresses the first objective of the thesis, which was to explore the nature of orphan needs. A framework, based on Maslow's theory of hierarchy of needs (see Figure 3.2), was used to analyse the interview and FGD data. Orphans' reported needs and the relationships between them are described with the participant quotes to evidence the analysis. Caregivers also reported their experiences in relation to the caring roles. The final section of this chapter explores the reported strategies orphans used to meet their needs and factors affecting their needs.

As discussed in chapter three, Maslow identified five needs that motivated human behaviour. These needs were physiological needs, need for safety, need for love and belonging, need for self-esteem and need for self-actualisation.

6.1 Physiological needs

According to Maslow, physiological needs were crucial because they were a minimum requirement for human survival.

6.1.1 The need for Life Sustenance

Maslow considered food and water as essential for sustaining life. It was common for households keeping orphans to lack year-round access to food. This suggested that there was food insecurity which was a life threatening condition. Participants reported that often food supply from their gardens lasted about six months of the year. The rest of the year, they either bought food or engaged in food-for-work jobs. These alternative means of accessing food supply were erratic and inadequate to achieve food security.

Orphans and caregivers reported that food production was in many ways influenced by household food production factors, which included land ownership, land size, use of fertiliser or use of innovative farming technology.

We find food with struggles because sometimes we do not harvest enough food, sometimes we get few bags of maize (1 bag is 50 kilograms) sometimes we get three bags of maize (150kgs). The food is often not enough; right now, we are buying food. When we have money, we buy food. If we do not have money, we stay without food.

(Maternal orphan, aged 16, living with father)

It appeared that participants experienced two problems because of food shortage: reduction in food intake and decline in food quality. Participants reported that lack of food inevitably resulted in reduction of the number of meals per day; breakfast was often missed. For some this was attributed to lack of money for buying food, but others suggested that breakfast was not considered a high priority. Some orphans said that when there was no breakfast at home, they did not go to school.

We lack money to buy sugar for making tea or eating maize meal porridge. It is too expensive to spend K90 (£0.33) to buy whole grain maize meal for breakfast porridge- it is better to top up the money to K200 (£0.70) and buy enough maize flour for a meal because maize meal is more filling.

(Paternal caregiver, aged 62)

It seems the frequency of meals differed with the type of household head. Varied responses were given by caregivers, regarding the number of meals eaten per day. It was common for most households to eat one or two meals in a day although some child-headed households reported that there were days when they had no meals. Food insecurity was not an issue for all households as some paternal caregivers reported having three meals in a day throughout the year.

The results suggest that it was a common experience that orphans struggled to find food and sufficient nutrition intake. Orphans and caregivers described the process of searching/sourcing food as ‘kupulutika’, which means a strenuous and hopeless activity. They also used the term ‘kukokera’to imply applying austerity strategies that compromise on food quantity and quality, to prolong food stock.

We have nothing to eat for breakfast and there is often too little maize flour for a meal at noon so we eat one meal in the evening. Sometimes, there is no food either in the evening, so we go without food for the whole day.

(Double orphan girl, aged 13)

Oooh...to say the truth, my children do not eat as other people's children because of 'kukokera' they eat mostly once per day. That's it, I'm the one 'Kholo' (only surviving parent) who runs about, 'kupupulika'.

(Maternal caregiver, aged 43)

Apart from reduced food intake, poor quality of food was a recurrent theme in narratives by the orphans. In particular, orphans said their diet lacked the right balance of different foods and often lacked protein. Some orphans suggested that the decline in food quality was due to lack of money. Others suggested that it was due to the death of their parents. Ultimately, lack of money was the main issue.

Mostly we eat pumpkin leaves and wild vegetables. We rarely buy relish and sometimes we may not even eat small dried fish for a whole month.

(Double orphan in child headed household, aged 13)

There is a difference between now and before my parents died. The food we have now is not nutritious because we have no money to buy nutritious food such as tomatoes and cooking oil.

(Double orphan caregiver boy, aged 16)

Some orphans and caregivers articulated knowledge of the constitution of a nutritious and healthy diet. This suggested that it was food insecurity, rather than lack of nutritional knowledge, that was responsible for poor quality of food.

I do not have a healthy balanced diet, not 3 food groups. Foods that make you grow, food that protect you from diseases and food that give you energy. I miss tea or porridge for breakfast. I miss beans, meat and groundnuts for growth and health. We learn these at school.

(Paternal orphan girl, aged 14 living, with mother)

Apart from lack of food, it seems orphans had different problems with access to clean water. Many orphans accessed water from wells or boreholes, but they had to walk

long distances to fetch water. Some of the water was not safe to use because they fetched water from unprotected wells or streams. A few orphans, who lived in semi-urban areas, reported that they had to buy water but money was not easy to find.

In other narratives, orphans reported having played in bilharzia-contaminated water, because they lacked information about health hazards of playing in unsafe water.

> *I suffered from bilharzia. I was bathing and playing in contaminated water with my friends. They told me afterwards, I did not know that bilharzia come from contaminated water.*
>
> *(Double orphan boy, aged 14, living with grandmother)*

6.1.2 The Need to Maintain Body Temperature

The responses by some orphans suggested that they experienced the need that was similar to Maslow's level of need for protection from life threatening conditions because they lacked good shelter and clothes. There were a number of shelter problems reported by respondents. For some, their housing was dilapidated. For others, the housing design was described as a football[2] pitch, suggesting lack of basic shelter requirements. Many orphans and caregivers reported that housing problems were difficult to solve because there was no hope of getting assistance. According to Maslow, shelter and clothing are physiological needs necessary for maintaining normal body temperature (homeostasis).

> *It has been very difficult time...to keep the roof from leaking. We have termites here and during rainy season, flying ants come from the floor. The bathroom collapsed when dad died. Since we have no money to buy plastic sheet, we use the toilet as a bathroom. There is also a problem at the back of the house. The foundation was dug on a site of an old toilet, when rain comes, the bricks sink into the ground so I have to repair it. I do it myself because I have no one to ask for help.*
>
> *(Double orphan caregiver girl, aged 15)*

---

[2] Football pitch was compared to a house that had no separated rooms for different use, lacked furniture and lacked proper sleeping room with some privacy.

It was common for orphans to report having limited access to appropriate clothing. Some only had one set of clothes with no change of clothes. Others were wearing clothes which were inappropriate sizes left by the deceased parent. Many orphans reported having no shoes. This led to sores and cracked feet during the hot season. Many orphans reported having no proper beddings. Orphans could not afford proper beds or mattresses; instead, they slept on mats and used pieces of cloth for a blanket. In some narratives, orphans said the mats were damaged by ants that came from poor quality housing floor (un-cemented floors). Therefore, with poor quality bedding, many orphans were exposed to harmful cold weather which threatened their health.

> *My daughter does not have problem with food but clothes because she compares herself with her friends. She also needs to sleep on a good place. When you do not have a blanket you begin to worry when it's getting dark and the night gets long.*
>
> *(Paternal caregiver with his children, aged 61).*

It was common for caregivers to report differences in finding clothes for boys and girl orphans. The caregivers explained that boys' clothes were more expensive than girls' clothes. Hence, caregivers took longer time to replace torn clothes of boys than for girls.

> *Clothes are a problem and my children cannot dress like other children. Sometimes they have one t-shirt and two shorts. Before long, you find that the clothes are torn. I buy for the one whose clothes are torn and others have to wait for their turn, it is a struggle you know!*
>
> *(Paternal caregiver, aged 62)*

6.2 The Need for Safety

Orphans reported that they were exposed to different safety risks that were connected to Maslow's level of safety need. Orphans reported the need for security of health, security of body, security of property, security of finances and security of work.

6.2.1 The Need for Good Health

Some orphans reported having lived in conditions that suggested the need for good health. Some orphans reported that they were living in poor sanitary and poor

hygiene homes. Others said their households' lacked basic facilities, such as proper toilets and bathrooms. All these factors increased the risk of orphans to infectious diseases and poor health.

Many orphans reported having suffered from malaria, diarrhoea, bilharzia and chest infections. Some orphans suffered from malnutrition and headaches. Some caught measles during an outbreak, which occurred during the time of this research. Some were at risk of contracting HIV/AIDS. Still others explained that their siblings had contracted HIV from their deceased mothers.

> *Our life is hard. This place is ours, the house is also ours but the house is in bad shape. A pit latrine is almost full and we have no bathroom, so we use the pit latrine as a bathroom. We have termites' problem here and during the rainy season, flying ants come from the floor of the house. We asked some, neighbours to assist with insect pests and that solved the problem for one year.*
>
> *(Double orphan caregiver, aged 15)*

> *We have many problems, sickness, hunger and poverty. This child is suffering from diarrhoea, the other one from malaria and the third one headache.*
>
> *(Grandmother caregiver, aged 71)*

> *Sometimes I suffer from malaria and headache because I am not protected, my blanket has holes and mosquitoes bite me and so I have malaria frequently. Some have 'chitetezo' (mosquito) nets. Some buy them at the hospital or at the shops. I do not have money to buy the net. I am sad that I suffer from malaria frequently, because I have no mosquito net.*
>
> *(Double orphan boy with grandmother aged 14)*

6.2.2 The Need for Security of Body

6.2.2.1 Physical security

Orphans suggested that fostered caregivers used preferential treatment between orphans and their own children. Orphans reported that some caregivers beat orphans, denying them food when they did not play their assigned roles. However, this treatment was not applied to their own children. Orphans said they were subjected to

different forms of physical abuse, mostly by caregivers, including corporal punishment and food denial. Caregivers also reported that at times orphans physically abused each other. This occurred when some older boys, with undisciplined behaviour, bullied younger orphans, for no apparent reasons.

> *In that household…the child does not go to school because the child goes to work in the farm. One day he went to the farm with his friend and got cassava from the garden. When his grandmother discovered this, she beat the child bitterly. Other relatives of the child were angry and reported the case to the chief and the chief resolved the issue.*
>
> *(Paternal orphan girl with father aged 16)*

6.2.2.2 Sexual Security

It appeared that girl orphans, who had no adult to protect them, experienced various forms of sexual abuse. Caregivers and orphans reported that it was common for girls to be raped by male relatives or other males in the community. Some girl orphans reported having been sexually harassed by male teachers in school. The orphans were told that if they refused sexual relationships with teachers, they would be given punishments and their academic work would be frustrated.

> *When I reported to the headmaster that the teacher is forcing me to have a sexual relationship with me, the headmaster said I will be better off having a sexual relationship with him because he was the teacher's boss. He said that he earned more money than the teacher.*
>
> *(Maternal orphan, father living away, aged 16)*

Only girls from female-headed households or from a household with no adult withdrew from school because of early pregnancy. Such girls started parental child-care roles at a premature age. Indeed, some orphaned girls claimed to have started a sexual relationship because of lack of parental material support. Some girls reported admiring other girls who did not have to struggle to get material things from their parents. They justified having to start early sexual relationships to obtain material help from men.

They [non-orphans] tell me that school is good, so I agree with them but I also remind them that they have parents and that is why their school is progressing well. I tell them that I have no parents that is why my schooling has not progressed well...I stopped school because I became pregnant. I did not plan to get pregnant but I thought that if I got married, then he would help me look after the other children.

(Double orphan caregiver, girl, aged 15)

Girls rely on boyfriend's help. Sometimes the boyfriend buys things or gives you money. Some people have parents so they buy things for them. We admire those friends with parents, but us we have to sweat to find things...My boyfriend helps me with my school work. Sometimes he brings me body lotion or soap. Sometimes my boyfriend comes after my sister's boyfriend has brought her some things and we share the items when one's items have run out.

(Maternal orphan girl, father living away, aged 16)

6.2.3 Security of Property

Orphans suggested that they had no protection from property grabbing. Some orphans, particularly those with no adult caregiver in the household, reported that their relatives grabbed their property. It was common for land (gardens) that belonged to their parents, to be given to another older member of the family on the pretext that orphans were too young to manage a garden. They said they were an easy target for thieves, who stole their domestic property. Some orphans reported that some building materials (like roofing materials) were stolen from existing dwelling structures.

When my mum died, her relatives agreed that her sister should take the garden. I told them that I would be farming but they did not listen to me. I felt sad and I wondered where I would get food, since they refused to take me in their homes.

(Maternal orphan boy, father away, aged 16)

6.2.4 Security of Finances

Orphans expressed the need for financial security to be able to meet their needs. Many orphans reported having engaged in 'ganyu' outside their home, mainly because they wanted to find money. Orphans said that they often endured child labour through 'ganyu' as they sought to earn some money to buy food, clothes and educational requirements. In various narratives, orphans reported lacking educational requirements such as school fees, school fund, school uniform, learning materials and clothes. As a result, most of the orphans did not complete basic primary and secondary education. Orphans engaged in 'ganyu' to find money for clothes. Many caregivers reported that they had no money to buy clothes for their children because they had prioritized food need. As a result, many orphans had to find clothes on their own.

> *My life is difficult because I lack school materials. I lack pens, exercise books, and uniform and sometimes they require us to pay money.*
>
> *(Double orphan with grandmother, aged 14)*

> *We work in people's garden and when they pay us, we buy clothes. Orphans often wear torn clothes. When they get good clothes, it means that they did paid work, if they are old enough to work that is.*
>
> *(Maternal orphan girl with father, aged 16).*

> *I always think about how to find money! Because when I find K100 (£0.37) I always think of buying food, and yet you need soap for washing clothes, lotion for your body and school items. Then the money is not enough. Those who can have money for helping us, they can easily pay for school fees, buy soap…but clothes are difficult, it is better to just give us money to buy clothes of our choice!*
>
> *(Double orphan girl, aged 13)*

6.2.5 Security of work (child labour)

The orphans reported the need for protection from child labour. Orphans said they felt 'ganyu' was child labour because it was a strenuous. It interfered with school activities and assignments. Many orphans reported that they did too many domestic chores, which could have otherwise been done by their caregivers. Domestic chores consisted

of two main categories: farming-related activities and home-related activities such as washing plates, cooking and cleaning the home.

It appears that there was a divergence of opinion between orphans and caregivers on what constituted child labour. Orphans reported that it was the duty of caregivers to do domestic work, farming related work and other chores, because they interfered with schoolwork and denied them the chance to play with friends. A few orphans reported having back pains due to hazardous work in the garden. On the other hand, caregivers felt that orphans, as family members, ought to help with all types of domestic work. The information that caregivers provided, suggested that orphans were expressing a want, not a need.

It appeared that caregivers considered farming and other domestic chores as a child-training process. Definitions of child labour and child work are provided in the glossary of terms. Overall, caregivers reported that younger orphans were only involved in helping with work associated with food preparation such as cooking and washing dishes. A few young orphans, under ten years of age, were involved in extensive work in the garden.

> *The girl helps us a lot. After school, she fetches water, do some farming, some cooking and when there is time, she studies. Sometimes she goes with her friends to do 'ganyu' and buys herself clothes. Sometimes she sells firewood at Nancholi market, about 15 kilometres from here. She fetches firewood from Mpemba Mountain with elderly women from a distance of about 20 kilometres from here. She is 12 years old.*
>
> *(Paternal caregiver, aged 61)*

> *I do not like to go to the garden in the morning before going to school. I feel tired, have a headache and back pain. One can get old too quickly you know, due to overworking*
>
> *(Double orphan girl in child headed household, aged 13)*

Some orphans expressed knowledge of the nature of chores that constituted child abuse. They said what mattered was the severity, timing, frequency of domestic work

as well as the consequences of work on orphan's wellbeing. Many orphans felt that farming, either for domestic purposes or for making money, were abusive activities. For some orphans, farming in their gardens replaced school. The intensity of domestic farming by orphans was reported to be very conspicuous.

> *I feel child abuse is like violence, forcing someone to work against their will, and working beyond their age, such as gardening or carrying a heavy container beyond their age. Parents do not seem to understand.*
>
> *(Paternal orphan boy with mother, aged 16)*

> *Often orphans do not go to school because the people who keep them are abusive. Instead of sending them to school, they work extensively. When their friends are going to school, that is when they take them to garden. From the garden, the elderly people just sit but these children have to cook and fetch water. Sometimes when they finish working, they give them time to play but very little time.*
>
> *(Maternal orphan girl with father, aged 16)*

6.3 Need for Love and Belonging

Orphans reported that the loss of parents meant they lacked some basic things in life. This reported lack was mainly of material things, such as housing and food, rather than recognition that they lacked parental care and love.

However, some orphans' responses did suggest that they recognised a need related to Maslow's level of need for love and belonging. For example, orphans admired their friends who had parents and reported that they missed what they saw other parents doing for their children. Some orphans valued visits from their relatives; they were happy to be visited and knew that at least they had relatives who cared about their welfare. A few orphans directly reported missing parental love.

> *I wish I had parents but I don't have, because of the benefits such as good house, good food, once in a while a cup of tea, eating lunch and supper, I would be happy!*
>
> *(Double orphan girl caregiver, aged 15)*

> *Some orphans lack the love of their parents because some do not have any and they live with their grandparents*
>
> *(Paternal orphan boy with mother, aged 16)*

Orphans reported the need to belong to a family. Orphans said that, thinking about orphan status depressed them and often made them cry, because they desired to receive the kind of attention that their friends, who had parents were enjoying. This feeling was worsened when people said things to them that reminded them of their status. This happened when they heard their friends talking about what their parents had done for them. For some orphans, lack of parents made them feel bitter and they lived with pain of their loss. For instance, some school teachers asked the orphans to go and call their parents or ask their parents to buy school material items, such as uniforms. This made the orphans feel sad. More orphans, regardless of sex and age, worried about loss of mothers more than loss of fathers. Indeed, sadness was the characteristic of many orphans.

Orphans and caregivers reported having felt the need to belong to community. Many participants reported that orphans were discriminated against and stigmatized in the community. Many orphans and caregivers explained that they felt isolated and lonely because if they did not reach out for friends, friends did not contact nor visit them. They suggested that the efforts by the community, to provide support were insufficient. Caregivers reported that failure to integrate into the community made them feel socially excluded. Some said that they had no friends and lived lonely lives. One caregiver said, “I live like a bird, like a raven”[3]

> *I have friends and we do play together, the only problem is that we have to visit them. They do not come to our place and this made me wonder.*
>
> *(Double orphan caregiver aged 16)*

---

[3] Living without a friend made a male caregiver feel like a bird that hops from one place to another looking for food, unable to produce his own food, not having a friend to share food with but depending on begging and eating other people’s waste food.

6.4 Need for Esteem

Maslow described esteem need as the need for self-respect and respect by others. The need for self-respect was related to a feeling of competence, confidence, independence and freedom. Whereas, Maslow related respect of others to gaining status, fame, importance, and feeling appreciated. Narratives of orphans suggested they did not seem to experience the need for esteem as related to Maslow's theory of motivation. Instead, orphans reported the need for psychosocial support to help them manage negative feelings related to death of their parents.

Some reported that orphan status was perpetually associated with sadness. Double orphans were particularly stigmatised as AIDS orphans because their parents died one after another, within a short period of time. Culturally, death of parents, due to AIDS, was associated with parental reckless lifestyle and if parents died of AIDS, the community suspected that their children were also infected with HIV as well. Many orphans reported that they had to hide their identity to protect themselves from discrimination. However, orphans said it was difficult to hide their identity because of poor dressing and poor housing condition.

> *It is not possible for an orphan to be happy. Of course, sometimes they can express some happiness, but not fully, there is something sad that always remain within you.*
>
> *(Double orphan girl in child headed household, aged 13)*

> *When one person knows that the parents of this child died of HIV/AIDS, then his or her friend shun away claiming 'this one has AIDS lets us not play with him or her.'*
>
> *(Paternal orphan boy, aged 16)*

> *When you are in a group of people and you are not dressed well, they begin to ask your background. Does she have her mother, who is her father? Then they figure out the answer, that ooh…okay…she is an orphan!*
>
> *(Double orphan girl in child headed household, aged 13)*

Some caregivers said they lived a depressed life and felt overwhelmed with orphan caring responsibilities to the point of thinking of committing suicide. A few orphans, but mostly caregivers, visibly expressed their anxiety and depression.

> *I am trying hard. His mum left this boy at two months. I do not know how I can care for these (fifteen) children! Eel!...Sometimes I reached a point, (when I think that) it is better to throw myself into the river and die, How far will I go on with this life?*
>
> *(Grandmother Caregiver of double orphans, aged 61)*

On the other hand, orphans reported that the school environment was an opportunity where they could play with friends. This suggested that besides providing education, a school environment had psychotherapeutic value for orphans. They had no time to play at home because of their engagement with 'ganyu', and other domestic work.

6.5 The Need for Self-actualisation

The orphans suggested having a need for actualisation which was different from Maslow's level of self-actualisation. Maslow's need for self-actualisation emerges after all the other four needs in the hierarchy were satisfied. Maslow's self-actualisation was a life fulfilment stage. Contrastingly, orphans reported that pursing education was a means to a long-term strategy for meeting needs. Orphans seem to refer to future self-actualisation.

Indeed orphans expressed great motivation for pursuing education. Orphans expressed the need to access education, persist in school and attain education qualification. Orphans reported that if they were educated they would find a job in the future to support themselves and help their siblings. Many orphans expressed the ambition to become medical doctors, pilots, teachers, nurses or lawyers.

> *If you are educated, you can find a job and you are able to find things you need in life so that you will have a good life. I would like to become a doctor when I finish school*
>
> *(Maternal orphan boy with father living away, aged 16)*

I wish I could go back to school. If I can get education, I will be better able to assist my sisters and may be they would be in higher classes requiring school fees, and then I would pay for their school fees. May be, they too would look after others in future

(Double orphan caregiver, girl, aged 15)

6.6 Hierarchy of Needs

Orphans suggested that food need took precedence over other needs. This means that the need for food drove the behaviour of orphans towards finding food above other needs. This is consistent to the Maslow's pre-potency model of needs. Sometimes orphans absented themselves from school because they were hungry. For some they went to school when they knew they would find porridge for breakfast at school. When orphans were found lacking nutrients in the body, they preferred to be admitted at the hospital to be fed with proper food instead of going to school. This was because they had to be admitted for some months.

Sometimes when am hungry, I know that I cannot learn well without food, so I go looking for food instead of going to school.

(Double orphan boy with grandmother, aged 14)

The mother died and left the seven -month's old child sick with swollen legs. The girl who is in form 3 was looking after him in hospital for months, while I was busy earning money to pay at the hospital. Later on the same boy suffered again. The legs began to swell and her older sister carried her to the hospital…At the hospital they gave him milk and other foods for 2 weeks, by third week he was well again.

(Paternal caregiver, with children, aged 62)

Orphans suggested that the motivation for doing 'ganyu' was to meet the food need. Both orphans and caregivers reported that they primarily engaged in 'ganyu' to supplement food shortage. When they worked in somebody's garden, they were either paid money to buy food or to buy fertiliser to increase food production. Orphans used

different strategies, which risked their protection. More information on this is reported in section 6.8: detrimental strategies for meeting needs.

> *We get our help from winter cropping. We start this in March, when the rains are almost ending, after harvesting the rain-fed maize. We do a lot of 'ganyu'. We get K1, 500 (£5.50) the three of us per week, we are three boys. We agree how much to use for food, then we share the balance for clothes.*
>
> *(Double orphan caregiver boy, aged 16)*
>
> *We would wait to eat a meal at noon and another meal in the evening. The next morning, we would go and look for more 'ganyu'. I find 'ganyu' in people's gardens and get paid maize.*
>
> *(Maternal orphan boy, father away, aged 16)*
>
> *We do not have fertiliser normally. We got some money from casual work, so we bought and applied some fertilizer in our garden.*
>
> *(Double orphan girl in child headed household, aged 13)*

Financial security was the second most important type of need identified by orphans. In section 6.2.4 orphan suggested that they needed to secure finances to be able to meet their needs; hence, the need for finances appears as a prerequisite for addressing other needs.

Box 6.1 indicates a case study of needs of one household, which also suggest food as a priority need.

Box 6.1 Case study of needs of one household

Naomi is a girl double orphan who lives in the suburbs of Blantyre district in Malawi. Naomi was 9 years old when her parents died in 2004. Her mother died first, at the beginning of the year, after suffering from tuberculosis. Later in the year, her father also died from tuberculosis. Naomi was in standard 4 when her parents died. She became a caregiver of her two younger sisters, who were five and two years old. Her late parents owned the place they lived in, but the house was dilapidated and sinking because it had no proper foundation. Naomi and her sisters had neither proper toilet nor proper bathroom. They used a full pit latrine as a bathroom.

Often they went to bed with no meal. They depended on begging food from neighbours. When Naomi's parents were alive, they had a small garden, but some people grabbed the garden on the pretext that it belonged to the Government. Sometimes well-wishers gave them food, but benevolence was erratic. Sometimes her sisters depended on school meals. When there was no meal at home, they refused to go to school. Naomi and her sisters had neither proper clothes nor beddings. Naomi and her sister had to do 'ganyu' to find money. They worked in other people's gardens and sometimes washed people's clothes or fetched water. Obtaining payment for work they did was also a problem. Sometimes they had to wait for weeks for their earnings

Naomi's young sister frequently used to be sick that disturbed schooling because she had to take her to the hospital. Naomi was overwhelmed with problems. When she was 14 years old, she started a relationship with a young man, hoping that if she married, the man would help to look after them. However, when she became pregnant, the young man refused to marry her because she was coming from a poor family. Naomi had a child, so caring for it was a problem because she did not have money to buy milk nor other requirements. Naomi had expressed interest in going back to school, if only she had someone to take care of her sisters and her child. Naomi and her sisters still cherish the good old days when they had their parents. They remember the nice food they used to have, including a cup of tea with bread!

6.7 Relationships between needs

Security of health and the need for education

Orphans suggested that some of the needs they experienced were beyond the pre-potency relationship. It appears some of the orphan's needs demonstrated an interdependence relationship. Girl orphans reported absenting themselves from school to look after the sick siblings.

> *Sometimes I go myself and sometimes my older sister goes- we take it in turns. Every time we go to get ARV for our young brother, we miss classes.*
>
> *(Double orphan girl, aged 13)*

> *My 17 years old grandchild stopped going to school when her mother died, to assist me looking after her sick sibling. At that time she was in standard four*
>
> *(Grandmother Caregiver aged 71)*

> *My youngest sister used to be sick frequently and that used to disturb my schooling, since I had to take her to the hospital. When she recovered, my school progressed well for two years*
>
> *(Double orphan girl, aged 15)*

Psychosocial Need as an Effect of Other Unmet Needs

Many orphans and caregivers explained that failure to meet their needs made them feel psychologically depressed. They cited a number of needs they lacked, which caused sadness, including the need for food, the need for education, the need for security of health, the need for love and belonging (to be included in the community) and the need for security finances.

> *At school, I sometimes think about what I'm going to eat when I go home, or my exercise book is full, where would I write my notes. If I had these things I wouldn't be worried about them.*
>
> *(Paternal orphan with mother, aged 14)*

> *I think that if we had assistance, it would be good so that someone who is needy should not be worried and miserable, and then he can go to school without problems. I think the effect of being needy is that one lives a miserable life and may fail to go to school. He might wander into town to look for help there.*
>
> *(Maternal orphan with father away, aged 16)*

Other Examples of Needs Inter-relationships

To avoid repetitions, other forms of needs relationship are being referred as follows: Section 6.2.2 shows the relationship between the need for education and security of

body when orphans drop school due to sexual relationships. The same section also indicates the need for security of body and the need for security of health when early sexual relationships increase the risk to HIV infection. These examples also suggest an intra-need relationship where both needs fall under the need for security.

6.8 Strategies for meeting needs

Orphans reported different strategies they used to address their needs. However, they suggested that the strategies were detrimental to their lives and increased their problems (see Figure 6.1).

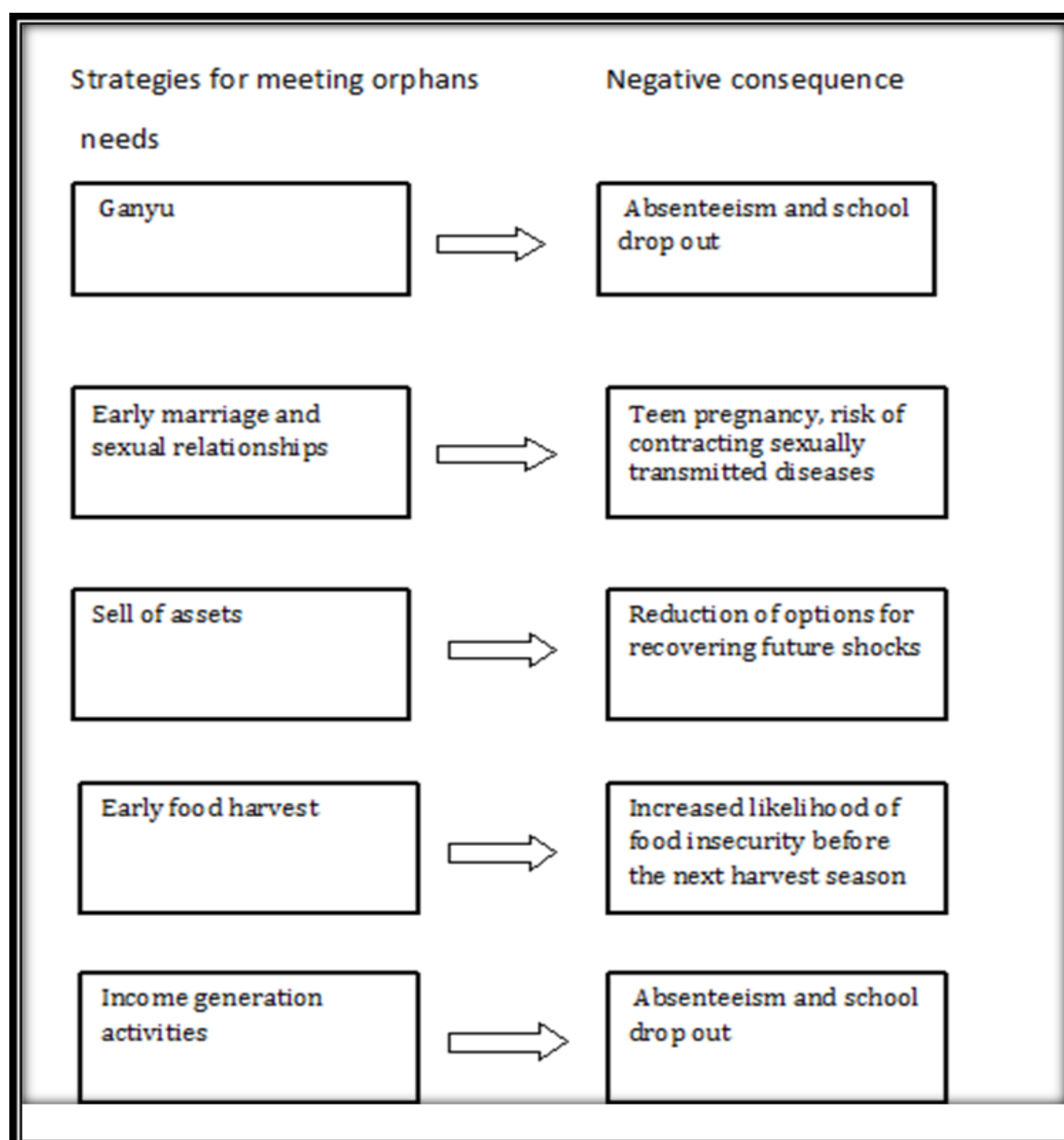


Figure 6.1: Detrimental consequences of strategies for meeting orphan's needs.

6.8.1 Ganyu

Orphans and caregivers reported that ’ganyu’ was not always a good strategy as a means for meeting their needs. While ‘Ganyu’ helped them to meet short-term needs, it could not free them from poverty. Furthermore, ‘ganyu’ appeared to have a potential to drag them into a poverty cycle and food insecurity trap.

> *Doing ’ganyu’ is difficult because you have your own garden but because you need money, you leave your garden and go to work for someone where they may gave you K1000 (£3.70) but you work for it maybe the whole month. You come back too tired to work in your own garden, so you suffer from hunger, Sometimes you want to get part of the money…because your children are suffering from hunger at home.*
>
> *(Paternal caregiver, aged 62)*

Some orphans provided evidence that engaging in ’ganyu’ had serious repercussions on school performance. Absenteeism was the most frequently cited education challenge. Many orphans expressed knowledge of the conflict of interest between ’ganyu’ and school work. Indeed, some orphans wished that there were a better means of meeting school needs. This suggested that orphans engaged in risky activities out of desperation or lack of alternatives, rather than lack of knowledge about the detrimental effects of their actions.

> *I think ‘ganyu’ retards my schooling. I miss classes and it is not always possible to copy notes from my friends afterwards, so that is a problem for me.*
>
> *(Double orphan boy with grandmother, aged 14)*

> *Combining ‘ganyu’ and school is hard. I have to do ‘ganyu’ early in the morning before going to school. I wish I had other means of finding what I need, like books, pens, shoes. It means instead of doing ‘ganyu’, I could have been doing school work, because time is very limited.*
>
> *(Paternal orphan boy with mother, aged 16)*

6.8.2 Early Sexual Relationships

As reported in section 6.2.2.2, the narratives of some orphans, particularly girls, suggested that they engaged in early heterosexual relationships as a means of getting

either money or material things. Some orphans reported that girls started prostitution to find money. Some orphans suggested that such behaviour exposed orphans to a high risk of contracting sexually transmitted diseases.

> *In this community, girls of about 15 years of age go into the city to look for money through prostitution. That is sad because they kill their future because they can get AIDS on top of money and die. They lack people who can help them. Even boys go to the city and start drinking and smoking (cannabis).*
>
> *(Maternal orphan girl with father, aged 13)*

6.8.3 Selling off Domestic Assets

It appears some orphans inherited property from their parents. However, orphans reported that whenever they faced problems, they were forced to sell the assets instead of keeping them.

> *We sell goats, which our parents left before they died and buy maize until the next harvest.*
>
> *(Double orphan boy caregiver, aged 16)*

6.8.4 Harvesting Premature Maize

Some orphans and caregivers reported that they consumed pre-mature maize from the garden as a meal before harvesting of dry maize, commonly known as 'green harvest'[4]. This reduced the yearly harvested food supply, hence worsening the overall food insecurity situation.

> *During this time of the year, we eat maize straight from the garden. This is the maize that has not yet been harvested because it is not fully matured but it is mature enough to be collected, dried and milled.*
>
> *(Double orphan boy aged 14)*

---

[4] *In Malawi eating green maize for a meal is a serious condition of food insecurity. Normally people eat green maize as a snack and not as a meal.*

6.9 Factors affecting Orphans and Caregivers Needs

6.9.1 Household Composition

It seems myriad household factors including age, marital status, household size, labour (ability to do work) and health of members contributed to needs of orphans and caregivers. Both caregivers and orphans suggested that household size meant having more mouths to feed but not necessarily, more labour for farming, because some of the children were too young to work in the garden or were not willing to work. It appeared the ability to provide adequate labour for farming affected the aging caregivers, female caregivers and young orphans, particularly girls. Aging caregivers reported having no physical strength to work in the garden or does paid work to earn a living to enable them adequately support their families. As a result, they relied on the orphans and other relatives to help them.

> *I get very worried when I have no food because food is life. There are a lot of people in this house and five bags of 50 kilograms of maize is not sufficient to last beyond October.*
>
> *(Grandmother caregiver, aged 69)*
>
> *Some people hire workers to assist them, so they complete farming quickly. I work alone.*
>
> *(Maternal caregiver, aged 47)*
>
> *The problem I have now is that I am getting physically weak than before, I have to rely more on my children to do the farming. Instead of me looking after the children, they are looking after me.*
>
> *(Paternal caregiver, aged 61)*

6.9.2 Decline in community assistance

Orphans and caregivers provided information that suggested that relatives and the community made efforts to provide for their needs, but the support was constrained for different reasons. Some orphans and caregivers reported having received food supply, usually maize, mostly from relatives, but less often from neighbours and local chiefs. Some orphans reported having received some education support from relatives,

such as brothers, sisters and aunts. This support was in the form of school fees and learning materials. Some orphans reported that they received clothes and beddings from the community through friends, neighbours and well-wishers. These gifts made the orphans feel happy.

> *'All my relatives are dead except my cousin who is now a chief. Sometimes he gives us a basket full of maize. Last year... he gave us maize twice'.*
>
> *(Maternal caregiver, aged 43)*

Caregivers suggested that community members provided help for psychosocial needs, and health care when they were sick. Participants reported that community members were helpful in providing moral encouragement that gave them some comfort and relief from anxiety. Some orphans reported that stigma and mockery stopped after the chief and the elders called for a village meeting to counsel the mockers. Orphans and caregivers reported that relatives appeared to be helpful in sourcing traditional herbs/medicine for preventing and curing illness. For instance, herbs were used to repel mosquitoes or to cure coughing.

> *I have been coughing for a long time. I am taking medicine but they are not helping me. I take traditional herbs, my relatives give me. My relatives cannot take me to the hospital…because they know that my grandchildren will have no one to take care of them. I am…the only one looking after them.*
>
> *(Grandmother caregiver, aged 69)*

However, orphans and caregivers said the support from relatives, friends and community had limitations. The community seemed to be overwhelmed to provide sufficient support to meet the needs of orphans adequately. Some orphans reported that when relatives, whom they depended on, died, the support suddenly stopped. Some relatives were too poor to help. Often orphans had to beg for food from people in the neighbourhood. For those who received food from the community, they often complained about inadequate quantities, poor quality or irregularity of the supply.

> *The chief gave me maize full of weevils! (rotten maize) He gave me the food enough for 2 days, in a small basin.*
>
> *(Grandmother Caregiver, aged 69)*

My mother's sisters live in the neighbourhood but they are also needy and so cannot depend upon them. Sometimes both them and us go without food for a whole day.

(Double orphan in child headed household, aged 13)

For some, educational materials and financial help were often unavailable, delayed or inadequate because those who offered help were needy too. Indeed, orphans reported that some relatives were not willing to help, even when they were capable of offering help. Generally, participants reported that there was a decline of assistance from the community.

I have a brother and a sister but they do not help the children or me. Sometimes I ask for salt but not soap. I do not know why, but they are rich. They have goats, pigs and have a good business. They know that I am looking after orphans but they are not helping me.

(Maternal caregiver, aged 43)

My relatives may cook food but my children may not be invited to eat with them because they may feel that they are feeding someone's children, because they are not theirs, some find it easier to give food to their own child only. Long time ago, parents and children used to live and eat together, sharing food and things.

(Paternal caregiver with children aged 62)

It was not usually the case that relatives and the community were unwilling to help orphans and caregivers. Sometimes, the caregivers considered that taking care of orphans was not the responsibility of their relatives and friends; but their own responsibility. Similarly, some orphans reported having felt tired of begging from relatives and felt that they had become a nuisance because they had been perpetually begging for many things.

My sisters do not assist me, they cannot assist me. Looking after these children is my problem, not there's.

(Grandmother caregiver, aged 69)

6.9.3 Gender and Living Arrangement

It appeared that orphans' engagement in domestic chores varied by gender between female and male caregivers and between boy and girl orphans. These differences appeared to reflect variations of needs of orphans by living arrangement. Culturally, cooking and food processing were accepted as female chores, but cooking was never a boy's chore. Caregivers reported that younger children, who grew up under the care of boy-headed households and male caregivers, had problems with food preparation. Water collection was associated more with girl orphans and women than boy orphans and male caregivers. Often boys collected water for personal use, while girls collected water for the whole household's use.

In addition, only girls reported being involved in caring for the sick people in the home. Orphaned boys in child-headed households and boys living with old grandparents did more farming and household chores compared to other orphans. The caregivers reported that they lacked physical strength as they get older.

> *May be they can cook, except that I have never asked them to cook. May be if I was ill, why should I ask the boys to cook while we females are here?*
>
> *(Grandmother Caregiver aged 69)*

> *There is a difference because girl orphan has to look after the home while boy orphan is not involved. Boy orphans just think about themselves while girls like me have to look after other children. Some boys only care about themselves, they may beg for food and eat on their own while if I went away, the children would follow me, and they would not follow a boy. Therefore, I go and work so that we have food.*
>
> *(Double orphan girl, aged 15)*

Consistently, orphans reported replacing the missing gender roles of the deceased parent. Some boys were replacing paternal roles of the dead father and girls were replacing maternal roles of the deceased mother. As a result, boys became breadwinners while girls did multiple motherly roles. Boys who lived alone and/or lived with old grandparents did extensive work in the garden.

> *The older children, I take them to the garden in the morning and afternoon after school. The little children do not go to the garden, they help with cooking, washing up and fetching water. Even the five years old girls fetch water. The 12 years old boy sometimes cut trees and burn charcoal and sell for his needs and he gives us money to buy food. He came few months ago from his uncle where he was learning car maintenance as an apprentice.*
>
> *(Maternal caregiver, aged 38)*

It appeared gender differences between paternal and maternal caregivers affected food security. A few male-headed households reported having food supply year- round while female-headed households were more food insecure. Caregivers suggested that there were a number of contributory factors responsible for relatively low food yields in female-headed households compared to male-headed households. Women had limited access to irrigation water pumps because ownership of a water pumps for irrigation was associated with male-headed households. When the male head of household died, the surviving female parent had problems accessing water pumps. Besides, women had difficulties to access and use water pumps because they were not user-friendly for them. Male orphans were also able to increase food production because they engaged in irrigation farming.

Paternal caregivers also enhanced food production and acquired farming technologies for increased production, through use of compost manure or fertiliser bought with savings or loans. Men acquired improved farming strategies and skills through membership to farmers' clubs in the community.

> *I have enough food throughout the year. Some people buy maize but I do my best to ensure that we do not buy maize, sometimes I give some maize to other people – we do not have food problem. We eat three meals every day, Maize meal, potatoes and if I have money, we buy rice. I also hire people to work in my garden.*
>
> *(Paternal caregiver, age 50)*

> *We eat the maize from the winter harvest after we have used up the maize from normal harvest. However, for the tomatoes, we sell at the market. Now*

that I'm alone I find it easier to grow these two crops only, but in the past before my husband died we used to grow and sell pepper, onions and other vegetables in bulk because he had a treadle pump.

(Maternal caregiver, aged 43)

Gender domestic roles also seem to have affected caregiver's roles. A male caregiver, whose wife had died, reported having experienced difficulties fetching water, because water sources were surrounded by women. Male caregivers were forced to collect water at night, when women had moved away from water collection points. It was noticed that housing related problems emerged as a gender-based problem, because it affected only women-headed households. Maternal caregivers reported having labour deficiencies and therefore unable to construct or renovate houses.

I am bothered that I lack assistance. I do not know. Right now, my house is collapsing. You wonder what you will do. My husband built my house before he died; now it is in disrepair and I do not know where to get assistance.

(Grandmother caregiver, aged 61)

Male caregivers provided information that suggested that they had better socio-economic status because they were physically more capable of cultivating more land than women. They reported having more abilities and opportunities to earn income than did women. Further, women's capacity and opportunities for employment were undermined by child-caring roles.

I try to do different things to find money. I go to town near the filling station, work in people's homes washing clothes, ironing clothes, and sometimes go to process food at the maize. Sometimes I spend a week working away from home and come during the weekends to see my children. At the moment I am not working because my two children were sick and there was no one to take care of them.

(Maternal caregiver, aged 43)

I have different ways of earning a living. I grow maize and other crops in my garden, I work as a security guard at the nearby school and I sell truckloads of firewood from my woodlot.

(Paternal caregiver, aged 52)

6.9.4 Culture

Some orphans and caregivers reported having experienced culture-related challenges. It appeared orphans were negatively affected by the matrilineal culture. This type of living arrangement is the situation where a man lives in a place where the wife comes from but does not have control over children nor property, especially land. The brothers of the wife have authority over the children and the property. When the wife dies, often fathers have to go *back to their home* or they are sent away, especially if he wants to remarry. Relatives of the deceased mother are responsible for the care of the remaining orphans. More details about matrilineal and patrilineal social systems were discussed in chapter one, section 1.2.4.

It was evident that mostly surviving maternal caregivers lived with their children. Some paternal caregivers went away from the household, remarried or unsuccessfully attempted to remarry. Often, when the surviving paternal caregiver went away, orphans changed living arrangements and lived with grandmothers on the maternal side. Many orphans explained that they experienced poorer quality of life in the changed living environment. Orphans said that it was because the assistance was erratic and discontinuous. Some caregivers reported that cultural issues created conflicts and uncertainties about who would be responsible for maternal orphans. Many orphans reported that living with a surviving mother was better than with the surviving father, because unlike a father, orphans believed that the mother could not leave them alone even if she remarried or went away.

> *When my wife died, I only took the baby who was under breast-feeding and left the older children with their grandmother because they did not have money to buy milk for the baby. One time when I visited the children, I found one of the children had dropped school and started domestic paid work because they lacked support. I withdrew her from work and she returned back to school.*
>
> *(Paternal caregiver living away, aged 52)*

> *There is enmity between me and my brothers and sisters, so that they do not have interest in my children. Once when I went away, they beat my wife with*

the children and later burnt our house. I know that if I die today, the children would be in trouble and they will be chased away because my wife came from a distant area, to live here at my place with our children.

(Paternal caregiver, aged 62)

6.9.5 Lack of parental support

Some orphans reported that lack of parents was the cause of food, and other related problems. For instance, some suggested that it was the parental role to encourage them to go to school, and to provide for their school material needs. Orphans suggested that assuming parental role of providing for basic needs was somewhat difficult. Indeed, surviving maternal and paternal caregivers' interviews suggested that they encouraged their children to work hard in school.

We have problems finding school materials. To say the truth we lack parental care…because a parent is a parent. Hmmm! For example when you have no school fees, you can tell your parents, they can pay...Now they send you back home. Sometimes... they tell you to go and call your parent, whom do you call? Hopeless! For clothes, you have to work extremely hard without that mmm!

(Double orphan girl, aged 13)

I was not happy with her performance; her spelling was poor for someone in standard seven, so I advised the teachers that she should repeat the class. Her performance has improved after repeating the class and she is now working hard.

(Paternal caregiver, aged 50)

6.10 Chapter summary

Chapter 6 has shown that orphans had needs that were related to Maslow's classification of needs. These included physiological needs, security and the need for love and belonging. However, the need for esteem and self-actualisation did not seem to fit very well with Maslow's classification of needs. In addition, orphans' behaviour suggested a hierarchy of needs for physiological and security needs. Beyond this level, the needs suggested an interdependency relationship. Orphans needs also seemed to differ by their living arrangement. The next chapter provides information regarding how service provision responded to the needs of orphans.

Chapter 7 – Results: Service Delivery to Orphans

Chapter 4, which provided the quality of care framework and the literature on orphan care service provision, has informed this chapter. This chapter addresses objective number three, which explored the quality of orphan care service implementation by the multi-sector service providers. The information in this chapter was based mainly on reported perceptions of services users and service providers, using in-depth interviews and focus group discussion (FGD) data collection methods.

The elements of the quality of care framework guided the analysis of data for this chapter by highlighting the strength/positive attributes and barriers to determine quality of services for orphans. Service provision to orphans is therefore discussed with reference to the eight elements of quality of service delivery namely; comprehensiveness, coordination, accessibility, effectiveness, equity, efficiency, acceptability and continuity. Chapter four sections 4.2.1, 4.2.3 and box 4.1 described definitions of the elements of the quality of care framework and how the elements of this framework were adopted in service provision to orphans.

In this thesis, orphan care service delivery was analysed across all service providers. Service providers were categorised by levels of service delivery namely, community, district or national level service providers. Service providers were also reported by their types as Government or NGOs. Details of orphan care services were provided in chapter two, section 2.4 and table 2.2.

7.1 Comprehensive Services

Narratives of service users reported that there were some instances of comprehensive services. The orphans said, sometimes they received services that addressed a number of their needs, when different aspects of a particular need were addressed. The reported instances of potential comprehensive services included, community based services and cash transfers. Overall cash transfer and services that helped to build service users' income base appeared to address comprehensive needs of orphans. Consistently, service users, as well as community, district and national service

providers reported the potential for some community based organisations to provide comprehensive/holistic services through community based childcare centres where food, education, health and psychosocial services were provided to young orphans.

> *Community based childcare centres (CBCCCs) address the nutritional needs of under five years old children. Children who go to CBCCCs are given a meal. We also give some health services, growth monitoring and immunisation*
>
> *(National government service provider)*

> *Government provides social cash transfer to very poor households and households that keep orphans. The money economically empowers the whole household because they get money at the end of the months for food, clothes and other family needs. The money varies with the number of people and increases with the number of children because they pay for school need and school fees for primary and secondary education respectively*
>
> *(National government service provider)*

It appeared that there were different opinions in reported information between service users and service providers regarding the value of orphanages having the potential to provide comprehensive services to orphans. Many orphans and caregivers said that orphanages were very helpful because they delivered diverse services such as food, shelter and education services. On the other hand, service providers reports suggested that despite the orphanages providing multiple services, the quality of their services were questionable. Service providers also suggested that it was better to keep orphans within extended family because hosting orphans in orphanages was foreign and not sustainable.

> *I would love to go to Akwedi home because they give you food, clothes and a home. The other benefit is that you do not do heavy work, so you concentrate on your school. When you pass well they pay for your secondary education. They even help your brothers and sisters at home, they give them food and soap.*
>
> *(Double orphan boy, household head, aged 16)*

On the other hand, service providers reported that often, it was not possible to provide comprehensive services to orphans. Circumstances and barriers that led to

failure to provide comprehensive services were also reported and are outlined as follows:

7.1.1 Failure to Address Whole Household Needs

Service users, district and national service providers reported that the services were not comprehensive enough to address the needs of orphans, their siblings, other non-orphaned children within the household as well as the needs of caregivers. Failure to address the needs of the whole family had detrimental effects to orphans.

> *I wish there were people who could assist with food and clothes for all children in the household because I fail to get them on my own. This is the quality of assistance I would be happy with.*
>
> *(Grandmother Caregiver)*

> *We have a case where an orphan was given a blanket. On arrival at home, a caregiver took the blanket away because in the caregiver's thinking, an orphan did not need to sleep under a blanket but under a piece of cloth.*
>
> *(District service provider)*

7.1.2 Insufficient Resources and Donor Over-Dependence

It appears that services to orphans were not fully comprehensive because the demand for services was disproportionally higher than the supply of services. Service users, district and national service providers consistently reported that it was common for service providers not to deliver holistic services because they lacked resources. Therefore, services failed to cover all orphans and caregivers who needed the service, services were either spread out thinly among the service users, or only few orphans were provided with the service and sometimes services only addressed part of the need. Service users cited educational services, cash transfer, subsidised fertiliser, health, protection services and psychosocial services as being grossly insufficient.

Community service providers reported that although they had planned to provide comprehensive services to young orphans at community based child care centres and to provide food to the whole family, their efforts were derailed due to insufficient resources. For example, they said they failed to give the orphans food to take home

and eat with their siblings and to provide the orphans' caregivers with psychosocial services.

> *We are happy that we are receiving farm input subsidy coupons but our complaint is that we are not receiving adequate number of coupons in comparison to our gardens the problem is that government send fertiliser coupons that are not enough. Here in Makata, they sent only 100 coupons and yet there are four hundred families and even more!*
>
> *(Paternal caregiver aged 52)*

> *The problem we have with the services in the community is that they are not enough. For example, food is the main need. Some of them only eat here at the CBCCC centre there is no food or very little food at home. We rarely give them little food to take home. Even with home based care service, we only focus on the patient, but no attention is given to relatives, we do not offer any help on how they can cope with stress and trauma. We rarely keep drugs in the community.*
>
> *(Non-government community service provider)*

> *Orphans who were only provided school fees did not perform well in class. We are not providing the other material support. So, probably if we had provided both material and school fees, maybe it would have helped them to perform better in class*
>
> *(National non-government service provider)*

Service providers reported that the reason for failing to provide comprehensive services was that Government did not provide enough funds for orphan's services. As a result, lack of resources in the country caused heavy reliance on donor funds. They said the following services were affected because donors only sponsored them; provision of school meals, cash transfer and educational material services. Further, despite having multiple educational material needs, only bursaries were provided to orphans because that was the focus of the donor. For some, failure to provide orphans with adequate services was exacerbated by poor coordination among service providers.

> *The Ministry of Gender, Children and Community Services (MoGCCS) receive very little money from government for operations. They fail to do monitoring of activities, to reach out to abused orphaned children and offer assistance. By the time they get to the needy child, it is too late for action.*
>
> *(District non-government service provider).*

We are only providing school fees and I have already said that educational material support is also another challenge. They require writing materials, school uniform, shoes…among other things and the current bursary scheme does not cater for those. However, the other challenge is if we introduce material support, are we going to sustain that…? This programme is funded by Global funds.

(National government service provider)

We do not have resources to cover the whole village; as a result, our services do not cover all needs of orphans. One organisation will provide education but is not willing to work with another organisation that provides food.

(National non-government service provider)

The consequence of insufficient resources was that service providers were forced to rationalise distribution of resources during service implementation. In this process national service providers said that although some services were meant for universal access, they had to target and prioritise the beneficiaries because those who needed the service were more than the available service. For instance, within the health sector, national service providers reported that due to constrained resources, more and better quality medical treatment was provided to younger children less than five years of age, pregnant or lactating mothers because of their increased vulnerability and higher health risk than any other group of patients.

Usually the common illnesses are the same, but you see, the under fives are a vulnerable group that are likely to drift into severe illnesses or they are likely to die and they are also monitored globally, even nationally. However, the Ministry of Health is also working in providing universal coverage. We struggle to reach out to every person requiring treatment at the same time giving attention to young children.

(National government service providers)

7.1.3 Lack of Access to Services

Some orphans reported that some services were not provided at all in their areas. Both Government and NGO national service providers also explained that they had difficulties in providing services such as provision of shelter or renovation of dilapidated houses and psychosocial services because they did not have the capacity, were resource constrained or not guided by policy. This is important as orphans and

caregivers in the chapter 6, section 6.1.2 and 6.3 respectively reported lack of quality of housing and lack of psychosocial services.

> *I am bothered that I lack assistance. I do not know. Right now, the house is collapsing; you wonder what you will do. My husband built my house before he died; now it is in disrepair and I do not know where to get assistance*
>
> *(Grandmother caregiver, aged 61)*

> *The area that we have not done well probably is the provision of shelter. I think it is the nature of the organisation that probably we are in. Government is not a direct service provider, so addressing issues of shelter, specifically are not easy. Probably the best way of addressing that issue would be through the foster care scheme. We need to review of entire regulatory system and make sure that children who have no shelter are provided with shelter*
>
> *(Government national service provider)*

7.2 Service Coordination and Collaboration

Generally, it appeared that national service providers had the potential to deliver coordinated services to orphans mainly when they operated under a similar union or grouping that bound them together. They said that some service providers who belonged to one sector or network had at times good collaboration. For example, NGOs that were funded by one donor, operated under one umbrella organisation, had good communication and performed joint activities. National service providers also said that it was common for international organisations to team up and work together for the common cause. For example, International organisations mobilised local NGOs and formed local networks as a coordination mechanisms for orphan care service delivery. In addition, faith based organisations from International and local organisations collaborated to support orphans.

> *On 6th May 2010, we decided what we called NGO coalition for child rights. It is a coalition of eight coalitions working to provide more and better children services. Membership is based on existing civil society networks. Two key advantages are that it will remove unnecessary duplication and provide common and collective voice. For example, when we say to the child bill, all the 8 networks have said yes. International Donor took about 70 per cent of leadership including funding.*
>
> *(National non-government service provider)*

We try to have linkages with other organisations that are dealing with orphans and other vulnerable children like World Vision International. We go to learn their models of operation, to find out if our partners can also learn so that they can replicate some of the models that have worked for World Vision; we also work with our network partners in health, to ensure that we don't overlap services. We also work with Family Health International on some of their practices.

(International non-government service provider)

Community, district and national service providers reported that community-based services had the potential for effective services. This is because they tend to have, good communication, feedback system (between different community service providers as well as between service users and service providers) and good service referral system between different service providers. They said the community-based organisation provided a source of information linkage between the service users and different sector service providers from government and non-governmental organisations. For instance, community service providers linked needs of orphans to social welfare service providers and to other institutions.

When some orphans are stigmatised and feel isolated in the village, the chief tell us. We also go to schools to find out challenges orphans face then we report to the Social Welfare assistants who provide counselling services to the orphans

(Non-government community based organisations)

Children from this community child care centre perform well in primary school. Teachers tell us that the pupils are doing well in class. We also meet the children and they tell us that they get good grades. Parents also tell us that some of the children jumped a class to standard two instead of standard one because of their good performance.

(Community based non-government organisation)

7.2.1 Poor Service Coordination

Community, district and national service providers suggested that they faced challenges to coordinate themselves to deliver services to orphans. It appeared there were different forms of poor coordination among orphan care service providers that were also caused by varying reasons.

First, district and national service providers suggested that there was lack of connectedness between higher and lower level service providers. From the lowest level, community based service providers reported facing difficulties working with higher-level service providers including donors, non-government service providers and Government service providers who came to support community service implementation. They said higher-level service providers had a tendency to change existing operating structures and protocols without consultation or agreement with community service providers (CBS) providers. For example, they created new rules of operation, which eventually interfered with the existing local systems.

> *On our own as CBOs we are united, but government is creating problems among us. Why does the Social Welfare create another community-based organisation within the same village when they already know that there is a faith-based organisation in the same village.*
>
> *(Community non-government organisation service provider)*

Often, higher-level service providers overlooked the local protocols and communication channels and were not transparent in service provision. For instance, district and national service providers bypassed the local communicating protocol of introducing service to service users through the chief, instead they opted to approach the orphans directly. Generally, it appears CBS providers were willing to work with higher-level service providers as long as they abided by their working structures and rules.

District service providers also reported that higher level, national service providers from Government, NGO and donors often bypassed the district assembly leadership and implemented services directly to orphans in the community without district assembly's knowledge. The district service providers reported that when this was done, the district assembly had problems to follow up or supervise the implementation of activities.

> *One of the United Nations Organisations funded an NGO directly in Blantyre district to support community based organisations activities for orphans without involving the district social welfare office. When things went out of hand, they asked the district office to follow up on activities and to liquidate the funds; they even consulted the district for a signature. The district office*

was reluctant to do the work because they were not aware of what was contained in the agreement. What donors forget is that when they provide funds to orphan activities, they are supporting the Government, so they should involve us!

(District government service provider)

Non-government organisations should work with local community based organisations. Right now, there is no coordination. Some NGOs start their own CBOs, when in reality CBOS are supposed to be self-formed by the community members based on local needs.

(Local government multi-sector service providers)

Secondly, it appeared that same level service providers were poorly coordinated. In particular, it was common for Government and non-governmental organisations to disagree on approaches to service delivery and there was evidence of poor coordination between Government and NGOs within the interviews. NGOs found it difficult to abide by government leadership and authority because of Government's bureaucracy that delayed service delivery and hence did not match up with NGOs working pace. Government felt it was because NGOs did not want to be transparent with their resources.

Ah! Coordination! Most the work is being done by NGOs. Now to coordinate from government there are problems and you know! We work differently. Outside government, they do a lot and we do a little so the partnership sometimes if not well embraced may cause problems. The other issue is that our friends have resources, we do not have resources. You need to move faster to meet them. In private they are flexible while we are not as flexible. It takes us a long time to distribute items, the same materials can be quickly be distributed by NGOs.

(District government service provider)

Working between Government and NGOs is a problem. We have an inventory of NGOs in the district, but we also see that new NGOs come in without us knowing them. When we ask them what criteria they used to choose the area, they cannot answer!

(District government multi-sector service providers)

Thirdly, district service providers and service users reported minimal coordination among the NGOs. The NGOs implemented services in isolation. Each NGO worked on specified scope of services and geographical area. It was difficult for different NGOs at

district level to jointly pool their resources towards a common orphan care activity to support orphans. This was because, those NGOs which competed with each other were not transparent with their resources and there was lack of a functional coordination structure. This rendered their services less effective to orphans.

> *There is need for more coordinated resources on service delivery. For example you work in a district which has NGOs but nobody knows how much they are spending on orphans. Every NGO does not know where the other NGO has stopped. But, you see, every NGO has a place they fit in the overall development plan. What we need is an accountability office to coordinate all the district service provider's resources. With the situation now, we cannot assist the orphans properly.*
>
> *(National non-government service provider).*

> *The other thing is that there is no coordination among NGOs; as a result, there is duplication of roles and power struggle...In the end we have a challenge to track output and measure impact because of poor coordination.*
>
> *(District government multi-sector service providers)*

The fourth factor that hampered coordination of service providers was non-functionality of implementation structures, like orphan care committees at different levels. To effectively implement orphan care services, Government initiated the formation of orphan care committees at different levels, ranging from village/community, district and national. These committees experienced many difficulties. The community, district and national service providers explained that there were too many orphan care coordination structures, the orphan care committees lacked information, technical capacity and proper guidance on their functions from the coordinating Government Ministry (MoGCCS). They also lacked resources to conduct activities and to undertake meetings. To conduct a meeting, they needed finances towards transportation, incidental expenses and accommodation of participants. At community level, the orphan care committees seldom involved people who were affected by the problems, including carers of orphans. Further within the district assembly, the functions of orphan care committees were not standardised. As a result, only committees which had funding were active.

> *Service implementation structures are not clear. Within one district assembly, there is child protection committee at City Assembly (report to District*

Commissioner) and child protection committee at District Assembly (report to District Social Welfare Officer). Why don't we just have one committee, so that we serve time and avoid duplication of work?

(District multi-sector service provider)

At national level, service (NOVCTWG) and policy (NOVCSC) committees were formed by the coordinating ministry (MoGCCS), but these were less functional because of irregular meetings and some committees lacked the capacity to handle orphan issues. Further, participants also explained that the MoGCCS was less committed to attend technical committee meetings organised by other sectors that needed their leadership and technical guidance.

We need to review composition of members who attend national steering meetings so that we have people who can provide proper guidance and have technical know-how. The major issue with technical committees is lack of technical knowledge on orphan issues and service delivery

(National government service provider)

We lack frequent technical meetings to be organised by Ministry of Gender because as I said coordination is crucial! We need to meet every quarter. When we don't meet, we lose focus on orphans because each organisation ends up doing their own things. Moreover the Ministry of Gender do not attend our technical meetings. They don't even follow up, nor monitor what we do nor guide us where and how to implement services

(National non-government service provider)

Coordination committee meetings between Government and NGOs thrived whenever there were resources. Participants consistently explained that government was allocating meagre resources to the (MoGCCS) for coordination of orphan and children activities, which undermined its capacity to lead orphan care services.

The challenges are that we must ensure that the subcommittees are functional but for them to function there have to be resources, but we don't have them. So in most cases we have an HIV/ AIDs committee, this is very vibrant because it has the resources but these others are dormant

(District government multi-sector service providers).

We have advocated saying that where partners feel they don't have resources, they need to identify one another and team up and provide that full package of health support, which includes prevention, treatment and social and mental development.

(National government service provider)

Poor coordination among service providers seems to have affected the service users negatively. Service users' reports suggested that they had to register their needs over and over again with different service providers. Unfortunately many reported having felt frustrated because although service users took a lot of time registering their needs, many service providers did not provide the service.

7.3 Service Accessibility

It appeared service users and service providers provided evidence that suggested that throughout, orphans had difficulties to access services from service providers. These challenges were caused by distance, structural problems, delays and cost of services.

7.3.1 Distance and Structural Barriers to Service Access

It appeared that many service providers failed to provide orphans service within accessible distances. Many orphans reported difficulties to access basic services because they were sparsely distributed and thus required them to walk long distances and long hours to access services. They said long distances constrained access to basic domestic services like boreholes, food processing facilities as well as public social services which included access to markets, schools and hospitals. Orphans effort to reach out to services posed a security risk because they had to walk through dangerous roads. It was common for service users to report having difficulties to travel and access services that were provided at institutions. Such services included schools, hospitals, skills training and institutional care.

I would want government to bring a maize mill here because they are scarce; we have to go to Lunzu. We leave early in the morning and come back in the afternoon. Boreholes are also scarce and far. We converge (timaunjikana)[5] at

---

[5]large crowd of people as if there is a big function or meeting with commotion and scrambling.

> *one borehole and people fight as they scramble and wait for their turn to collect water.*
>
> *(Maternal orphan girl, aged 13)*
>
> *Because hospitals are far, people go to hospital as a last resort, people go to herbalists in the village even for birth delivery; there are no drugs in the village clinics.*
>
> *(District government service provider)*

Caregivers also explained that despite provision of coupons for buying subsided fertilisers, they lacked nearby markets where they could buy fertiliser and fertiliser availability was irregular. As a result, there were times when they slept at the market for a number of days and that process exposed female caregivers to sexual abuse.

> *There are many challenges when we want to buy fertiliser. The agriculture markets are far and there are many people; some who come late can buy before those who come early. Sometimes we take three days, waking up early at 2 o'clock in the morning and come back in the evening. Some people start promiscuous behaviour right there! If we are many we contribute money and hire a car.*
>
> *(Paternal caregiver, aged 61)*

It appears distance challenges to access service were compounded by structural factors. Community, district and national service providers reported that ARV treatment for HIV patients was administered only in referral and district hospitals in urban areas. Since these hospitals were far from rural service users, rural service users had more challenges with travel than those in the urban areas. Service users and district service providers reported that young orphans had difficulties travelling long distances to access ART[6]. Likewise, skills training programmes were offered in towns and rarely in the community areas. It seems age of caregiver compounded the problem of young orphan's access to ARV and other medical services since older caregivers had difficulties walking long distances to take younger orphans to hospitals. ART access challenges compounded problems that households were facing.

---

[6] ART treatment in Malawi required that each patient should physically go to the hospital to receive the ART medication.

The other problem is that sometimes the caregiver who is a grandparent and old are not able to take a child to the ART centre because they are far away. Old caregivers are not able to make it.

(Community government multi-sector service providers)

When we went to the hospital, they found that my young brother was HIV positive. We went to town where they gave us ARTs. We have transport problem the child does not take ARTs for some days until we get money to go and get some more ARTs. We take two buses to get to the hospital. If we do not go, he does not take medicine for days. Every time I go to hospital with him, I miss classes.

(Double orphan girl, aged 13)

In the areas where we are working, many people complain about access to ARV because they are only given at district hospitals. People in rural areas mainly have problems because they need transport to travel.

(National nongovernment service provider)

Indeed inequitable service access among orphans was caused by unequal geographical distribution of services with better infrastructure and facilities in urban than rural areas. This affected mostly services that were delivered in institutions which included health and education services than other services. Consequently such services discriminated against orphans living in rural areas and more also to those with financial difficulties to pay for services and transport to reach services.

Vocational skills are good but they are not found in rural areas. So if you are in rural areas, you may complete your secondary school but have problems of getting enough money to go and attend them.

(Paternal orphan girl, aged 14)

Service users and Government service providers appear to have different opinions regarding provision of transport service to ease difficulties of travel. Service users expressed a desire to be provided with means of transport by the service providers either through provision of bicycles or money to pay for transportation. On the other hand, while the district service providers acknowledged orphans need for transportation service, they failed to provide the service directly to orphans. Instead, district service providers assisted community-based organisations with bicycles to use

for reaching out to orphans. It appeared there was no policy to provide service users with transport or financial means to access transport.

> *I walked to get a minibus. I had little money so I paid for a short distance, so I had to walk again a long way to get to the clinic. My legs were painful and I felt it was difficult. If I had a bicycle, it would be easier but buying a bicycle requires a lot of money. I do not have money. I expect these organisations to give us bicycles but they do no help us.*
>
> *(Maternal orphan boy with father living away, aged 16)*
>
> *Free government hospitals are far and so for poor people to access the free hospital services, they need to have a means of transport like a bicycle, but there is no support towards that.*
>
> *(District multi-sector government service providers)*

7.3.2 Financial Barriers to Service Access

Service users reported that despite some service being made available, they were not free of charge at the point of use. This was because the Government and other service providers required the recipient to contribute money towards the service. Government charged contributory fees towards the cost of the service and the service user had to contribute the balance of the cost of the service. Sometimes, these costs required upfront payment.

For example, orphans had to contribute upfront money towards the cost of education. Some orphans from same families shared uniform so that while one orphan was in school, the other orphan stayed home. Orphans also required cash to pay for secondary education, examinations, school fund, uniform and extra tuition for examination classes. After secondary education, orphans had to source money for further education or for undertaking vocational training. Orphans also failed to pay for the cost of health services, food-related costs and other services. This meant that orphan households were disadvantaged to access to the services that were not free of charge.

> *The problem we have with fertiliser coupons is that the caregiver of orphans usually has no money to buy the fertiliser. Although we had good rains, those*

households were not able to produce enough food. Government expect people to buy fertiliser but they should have provided means of finding money.

(Local community service provider)

I think money is the answer to many of our problems! You can build a house or even buy clothes because it is difficult to buy clothes for other people. You know what...even for rich people, they can buy everything for their child who goes to a boarding school...but on top of that, they give the child pocket money!

(Double orphan girl aged 13)

7.3.3 Service Timeliness

It appeared there was a mismatch between the time when some services were delivered to orphans and the time the service users needed the service. Service users, district and national service providers explained that although efforts were made to provide services to orphans and their households, often services were delayed. As a result, they had little or no impact on the service users. It was common for school bursaries to be paid late when the orphan had already been withdrawn from school. In addition, service users reported that often they accessed fertiliser coupon late and by the time they find market and money to buy the fertiliser, it was too late to apply the fertiliser.

The head teachers are often impatient; they cannot wait for late payment of school fees for orphans, so the children are sent away. The orphans go to social welfare offices to check fees, then the social welfare officers telephones the Ministry (MoGCCS) headquarters, which also check with National AIDS Commission. Therefore, there are these bottle necks.

(National non-government service provider)

They registered my grandchildren for many years, may be 10 or 12 times now, and we keep on waiting for assistance. Some say they will come to get the children to take them, to where, I do not know. From there they will start to receive assistance. We keep waiting in vain.

(Grandmother Caregiver, aged 69)

7.4 Service Effectiveness

Service users suggested that services were effective if they empowered them and made them become autonomous so that eventually they become independent of the

service providers' support. The district and national service providers described service delivery strategies that promoted service user's autonomy. They said services that helped to build the capacity of users to earn money made service users financially independent. This was important because in the previous chapter, orphans and caregivers suggested that money was a means for addressing many needs. District and national service providers explained that services that provided skills for the production of items for sale and services that provided business start-up loans (to build household income) also empowered service users. They said that once service users gained capacity to earn money, they could become self-reliant. The district and national service providers reported that the benefit of service users' ability to earn money was that they gained freedom to make choices and decisions on how best to address their needs.

> *Teaching orphans skills like tinsmith, sewing, carpentry and others keep them busy and help them to forget their situation. These skills also help them support themselves from sales of products they make, without relying on someone.*
>
> *(Community government multi-sector service providers)*

Both district and national level service providers suggested that local level capacity building and entrepreneurship development (local-village business strategies) appeared to spur meaningful income generating activities for orphan hosting households. They explained that Commercial Banks' credit access conditions restricted local poor people's access to credit. In contrast, village savings systems facilitated local entrepreneurial activities. Alternatively, national service providers said service users could be empowered if they were directly provided with cash transfer, which they could use to pay for services. Cash transfer appears to provide orphans with both effective and comprehensive services, as reported in section 7.1.

> *We encourage the poor families to save from the little money they have within a village and not depending on loans from banks. Why? This is because when they sweat for their money they are able to save and have strong attachment to the little money and say this is mine! When they get loans, they mismanage because they feel it is not their money. Banks also require high interest rates and collateral which the poor cannot afford*
>
> *(National non-government organisation).*

We have seen a lot of change in households that receive cash transfer in terms of meeting basic needs, I visited them when they were starting and when I went back; I notice a big change, like roofing their house(with iron sheets and not grass), eating 3 meals a day. Some even have livestock. Children are able to go to school and it gives them independence to decide on what to do with money unlike other modes of support. They have a choice of what to spend the money on.

(National government service provider)

Some orphans and district service providers also reported that services that provided education support and promoted orphans learning/education consistently on long term basis, helped orphans become self-reliant because once they finished school and attended vocational courses, they could find a job, earn income and become independent.

Some services have really had big impact, for example school bursary. After consistently paying fees for years, we have now so many orphans that have finished form four and other are even in the university. One has completed medical college training, is now a doctor and has become self-reliant.

(District government multi-sector service providers)

7.5 Service Equity

Participants provided evidence of orphans accessing equitable services as well as limitations in the provision of equitable services.

7.5.1 Need-Based Equitable Services

Service users reported that some community service providers delivered equitable services, based on the needs of orphans. This was because orphans who had needs received the service while those without need did not receive the service.

They do not give me anything because my father is well off; they say they only give help to those who do not have things to support themselves (obvutikitsitsa)[7]. Our fellow orphans really look terrible; they do not clean their bodies properly and do not wash their clothes. They say because they don't have soap.

(Maternal orphan girl living with father aged 13)

---

[7] People with acute poverty and they have hardly any income or material items.

This quotation was from an orphan from a relatively wealthy household who expressed awareness of the criteria for targeting of orphan services. However, it appears that although she understood that services were meant for orphans with more needs, she later on reported having felt resentment for not receiving a blanket. She felt that she should have received that service because the services were meant for orphans. In essence, her reason for wanting to receive the service was not based on need but on orphan status.

> *I have my own blanket but I want to receive a blanket like other orphans because when I see the blanket I want to remember that I am an orphan.*
>
> *(Maternal orphan girl living with father aged 13)*

It appears there were contradictions between service users and community service providers regarding who should receive Government-sponsored subsidised fertiliser coupons. While many reported that subsidised fertiliser coupons should be targeted to households who were poor regardless of orphan status, others felt that government services were meant for universal distribution for all citizens regardless of socioeconomic status. This may suggest that some participants wanted services to be based on need and not just focusing to a particular group of people. But, it may also imply that many people were needy.

> *I am thankful to government because they give fertiliser to all households who cannot afford to buy fertiliser. There are households in the village who are not caring for orphans but they are as poor as those who keep orphans.*
>
> *(Local Community service provider)*

7.5.2 Lack of needs assessment skills

Community and district service providers said that service provider's lack of competence to carry out orphan's needs assessment resulted in the provision of inequitable and inappropriate services to orphans. This was because service providers failed to match service to appropriate service beneficiaries. For instance, some community and district service providers wondered why some non-orphans who were poorer than others were not provided with services. Alternatively, poor classification of orphans needs resulted in orphans needs being generalised and orphans being treated as a homogenous group.

What is needed is to establish how the child is living before bringing any service. In the villages, we have some orphans who are needy but other orphans are not needy. The problem with us in government, those on NGO and CBO, we don't assess the needs of children, we just rush to orphans and give them support. Some children with both parents lack many things.

(District government service providers)

We need to do more to address all the needs of orphans. The way we do provide services now is like 'one size fit them all' but orphans have specific needs and we need to provide those specific individual needs.

(National government service provider)

Why did government choose to give material support to child headed households only when there are orphans who live with others only who have no blankets. There are also children who have parents but have no daily basic necessities because the parents are poor.

(Community non-government organisation)

There appears to be an equitable service provision debate in the minds of service providers who appear to question the rational of targeting orphans with services when there are other non-orphan children who are just as vulnerable as orphans are.

7.5.3 Consequences of Corruption

Many service users and community service providers reported that efforts to provide equitable services to orphans were hampered by corrupt practices by service providers. Service users suggested that service providers and the local leaders used their positions of power to engage in corrupt practices in the delivery of services. As a result, they gave more and better services to people who were well off and offered bribes. Secondly, service users implied that leaders and service providers who were involved in the distribution of services practiced nepotism by providing more services to their close relatives than other orphans.

They cannot give me fertiliser coupons with this poor house, which has no proper door. They give those with better houses, who can give them tea, what can I give back to them; I have nothing.

(Grandparent caregiver of double orphans, aged 71)

Service users also suggested that community service providers practiced favouritism where services were provided only to orphans and households that were affiliated to their religion or political party. This meant that those who were not members of the political party or religion were denied that service even when they were needy.

> *I think it is wrong to give services only to those from their church because orphans are found among all people. Religious schools want children from their faith; they want to teach you their faith. The problem is that their priority is their faith above everything else.*
>
> *(Paternal orphan girl with mother, aged 14)*

> *I have heard that the priority of the youth to access the credit for enterprise activities will be those from the ruling party. I think this is not good because orphans who are not in a party will not receive the money. We need services that are not attached to a party but based on the needs of the youth.*
>
> *(Community non-government organisation)*

7.6 Service Efficiency

It appeared that poor governance, particularly corruption, apart from affecting service equity, had an effect on service efficiency. Indeed, it seemed that service implementation was deeply rooted in corrupt practices by different service providers including government officers, NGOs and CBOs. Service users reported that they incurred hidden costs because of bribes given to some service providers to access a service. For instance, they had to bribe officers who were responsible for identifying beneficiaries in order to receive farm input subsidy coupons.

> *Some NGOs and CBOs are operating as opportunist who exploits the plight of orphans as cash cows[8] for personal gain. Some are being started with the aim of benefiting themselves rather than the orphans. Some services providers are motivated by greed to divert orphan care services for their personal gain.*
>
> *(National non-government service provider)*

---

[8] Traditional people use this language to signify deep corruption because milk from cow is intended for a calf instead of human beings. In this case orphans are being used as a means of accessing resources by service providers who were not intended beneficiaries .

> *There is a lot of bribery in the distribution process of subsidised farm inputs coupons. Some people are given two coupons per household. Those who have not been given coupons end up buying coupons from the people responsible for coupon distribution.*
>
> *(Grandparent caregiver)*

> *Chiefs are corrupt. After we had completed distribution of commodities to orphans, chiefs asked us where their share of commodities was.*
>
> *(Community government service providers)*

Service users and district service providers reported that factors that led to increased corruption in orphan care service provision included lack of transparency and accountability in service delivery structures and lack of enforcement measure to control corruption. Corrupt service providers used service provision as a means of making their own livelihood.

> *There were transparency and accountability structures at local level, namely Village Development Committees and Area Development Committees that are responsible to the District Assembly but these structures were not functioning effectively.*
>
> *(Local Community service provider)*

> *If the Anti-Corruption Bureau were to visit the Government offices and interview us, they would find out that there is corruption in that office.*
>
> *(Non-Government Community service providers)*

> *Although there are many Government and Non-Government Organisations orphan care activities, little help is getting to the orphans. Commodities for orphans are received by senior people and often they start by sharing the items among themselves. By the time commodities reach orphans, large quantities are already taken by senior people.*
>
> *(Community government service providers)*

District service providers reported that the consequences of corruption was that very little help was getting to orphans although many orphan care services were provided by Government and non-Government organisations. Service users reported having felt angry, afraid and powerless when powerful and influential service providers diverted their services. They said they felt helpless because there was nothing they could do to hold powerful abusers of orphan care accountable. Attempts to hold chiefs

accountable were met with threats of either being evicted from the village or being denied access to services in future. Some community service providers said that they feared that if corruption persisted with impunity, some service providers would discontinue service provision to orphans. Indeed service users provided information that suggested that they had ideas about ways of improving their status but felt powerless to engage meaningfully in discussion with service providers to improve service delivery and make it more responsive to orphan needs.

> *If corruption persists, the organisations assisting orphans might withdraw their assistance and that will create problems for the orphans.*
>
> *(Child protection worker)*

> *Those who donate items give them as free hand-outs. We do not have courage to go and complain about the distribution of items. When wrong people receive commodities meant for orphans, we feel that even if we complain, it will not make any difference, so we just watch knowing that there is nowhere we can take the matter to.* (Paternal caregiver)

In addition, national service providers' reports suggested that they had difficulties to manage and account for donor money which resulted in discontinuity of flow of funds and consequently, discontinuity of service provision to orphans.

> *Funding has been the major problem to implement cash transfer which relies on Global fund. Sometimes accountability of funds delays funding and timely implementation of service.*
>
> *(National Government service providers)*

Apart from evidence of inefficient services and its consequences, service users and service providers reported different reasons that influenced service inefficiency. The factors included capacity building and technical competence, access to information and monitoring information system.

7.6.1 Capacity Building and Technical Competence

Community and district service providers suggested that the capacity to provide efficient services to orphans was compromised by lack of technical competence by service providers at community level despite volunteers' willingness and commitment.

They said usually, services at community level were delivered by untrained volunteers. The problem was exacerbated by an increased rate of illiteracy among volunteers. Community level service providers said they depended upon district and national service providers to build their capacity.

> *The people who are providing services at community level are volunteers. These people are doing commendable work but the general challenge is competence. Some of them are illiterate and have no training on the needs and care of orphans.*
>
> *(District multi-sector government service providers)*

Likewise, the district and national service providers expressed concern about limited technical competence and skills to deliver some services including psychosocial services. National service providers expressed difficulties to train and build the capacity of volunteers as well as other service providers because of insufficient funds.

> *In terms of services delivery, I think we're trying but I think quality is an issue aah…because to make quality you need to use well-trained service providers, you need adequate resources and materials, which is currently a challenge. You see that there is a greater proportion of our service providers have not been trained, they need training in order for them to be able to deliver.*
>
> *(National government service provider)*

> *The children are supposed to go to school but the teachers are unqualified volunteers. We need to liaise with Ministry of Education to provide qualified teachers.*
>
> *(National Government Service provider)*

National service providers described the negative repercussions of service providers' technical incompetence on the quality of services to orphans. They said service providers delivered inappropriate services to orphans; for example instead of providing psychosocial services to traumatised orphans, they provided protective services as if those orphans had problems against the law.

> *What we need is proper training and institutional set up for helping children with psychological problems. Right now we send orphans with psychological problems to reformatory centres, this is wrong. That place is meant for children who are unruly, who steal things and with bad behaviour. Preferably,*

we need to keep orphans within the extended family not in institutions care. It is like getting rid of the child not helping them.

(National non-government organisation service provider)

7.6.2 Access to Information

Service users, district and national service providers consistently said that orphans experienced challenges to access information about the service. They said dissemination of service information was inconsistent. Some orphans had no knowledge about service provision, while others had knowledge of service but did not know where to find the service. Orphans and caregivers struggled to get information about sources of school bursaries, protection services, psychosocial services, where to report child abuse cases and children from rural areas did not know where to access ART. Consequently, orphans said, without knowledge of the services, they did not utilise such services.

We just hear that there are organisations that promote the rights of orphans. We have a problem in this area because we do not know how and where to report child abuse cases. If we knew, we could have been reporting daily, because many orphans are abused...child labour…farming and a lot of work.

(Double orphan caregiver boy, aged 16)

It is a question of may be limited information in terms of who does what among service providers. There are many opportunities! There are education bursaries; others offer credit facilities which orphans can access if only they knew about them.

(Non-government national service provider)

Service users, community and national level service providers said that when service providers gave service users relevant information about the service, they helped users to make informed decisions, increased the demand and utilisation of services and made a positive impact by changing negative attitudes and behaviour of people in society towards services.

When I tested HIV positive in 1999, I could not tell people about my HIV status. Now with sensitisation, there is change, people are open, and they accept you and want to learn from you. Now I am a role model in the community and

> *these days more people go for voluntary counselling and testing services.*
>
> *(Maternal caregiver aged 43)*

> *With awareness raising by child protection workers, we have seen many child abuse cases reported by the families and community.*
>
> *(National government service provider)*

District and national service providers reported a number of reasons that contributed to poor access to information about services by service users. These included lack of service dissemination mechanisms, poor coordination of service providers and conflicts among service providers. It appears there was a contradiction between national and district service providers regarding challenges of disseminating of information. National service providers reported having assumed that all necessary actions were done to provide information about services, including development of policy guidelines, setting up operation structures for implementation and that service providers were available at district and community levels to implement the services. On the contrary, district service providers reported that although they received policy guidelines, they failed to distribute and disseminate the information about the services because they did not have transport and finances for taking the policy guidelines to community service providers, let alone to orphans and caregivers.

> *In terms of awareness raising for orphan's services, there are structures in place, community based organisations, the orphan committees, and they are there to tell people services that are available. There are also guidelines that were translated into local language and are distributed to stakeholders to share with communities. This is done through Social Welfare services.*
>
> *(National government service provider)*

National service providers also reported that poor coordination among service providers regarding roles of organisations on dissemination of information to orphans also exacerbated the challenge of information flow. They also expressed awareness of importance of communication and networking to ensure coordinated services. However, local service providers reported having communication challenges because they worked in competition for resources. Consequently, service providers were ignorant of services that were implemented by other service providers.

Networking is very important because you cannot provide everything on your own. For example if you need school fees, work with the social welfare officer, if you need sibusiso (body immunity boosters); work with Ministry of Health or NGO. With networking, you find that things work easily, you share experiences and you know the gaps or how best to handle these problems together, you create space for planning and complementing each other, you reduce duplication. The problem is we do not want to share information because other organisations will copy our strategies and use them to find funding or know how they got empowered.

(National non-government service providers)

7.7 Service Acceptability

7.7.1 Service Users Preferences

Service users reported information that suggests that they had classified needs according to preferences. First, they reported that service had to be provided in response to what they considered a priority need. Consistently, service users reported having prioritised the need for food-related services. For instance, service users explained that they valued some services because they incorporated food in the programme. Generally, it appears food was treated as a means to satisfy other needs and promote the utilisation of other services. In agreement, national service providers reported that food made a major contribution to improving education and health outcomes. For example in education services, school feeding programme was cited as a major contributory factor in reducing absenteeism among orphans as well as minimising school dropout.

When the children eat porridge at school they stay in class until the end of the lesson, they do not run away from classes because of hunger. They also do not ask for any money to buy food at school during break.

(Maternal caregiver, aged 38)

My child was treated at Mpemba hospital. He was given milk and other foods. The swelling of the feet healed. After few months, he was able to walk.

(Paternal caregiver, aged 62)

We have been providing school meals. We are able to see that dropout rates have reduced. 2004 it was 16 per cent; while 2008 it was 8.4 per cent in terms

of schools that have the school feeding program. Therefore, you can see that these interventions have impact.

(National Government service provider)

Service users and district service providers reported that after food provision, orphans should be provided with clothing and shelter as part of basic needs because they had problems acquiring such a basic service. This finding may also indicate a relationship between service acceptability and service comprehensiveness.

I like it when they gave us maize flour, sugar, tea, salt, milk for the baby, wheat flour and cooking oil. The quantities of food were large. The whole of last month we had maize flour. When we eat, we have energy. We are happy to have food in the morning, lunch time and supper. They also gave us clothes. This is really, what I wanted, but I would have liked if they had assisted me with repairing of a house and a toilet.

(Double orphan girl, household head, aged 15).

The ministry of Gender (MoGCCS) with support from UNICEF has introduced household kits for supporting child headed households. These kits contain two mattresses, two blankets, some pails and cups plastic sheets, soap and other small items. So ... we argued that why don't we also provide food, even clothes, even shoes, that could suffice! These are all basic needs.

(Government district service provider).

Second, service users reported having felt empowered when they participated or were involved in service provision process rather than when services were just given to them as hand outs. They explained that when they were involved in service delivery, they gained control of the process. On the other hand, when they were not involved in the service delivery process, they felt helpless and voiceless because they could not participate in decision-making and could not determine when and where the service would be made available. Some service users felt that they had to sweat and struggle to have sustainable empowering services rather than receiving handouts, which promoted laziness.

You have no say on how free hand-outs are distributed but when it is your own thing, you have a say. One needs to sweat to acquire something. One does not work hard to acquire free hand-outs.

(Girl double orphan)

Third, service users reported that the proximity of community-based services to service users facilitated participatory approach in service delivery. Participatory services helped to provide comprehensive services, adhered to users preferences and suited the local setting. Caregivers of orphans become actively engaged in orphan care service delivery. In this regard, community service users mobilised resources, constructed shelter for orphans, constructed a pre-school structure and contributed money to buy medicine for home based care. Some service users also helped to construct training centre structure, procuring of equipment and operated a village level skills training unit for orphans and vulnerable youths.

> *We visited the orphans in the households and check the surrounding. We found the house was in bad shape. We worked on the roof and bought iron sheets, we bought locks and blankets for the orphans.*
>
> *(Community non-government organisation service provider)*

> *Now, people in the village are moulding bricks to help solving a shelter problem for orphans.*
>
> *(Community government service provider)*

Further, orphans and community service providers expressed contradictory views from national service providers regarding who should be targeted with skills training services in the community. Orphans and community service providers expressed the need for orphans to undertake vocational skills training while in school so that they can produce some items for sale and earn some income. However, national service providers reported that community skills training should target out-of-school children and that orphans should enrol for skills training after completing school as part of career development. Orphans explained that promoting skills training among out-of-school children could be an incentive for children to drop out of school. This may imply the need to provide such services to both in school and out of school orphans.

> *I think government is failing to provide the orphans who are in schools tangible skills that could be useful in the village. Government should open skills centres where orphans can learn carpentry, tailoring, plumbing, brick laying. The main problem here is equipment for training. The CBOs lack equipment and materials like sewing machines, piece of cloth and other things.*
>
> *(Local community service provider)*

> *We conduct what we call village polytechnic where we impart skills for out of school youths so that they can earn a decent living. However, government does not provide this service to orphans who are in school. The technical colleges offer vocational skills after secondary education as a career development course.*
>
> *(National government service provider)*

7.8 Service Continuity

Service users and community service providers expressed concern that although the needs of orphans were persistent, orphan care service delivery appeared to be poorly planned and therefore availability was by chance. This caused service inconsistence and discontinuity, and service users often experienced long spells of time between service deliveries.

> *I received food items, which came as a surprise because I was not expecting anything. It takes a long time before organisations come again to give us assistance. Last time I received some assistance was over a year ago.*
>
> *(Maternal caregiver, aged 38)*

> *Assistance from organisations is ad hoc while the needs of orphans are persistent. They come with assistance today and they do not come again for a long time.*
>
> *(Community nongovernment service provider)*

> *I wish organisations could provide support continuously but they do not and many times our needs are not met. For example, sometimes we have no food to eat.*
>
> *(Girl double orphan, caregiver, aged 15)*

Service users and district service providers reported a number of reasons that created discontinuity of service delivery which included, discontinued donor funds, phased approach or pilot approach to service delivery, poor coordination among service providers and resource constraints. Other service providers reported that donors discontinued service provision because national service providers failed to account for the resources. For some services users, lack of services for prolonged periods of time lead to loss of hope for a better future. Service users wished they had other means of helping themselves to supplement services they received.

The process does not work well because service providers sometimes provide assistance in phases, so it might be a year or more before an orphan receives assistance.

(Girl double orphan aged 16)

Social Welfare started paying school fees for me then stopped. They only paid for form one school fees. In Form 2, they were paying my fees with hassles because they said they did not have enough money so that I was staying home for many days.

(Maternal girl orphan, aged 14)

7.9 Summary of Characteristics of Quality of Services

Throughout the chapter, positive attributes and barriers to provision of quality services to orphans have been provided (see table 7.1). Besides, unlike the individual dimensions of elements provided in the framework of quality of care by Maxwell and the Health Service Research Group, the provision of services to orphans suggested an interaction between the elements. Coordination of services interacted with many of the elements of quality. When services are coordinated, the other elements seem to work well. Figure 7.1 shows the interaction between the elements of quality in service provision to orphans.

Table 7.1: Summary of Characteristics of quality in service provision to orphans.

Number	Quality element in service provision	Positive attributes	Barriers
1	Comprehensiveness	-Address household needs, -Provide holistic services	Insufficient resources& donor dependency, poor coordination
2	Coordination	-Set up implementation structures	Lack connectedness of service levels, lack resource transparency, conflicting approaches, non-functional structures
3	accessibility		Lack of policy, distances, cost & no transport support, structural, poor coordination and untimeliness.
4	Effectiveness	Empowering services	Lack of ownership, poor coordination
5	Acceptability	Address priority needs	Lack of, coordinated and comprehensive services, lack of priorities
6	Efficiency	Joint planning and monitoring	Corruption & poor governance, limited technical capacity, poor monitoring systems and limited access to information
7	Equity	Need-based services	Lack of needs assessment skills, corruption,
8	Continuity		Lack of resources

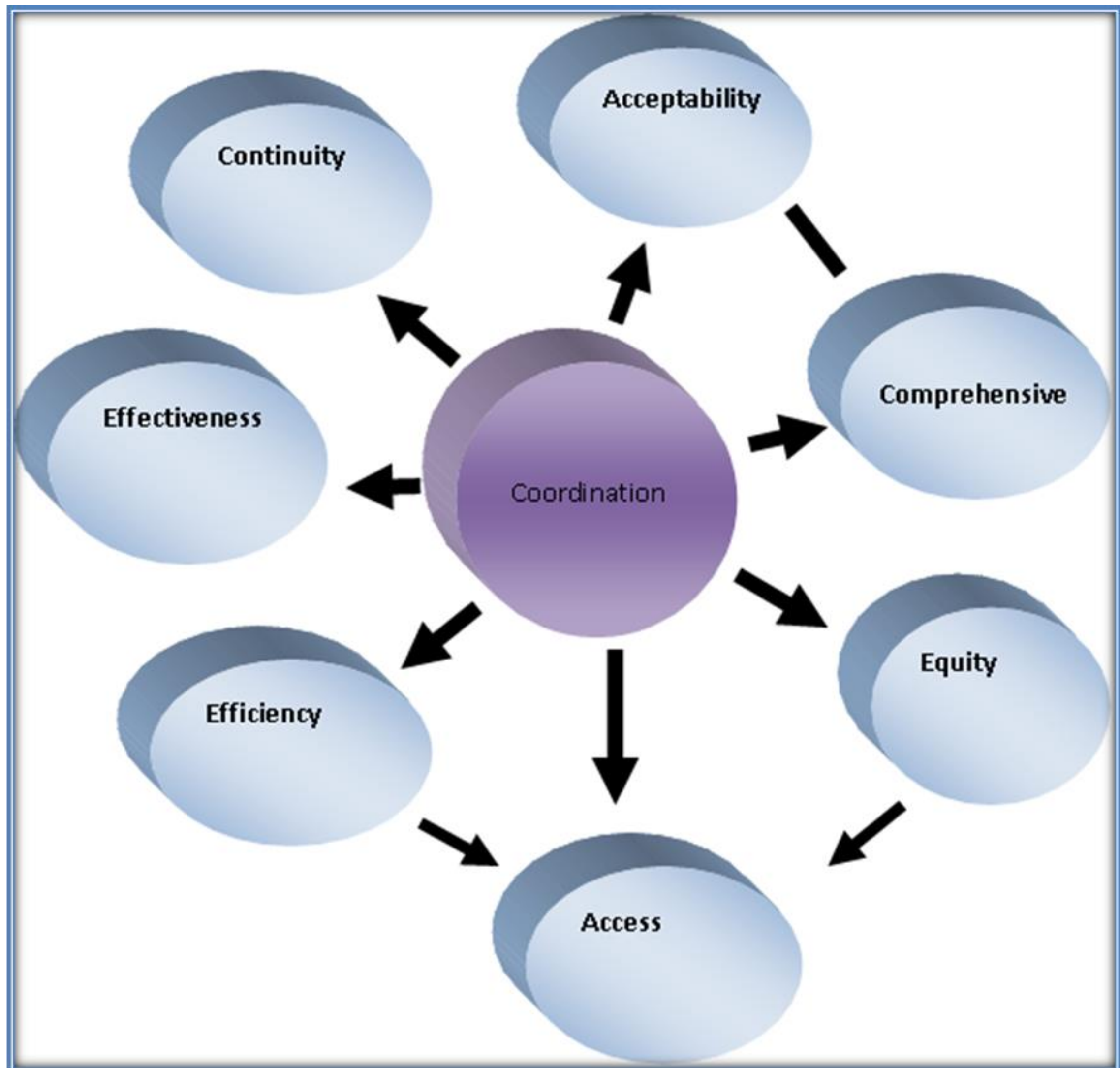


Figure 7.1 : Interaction between elements of quality in service provision to orphans.

7.10 Chapter Summary

The elements of the quality of care framework used in this research showed that orphan care services had both positive attributes and limitations. Although the framework suggested application of single independent elements of quality of care, the findings suggested an inter-relationship between the elements. This chapter described both positive and negative factors of service delivery and in turn how the factors influenced service responsiveness to orphans. Coordination seemed to link with a number of other elements. The next chapter will discuss the influence of policies on service delivery.

Chapter 8 – Policy Influence on Service Delivery

The preceding two chapters presented findings of orphans' needs and how orphan care service provision contributed towards addressing the needs of orphans. The analysis was predominantly based on perceptions and experiences of service providers and service users. This chapter assesses how policies, presented in appendix U, guided service provision in Malawi. In this thesis, policies are seen as a tool that guides service provision to address the needs of orphans in the most appropriate way. Information for this chapter was drawn from content analysis of child-related policies, in-depth interviews with mainly policy makers and some service providers. Analysis of Malawi government policies was done using four elements of quality of care framework described in chapter four. These elements were coordination, comprehensiveness, access and equity.

8.1 Policy for Coordination

Coordination of policies describes the existence of coordination guidelines to facilitate the provision of services for supporting orphans in Malawi. Each organisation or sector maintained their identity and only worked together through established structures. Coordination of service provision appeared to work well when orphan care stakeholders performed their functions and when they were guided by policies or agreements on how to implement services to orphans.

8.1.1 Adherence to Collaboration Roles

Malawi Government adopted a multi-sector service implementation structure which involves activities of different stakeholders, including Government, donors, local and International non-government organizations. An institutional coordination structure was set up with distinct roles and responsibilities for respective stakeholders. While the Ministry of Gender, Children and Community Services (MoGCCS) was mandated to coordinate orphan care activities of all service providers at the national level, including donors and non-government organizations, District Social Welfare Officers were mandated to coordinate implementation of orphan care activities at the district level

through the decentralisation policy. Further, MoGCCS created the National OVC Steering Committee (NOVCSC) and National OVC Technical Working Group NOVCTWG) to provide guidance at policy and service delivery levels respectively. These committees facilitated coordination of service providers and provide orphan care service providers a framework for operation. More information on service implementation structure is provided in section 1.2.1.1 and section 2.4. The Office of the President and Cabinet coordinates the development of all Government policies.

> *The Ministry of Women and Child Development has developed legislation, policies and guidelines within which stakeholders implement orphan and other vulnerable children interventions. It is crucial that there should be proper coordination and collaboration among different players in order to avoid duplication of effort and make a difference in the lives of orphans.*
>
> *(Government, 2010c:30)*
>
> *Malawi Government instituted policy coordination department in the office of President and Cabinet to undertake research on policy issues, analyze all policy proposals, guiding and directing the development of public policies in the public sector, guiding the donor community and the civil society on government policies, coordinating the formulation of policies and programmes of line Ministries…to ensure that there is consistent and coherence of public policy.*
>
> *(Government, 2008c)*
>
> *The National OVC steering committee, chaired by the Ministry of Gender, Child Welfare and Community services will oversee and advise on key policy related matters. The technical working group will provide technical assistance and coordination*
>
> *(Malawi Government, 2005:30)*

National policy makers provided information that suggested that coordination of different orphan care service providers helped to build consensus during the formation, development and implementation of some orphan care policies. The multi-sector service implementation system worked well when there was consensus among the orphan care service providers in their operations. National policy makers said stakeholders implemented orphan care services in harmony when the stakeholders adhered to their roles and worked to complement each other’s efforts. For example,

National policy makers said donors assisted Malawi Government raise funds for formulating, reviewing and implementing policies.

Donors, through UNICEF, also provided leadership, technical support and funding for establishing a NGO coordination network, a strategy that was adopted from other African countries. The NGO network promoted unity and bonding among local and International NGOs in providing orphan care services, so that they had a common purpose and a shared vision. Prior to the formation of the network, local NGOs had fragmented orphan care services and did not speak with one voice, which undermined their influence in the policy formulation process. Apart from donors and international organizations, NGOs contributed to the policy development and implementation process by lobbying Members of Parliament to enact child friendly laws and lobbying government to increase funding for orphan care activities.

> *We also advocate for policy changes. In education for example, we ask why are children not going to school? So our role is to ensure that there is enough provision in the budget for orphans vulnerable children. We also advocate against user fees levied on children who are not able to pay user fees. It defeats the idea of free primary education when the policy does not allow that. We hold the nation accountable.*
>
> *(Network of organization for orphans and other vulnerable children)*

> *NGOs are of late coordinated through a coalition of NGOs on children rights. UNICEF facilitated the formation of this coalition and all NGOS met and agreed to form it. Membership is based on existing civil society networks such as gender, water, health, orphans, education and others. It will remove unnecessary duplication. Within the NGO circles, we had blamed each other for holding information and duplicating geographical coverage. In certain cases, there has been several NGOs working in the same location but not working together. The other advantage is that the coalition provides common and collective voice.*
>
> *(Children NGO coalition)*

In addition, national policy makers suggested that inter-Government Ministries' collaboration succeeded when there was a formal binding coordination strategy or binding agreement on how they could function together. Different Government Ministries stipulated how they were going to link up with other service providers and perform their roles together in a coordinated manner. Some agreed to design and implement policies jointly. For example, food security policy was developed by the

Ministry of Agriculture while the Food and Nutrition Policy was developed by the Department of Nutrition and HIV/AIDS. When similarity of the two policies was noted, Government developed revised guidelines on how the two organizations could coordinate their activities and the implementation of the two policies together. Likewise, Ministry of Health and Population (MoHP) and MoGCCS also agreed to jointly develop and implement the Integrated Management of Childhood Illnesses Policy (IMCI).

> *An institutional arrangement that is practical and maximizes collaboration, harmonization and coordination of food security and nutrition efforts will be put in place. The Food Security Joint Task Force will therefore be converted to National Food and Nutrition Security Joint Task Force to bring together and coordinate the implementation of the Food Security and Nutrition Security policies which are handled by different Government institutions.*
>
> *(Malawi Government, 2006e:6)*

> *Malawi adopted the IMCI approach strategy in 1998.There was no policy to guide implementation during the early phase. This made it difficult to coordinate activities at all levels. To address this gap, the Ministry of health in collaboration with the Ministry of Women and Child Development coordinated the development of IMCI policy to guide implementation, provide guidance and mobilize resources*
>
> *(Malawi Government, 2006e:3)*

8.1.2 Resource Sharing Agreement

Apart from the collaboration of roles, district and national service providers reported that sharing of limited resources was a reality between private and public service providers when there was a binding agreement between different organizations to work together. Joint resource utilisation was practiced between Government through the MoHP and a private organization, Christian Health Association of Malawi, which brought about reciprocal benefits to the two organizations. The agreement involved a private health facility providing free medical treatment to patients at Government expense, while Government trained health personnel from the private health organizations. The agreement between Government and private sector on coordinated resource utilisation was also stipulated in the health policy document. This agreement improved service users' access to health services because private hospitals, which were located closer to service users, were now accessible by poor clients.

The signing of service level agreement with Christian Health Organization of Malawi institutions for delivery of Ministry of health services is one way of ensuring that all Malawians regardless of the their socioeconomic status have access to essential health services.

(Government, 2011a:4)

I am thankful to the Government. The under five children and other poor people, are sent to Mlambe, a private hospital where they are admitted and attended to at Government expense. We do not have a District Hospital in Blantyre, we have health centres whose capacity are low and when they come as referrals to Queen Elizabeth Central Hospital, it is difficult to attend to them, sometimes they are sent back. So to ensure that we should cover all costs, there is an agreement (by Government) with Mlambe private hospital to give poor people free treatment.

(District government multi-sector service providers).

Furthermore, national policy makers reported that a number of policy makers from Government, donors and NGOs agreed to jointly plan and implement services with pooled funding when Government introduced policies that allowed joint utilization of resources. For instance, they explained that the MoHP adopted a sector wide approach policy, which promoted different donors and service providers to pool their resources, plan and deliver services together.

Through Sector wide approach policy, donors help government to develop the agenda. This will help government to avoid duplications and unnecessary failures and programmes can easily scale up.

(National Policy maker, FAO)

While coordination of services was possible in some cases, there were times when there was apparent poor coordination of services. Poor coordination leadership, non-alignment with coordination structures and lack of policy makers and service provider's connectedness affected effective delivery of orphan care services.

8.1.3 Lack of Leadership Capacity

District and national service providers and policy makers suggested that it was not always the case that activities of orphan care multi-sector service providers were coordinated. They said despite having a coordination structure with well stipulated

roles and responsibilities, sometimes service implementation was hampered by poor coordination of policy makers. Poor policy coordination was reported to stem from lack of political will and poor coordination leadership by MoGCCS. In addition, the national policy makers and district service providers suggested that the MoGCCS at national level and the Social Welfare Staff at the district assembly level had limited understanding of the scope of coordination responsibilities.

As a result, the MoGCCS sidelined and under-played its leadership and coordination roles and was more engaged in implementing services than guiding service providers. Lack of effective leadership resulted in service providers' confusion of roles and provision of services that were not integrated. Among other factors, national policy makers and district service providers suggested that the MoGCCS had limited capacity in terms of personnel and financial resources, as Government was not allocating adequate funding to finance the Ministry's coordinating role. Limited coordination capacity of the MoGCCS was also noted in the United Nations documents as well as the national policy documents. This is consistent with the observations of service providers that poor policy coordination affected district service coordination, as reported in chapter seven, section 7.2.1.

> *District Social Welfare should interconnect with other sectors, they should not be busy distributing fertilizer, and they should let the other responsible sectors do that! Likewise the Ministry of Gender (MoGCCS) should focus on providing policy guidance, leadership and coordination, so that the actual implementation rests on other partners.*
>
> *(International non-government organization service provider)*
>
> *The institutional arrangement is missing. It has to do with a set up. The Ministry of Gender (MoGCCS) needs a strong department to deal with orphans, with staff ready to work with other stakeholders, with a legal mandate so that other sector ministries understand and appreciate the role of the coordinating Ministry (MoGCCS). Stakeholders would go to it for advice, cooperation and the like. Right now, children activities are all scattered in various ministries.*
>
> *(National policy maker, UNICEF)*
>
> *Decentralization policy states that District Assemblies are policy implementers while Central Government's role is to provide policy direction and regulation.*

What we see instead is that Central Government is implementing and there is nobody to monitor.

(District government service provider)

While noting the progress made by the Ministry of Women and Child Development (MoGCCS) to coordinate child rights related activities, the committee remains concerned that additional human and other resources are required to ensure effective coordination both at national and district levels.

(United Nations, 2009:3)

8.1.4 Lack of Alignment to Coordination and Implementation Structures

The decentralisation policy stated that Government was mandated to set up service implementation structures that reached the communities/grassroots through the District Assembly. Therefore, all Government and NGO service providers were required to implement their policies through District Assembly structures in compliance with decentralisation policy. The analysis of Malawi Government policies showed that the problem of coordination in service delivery appeared to occur when line Ministries created their own service implementation structures instead of using structures that were stipulated in the decentralisation policy. Furthermore, the Decentralization Policy set up clear service delivery functions of central and district levels. Only the District Assembly was empowered to create local policy implementation committees.

The Central Government will support the District Assembly with policy guidance, financial and technical assistance. Line ministries will retain responsibility over the following areas: policy formulation, policy enforcement, inspectorate, establishment of standards, training, curriculum development, international representation etc. In undertaking this responsibility, line ministries will have direct links with local authorities as instruments of service delivery over professional and operational issues. However, policy and other issues affecting all local authorities as instruments of local government and development will be channelled through the Ministry of Local Government of Local Government.

(Malawi Government, 1998c:13)

The Assembly may establish other committees at a local government area level. The Assembly may establish such other committees at Ward, Area or village level. The composition of service committees shall be determined by the

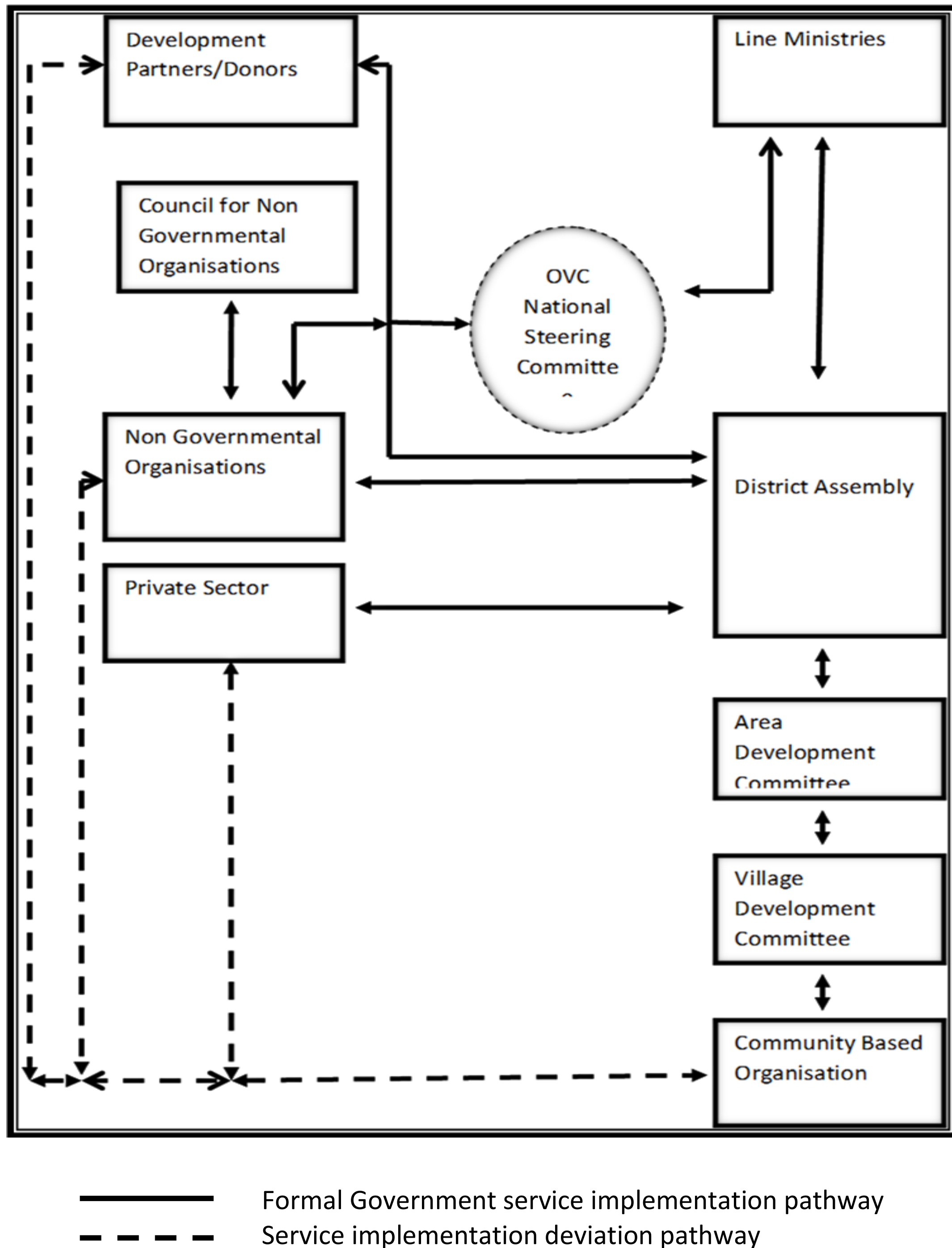
> *Assembly. The Assembly may arrange for the discharge of any functions by a sub-committee or an officer of the Assembly*
>
> *(Malawi Government, 1998c:42)*

However, the analysis of policy documents suggested that line Ministries deviated from the normal service implementation structures and created their own service implementation structures. In some cases, some line Ministry policies created structures that did not reach community level, some line Ministry policies had new structures that were parallel to the existing decentralization policy implementation structures, other line Ministry policies developed implementation structures that bypassed the District Assemblies, while other line Ministries' policies created multiple implementation structures. For example, the national gender policy has two routes for reaching the grassroots: one route through the District Assembly and one route that bypasses District Assembly and goes direct to the grassroots level. This may explain why the community and district service providers reported confused implementation of services, in chapter seven (section 7.2.1) since they had to work with multiple structures that emanated from different child-related policies.

Apart from Government line Ministries, some NGO service providers appeared to bypass the District Assembly as well. NGOs in Malawi are coordinated by the Council for Non-Governmental Organizations (CONGOMA) and there appears to be no formal link between CONGOMA and the National OVC Steering Committee, as well as the District Assembly, as stipulated in existing policies. This suggests that the District Assembly has to go through informal channels to regulate operations of NGOs that are not complying with decentralisation policy.

Figure 8.1 depicts both the normal and deviated orphan care service implementation structure in Malawi. The straight lines represent the normal structure set up by the decentralization policy. All the key policy makers dealing with orphans, including Government line Ministries, donors and NGOs are expected to work with the National Orphan and Other Vulnerable Children Steering Committee (NOVCSC) and implement services through the District Assembly. Some donors and NGOs do not always go through the orphan care steering committee, but all services are supposed to be

implemented through the District Assembly. The dotted lines depict donors and NGOs who sometimes bypass the decentralisation structures while the continuous lines depict the normal service implementation structures.



Formal Government service implementation pathway
Service implementation deviation pathway

Figure 8.1: Normal and Deviated Service Implementation Structure in Malawi.

8.1.5 Limited Multi-Sector Connectedness

Sometimes the multi-sector orphan care environment did not work well, because policy makers and service providers lacked consensus caused by adoption of conflicting approaches. National policy makers' statements suggested that there was tension between donors and Government policy makers when donors digressed from the national policy agenda. This tension might also suggest weak capacity of Malawi Government to coordinate international contributions to orphan care service delivery. International NGOs, policy makers, donors, Government, and national service providers reported that because donors providing much of the resources to Government and NGOs for service delivery, sometimes donors had their own agenda which differed from the Government's agenda and did not always conform to national direction and coordination patterns. For example, they said sometimes donors selectively funded services that they were interested in and did not fund some activities that were Government priority. They also said sometimes international donors diverted from their mandate of providing advisory and technical services to local service providers, instead donors implemented orphan care service projects.

> *NGOs have suffered donor push. We focus in areas that donors want to spend their money on. That is how psychosocial has suffered because not many donors are interested in this area.*
>
> *(National service provider, Local NGO coalition)*

> *When there is international pressure to focus on a particular issue, development partners become active and a lot gets done. If the political environment is not favourable, it affects the development of laws.*
>
> *(National policy maker, UNICEF)*

> *Even though the donors were the main health financial source, disbursement of funds was untimely forcing government to borrow from domestic market. A significant amount of donor funds remain off budget and sometimes these donors fund NGOs on interventions that are not a priority for the health sector.*
>
> *(Government, 2011a:20)*

This was consistent with the observations by the district service providers who explained that it was difficult to coordinate district activities because some

international NGOs did not comply with Government policies. Instead the NGOs were governed by their own policies and they were more loyal to their donors than the national coordinating Ministry (MoGCCS). For instance, they said some NGOs were reluctant to hold joint orphan care planning meetings with other service providers and they were not transparent with their resources.

> *While there is a policy providing guidance, there are some NGOs that ignore policy guidelines and instead, they use their own guidelines from their donors.*
>
> *(District government multi-sector service providers)*

> *Not many NGOs are accountable for the resources or to the people they serve or Government in terms of responding to policies. The focus is mostly to respond to the agreement with their donors. These should be encouraged to be responsible to the people they serve.*
>
> *(District service provider)*

8.1.6 Inconsistent Policy content

National policy makers suggested that policy coordination was undermined when there was poor multi-sector consultation during the development of policies, resulting in inconsistent or conflicting guidelines. Government, international donor organizations and some NGOs policy makers reported that it was common to come across policies that had short-falls. As a result, some policies from different Ministries had contradictory information. For example, one policy says that the age of consent for sex is sixteen while another policy says that a girl can marry at age 14. Consequently, lack of harmony in policy content resulted in non-standard provision of services and confusion among implementers, which compromised service delivery.

> *Policies are supposed to be guidelines. In health, there are times when policies have to be reviewed to be in tune with whatever is going on. Therefore, in health, yes, like the Health Act that is in place right now over 60 years old. It was enacted in 1948. Therefore, it's out of tune.*
>
> *(National government policy maker, Ministry of health)*

Other examples of policy content limitations were reported when different Government departments had separate policies covering similar orphan care services. They said the MoGCCS and Ministry of Education had two distinct policies towards education support and bursaries for orphans, with different strategies. For example,

the Ministry of Education was providing only school fees while the MoGCCS was providing school fees and other educational materials. In addition, they also reported that there was an overlap between the mandates of youth policy and policy on orphans and other vulnerable children because the two policies had similar programmes, targeting the same age group. The OVC policy addressed children under 18 years, while the youth policy covered children between 10 and 29 years. The inconsistencies in policy content were also noted in the analysis of policy documents. For instance, the policy documents showed a lot of overlap between functions of different Government Ministries with no proper coordination strategies. For instance, vocational skills training were provided by four different Government departments through four different Government policies that dealt with youth, enterprise development, child labour, and education. Inconsistent policy content hampered service implementation at district level, hence making services not responsive to orphan's needs.

> *It would be better if there was coordination between youth and OVC policies because they both cover orphan care issues and they both deal with older orphans.*
>
> *(District multi-sector service provider)*

> *There are two different education bursaries, one by International organization and one by Government, instead of the two combining their efforts. Both bursaries cover partial educational expenses.*
>
> *(District government service providers)*

8.2 Policy Comprehensiveness

Government and international NGO policy makers suggested that provision of comprehensive services to orphans was feasible when the policy vision matched with service implementation strategies. A comprehensive policy approach was advocated through the Early Childhood Development (ECD) Policy and the Plan of Action for Orphans, which prescribed a diverse support package for assisting orphans. The national policy makers said that comprehensive service provision was possible through community based service delivery. Ultimately, both the policy vision and the integrated community based service delivery made it feasible to address diverse needs

of orphans. Diversity of orphan needs was one of the characteristics of orphans' needs that were reported in chapter six

> *Implementing a holistic package of care, support and protection requires the ability to access essential services (education, health, nutrition, water, sanitation and birth registration)…within a family environment that protect children from abuse, exploitation, stigma and discrimination.*
>
> *(Malawi Government, 2003c:27.39)*

Indeed, the international organizations reported that Malawi Government had a good reputation of offering comprehensive ECD policy globally, which included provision of food, education, health, psychosocial, and health services to young orphans through community child based care centres by the concerted effort of multi-sector players.

> *Coming up with community based child care centres was a global plus for Malawi. We have the community based child care centres which have an early childhood development focus, having an Early Childhood Development policy which focuses on orphans and other vulnerable children. So I feel that is a great opportunity because it has also helped our children appreciate school apart from getting meals.*
>
> *(International NGO Oxfam Malawi)*

On the other hand, policy makers suggested that sometimes, policies did not facilitate comprehensive provision of services. Comprehensive services were not provided because of lack of policies or failure to adopt holistic approach to service delivery.

8.2.1 Absence of Essential Policies and Guidelines

District and national service providers and policy makers reported that some essential policy guidelines were not included in a number of policies to guide effectively implementation of services to orphans. These missing policy guidelines that were reported included children access to ARV treatment, psychosocial care for orphans and their households, juvenile justice legislation, alternative care for children without parental care and provision of shelter. District, national service providers and policy makers reported that Government needed to have a clear policy on the provision of incentives for volunteers. They said provision of incentives would motivate volunteers to contribute more effectively towards orphan care services and to compensate them for their time.

We have many gaps in the policies for children. We have not focused on counselling of traumatized children and children who are sexually abused. I feel education should have been free for orphans including secondary and tertiary levels but we only have free primary education.

(National policy maker, OXFAM Malawi)

I think our organization is motivating volunteers through provision of incentives through some incentives are like short term incentives but then we don't have a policy that is backing us to providing these short term incentives, and how much support is enough , K100 (£0.37) per month? However, we are really working to support these people (volunteers) so that they do their job

(National service provider, Network of organization of orphans and other vulnerable children).

The committee remains concerned at the increasing number of orphanages and children homes often operating without being registered and regulated by the Government due to absence of appropriate policies and guidelines.

(United Nations, 2009:9)

It appeared that lack of policies might have contributed to failure by service providers to provide some services. This is because service providers lacked direction and guidance on service provision. Absence of policy also implied compromised quality of services since service providers used inappropriate alternative services. For example, service providers said that children offenders were kept in prisons with adult offenders because of lack of reformatory services for children offenders. As discussed in chapter seven, these findings were consistent with service users' experiences and community service providers' perceptions. They reported lacking guidance and support on provision of the following services to orphans: shelter, ARV treatment for HIV infected children, psychosocial services, and assistance of bicycles to facilitate easy access to services.

National policy makers explained further implications of lack of policies. They reported that having no policy meant no funds for implementing the services. This is because Government departments used policies to lobby funds from the Ministry of Finance. For example, the Ministry of Labour explained that Government did not fund them to undertake child labour initiatives because the Ministry of Labour did not have a child labour policy.

Nevertheless, even with existing policies, some national policy makers reported that it was not possible to implement some policies because of lack of laws or enforcement guidelines. For instance, the MoGCCS failed to close orphanages with poor standards because Government lacked appropriate laws for enforcing orphanage policy guidelines. Further, the MoGCCS reported that the absence of legal guidelines on adoption of children and child abuse laws meant that lawyers applied laws meant for a different purpose to try child abuse cases, which resulted in inconsistent legal interpretation among lawyers when judging children cases in courts. Usually when that happened, the judgment was likely to be non-standardized, not objective and hence likely to deny children child justice services. Lack of policy guidelines was consistent with the information reported by service providers in chapter seven, section, 7.1.3.

> *When it comes up to adoption of orphans, you see it's a 'pick and choose' sort of approach because the government does not have proper guidelines and record of children that would qualify for adoption.*
>
> *(National policy maker, High court)*
>
> *In some cases in our legal system, provisions are not that strong, they have got some gaps and for us to act as a 'dog with biting teeth.*[9] *As a Ministry responsible for children, we need to strengthen some of the legal provisions that are there and also for the relevant institutions to make sure that our laws, especially related to children are strengthened.*
>
> *(National policy maker, Ministry of Gender and child development)*

8.2.2 Holistic Policy Strategies

The national policy makers suggested that policy implementation worked well when they adopted a holistic service delivery approach. They reported that a holistic approach meant addressing the whole person in the provision of care. The national policy makers reported that a holistic service delivery approach meant that services addressed the body, the spirit, and the soul of the person simultaneously.

National policy makers reported that Government had stipulated policy guidelines for the provision of holistic care in the Early Childhood Development policy through

---

[9] A dog that bark without biting teeth locally means a weak dog that is harmless. It is used to show that if policies have no Acts, they cannot be enforced.

community based service delivery. However, non-government organizations reported that service providers mainly provided services to address the physical needs of the body, such as food and clothes, because the services were relatively more practical to deliver, and that they lacked knowledge on the other services like the psychosocial services that address the mind.

> *The early childhood development aims at promoting care and attention to the child…during the first 8 years of life…with holistic approach to childcare.*
>
> *(Malawi Government, 2003c:iii)*

> *In order for children to realize their full potential, it is important that their mental/cognitive, physical, emotional, social, spiritual and psychological as well as health are met simultaneously.*
>
> *(Malawi Government, 2006b:15)*

National policy makers said holistic care worked when policy strategies did not only target the needs of orphans but also empowered both the families and the community to support the orphans. One international donor explained that food security strategies were effective when they targeted households as opposed to individual orphans. They said the reason for including the family and the community in food security strategies was that the family and the community played unique complementary roles that were not provided by the service providers. For instance, the family provided land and energy whereas the local community service providers assisted with some agriculture skills training for the families. Furthermore, some local NGOs suggested that through the home-based care system, empowering the caregiver brought about better health outcomes of the patient and complemented the community volunteers' work.

> *The child is not isolated, he does not live alone. There is no way you can address the problems the child without involving the household. For us, the farming entity is the household because the land belongs to the households. The labour that is put into is from the household so the productive factors are also seen as belonging to the household. You also have more impact if you look at the child as a member of the community because we offer certain trainings through agriculture extension staff who act as extension agents in their communities and this has a multiplier effect.*
>
> *(National policy maker, FAO).*

The volunteers will be there just to monitor how the patient is taken care of. .. But I think it's better to empower and give more information to primary caregiver, the person who is staying with the patient. When we gave information to caregiver on ART, adherence to ART improved.

(National local service provider, National network of people living positively with AIDS)

8.3 Limited Access to Policy Information

The district service providers and international NGO policy makers reported that they had difficulties to access policy information was difficult because of poor dissemination. The national Government policy makers said that Government failed to disseminate policy documents widely to relevant stakeholders because of insufficient financial resources. Therefore, lack of policy guidelines prevented effective service delivery. Essentially, district service providers consistently reported that many community service providers did not fully understand issues of orphan adoption and fostering because they did not access legal documents.

The experience I have seen is that we do not look at the child in totality, we look at the child from an angle. Some provide fees but she has no clothes, she has no food. I was very touched the other day, a girl came crying and said, "You have given me school fees, but this is my only dress and I have borrowed these slip-ons (shoes) to come here". We need to have a deliberate policy to look at a comprehensive package of orphans. It may not be everything but at least there should be a standard package.

(District government service provider)

We work with Ministry of Agriculture. I do not think that people at the service delivery level know the orphan policy or the plan of action for orphans. There is lack of knowledge. This is a threat. How can you make sure that information is disseminated to all sectors, not just those working directly with orphans and other vulnerable children? People are also talking about sector wide (approach) in HIV/AIDS … but we have not seen it. The question is, can we say policy is guiding service delivery?

(International policy maker, FAO)

8.4 Inequitable policy design and service distribution

National policy makers from Government suggested that poor policy design contributed to limitations of providing equitable services to people in need. They suggested that lack of inclusive policy strategies for reaching service users meant that

some potential beneficiaries of services were left out. For example, the Ministry of Health clearly stipulated guidelines on the provision of ARV for adults but did not include clear guidelines for provision of ARV for children with HIV/AIDS.

Analysis of Malawi Government policies presented different ways and challenges in which poor policy information caused inequity in service distribution. For example, some policies stipulated the need for provision of services targeting the most vulnerable households but did not include strategies for implementing the policy. For example, housing policy had no strategy for service provision to poor and vulnerable households, including those with orphans. This was also consistent with the observation that was reported by the United Nations in the analysis of national policy environment. This finding corresponds with the findings from the orphans and caregivers who reported having no access to any housing support service.

> *The UN CRC committee noted with concern the difficulties encountered by a high number of families in meeting their parental responsibilities due to poverty, particularly in rural areas, the precarious situation of single parent households, the child headed households, and the grandparent households due to impact of HIV, lack of protection of orphans' inheritance rights, and the very limited services available to support these families.*
>
> *(United Nations, 2009:9)*

Poor policy design meant that policies did not provide guidelines at all for providing equitable services to service users. Government policy makers reported that the gender equality law that was developed to address cultural practices that are harmful to females was written with the perspective of women and not girl children. Consequently, they did not address the needs of female orphans. The United Nations observed that many girls were subjected to harmful cultural practices such as genital mutilation than the boy child and that those were not yet addressed in the policies.

> *We need to develop deliberate policies that protect children from these negative cultural impacts. We have a gender equality law but we have not focused on children but women. Although the policy is not targeting orphans, it is they who are vulnerable and they should benefit more out of it. Other*

> *children have families to protect them. One of the issues is to get rid of cultural practices that are harmful at work and school institutions. There is a lot of gender inequality, a teacher may seduce an orphan, make her pregnant and the child leaves school. Adults impregnating a child should be criminal case, and the issues of 'fisi'*[10]
>
> *(National policy maker, Law commission)*

The policy analysis also presented some policies that did not meet the needs of special age groups of children. For example, the comprehensive policy on early childhood development was designed to meet the needs of orphans less than eight years of age through community-based childcare centres. This was done on the pretext that older orphans would be in school. Nevertheless, there were many older orphaned children who lacked similar services, like psychosocial services, because they were not addressed anywhere. For example, many orphans and children did not enrol in school and therefore could not access services in the community.

A number of policies documented unequal distribution of services between the rural and urban areas. The Ministry of Health policies reported that urban areas had better facilities, within a recommended 5 kilometres radius from households, than rural areas. This disparity in service delivery from the policies was consistent with the reality on the ground. Service users reported that there were more services and better facilities in urban areas. They cited limited access to institutional services, like skills or vocational training, hospital facilities and social welfare services, in rural areas because these services were better provided in the urban areas.

> *Universal coverage looks at geographical coverage and proportion of Malawians living within a 5 kilometres from the health facility. In urban, health services can be physically within reach of the poor and the vulnerable populations. In rural areas, health facilities are not available or dysfunctional while in others the challenge is provision of health care to widely dispersed places.*
>
> *(Government, 2011a:5)*

---

[10] Fisi is a local name for hyena, an animal that normally causes harm at night in the dark. Culturally in some tribes when a girl grows into puberty, the elders chose a man to have sex with the child. This is often takes place at night so that the girl should not identify the man. Sometimes, girls get pregnant in the process.

Furthermore, national service providers and national policy makers from Government and donors reported that some services were only provided to selected geographical areas. This was partly because the implementation was a pilot scheme, but mainly it was due to limited resources. For instance, the cash transfer was provided in six pilot districts only, while the remaining twenty-two districts which needed the same services were left out. Likewise, in the health sector, coverage of HIV related services, including prevention of HIV transmission from mother to child, voluntary counselling and treatment centres, and provision of ART, were provided in a limited number of health centres because of financial limitations.

> *Some policies are good but the problem is implementation. The universal health services access and prevention of mother to child transmission of HIV is provided to very few health facilities; it is 172 out of more than 500 facilities in the country.*
>
> *(National association of people living positively with AIDS)*

8.5 Other Factors that influence policy

Apart from the four elements that were used to assess child-related policy influence, there were other factors that emerged from the data that contributed to policy influence on service delivery, as discussed in this section.

8.5.1 Participation in Policy Development and Implementation

National service providers and national policy makers suggested that policy development was not inclusive enough because some key stakeholders did not participate. For example, faith-based organizations, the private sector and the orphans themselves were not involved. They said that failure to involve these stakeholders had negative implications on the policy process because their interests were not considered during the policy negotiation process. Likewise, failure to involve the orphans in the development and review of policies denied the orphans the opportunity to share their experiences and hence improve responsiveness of the policy. International NGO policy makers also observed that lack of involvement of the private sector in the orphan care development process was an anomaly. Limited participation of stakeholders at policy level corresponded with the information reported by service

users in chapter seven about the missing roles of faith-based organizations in the delivery of psychosocial services. Figure 8.1 indicates that the Council for Non-Governmental Organizations, the policy making body for NGOs in Malawi, and the private sector were not members of the National OVC Steering Committee.

> *All the policies were developed without involvement of the faith leaders so the challenge which is there is to ensure that the contents in the policy were disseminated through the faith community. The church feels proud that it has maintained the traditional care systems of the orphans, we feel this is an area that should have been exploited further by the policies and the policies to stipulate what other kind of services should be included.*
>
> *(National association for faith-based organizations)*

> *There is need to review the existing orphan policy. The review will enable the orphans themselves to feed into the policy. Nobody should write a policy for orphans. There must be community consultations with the orphans themselves, what are their problems, how they can overcome them, what support do they need! Then the foster parents, the grandparents, interview all of them, the Village headmen, Members of Parliament everybody should have an input. I know how the previous policy was written, people sat down to say these are orphans and this is what they need.*
>
> *(National policy maker, Law commission)*

Similarly, the District Assembly reported that it was necessary for District Commissioners to be represented at the NOVCSC meetings to contribute towards policy formulation, implementation and to provide guidance on emerging district implementation issues. The district service providers felt that there was inadequate consultation during policy formulation.

Furthermore, national policy makers reported that a number of child-related laws were being reviewed in the country. However, the process of review suggested that there was limited consultation, which could lead to un-harmonised laws.

> *I have been reading through all these bills and the problem is not that they have left out elements of children but the problem is that there is no cross reference and that would create a problem once the laws come into operation because the amendments have not looked at other laws. For example, this new marriage law is outlawing polygamy but other laws recognize polygamy including the constitution of Malawi.*
>
> *(National government policy maker, High court)*

The classification of levels of Government policies also seemed to have influenced the participation in policy decision making. National level policy makers suggested that there were higher and lower level policies, reflecting relative Government priority. Orphan care policy was categorized as a lower level policy. For example, a district officer said that District Social Welfare services received meagre resources for orphan care services in comparison with other services. International policy makers concurred with national policy makers that some orphan issues had not received adequate attention in child related policies hence; implementation of orphan activities was undermined.

8.5.2 Policy Monitoring and Evaluation

The national policy makers and service providers suggested that monitoring and evaluation of policies did not work well because of poor data management. National policy makers reported that there was lack of centralised orphan data management because of poor policy monitoring design. The National Plan of Action for Orphans and Other Vulnerable Children included three independent structures for reporting orphan data at the central level: the MoGCCS, UNICEF, and the National AIDS Commission. It appeared that the donor organizations had an interest to monitor orphan data independently from the Government. Fragmented pieces of information in different organizations made it difficult to build a full picture or scale of the impact of orphan care services.

> *Parallel OVC systems exist in Malawi based on funding sources: Government, national AIDS commission and UNICEF. A single and integrated annual work plan based on priorities in the national plan should be the norm.*
>
> *(Malawi Government, 2005:26)*

Indeed, analysis of Government policies showed that monitoring of orphan data was not harmonised at Inter-Ministerial level. For example, the Ministry of Education and the MoGCCS had two independent school bursaries monitoring data sets for orphans. The Ministry of Education monitored orphans from the school environment, whereas the MoGCCS monitored the orphans from the community through the District Social Welfare services. Apart from data management, evaluation of orphans' service delivery was hampered by lack of research and sharing of experiences and best

practices among service providers. Some donors reported that orphan care stakeholders did not share best practices and missed the opportunity to learn what was working well and how to improve the weak areas in service delivery.

> *I think there is lack of data on what works in orphan care. We have not been documenting what works. From the services we provide, we need to know what is working, what is the cost benefit analysis results between service A and service B. We need to generate evidence data. We need to know how to make things better. So research is needed.*
>
> *(National policy maker (USAID), International donor)*

8.5.3 Feasibility of Implementing Policies

National policy makers from Government, NGOs and donors consistently suggested that Government had limited capacity to implement the policies for orphans. Partly, it was because Government lacked political will and commitment to fund the implementation of orphans' activities. They said Government could only afford to provide funds for operational and administrative costs and not for service implementation. Apparently, lack of Government commitment to sponsor orphan care services was guided by Government policy design. The National Policy on Orphans and Other Vulnerable Children stipulated that Government had no funds for the implementation of orphans' services; instead, the Government would depend on donor funds. Ultimately, due to lack of finances, Government over-depended on donor funds to implement services such as cash transfer and school feeding programs. The national policy makers also explained that implementation of decentralisation policy was delayed because of lack of funds since the donors stopped funding before completion of implementation. Some service providers reported that reliance on donor funds was a fragile source of funding. This was also reported in chapter 7, section 7.1.2

> *The social protection policy implementation challenge is resources. If you take away donor money, how much is there? I tend to see cash transfers in that line. The scheme is now in 7 districts. If we need to scale up, the amount of money that is being mentioned is mind boggling.*
>
> *(National policy maker, USAID)*

> *I have already talked about lack of resource. The Ministry of Gender has been getting very little funds from Government treasury. So, most of the activities are limited to administration. So if you send money for only utilities, how can you run the programs?*
>
> *(National service provider, Ministry of Youth)*
>
> *The National AIDS Commission manages the Global fund which includes the element of orphan care, protection and support programmes under the impact mitigation component. The Malawi Government treasury also contributes but more in terms of providing human resource capacity.*
>
> *(Malawi Government, 2005:31)*

8.5.4 Contextual Factors

Apart from policies and service providers' compliance to policy guidelines, implementation of policies was also influenced by contextual factors. National government policy makers suggested that orphan service delivery was also compromised by poverty. For example, it was reported that there was clear legal provision that a teacher who impregnated a school pupil should be dismissed and face justice. However, sometimes the sex offending teacher would bribe the family of the abused pupil to prevent them from reporting the case to the police, on the pretext that the teacher would marry the pupil. As a result, the teacher was not prosecuted or dismissed. Similarly, women were confronted with a dilemma whether to report child defilement or rape by the father, or keep silent especially when the father was a family breadwinner, fearing loss of income if the father was arrested. These narratives point to the importance of appreciating the contextual complexity of policy/service delivery environment.

8.6 Chapter Summary

This chapter has shown that there was potential for policies to influence service implementation positively. What is clear is that there were more policy barriers than policy strengths. Service implementation seems to be predominantly influenced by policy comprehensiveness and coordination than access and equity factors. Further,

the chapter has also provided information that there were some issues that were not included in the policies at all. Indeed, there was no policy that was exclusively designed to address psychosocial issues. Even when a good policy was available, the quality of services was sometimes undermined by other factors, including limited resources. Apart from elements of quality of care other factors emerged from the data. This is consistent with the framework analysis that was used to analyse data, as discussed in chapter five, section 5.6.2.

Chapter 9 – Discussion of Findings, Recommendations and Conclusion

Discussion of Findings, Recommendations and Conclusion

This chapter aims to bring the whole thesis together and discuss the findings and their relationship to the existing literature on this topic. The purpose of this doctoral thesis is to establish how child-related policies and services respond to the needs of orphans in Malawi. The chapter focuses on the major themes which emerged from a cross-sectional analysis of the three research findings chapters on needs of orphans, service provision to orphans and policy guidance.

The major themes for discussion include: need based approach, comprehensiveness, equity, coordination, empowerment and policy and practice. Some themes have been grouped together for ease of discussion. For instance, the themes on efficiency, accessibility and continuity have been placed under the theme of policy and practice to show the interaction between policy design and service implementation.

9.1 Discussion of Results in Relation to Literature

9.1.1 Needs Based Approach

The first objective of this thesis was set to explore the nature of the needs of orphans in Malawi. The concept of need was explored in the literature, by using Maslow’s humanistic psychological theory of motivation. From the findings of this thesis, orphans' consideration of food as the highest priority need is consistent with Maslow’s claim that physiological needs are priority needs. Indeed, Maslow explained that failure to meet physiological needs may be ‘life threatening’ (Maslow 1987b). Food insecurity meant that orphans persistently engaged in food-seeking behaviour as a priority above other needs.

Caregivers said that sourcing food was a very demanding and stressful activity. The term used by caregivers to describe the struggle of finding food was ‘kupuluputika’, which meant working hard to the point of exhaustion, suggesting extreme desperation

due to unmet food need. Lack of food undermined chances of orphans completing their education because without breakfast, orphans absented themselves from school. Consistently, it was reported that services that incorporated food were well received and utilised.

Studies, done in different countries to assess the impact of the World Food Programme school feeding intervention on the education of pupils (food for education programme), appear to achieve positive educational outcomes, particularly with reference to school enrolment (Gelli, Meir and Espejo 2007; Dréze and Kingdom 2001; Ahmed et al. 2007). The impact of school feeding programmes on other educational outcomes varied from country to country.

Gelli, Meir and Espejo (2007) suggested that provision of school meals improved and reduced dropout rate in general, especially for girls. Similarly, in rural India, Dréze and Kingdom (2001) found that school meals improved educational indicators for girls but not for boys. This was because parents and caregivers were more willing to pay towards the cost of boys' educational requirements than for girls. In Pakistan, Ahmed et al. (2007) found that take-home rations, with a condition of school attendance, increased girl's enrolment and reduced absenteeism, but did not improve school completion rates.

These studies imply that school meals, specific for orphans, should be a priority in Malawi. There is need for continuity in the provision of a school food programme and the need to complement food with other services. Further, it may mean that girls require more diversified school meals programmes than boys; that is, having meals at school and at home. Boys may not require much motivation to go to school, compared to girls, because parents and caregivers in Malawi suggested that they prioritised boys' education over girls' education.

This thesis suggested that financial security need was the second level of needs, because, after satisfying food needs, orphans and their caregivers needed money to pay for various services. Money was seen as the best option for satisfying needs. Orphans demonstrated different behaviours to pursue money. They pursued money using a number of strategies such as 'ganyu', early sexual relationships, early marriage,

income-generating activities and selling of domestic assets. The irony of this finding was that, while such strategies of sourcing finances were meant to solve orphans' problems, they created other security needs, such as security of body, security of property and security from child labour. This was because the strategies used to find money were harmful to the orphans. In this case, it meant finding a problem within a solution. In essence, it shows that only financial security belonged to the second level of needs. The other three forms of security were not prioritised. Therefore, even though they found strategies for finding money, pursuance of money had negative consequences for orphans. Negative consequences of the strategies for finding money have been presented in chapter six, section 6.8 and figure 6.1.

Other studies have shown that households that hosted orphans, adopted strategies that were likely to have negative long-term effects on orphans. Munthali (2002) had similar findings to this thesis. He found that in Malawi orphans from HIV/AIDS households sold land, property, engaged in child labour and small scale businesses as a means of adapting and coping with orphan hood. In addition, there is a possibility of gender bias dimension of the problem, with girls, through marriage or early sexual activity, failing to complete education. In Nairobi, Kenya, when mothers died, some fathers forced their daughters to engage in early marriage in exchange with cash dowry payment (Yamano, Yayne and McNeil 2002). Although marriage was intended to bring income, early marriage had negative reproductive health effects.

A number of studies suggest that death of parents increased the risk of girls' HIV infection, as they searched for money through transactional sex (Foster and Williamson 2000; Palermo and Peterman 2009). Other authors have found that girls' vulnerability to sexual abuse increased with the death of the mother but not the father (Birdthistle et al. 2008). These research findings highlight caregiver's and gender dimensions of orphan care needs.

These studies suggest that orphans who are not assisted to find money may be at risk of increased vulnerability. Therefore, there is need for service-providers to scale up the provision of financial services, to boost household's income, as a strategy for

addressing orphans’ needs. In addition, there is need to promote girls' education, and to prevent orphans' risk of HIV/AIDS infection. Some researchers, Barnes (2003) and Roby and Shaw (2008), have provided evidence that better strategies and appropriate assistance can improve the quality of life of orphans.

Barnes (2003) found that implementing a locally based micro-finance programme (that provided family business loans), improved the income of households affected by HIV/AIDS. The author suggested that considerations should be made to provide loan insurance service to families affected by AIDS to protect them against business uncertainties. In addition, lenient loan repayment terms should be considered because the households were labour constrained due to the burden of caring for sick household members. Further, Roby and Shaw (2008) suggest that it is feasible for orphans to meet physiological needs with community-based integrated services. In Uganda, through an integrated community service called ‘action for children services’, there was a decreased need for food and housing services.

In addition, some authors have suggested that keeping orphans in school, by meeting their educational requirements, and giving girls cash while in school prevented girls from getting involved in transactional sex (Cho et al. 2011; UNAIDS and UNICEF 2004). Cash transfer also helped households with orphans to meet costs related to needs (Miller, Maxton and Kathryn 2008; Namibia NGO Forum 2009). Similarly, Kirby, Obasi and Laris (2006) suggested that school-based sex education and HIV education interventions were effective in reducing risky sexual behaviour among adolescents in developing countries. This was because curriculum-based interventions were more intensive and more structured than non-curriculum-based services.

The findings of this thesis suggested that the needs of orphans were consistent with the first two levels of hierarchy, namely, physiological and security needs. This was because after these levels, orphan’s needs had interdependent relationship. For example, there was a relationship between the need for education and the need for security of health. Accessing health services interfered with going to school. The inter-dependence relationship between needs of orphans was discussed in chapter six, section 6.7. The implication of inter-dependence relationship is that the needs can be

solved by providing comprehensive services to orphans. This is discussed in detail in section, 9.1.2.

In this study, orphans demonstrated motivation to pursue education which suggested that they valued education. Notably, orphans' pursuance of education was taking place, even though lower level needs in Maslow's hierarchy were not fully satisfied. For instance, although orphans' lower needs for love and belonging were not fully satisfied, they nevertheless pursued a higher level need of education. This challenges Maslow's hierarchy of needs theory, which suggested that lower needs had to be satisfied first before the higher needs could provide strong motivation (Maslow 1954).

Indeed, Hollyford and Whiddett (1999) argued that Maslow's human motivation theory fails to address the observation that some needs remain motivators, even when the lower needs are not satisfied. Perhaps the reason was that orphans pursued education not fully for psychological growth (self-actualisation). Instead, it was a means of escaping food insecurity (through accessing school feeding programme). Nonetheless, there is need for Government to take advantage of orphans' motivation for education and remove barriers to education access.

This thesis established a relationship between the needs of orphans and the contextual environment in which they live, such as their living arrangements. For example, the ability to satisfy orphans' needs was influenced by their caregiver's type or living arrangement. Caregivers' care giving capacity appeared to depend on caregiver's skills, age or gender. Orphans and caregivers' needs were exacerbated by decline in community and extended-family support systems.

Apart from caregivers' influence, orphans' ability to satisfy their needs appeared to have been influenced by culture. In chapter six, section 6.9.4, one of the cultural factors that affected orphan's needs was matrilineal culture. Orphans whose mothers died and had surviving fathers, faced difficulties in meeting their needs because of cultural influence. As discussed in chapter one, section 1.2.4, under matrilineal culture, the responsibility for child-care rests with the mother and her extended family, but not with the father. When the mother dies, the child may end up living with a grandparent.

This was consistent with the findings by White (2007), as reported in chapter one, section 1.2.4.

The relationship between the child and his or her contextual environment can be well comprehended with Bronfenbrenner's ecological theory (Bronfenbrenner 1979). The theory suggests that child development is shaped by the context, which is complex and allows for interactions of different systems. Figure 9.1 describes Bronfenbrenner's ecological theory in relation to child development. The Microsystem is the immediate innermost and closest environment where the child lives and interacts with his/her environment directly thus, the home is where the child interacts with his/her family members, peers, neighbours and the family forms, the most influential institution for child development.

The Mesosystem is a "set of interrelationships between two or more settings in which the person (child) becomes an active participant" (Bronfenbrenner 1979:209). This is where the child interacts directly with the school or religious institutions. Orphans' parent or caregivers might also interact with the school to provide for the school requirements. The Exosystem is the third layer. It forms a wider community which consists of community networks, social services and other services with which the family interacts.

For the orphans, it may be the interaction between community service providers and the caregiver. Lack of social services affects the family and the child. The fourth layer, Macrosystem, represents cultural values and laws that affect the child. For the orphans, this might be the influence of matrilineal culture on their lives and the movement of the fathers when the mother dies.

Bronfennrenner's theory emphasises that a child should be studied in context, primarily his/her family and community. These interactions suggest that meaningful policies and services should embrace family values, roles and culture. These findings might suggest the need to strengthen families' capacity to support orphans.

Based on a 4 years ethnographic study that was conducted in Zimbabwe among HIV orphaned children, Kwenda (2009) found that religion and cultural rituals helped

orphaned children to understand AIDS, develop their self-concept and improve their learning. Thus, teachers were encouraged to integrate school and home-learning to enhance the learners' environment.

In Africa, the extended family plays a significant role in the care of children, as discussed in chapter two. Significantly, after the death of parents, more than 75 per cent of orphans are cared for by female caregivers. (UNAIDS, UNICEF and USAID 2004; Beegle et al. 2009; Birdthistle et al. 2008). The United Nations General Assembly adopted family strengthening as an effective and sustainable strategy for nurturing orphans and vulnerable children (UNAIDS, UNICEF and USAID 2002). In this thesis, it was reported that more women than men provided care to orphans, through community-based child care centres in rural areas. Therefore, there may be a need for service delivery to equip women with knowledge and skills for improved child care.

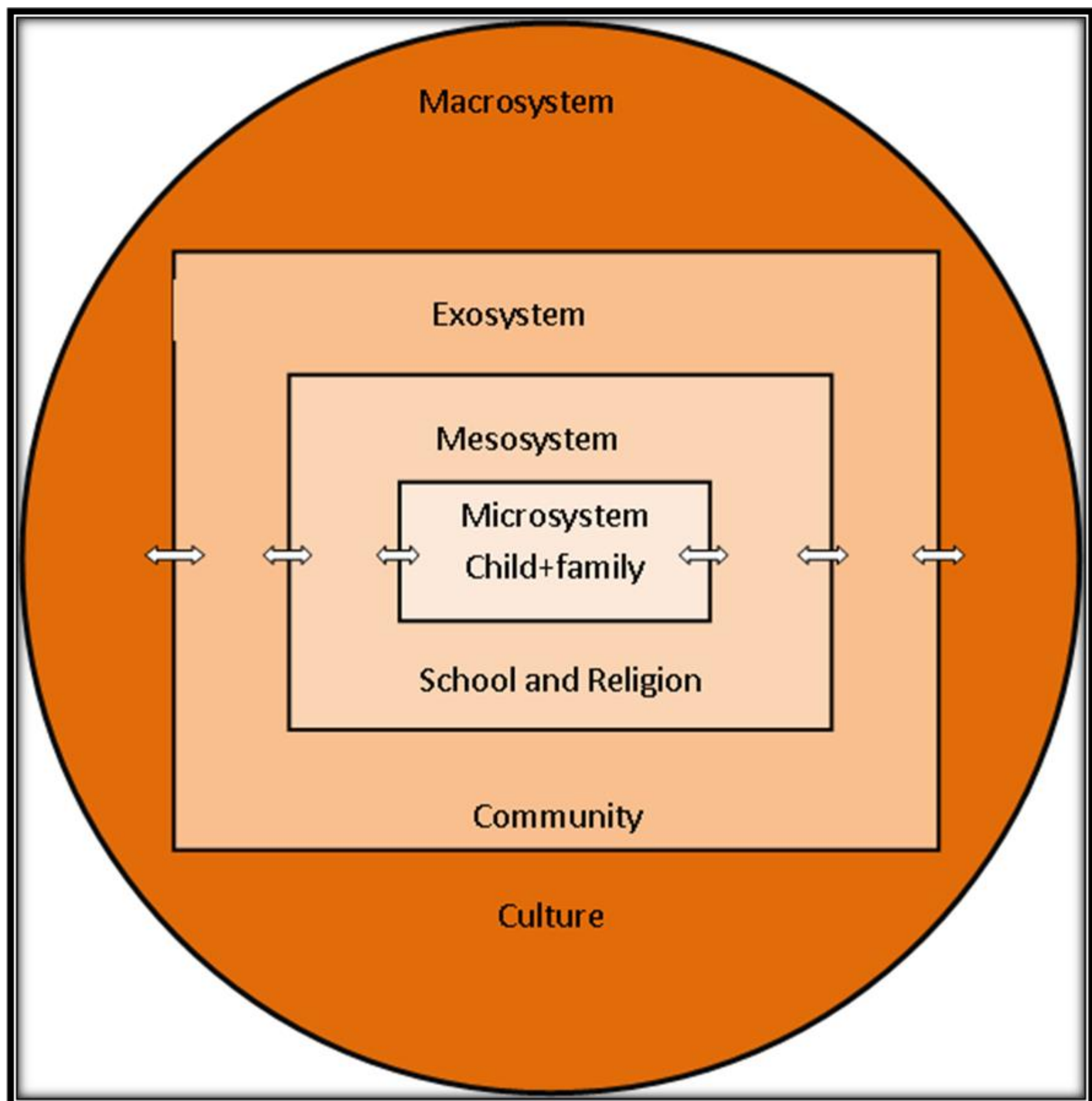


Figure 9.1: Bronfenbrenner ecological theory & child development

Nyamukapa and Gregson (2005) suggested that, within the extended family, females contributed positively to the educational outcome of orphans. Sustained high levels of primary school completion were found among orphans under the care of females than other carers. Similarly, Angelucci et al. (2010) suggested that in Mexico, high secondary education enrolment of children affected by AIDS was caused by the ability of extended families to redistribute resources within the family networks, using money they accessed from cash transfers.

9.1.2 Comprehensiveness

The findings in this thesis suggested that, while many service providers, from NGOs and Government of Malawi, made an effort to provide an increased number of services, the services did not address the wide needs of orphans. The orphans suggested that the services were either partially provided, or not provided at all. The implications of not providing comprehensive services is that orphans may spend more time finding alternative means of meeting their needs and they may feel depressed about their needs instead of advancing their education.

Chapter four, section 4.4.1 reported that, in sub-Saharan Africa, service providers adopted different strategies that showed potential for providing comprehensive services to orphans. The strategies included: provision of integrated services (Hometruth, 2009) family centred services (Wakhweya 2008; Loewenson et al. 2008) community-based services (Birdthistle et al. 2008) and cash transfer (Miller, Maxton and Kathryn 2008; Adato and Bassett 2007; Desmond 2007; Levine 2001; Filmer et al. 2000; Namibia NGO Forum 2009; Cecchini and Madariaga 2011). In Malawi, the findings indicated that provision of comprehensive services was hampered by lack of policy guidance, limited resources and lack of technical capacity by service providers.

Hence, before adopting the above strategies, there is need for the Malawi Government to incorporate policies and strategies for promoting comprehensive services and build the capacity of community service providers to deliver comprehensive services. Alternatively, policy makers could consider the resource constrained environment in Malawi, cut through to the source of the problem and prioritise food and cash or economic empowering services. This is because the other needs appear to emerge, due to failure to provide these two needs. Economic empowering services, which were effective to meet financial needs of poor people, were provided in selected districts. They included cash transfers and micro-finance initiatives.

9.1.3 Equity

In this thesis, the findings suggested that orphans were provided with inequitable services based on age, and geographical (structural) factors. There was inequitable service distribution between younger and older orphans. Younger orphans received more and better services through CBCCS but there were fewer services for older orphans in schools. By assuming parental roles, older orphans appeared to have more diverse needs than younger orphans. Older orphans reported having additional needs, including protection from child labour and sexual harassment and were more likely to drop out of school. On the other hand, because of poor policy guidance and structural factors, orphans had more problems accessing ARV treatment than adults

In this thesis, the findings suggested that there was inequitable service provision and distribution between rural and urban areas. There were better services and more accessible services in urban than rural areas. These are well reported in chapter seven and eight. For example, there were better skills training and health facilities in urban than in rural areas. The service users suggested that these differences were experienced in relation to needs of orphans. For example, in the semi-urban areas, food insecurity was compounded by lack of land and lack of effective community child care, compared to rural areas.

The literature that was reviewed, in chapter four, section 4.4.2 reported similar findings. Guyatt (2003) and Kendall and O'Gara (2007) found variation in service equity between school-based and community-based strategies. Such differences would encourage older orphans to drop out of school, in search of better services in the community. Hence service providers might need to diversify services for older orphans.

Ntata (2007) found that, in Malawi, policy guidelines did not promote the provision of ARV in rural clinics. Indeed in chapter eight, section 8.4, it was noted that policy design contributed to service inequity. It is, therefore, envisaged that improvement in policy design and guidelines, would address inequitable service provision to orphans. Munthali (2002) reported that there was limited information and research on the needs of older orphans. This was because more research focussed on younger orphans. This research provided information about the needs of older orphans.

9.1.4 Coordination and Collaboration

Coordination and collaboration are two concepts that are closely related. They are often used interchangeably in organisations' working relationships. Mattessich, Murray-Close and Monsey (2001) defined collaboration as a mutually benefiting and well-defined relationship entered into by two or more organizations, to achieve a common goal. The focus of discussion is related to three barriers that hindered coordination of orphan care multi-sector policy makers and service providers, namely: poor leadership, conflicting approaches and coordination structural problems.

Inter-organization integration theory (Horwath and Morrison 2007) and the work of (Walt 1994) were explored to aid the understanding of coordination of multi-sector coordination. The inter-organization integration framework provides rationale and key coordination concepts that were similar to the findings in this thesis

a) Poor Leadership

Findings in this thesis indicated that there was poor leadership in orphan care services because the MoGCCS lacked leadership capacity to coordinate the orphan care functions and the stakeholders. The MoGCCS policy level and the Social Welfare services, at the district assembly level, had limited understanding of the scope of coordination responsibilities. Instead of coordinating other orphan care service providers and policy makers, they were busy implementing activities to orphans. Coupled with this, the MoGCCs lacked coordination resources, lacked knowledge and expertise in orphan care services because the staff were not trained.

The findings indicated that lack of leadership coordination had a number of serious repercussions on the implementation of services to orphans. Poor policy leadership at service implementation resulted in duplication of services, inequitable provision of services, inefficient utilisation of resources and other areas. Indeed, coordination seemed to play a major influence on improvement of quality of services and service responsiveness to orphans. It affected quality of other elements of care (see chapter seven and figure 7.1). This implies that addressing coordination challenges, would greatly improve overall quality of orphan care services.

Horwath and Morrison (2007) suggest that strong inter-agency coordination hinges on strong leadership. Effective coordination of organisations requires competent leadership which encompasses knowledgeable, committed, motivated and influential leadership (Horwath and Morrison 2007). Mattessich, Murray-Close and Monsey (2001) observed that coordination leadership requires the development of clear agreed roles and responsibilities, and a shared vision of the common goal. In addition, Parson (1995) suggested that for policy implementation to be effective, policy implementation leaders should have policy enforcement powers, because policy without enforcement makes service delivery uncertain.

These studies suggest that there is an urgent need to build strong leadership with the Ministry of Gender, Children and Community Services (MoGCCS) to coordinate orphan care stakeholders and service delivery. This requires building leadership capacity of staff through training in coordination skills and child care practices. To help maintain vision and direction, the MoGCCS need to facilitate development and review of key policies, as well as strategies for implementing policies.

b) Conflicting approaches

Findings in this thesis indicated that there was conflict between Government and other stakeholders because of adoption of different approaches. These were discussed in chapter eight, section 8.1. Conflicts existed between levels, between different service providers and policy makers and within similar groupings of service providers. In addition, because of lack of agreements in orphan care approaches, conflicts manifested at district and community level as reported in chapter seven, section, 7.2.

One of the areas of conflict was when donors took full control and utilised their resources, according to their priorities and direction, without abiding to Government rules. As a result, Government had no resources for implementing services according to national priorities, and they provided non-responsive services to orphans.

Myriad reasons have been suggested for creating conflict in coordination of multi-sector environment. Rosenberg, Hartwig and Merson (2008) suggested that conflict existed between Government and NGOs, when they did not agree on roles. This

resulted in duplication of services. Conflicts and tensions in inter-organisational coordination sometimes occur because of power differences between actors associated with the control of resources or differences in levels of knowledge (Parson 1995; Hogwood and Gunn 1984). Walt and Gilson (1994) argued that, sometimes, donors and international organizations often use their power associated with the resources they control to influence policy towards their interests.

Walt et al. (1999b) suggested that lack of coordination of stakeholders is caused by both Government and donors. This diminishes the potential for effectiveness of donor aid. This is because Government fails to coordinate donors who tend to have varying objectives and operational guidelines. This confuses government and delays service provision. Walt (1994) suggested that sometimes Government lacks policy vision to guide external donors.

Further, UNICEF (2008c) suggested that external agencies and civil societies, which engage with Government, should align their activities with the vision, principles, and strategies contained in national plans of action. Nonetheless, Hudson (1997a) argued that conflict is inevitable in an inter-organization set up. He suggested that conflict resolution strategies for trust building and nurturing relationships should be practised.

This implies that Government needs to be pro-active in setting a national vision, by developing policies to guide donors according to the national vision and priorities. Donors and civil society need to align with Government, by supporting national policies, vision, values and strategies in implementation.

In this thesis, policy makers suggested that there was potential to coordinate donor resources, by adopting sector wide approach (SWAp). Through SWAp, all organisations under the health sector pooled their resources into one budget and implemented coordinated services to orphans.

Studies conducted in sub-Saharan Africa suggested that a sector-wide approach helped to improve coordination and utilisation of donor aid. This eventually improved the responsiveness of services (Walt and Gilson 1994). In Malawi, Bowie and Mwase (2011) evaluated health SWAp and found that the rate of provision of services

increased for both in-patients and outpatients. In Mozambique, pooled resource donor funding improved service efficiency and equity (UNICEF 2008c). However, Walt et al. (1999b) found that in Bangladesh, Cambodia, Mozambique, South Africa and Zambia, a sector-wide approach did not improve service utilisation, because of weak institutional capacity, mismanagement of donor aid and the interplay of power relations.

In Malawi, a sector-wide approach was piloted in the health sector. There might be a need for Government to expand the policy to other sectors, such as the education sector, to offset the cost of education and food-related costs that are currently paid by service users. There might be a need to include institutional capacity improvement as part of the SWAp package.

Furthermore, Cassels (1995) and Brinkerhoff (2003) suggested that Government could have better leadership and control over donor funds and deliver better services, if national Government were accountable to the public for their finances and performance. Brinkerhoff (2003) suggested that in a multi-sector service delivery, accountability could be improved by mapping accountability linkages where stakeholders should have authority to demand and supply information and impose sanctions for non-compliance. Other strategies included improving procedures and standards for monitoring and reporting issues and involving the community in accountability measures.

c) Structure Problems

The findings in this thesis suggested a number of structural issues that affected both policy and service delivery. Chapter eight, section 8.1 and figure 8.1 reported a number of poor alignments of policy structure. The problems of poor policy structure were that service implementation was hampered because policy makers and service providers were not properly guided. In addition, parallel structures resulted in Government failure to monitor service implementation.

In addition, this thesis found that orphan care data from the community, through the district assembly to the national level, were poorly managed and not centralised.

There was limited sharing of information and dissemination of policy documents. There were parallel structures that reported data from the community level to the national policy makers. The consequences were conflicting and inaccurate orphan information which provided an unreliable basis for planning services. There appears to be a need for a streamlined centralised data management system, for compiling and transmitting data from the community through the MoGCCS to other stakeholders.

Some scholars have suggested the need to manage communication and monitoring structures to facilitate the good coordination of stakeholders. Mattessich, Murray-Close and Monsey (2001) observed that effectiveness of communication in inter-organizational working partnerships depended on the establishment of formal and informal communication channels/structures which allow continuous exchange of information and flexible communication patterns that accommodate each partner. Communication is essential for building trust between organisations.

The need for a strong and stable monitoring and evaluation system in inter-agency integration, to facilitate successful service delivery, has been emphasised by Hubley, Tilford and Walley (2010). Monitoring helps to follow progress and maintain service quality. An evaluation process is essential for assessing effectiveness and efficiency of service delivery (Hubley et al., 2010). Both monitoring and evaluation provide feedback that is necessary for controlling policy processes. Hogwood and Gunn (1984) argued that monitoring and evaluation may be undermined by the following barriers: a fragmented and discontinued monitoring system, the problem of separating service impact from other influences, the problem of interference by other players and the cost of doing the evaluation.

The MoGCCS, as a coordinator for children's services, was better placed to hold a strong and proactive communication network between the stakeholders and within the MoGCCS. However, their effort to improve communication was hampered by resources and capacity limitations. There appears to be a need to strengthen the communication system by increasing resources and building the capacity of the MoGCCS to manage effectively orphan care multi-sector information.

These findings imply that, to improve coordination and alignment of orphan care, different stakeholders, including Government, civil society and donors, need to play specific roles. Government needs to be pro-active in setting a national vision, by developing policies to guide donors according to the national vision and priorities. Donors and civil society need to align with Government by supporting national policies, vision, values and strategies in implementation.

9.1.5 Empowerment

There are different definitions of empowerment within the literature. Empowerment relates to participation and decision making (Walt et al. 1999a). Wallerstein and Bernstein (1988) described empowerment as a social action process that promotes participation of people, organizations, and communities in gaining control over their lives. Empowerment is the expansion of assets and capabilities of poor people to participate in, negotiate with, influence, control and hold accountable institutions that affect their lives (Narayan et al. 2000:10).

Empowerment is a process which involves taking people from a point of powerlessness to the point where they assume control and mastery over their lives, by interacting with their social and political context (Freire 1970; Wallerstein and Bernstein 1988). In this thesis, empowerment has been defined as the process where individuals and organisations recognise their powerlessness and its associated factors, build their capabilities by interacting with their social, political context and gain mastery over their environment and begin to take decisions, control their situation and take action.

This study suggested an action-based approach to empowerment was needed. The tenet of empowerment, therefore, lies on whether there was empowerment or disempowerment (powerlessness) for taking action. The thesis identified three sources of empowerment: empowerment in decision making, control of resources and participation in policy development and service delivery. These forms of empowerment manifested among service users and in organisational setting, at policy and service delivery points.

9.1.5.1 Forms of Powerlessness

a) Organisational powerlessness

In this thesis, it was observed that the district assembly demonstrated lack of empowerment, failed to either make independent decisions or control service implementation processes. This was because the national central level policy makers had control over the decentralisation decision process and resources. For example, funds for decentralisation were held at the central level, delaying full implementation of decentralisation policy. In addition, the district assembly failed to guide NGOs on service delivery, in part because the NGOs had more funds from donors than local Government. As a consequence, some NGOs and donors undermined the leadership of district assemblies and community rules, protocols and procedures; the actions which induced conflicts.

Evaluation of health-sector reforms, that were carried out in different countries in sub-Saharan Africa, provided reasons why district assemblies failed to make decisions and control resources (Sikosana and Dlamini 1995; Cassels and Janovsky 1992). The findings indicated that in Zambia and Mozambique, the central level had devolved powers to districts; whereas in Nigeria and Botswana, the central level had difficulty transferring power to the district (Sikosana and Dlamini 1995).

As a result, the district assembly did not make decisions regarding prioritisation of resource utilisation in Nigeria nor Botswana (Sikosana and Dlamini 1995). Further, Sikosana and Dlamini (1995) found that, in developing countries, some central level policy makers at the Ministry of Health failed to transfer administrative powers to the district assembly on matters of resources, because the district assembly lacked managerial skills.

This suggests that Government should fully decentralise service delivery functions, with clear demarcation of functions between central Government and the district

assembly. The Government needs to train the district assembly staff to coordinate effectively and monitor service implementation.

Datta, Phillip and Verma (2012) found in the Nyanza Province of Kenya that capacity building of district education personnel and local civil society organisations addressed challenges of in-school and out of school pupils, as well as promoting cooperation between civil society and Government service providers. Initially the pupils were exposed to corporal punishment and poor academic performance.

In chapter eight, section 8.5.1, service providers and service users suggested that not allowing them in policy formulation and implementation, made them feel disempowered. Similarly, Chinsinga (2007) argued that the Malawi Social Protection policy-making process was not participatory and it lacked Government leadership. As a result, the process was driven by donors. Consequently, Chinsinga (2007) suggested that the civil society, members of parliament and the local people were not involved. Failure to involve these stakeholders resulted in policy that did not address poverty and equity matters. Government should also involve local people in policy development, so that people's aspirations and needs form part of the policy.

b) Service user's powerlessness

At community level, service users suggested that they were powerless either to make decisions or take action or participate in service delivery because they felt unable to question service providers. The orphans and caregivers felt powerless to question service providers, even when they experienced social injustice. For instance, when the corrupt local chiefs took away welfare materials meant for orphans, caregivers were powerless to confront the chiefs because they were afraid of being punished by them, or being labelled as trouble makers, as reported in chapter seven, section 7.6. In addition, service providers felt powerless because they had no sources of earning income, therefore had no control over choices of things they wanted in life.

Service users suggested lack of gender empowerment of women, perpetrated by cultural values and gender roles. For example, women could not construct or renovate houses because these were considered to be male roles. Women had difficulty

engaging in income- generating activities compared to men, due to child-care responsibilities. In addition, when there were inefficient services at the clinic, some of the orphan care committees suggested having felt disempowered to question the health care officials.

Wallis, Dukay and Mellis (2010) and Freire (1970), suggested the need for community members, instead of being passive, to assume an active role in influencing service delivery. Service providers need to orient service users on the roles they can play and train them accordingly.

9.1.5.2 Empowerment Process

Studies have shown that it is feasible for service users to shift from being powerless to being empowered. Freire (1970) suggested that it is through dialogue, a two way communication process where people gather information, realise their own powerlessness and begin to gain empowerment. Frere suggested that people need a forum to enable this dialogue. Some authors suggest that empowerment can occur through individual and collective strategies. Individual empowerment focuses on building self-determination, self-sufficiency, decision making abilities and mastery or self-control (Staples 1990; Tones and Tilford 2001).

Collective empowerment may be achieved through community or group action (Boehm and Sataples 2004; Tones and Tilford 2001). Community engagement refers to people being involved and gaining control over organizations in the community, by working through social networks. It has been suggested that communities offer beneficial features for people, which include: feeling of belonging, sense of influencing, integration and fulfilling of needs and emotional sharing (Tones and Tilford 2001). Collective empowerment promotes a bottom-up approach to development. It utilises local resources such as skills, talents and gifts (Turner and Pinkett 2000).

As reported in chapter four, Skovdal et al. (2010) found that service users in Kenya can be empowered to make decisions and take action to mobilise the community, to raise funds for managing community-based cash transfers. The process of building

community mobilisation for cash transfers was achieved because of increased awareness, skills training, building community cohesiveness and partnerships.

The literature on empowerment might imply that it is possible to empower service users in decision making and participation in service delivery, using both individual and collective approaches. The viability and appropriateness of the approach varies depending on the circumstances and the issue or need being addressed. Collective empowerment, particularly through community mobilisation, fits very well with Malawi, which has the potential to deliver quality community services to orphans and caregivers. Unfortunately, the CBS volunteers lacked skills and knowledge to provide quality care to orphans.

From the literature, community-based services demonstrated the potential to deliver service effectively due to the commitment of women volunteers (Uny 2008). The communities' cohesiveness and unity helped members to share responsibilities to support orphans (Munthali 2002). In addition, a collective approach may be achieved through the formation of networks. The findings in this thesis suggested that NGO networks were able to lobby for increased Government funding towards orphan activities.

Some authors have suggested that children can participate in service delivery and help to reach fellow children, through mentoring and peer education strategies. Van der Heijden and Swartz (2010) found that peer education among youth has been an effective strategy for HIV prevention. In South Africa, Van der Heijden and Swartz (2010) found that peer-led strategies circumvented the cultural taboos of silence on issues of bereavement and loss.

Children were able to cry or talk about death among themselves as a means of achieving psychological release. What seems clear in this literature is that children should be allowed to participate in service delivery. It shows that children could have special skills and approaches for reaching other children with difficult circumstances, such as traumatised and street children. The implication of this is that children should be properly trained by service providers to handle and manage emotional cases.

While community-based services appear to demonstrate the potential for promoting empowerment of service users, the literature review in chapter four, section 4.4.4 highlighted their weaknesses, in relation to technical and management capacity (Narayan et al. 2000). This may imply the need to build the capacity of community-service providers to deliver quality services and empower service users.

The above literature suggests that service providers, by neither involving communities, nor individuals nor children in service delivery, they may be underutilising the existing resource for improving service responsiveness. For effective utilisation of service users, there is a need to build their capacity to enable service users gain confidence to take part in service delivery.

9.1.6 Resource Capacity

Chapter eight highlighted that, having polices in place may not be sufficient to ensure service implementation, if required resources were not available. Furthermore, the findings showed that the quality of services was compromised. Services were in many ways not responsive to the needs of orphans, because of constrained resources in the form of finance, staffing quantity and quality, equipment and transport. For example, lack of resources resulted in Government failing to fully decentralise service delivery, absence of some services such as housing and discontinuity of services.

Similarly, in South Africa, Debbie, Paula and Lucy (2008) found that Social Welfare service provision to orphans was not effective, because government was in short supply of resources, staff were not properly trained and were poorly paid. This thesis explored theoretical and practical barriers that influence non-availability of resources for implementing orphan care services, including limited resource planning, failure to manage resources and user fees.

a) Resource planning and mobilisation

Implementation management theory, applied in policy analysis, suggests that service implementation feasibility could be improved if management of resources was an integral part of policy design (Parson 1995; Hogwood and Gunn 1984). Hill (2009)

argued that modern challenges of resource constraints propel public policy to adopt a stringent management style. Implementation management theory focuses on guiding managers to accomplish policy objectives and the operational administration of policy.

Planning is seen as defining objectives and developing strategies to attain the goals. Therefore, the feasibility of policy implementation ought to include planning and mobilisation of staff, financial resources and appropriate monitoring systems (Hogwood and Gunn 1984).

Service providers suggested that due to limited resources, they failed to implement services Service implementation planning theory might imply the need for Government to develop policy plans that are realistic according to available resources. This might mean Government streamlining activities and prioritising services with high demand and more impact than others, such as food and cash transfer.

b) Cost contribution to service delivery

In chapter seven, service users suggested there were some services that demanded cash contribution from users. Some of such services were subsided fertiliser and contribution of school funds. In Malawi, hospital-user fees were mainly implemented by private hospitals. The results suggest that, even where the cost of contribution from the users was low, service access was compromised for the poor. This was because poor people from the rural areas failed to pay even the low cost for the services. Similarly, in Uganda, Amone et al. (2005) found that user fees promoted inequitable service access, because the poor could not afford the services.

The findings suggested that preferably, a low rate or a fee-waiver should be adopted for all vulnerable groups. Many African countries have abandoned, or reduced, user fees in the health sector because user fees reduced service access (Ridde and Morestin 2010; Lagarde and Palmer 2011).

Service users' failure to access services because of related costs might require Government to intensify strategies for subsidising fully the cost of services for poor people. This could be achieved if Government could identify additional sources of

funding the cost of services to the most vulnerable households, through the public sector.

9.1.7 Policy and Practice

One of the objectives in this thesis was to examine the extent to which policy guided service implementation. The findings in this research suggest four scenarios showing varying degrees in which policies influenced service delivery. First, this thesis found that some services were implemented in accordance with policy guidelines. This meant that policy was effective in guiding service delivery to orphans. In chapter nine, for example, one of the characteristics of policy responsiveness was the coherence between policy vision, service delivery approaches and service users' experiences on comprehensiveness of services to orphans.

Through community-based service delivery, different service providers were guided by the Early Childhood policy, to deliver diverse services to meet the diverse needs of orphans. This is consistent with the definition of policy as a guide for taking action as "broad statements of goals, objectives and means by a group of decision makers, that create a framework for activity" (Buse, Mays and Walt 2005:5). It is also consistent with definition of a policy as "practices, statements, regulations and laws" resulting from decisions on how things should be done (Barker 1996:8).

Another example was the Ministry of Health who made a provision for a formal agreement between Government and the private hospitals, to provide free medical treatment to the poor, at the expense of Government. Indeed, the district health officer and service users agreed that service users benefited from this cooperation.

The second observation from chapter nine was that when there was no written policy, implementation was subsequently not guided. For instance, service users lacked policy guidance on the provision of ARV to children, provision of incentives to volunteers, and guidelines on alternative homes to children without parents. These caused service delivery irregularities, non-standardised service provision and poor quality services.

Thirdly, when policy design was bad, practice was bad. In the thesis, similar policies were implemented differently between the sectors, resulting in the confusion of service providers and duplication of services. Similarly, Robison and Kanyanta (2007) suggested that lack of inclusive policies undermined quality of education for orphans and other vulnerable children. Factors that led to poor quality of education included lack of learning materials, lack of strategic planning, poor policy design and lack of staff development.

In chapter eight such inconsistencies were reported in the skills development and education support policies. Malawi could learn from National OVC policy from Uganda. The policy linked key services that were to be implemented by stakeholders in the policy. Furthermore, the Uganda Government clearly stipulated policy coordination roles for different stakeholders. The policy stipulates coordination linkages between Government and other key stakeholders, including donors and NGOs (Uganda 2004). As a result, the services and stakeholders were well coordinated in practice.

While the Ugandan Government is responsible for policy formulation, civil society service providers are coordinated through an umbrella organisation, called Uganda Network of AIDS Services Organisations (UNASO). UNASO is a national network with district structures and affiliated to African Council of AIDS Service Organisation. The National Council for Children has a monitoring and evaluation role.

As noted from this thesis in chapter eight, figure 8.1, there were no linkages at the policy level between Government and the NGO coordinating body, Council for Non-Government Organisation Council (CONGOMA). The NGO policy body was not part of the national orphan care steering committee. This caused poor structural alignment and brought disharmony in service delivery.

Fourthly, sometimes policy design may be good, but service delivery may not follow the policy. In this thesis, the policies stipulated clear guidelines for the provision of equitable services, based on social economic status with the aim of providing services with preference to the most vulnerable children. In practice this thesis established

that orphans and caregivers received inequitable services based on socio-economic status because of nepotism, bribery and corruption of service providers.

Varied reasons have been suggested for the discrepancies between policy design and practice, which include: deliberate inaction, inefficiency through corruption, insufficient resources, politics and other threats (Parson 1995; Hogwood and Gunn 1984). Parson (1995) argued that policy is not precise, because it denotes a course of action that is intended or not intended in the practice of implementation and administration. Hogwood and Gunn (1984 :14) suggested that policy contains a 'deliberate decision not to act'.

Another well-documented reason why policy may not be implemented according to policy makers' intention is the influence of 'street level bureaucracy', or the influence of front line public servants (Lipsky 1993; Hudson 1997b). Front line public servants, for example, possess discretionary power to act or not to act according to policy. Sometimes they modify policy, not out of ill will, but to increase the chances of achieving the intended outcome. In this thesis, community-based service providers changed the time of school meals from ten o'clock to one o'clock, to help orphans, who do not have food at home, to eat at mid-day. The policy suggested an early meal to promote learning concentration. Boler and Carroll (2003) suggested that, to improve learning outcomes, school meals should be in the morning.

One of the findings in this thesis was that the quality of services was poor, because of service providers' inefficient practices at all levels. In addition, in the distribution of services to orphans, local community service providers practiced nepotism and bribery. Hudson (1997a) suggested different accountability measures, like sanctions and incentives, use of voucher systems to make payments to service users and legal penalties to control corrupt practices among service providers, particularly street level bureaucrats.

9.2 Discussion of Methodology

9.2.1. Strength of Study Methodology Design and Framework

a) Third party reporting

As stated in the research methods, information regarding lived experiences of younger orphans was collected through caregivers. Caregivers' views posed some limitations, in that they may fail to capture the full experiences of children, since they play different roles in the home. Some researchers in Zimbabwe, found that the list of needs that came from orphans was different from that of caregivers (Mangoma, Chimbari and Dhlomo 2008). It was difficult for caregivers to provide information related to younger children, without providing information for the whole family's experience, which might overshadow children's experiences.

Throughout the interviews, caregivers were reminded to separate their views on the younger orphans from those of the household. Another limitation that might have come from caregivers could be exaggerating the situations of orphans with the hope of receiving support from the researcher.

Holding discussions with caregivers helped explore the capacity of caregivers to provide support to children. For instance, how caregivers struggled to find money to feed the children, or how their psychosocial needs influenced the children. Conducting interviews with the children was important because conducting research with them to hear their views, was a research gap. Moreover, accessing information from orphans provided lived experiences.

b) Flexibility of interviewing research participants

This study involved older orphans aged 13-16 years and younger orphans, using in-depth interviews. By involving orphans directly, this research has contributed to the research gap, in Sub-Saharan Africa studies, of failing to involve and capture the expressed needs of orphans. It appears there is a growing need to involve children in research (Byrne and Gregory 2007).

The use of interviews helped orphans to express their views freely without comparing themselves with other children, to use metaphors, share personal experiences, and expose some issues which could have been hidden in the presence of service providers. It could have been difficult for orphans and caregivers to talk about corruption of chiefs and other service providers in a focus group discussion. The flexibility of qualitative data collection from service users helped to adjust sampling in the field. For example, when it was difficult to find paternal orphans, using the village register, a snowballing method was utilised, by using orphans and caregivers to identify other participants.

c) Holistic and multidisciplinary study

The research helped to explore the diverse needs of orphans in order to understand how orphans perceived and prioritised help for their needs. This was possible because of the methods that were used; asking orphans to share their experiences, using storytelling method or pictures. A holistic approach to needs assessment helped fill the literature gap of limited studies that look at broad needs of orphans. Many studies in Sub-Saharan Africa focused on only one or a few needs.

Studying needs, services and policies helped to understand the interplay between them. This approach facilitated the success of process evaluation that aims to improve policy and service responsiveness.

d) Influence of the researcher

The researcher is a senior policy level officer working in the Ministry of Gender, Children and Community Services that is responsible for orphans' welfare. Knowledge in the subject matter could have brought some bias on reporting and analysing of information, due to the researcher's own assumptions. Bias was controlled by documenting and reflecting upon my views, beliefs and by being honest and keeping a record of each step and process.

As somebody who came from Malawi, there were some things with which I was familiar. Knowledge of study environment made it feasible to understand and identify

cultural effects on the study, to understand the policy and service delivery environment, to gain easier access to confidential and other government documents and to utilise the findings of the study to improve policy and service delivery for orphans. On the other hand, working with service providers with whom I was familiar could have influenced their responses during the interview, a factor difficult to know and to control.

Playing the role of a researcher helped me to be detached from programming responsibilities. It gave me the chance to perceive service implementation and policy through a different lens. Initially, my assumptions were that, once programmes are planned, good implementation was guaranteed. The wide consultation with several partners made me realise that there are so many things that could frustrate implementation, hence the need to engage in rigorous monitoring.

9.2.2 Limitations of study methodology design and framework

a) Household Approach

By interviewing the orphans from their household, it was not possible to include all forms of orphans, such as those under institution care or orphans who had moved to the street. On the other hand, household interviews with service users helped to confirm physically the social economic status. It has been reported that in sub-Saharan Africa, high levels of orphans are involved in child labour (Monasch and Boema 2004) and are less likely to be found at home. In addition, Laura, Simon and Geoff (2010) found a discrepancy in prevalence of maternal orphans between data from UN models and DHS survey estimates. This was because foster mothers reported orphans as their own children. Foster and Williamson (2000) suggested that orphan numbers are normally based on demographic data that define orphans as children under the age of 15, resulting in the underestimation of orphans.

b) Misconceptions of research approach

The use of interviews to collect information from service users was similar to methods used by Social Welfare and other service providers, during routine assessment, with

the aim of providing material support to service users. It was felt that some participants exaggerated their challenges and needs, expecting to receive support from the research team. Indeed, some caregivers visibly expressed anger and disappointment on realising that there was no material support package. To mediate this, throughout the interviews, participants were reminded of the purpose of the discussions.

c) Non accessibility of some areas

As discussed under sampling of participants, due to the terrain of some areas, distance and heavy rains, it was difficult to reach some orphans who were sampled. This might have left out some unique experiences of orphans. Since this research is about service distribution and access, it could be possible that those were the orphans who were not targeted with services, because their places are hard to reach.

9.3 Modification of conceptual framework

There was no framework from the literature for assessing Sub-Saharan orphan care service delivery quality. Using the theoretical approach to literature review is an innovative way of understanding orphans' situations. Adopting Maslow human motivation theory helped to understand the needs of orphan's better. Maslow helped to understand orphans prioritisation of needs, by their behaviour. In that sense, orphan's behaviour was a verification of needs. This provided a useful to guide for prioritising service implementation, especially in a resource constrained environment. In this thesis only two of Maslow's hierarchy levels were in tandem with his theory.

The other needs did not fit in the manner in which Maslow's interpreted the needs, such as esteem and self-actualisation discussed in chapter six, section 6.1. The thesis acknowledges the ethnocentricism of Maslow's theory that was adopted from a different cultural setting. For example, Maslow placed education high up the pyramid. Orphans put education as their most important need after food, because they recognised the importance of education for provision of good jobs and money for

food. The differences may suggest the need for applicability verification and flexibility in the application of theories from different cultural backgrounds.

This thesis adopted two frameworks for evaluating quality of care by Maxwell (1992) and Health Services Research Group (1992), to develop a hybrid framework for assessing quality of orphan care service delivery and policy content. This framework was used successfully to undertake process-evaluation of orphan care policies and services in Malawi. The healthcare research group framework helped to broaden the scope of evaluation, by including comprehensiveness and coordination elements of services. These were very important in relation to the needs of orphans. They helped assess the complex multi-sector and integrated services, as reported in sub-Saharan Africa literature in chapter four.

Analysis of both policy and service implementation has suggested that the elements of quality of care were inter-related. This is different from the original theories. In addition, coordination has shown to be the major factor for improving service quality, because it influenced the other elements. This suggests that improving coordination of policies and services is a good entry point for ensuring quality of services for orphans.

By developing a framework for assessing service delivery, this research has contributed to the methodological use of frameworks in research. During the application of the framework, some adjustments were made in the field, to suit the study setting. For instance, the element of 'relevance' was dropped because it was difficult to apply in a multi-service and multi-sector environment. It was noted that there were meaning overlaps when the elements were translated into local language. This resulted in respondents giving similar information in response to different elements. For example, effectiveness and acceptability were producing overlapping information. This suggests that the English language has a relatively richer vocabulary than the local language.

9.4 Recommendations of study

This section presents feasible recommendations that have the potential to improve significantly the quality of orphan care services in Malawi, in the short to medium term. Policy makers' recommendations should be lead by the National OVC Steering Committee, Service implementers' recommendations should be lead by the National OVC Technical Working Group. In a resource-constrained service-delivery environment, it may not be possible to determine the adoption time-frame for the recommendations. The sectors from the multi-sector policy and service environment will implement the recommendations according to their needs, work plans and budget.

9.4.1 Recommendations to Policy Makers

9.4.1.1 Recommendations to Government policy makers

a) Short term recommendations (< 2 years)

- Review the terms of reference of the National OVC Steering Committee's composition and include additional key stakeholders involved in orphan care activities, such as District Assemblies and the Private Sector.
- Develop guidelines to strengthen the collaboration and communication system between the MoGCCS and other Government departments, as well as with NGOs.
- Promote gender disaggregated data collection during orphan needs assessment processes, to facilitate the determination of how resources can be distributed in a gender-sensitive manner during service delivery processes.
- Improve coordination of donor funds through quarterly coordination meetings between Government and donors, to agree on policy strategies/priorities and review progress.
- The Office of the President and Cabinet should set up a coordination structure for the National OVC Steering Committee, NGOs and the private sector, to ensure that Government child-related policies are aligned with the decentralisation policy.

- Develop terms of reference for conducting orphan-care research, and promote participation of academics and other researchers to continuously carry out research on children.
- Broaden NGO stakeholders' participation in orphan-care monitoring and evaluation system. Centralise orphan-care information management system in MoGCCS.
- Disseminate policy documents, plans of action and legal documents to the district assembly and other service providers.

b) Long term recommendations (>2 years)

- MoGCCS to facilitate the review of existing laws to fill in the policy gaps identified in this thesis and to speed up the legislation of children laws.
- Mobilise financial resources to increase coverage of services to orphans, improve on the quality of service delivery to orphans and improve coordination activities. For example, Government may set up an orphan fund and promote fundraising activities with the private sector and the public.
- Undertake appropriate professional training of personnel in areas that were identified in this research, including: social workers, child protection staff, research and psychosocial areas.
- Conduct a policy review to incorporate recommendations and strategies to fill policy gaps. Some of the policy gaps to be addressed include guidelines for services such as psychosocial, child protection, housing, transportation, promotion of cash/income generation, skills training and ARV access for children and equitable distribution of services.
- Strengthen enforcement strategies for transparency and accountability, to promote prudent management of resources, control corrupt practices and inefficient utilisation of funds. Strengthen enforcement of financial management legislations.

9.4.1.2 Recommendations to donors: policy makers

a) Short term recommendations (> 2 years)

- Align with Government data monitoring and evaluation channels, and avoid creation of parallel policy implementation structures to Government existing structures.
- Avoid bypassing district assembly when implementing services in communities.
- Embrace Government policy and service delivery vision and priorities.
- Strengthen the leadership and management of the MoGCCS in the coordination of orphan care services through training, increased funding and exchange programmes with successful countries like Uganda.
-

b) Long term recommendations (> 2 years)

- Intensify financial resource mobilisation to increase funding to Government and NGOs for scaling-up orphan care programmes.
- Provide technical and financial assistance to Malawi Government to build human capacity, through training and full decentralisation.
- Assist NGOs to build the capacity in weak areas identified in this research, including advocacy and resource mobilisation.
- Facilitate the expansion of sector wide approach to other Government Ministries, including the education and agriculture sector.

iii) Recommendations to NGOs: policy markers

a) Short term recommendations

- Intensify lobbying donors and Government to increase funding towards orphan care service delivery and towards improved legislation of children laws.
- Align with Government policies in the implementation, coordination and monitoring of orphan care service delivery.

- Improve on transparency, accountability and efficiency in the utilisation of donor funds.
- Support Government with the training of volunteers.
- Promote coordination with other stakeholders to help the provision of integrated services that prioritise food and income raising.

9.4.2 Recommendations to Multi-sector service providers

The recommendations in this section should be implemented by the National OVC Technical Working Group, which consists of Government and NGO service providers.

a) Short term recommendations

- Develop comprehensive needs assessment criteria for identifying the needs of orphans to include characteristics which were identified in this thesis, such as demographic characteristics of orphans, characteristics of caregivers (gender, age, and labour demand), socio-economic status, cultural influences, geographical location, health status, household size and household asset base.
- Promote integrated services that include provision of meals and food rations in the community and schools, using locally grown foods.
- Increase participation of orphans and caregivers in service delivery, including needs assessment, networks, role modelling, peer training and community resource mobilisation.
- Conduct gender empowerment through encouraging girl orphans to go to school, and promote reproductive sexual rights among orphans.
- Promote local resource mobilisation through private sector involvement, establish orphan care fund or develop proposals for accessing grants.

b) Long term recommendations (>2 years)

- Intensify promotion of food security through food production and income building strategies.

- Sensitise local leaders and community leaders to promote the eradication of harmful effects of some cultural practices on orphans and children.
- Train volunteers and other service providers in effective strategies for child care.
- Promote accessibility of services through increased local community level strategies and technology including, village revolving fund loan schemes and community skills training.

9.4.3 Recommendations for further research

While undertaking this research, a number of issues were identified that need further research. The aim of this section is to discuss the study's methodological contribution to research and suggest areas for future research.

- Research should explore how service providers could provide support to strengthen families' capacity to overcome their limitations, through family-centred strategies. This is because the thesis identified negative strategies that orphans and caregivers adopted to cope with their challenges, and the adverse consequences of these strategies on the lives of orphans.
- Research should aim at identifying strategies for engendering the orphan care-service delivery. Special gender research should focus on identifying strategies for empowering women, and promoting girl child-education by providing strategies for overcoming gender-based barriers. This is because the thesis highlighted orphan care limitations of caregivers. Key to caregivers' living arrangements was gender-based variations of orphan needs between males and females. Women appeared to have unique challenges that limited women's capability to better provide care to orphans.
- The extended family is a major resource that should be explored and utilised, to provide care to orphans. Research is needed on interventions to enhance this.
- Research should determine the extent to which monetary service contributions are a hindrance to orphan access and utilisation of services and propose strategies to increase service access. This is because this thesis suggested that

service users failed to access services that needed some contribution in monetary terms. The full extent of this effect on orphans and caregivers was not known.

9.5 Thesis Conclusion

This thesis explored orphan care policy and service responsiveness to the needs of orphans. Policy responsiveness assessed the extent to which policies guided and contributed towards improving service delivery. Service responsiveness was determined by the manner in which multi-sector orphan care service providers delivered services, guided by policies to address the needs of orphans. While the multi-sector service providers made efforts to increase the number of services and geographic coverage of services, the quality of service delivery was compromised, that is, the efforts were not commensurate with the demand for services nor the expected quality by the service users. The services to orphans were inequitable, inefficient, poorly coordinated, not comprehensive, not accessible and hence, not acceptable to service users.

The Malawi Government made an effort to develop many relevant child-related policies. It set up the orphan care institutional structures for coordinating multi-sector policies and stakeholders. However, policy influence on service delivery was undermined by poor coordination, poor policy design, lack of access to relevant policy information, limited technical and resource capacity and limited participation of stakeholders in policy design and implementation.

It can be concluded that child-care related policies and services were not fully responsive to orphans' needs. To improve quality of policies and services, the barriers identified in this thesis, need to be addressed. The Malawi Government needs to build both resources and technical capacity, intensify policy and service coordination as well as prioritise provision of food and financial services to orphans.

References

ABBOTT, S., S. SHAW and J. ELSTON. 2004. Comparative Analysis of Health Policy Implementation. . *Policy Sciences,* **25**(4), pp.259-266.

ABEBE, A. 2007. Children, AIDS and the politics of orphans care in Ethiopia: The extended family revised. *Social Science and Medicine,* **64**, pp.2058-2069.

ADATO, A. et al. 2005. Children in the Shadow of AIDS: Studies of Vulnerable Children and Orphans in Three Provinces in South Africa.

ADATO, M. 2008. Social Protection for Families affected by HIV and AIDS: Implementation issues in Economic Strengthening through Cash Transfers. International Food Policy Research institute. Joint Learning Initiative on Children and AIDS.

ADATO, M. and L. BASSETT. 2007. What is the potential of cash transfer to strengthen affected by HIV and AIDS?

ADAY, L., A. et al. 1933. *Evaluating the medical and care system effectiveness, efficiency and equity.* Michigan: Health Administration Press.

AHMED, T. et al. 2007. Food for education improves girls' education: Pakistan girls education programme. World Food Programme.

AINSWORTH, M. and D. FILMER. 2002. *Poverty, AIDS and schooling: a target dilemma.* Washington DC: World Bank.

ALDERSON, P., K. SUTCLIFFE and K. CURTIS. 2006. Children as partners with adults in their medical care. *Archieves of Disease in Childhood,* **91**, pp.300-303.

AMONE, J. et al. 2005. User fees in private non-for-profit hospitals in Uganda: a survey and intervention for equity. *International Journal of Equity in Health,* **4**(6).

ANGELUCCI, M. et al. 2010. Family networks and school environment: evidence of randomised social experiment. *Journal of Public economics,* **94**, pp.197-221.

ARKES, H., R. and J. GARSEKE, P. 1982. *Psychological theories of motivation. 2nd Edition.* California, USA: Core Publishing Company.

ATTAWELL, K., J. CHITTY and G. PURVIS. 2005. Assessment: Care Tumaini Programme.

AUDEMARD, C. K. V. 2006. Orphan and Other Vulnerable Children due to HIV/AIDS in Sub-Sahan Africa http://www.ceped.org/cdrom/orphelins_sida_2006/en/index.html

AYIEKO, M. A. 1997. From single parents to child-headed households: The case of children orphaned by AIDS in Kisumu and Siya Districts. HIV and Development, UNDP.

BAQUELE, A. 2004. The Emerging Challenge of Children Heading Households: Some reflections.

BARBOUR, R. and J. KITZINGER. eds. 1999. *Developing Focus Group Research:Politics, Theory and Practice.* London: Sage Publications Ltd.

BARBOUR, R. S. 2001. Checklist for improving rigour in qualitative research: a case of tail wagging the dog? *BMJ,* **322**.

BARKER, C. ed. 1996. *The Health Care Policy Process.* London: Sage Publications Ltd.

BARNES, C. 2003. Microfinance and households coping with HIV/AIDS in Zimbabwe: an exploratory study.

BARNETT, C. et al. 2006. Evaluation of DFID Country Progress, Malawi Country Report. Lilongwe, Malawi

BAZELEY, P. 2007. *Qualitative data analysis.* London: Sage Pubications Ltd.

BEEGLE, K. et al. 2009. *Orphanhood and living arrangements of children in Sub Saharan Africa*.

BENNELL, P. 2005. The impact of the AIDS epidemic on the schooling of orphans and other directly affected children in Sub-Saharan Africa. *Journal of Development Studies,* **41**(3), pp.467-488.

BIRD, K. and D. BOOTH. 2003. Food security crisis in Southern Africa: The political background to policy failure. Forun for Food Security in Southern Africa.

BIRDTHISTLE, I., J et al. 2011. Child sexual abuse and links to HIV and orphanhood in urban Zimbabwe. *Journal of Epidemiological Health Community Health,* **65**, pp.1075-1082.

BIRDTHISTLE, I. J. et al. 2008. From affected to infected? Orphanhood and HIV risk among female adolescents in urban Zimbabwe. *AIDS,* **22**(6), pp.759-766.

BOEHM, A. and L. SATAPLES, H. 2004. Empowerment: The point of view of a consumer. *Families in Society,* **85**(2), pp.270-280.

BOLER, T. and K. CARROLL. 2003. Addressing the educational needs of orphans and vulnerable children. Policy & Research: issue 2. UK working group on education and HIV/AIDS.

BOOTH, D. et al. 2006. *Drivers of change and development in Malawi.* London: Overseas Development Institute.

BOWIE, C. and T. MWASE. 2009. Health Portifolio review for Malawi. Lilongwe.

BOWIE, C. and T. MWASE. 2011. Assessing the use of an essential health package in a sector wide approach in malawi. *Health Research policy and systems,* **9**(4).

BRINKERHOFF, D. 2003. Accountability and health systems: overview, frameworks and strategies.

BRONFENBRENNER, U. 1979. *The ecological human development.*

BROOK, R., H and P. CLEARLY, D. 1996. Measuring Quality of Care. *The New England Journal of Medicine,* **335**(13), pp.996-970.

BRYCESON, D. F. 2006. Ganyu casual labour, famine and HIV/AIDS in rural Malawi: causality and casualty. *Journal of Modern African Study,* **44**(2), pp.172-202.

BUSE, K., N. MAYS and G. WALT. 2005. *Making Health Policy.* Berkshire: Open University Press.

BYRNE, E. and J. GREGORY. 2007. Co-constructing local meaning for child health indicators in community-based information system. pp.78-88.

CAMMACK, D. 2004. Poorly performing countries:Malawi, 1980-2002, background papre 3. Overseas Development Institute.

CAMMACK, D. 2011. Malawi's political settlement in crisis. African Power and Politics Working Paper no. 4.

CAMMACK, D. et al. 2003. Food Security Issues paper (Malawi). Prepared for Forum for Food Security in Southern Africa.

CAMMACK, D., T. KELSALL and D. BOOTH. 2010. Development patriminilism? The case of Malawi. African Power and Politics.

CASE, A., C. PAXSON and J. ABLEIDINGER. 2004. Orphans in Africa: Parental death, poverty, and school enrollment. Princeton, New Jersey, USA: Center for Health and Wellbeing.

CASSELS, A. 1995. Aid instruments and health systems development: an analyis of current practice.

CASSELS, A. and K. JANOVSKY. 1992. A time of change: health policy, planning and organization in Ghana. *Health Policy Plan.,* **7**(2), pp.144-154.

CECCHINI, S. and A. MADARIAGA. 2011. Conditional cash transfer programmes: The recent experience in Latin America and the Caribian.

CHALLE, J. F. X., A. NIEHOF and P. C. STRUIK. 2011. The significance of gathering wild orchid tubers for orphan household livelihoods in a context of HIV/AIDS in Tanzania. *African Journal of AIDS Research,* **10**(3), pp.207-218.

CHAMBERLAIN, E. et al. 2011. Pluralism in quantitative research: From multiple methods to integrated methods. *Qualitative Reserach in Psychology,* **8**(2), pp.151-169.

CHEETHAM, J. et al. 1992. *Evaluating social work effectiveness.* Open Press, Buckingham.

CHILDREN COUNT. 2005. Facts about Children: Orphans Residing with their Remaining Parent http://www.childrencount.ci.org.za/.

CHINSINGA, B. 2007. *Social Protection policy in Malawi: processes, Politics and challenges.* Zomba, Malawi.

CHIRWA, W., C 2002. Social exclusion and inclusion: challenges to orphan care in Malawi. . *Nordic Journal of African studies 11(1): 93-113*.

CHIRWA, W., N. PATEL and E. KANYONGOLO. 2004. Democracy report for Malawi.

CHO, H. et al. 2011. "Keeping Adolescent Orphans in School to Prevent Human Immunodeficiency Virus Infection: Evidence from a Randomized Controlled Trial in Kenya." *Journal of Adolescent Health,* **48**(5), pp.523-526.

CIANCI, R. and P. A. GAMBREL. 2003. Maslow's hierachy of needs : Does it apply in a collective culture? *Journal of Applied Management and Entrepreneurship,* **8**(2), pp.143-161.

CLARKE, A. 2005. *Evaluation research: An introduction to principles, methods and practice.* London: Sage Publications Ltd.

CLARKE, A. and M. RAO. 2004. Developing quality indicators to assess quality of care. *Quality and Safety in Health Care,* **13**(4), pp.248-9.

CLAUSSEN, J. et al. 2006. Evaluation of General Budget Support- Malawi country Report.

CLUVER, L., D, ORKIN and F. GARDENER, BOYES, ME. 2012. Persistent mental health problems among IDS-ORPHANED CHILDREN IN South Africa. 0. *Journal of Child Psychology, Psychiatric & Allied Diciplines. ,* **53**(4), pp.363-7.

CLUVER, L. and F. GARDNER. 2007. Risk and protective factors for psychological well-being of children orphaned by AIDS in Cape Town: A qualitative study of children and caregivers' perspectives. . *Aids Care,* **19**(3), pp.318-325.

CLUVER, L. et al. 2011. Transactional Sex Amongst AIDS-Orphaned and AIDS-Affected Adolescents:Predicted by Abuse and Extreme Poverty *Journal of Acquired Immunity Defficiency Syndrome,* **58**(3) pp 336-343.

COOK, P. H., A. SANDRA and M. ALAISTAIR. 1999. *Starting from strength: Community care for orphaned children in Malawi*.

COYLE, A. 2010. Qualitative research and anomalous experience: A call for interpretive pluralism.*Qualitative Reserach in Psychology,* **7**(1), pp.79-83.

CRAMPIN, A., C et al. 2003. The long term impact and orphanhood on the mortality and physical well-being of children in rural Malawi. *AIDS,* **17**, pp.389-397.

CRESWELL, J. 2008. *Research design:Qualitative, quantitative and mixed methods appraches.* 3rd Edition ed. London: Thousand Oaks.

CRESWELL, J. W. and D. L. MILLER. 2000. Determining validity in quantitative inquiry. *Theory into Practice,* **39**(3), pp.124-131.

CROMWELL, E. and N. KYEGOMBE. 2005. *Food security options in Malawi: good neighbours make good friends?* Forum for Food Security in Southern Africa.

CSCQBE. 2008a. Education for all: progress, problems and the way way forward.

D'CRUZ, H. and K. STAGNITTI. 2008. Reconstructing child welfare through participatory andchild-centred professional practice: a conceptual approach Child and Family Social Work, Vol 13,(2) p 156-165. *Social Work,* **13**(2), pp.156-165.

DALEN, N., A. J. NAKITENDE and S. MUSISI. 2009. "They dont care about us". The situation of double orphans heading households in Rakai District, Uganda. *BMC Public Health,* **9**.

DATTA, D., S. PHILLIP and P. K. VERMA. 2012. Capacity building of a district education system: insights from Kenya. *International Journal of Primary, Elementary and Early Years Education,* **37**(3), pp.203-217

DEBBIE, B., P. PAULA and J. LUCY. 2008. formulating and implementing socioeconomic policies for children in the context of HIV/AIDS **39**(5).

DESCOMBE, M. ed. 2007. *The Good Research Guide for Small-scale Social research projects.* 3rd edition ed. New York: Open University Press.

DESMOND, C. 2007. Can a developing country support welfare needs of children affected by AIDS? IDS Bulletin, Vol 39 (5) pp 94-99

DFID. 2011. Cash transfers. Evidence Paper, Policy Division 2011.

DONABEDIAN. 1988. The Quality of Care, How can it me Assessed? *Journal of American Medical Association,* **260**(12), pp.1743-1748.

DONAHUE, J. 1998. Community-Based Economic Support for households affected by HIV/AIDS.

DONOVAN, C. et al. 2003. Prime-Age adult morbidity and mortality in rural Rwanda: Which households are affected and what are their strategies for adjustment?

DRÉZE, J. and G. KINGDOM. 2001. School participation in rural India. *Review of Development Economics,* **5**(1), pp.1-24.

EDSTORM, J. and H. MACGREGORY. 2011. Aid for AIDS: How do community groups and other stakeholders negotiate the new financial architecture in Kenya, Malawi and Zambia?

EDWARDS, M. 1996. NGO performance-Whats breeds success? A study of approaches to work in South Africa, Save the children

EMERSON, R. M., R. FRETZ and L. L. SHAW. 1995. *Processing fieldnotes: coding and memoing.* London: University of Chicago Press.

ENWEREJI, E. E. 2007. Strategies for improving the nutrution of children orphaned by HIV/AIDS in rural area of Abia State, Nigeria.

EVANS, D. B. et al. 2001. Measuring Quality:from the system to the provider. *International Journal of Quality Health Care,* **13**(6), pp.439-46.

EVANS, D. K. and E. MIGUEL. 2007. Orphans and schooling in Africa: A longitudinal analysis.Demography. . *Demography,* **44**(1), pp.35-57.

FARGA-MALET, M. et al. 2010. Research with children: methodological issues and innovation techniques. *Journal of Early Childhood Research,* **8**.

FINCH, H. and J. LEWIS. 2003. Focus groups In Ritchie, J and Lewis J (Eds) qualitatitive research practice.

FISCHER. 2005. *In God we trust, all others bring data: Assessing the state of outcomes measurement for faith based and community based programming. In George, Levine, Carroll and Williamson,J (Eds) A generation at risk: The Global impact of HIV/AIDS on orphans and vulnerable children.* Cambridge: Cambridge College Press.

FOPPENA, B. 1996. The no hope future generation: the problems and solutions of the orphan crisis in Malawi.

FOSTER, C. and J. WILLIAMSON. 2000. A Review of literature of the impact of HIV/AIDS on Children in SubSaharan Africa. *AIDS,* **14**(3), pp.S275-S284.

FOSTER, G. 2002a. Supporting Community Efforts to Assist Orphans in Africa. *N Engl J Med,* **346**(24), pp.1907-1910.

FOSTER, G. 2002b. Understanding community responses to the situation of children affected by AIDS: Lessons for external agencies, united Nations Research Institute for Social Development.

FOSTER, G. 2003. The magnitude of faith-based responses to orphans in sub-Saharan Africa. *Sexual Health Exchange. ,* **1**(2).

FOSTER, G. 2004a. Safety nets for children affected by HIV/AIDS in Southern Africa. In Pharaoh Robyn, (ED) Generation at risk? HIV/AIDS vulnerable children and security in Southern Africa. Monograph, number 109.

FOSTER, G. 2004b. Safety nets for children affected by HIV?AIDS in Southern Africa.

FOSTER, G. 2005a. Channeling resources to communities responding to orphan and ulnerable children in southern Africa

FOSTER, G. 2006b. Future imperfect?: Charting a roadmap for children living in communities affected by HIV. . *Children First,* **64**.

FOSTER, G. 2010. Vulnerable children and youth studies. *Intedisciplinary Journal of Research,* **5**(20), pp.92-100.

FOSTER, G., M. DESHMUKH and A. ADAMS. 2008. Strengthening community responses to children affected by AIDS.

FOSTER, G. et al. 1997a. Factors leading to the establishment of Child Headed Household: case study of Zimbabwe, . *Health Transition Review,* **7**(2), pp.155-168.

FOSTER, G. et al. 1997b. Factors leading to the establishedment of child -headed households: the case of Zimbabwe. *Health Transition Review,* Supplement to Volume 7, pp.155-168.

FRANCE, A. 2004. *Young people. In Doing Research with children and young people. Fraser S, Lewis,V, Ding ,S Kellettt,M, Robinson,C (Eds).* London: Sage in association with Open University.

FREIRE, P. 1970. *The pedagogy of the oppressed.* London.

FROST, N. A. and S.-M. NOLAS. 2011. Exploring and expanding on pluralism in qualitative research in psychology. *Qualitative Reserach in Psychology,* **8**(2), pp.115-119.

FUNKQUIST, A., B. ERICKSSON and A. S. MUULA. 2007. The vulnerability of orphns in Thyolo District, Southern Malawi. *Tanzanian Health Resrach Bulletin,* **9**(2).

GELLI, A., U. MEIR and F. ESPEJO. 2007. Does provision of food in school increase girls' enrolement? Evidence from school in Sub-Saharan Africa. *Food and Nutrition Bulletin,* **28**(2).

GILSON, L. and A. MILLS. 1995. Health sector reforms in sub-Saharan Africa: lessons of the last 10 years. *Health Policy,* **32**(1-3), pp.215-243.

GLASER, B. G. and A. L. STRAUSS. 1967. *The Discovery of Grounded Theory: Strategies for Qualitative Research.* Chicago: Aldine Publishing Company.

GOEBEL, B. L. and D. R. BROWN. 1981. Adifferences in motivation relted to Maslow's need hierachy *Development psychology,* **17**(809-815).

GOLAFSHANI, N. 2003. Understanding reliabilty and vaidity in qualitative research. *The Qualitative Report,* **8**(4), pp.597-607.

GOODENOUGH, T. et al. 2003. "What do you thnk about that?" Researching children's perseptions of participation in a longitudinal genetic and epidemiological study. *Children & Society,* **17**, pp.113-125.

GOODWIN, D. 2006. *Ethical Issues In Pope C., Mays N., (Eds) Qualitative Research in Health Care.* Massachusetts: Blackwell Publishing, Inc.

GOVERNMENT, M. 2005-2008. Combating HIV and AIDS in the Education Sector in Malawi.

GOVERNMENT, M. 2007b. *First periodic report of Malawi on the implementation of the convention on the rights of the child.* Lilongwe.

GREEN, C. and S. BADEN. 1994. Women and development in Malawi. Bridge Development Report no.23.

GREEN, J. and N. THOROGOOD. 2009. *Qualitative Methods for Health Research.* 2nd ed. Sage Publication.

GREENBELT, K. and K. GREENWAY. 2007. Food security and nutrition, meeting the needs of children affected by AIDS?

GREENE, S. and M. HILL. 2005. *Researching children's experiences; Methods and methodological issues. In Greene Sheilla and Hogan Diane (Eds) Researching childern experiences: Approaches and methods.* London: Sage Publication Ltd.

GRINDLE, M. S. and J. W. THOMAS. 1991. Public choices and policy change.

GUARCELLO, L. et al. 2004. The influence of orphanhood on children's schooling and labour: Evidence from Sub-Saharan Africa. Interagency Research Cooperation Project.

GUION, L. A., D. C. DIEHL and D. MCDONALD. 2011. Trianguation: Establishing the validity of qualitative studies. Department of Family, Youth and Community Sciences, Florida Cooperative Extension Services, University of Florida.

GUYATT, H. 2003. The cost of delivering and sustaining a control programme for schistomiasis and soil-transmitted helminthiasis. *Acta Tropica*, pp.267-274.

GWATKIN, D. et al. 2006. Malawi Health SWAp. *Malawi Medical Journal*.

GYAPONG, J., OWUSU, R. SEBY, ATO and K. ANAKWAH, ANTWI. 2009. Challenges in linking health research to policy: a commentary on developing a multi-stakeholder response to orphans and vulnerable children in Ghana. *Health Research policy and systems,* **9**(Supp 1), ps14.

HADAD, L. and S. GILLESPIE. 2001. Effective food and nutrition policy responses to HIV/AIDS: what we know and what we need to know. *Journal of International Development,* **13**(4), pp.487-511.

HALL, A. et al. 2010. Case-Control analysis of the health and nutrition of orphan school children in Ethiopia. *Tropical Medicine and International Health,* **15**(3), pp.287-295.

HANSEN, E. C. 2006. *Successful qualitative health research.*

HEALTH SERVICES RESEARCH GROUP. 1992. Quality of Care:What is quality and How can it be measured? *Canadian Medical Association Journal,* **146**(12), pp.2153-2158.

HECLO, H. 1972. Review artcle, Policy analysis. *British Journal of polical Science,* **2**, pp.83-108.

HELP AGE INTERNATIONAL. 2006. *Why social pensions are needsd now.* Help Age International.

HENNINK, M. 2007. *International Focus Group Research: A handbook for the Health and Social Science.* London: Cambridge University Press.

HESSEY, J. and R. HUSSEY. 1997. *Business researc h.* MacMillan.

HEYLIGHEN, F. 1992. A cognitive-systematic reconstruction of Maslow's theory of self-actualisation. *Behavioural Sciences,* **37**.

HEYMANN, J. and R. KIDMANN. 2008. Weaving a tighter safety net: supporting children and families amidst the AIDS pandemic.
HILL, M. 2009. *The public policy.* 5th Edition ed. Pearson Education Limited.
HIRST, J. 1999. *Women perseptions of Quality of their maternity Care: AComparison of Parkistan & Indeginous white women:PhD Thesis.* Leeds: University of Leeds.
HOFSTEDE, G. 1984. The cultural relativity of quality of life concept. *Academy of Management Review,* **9**(3), pp.389-398.
HOGWOOD, J. and L. GUNN. 1984 *Policy analysis for the real world.* Oxford: Oxford Press.
HOLLYFORD , S. and S. WHIDDETT. 2002. Motivation Handbook. Chartered Institute of Personnel and Development, London.
HOLSTEIN, J. A. and J. F. GUBRIUM. 1995. *The active interview. Qualitative research methods series 37.* Sage Publications.
HOMETRUTH. 2009. Facing the facts on children, AIDS and poverty.
HORWATH, J. and T. MORRISON. 2007. Collaboration, interation and changen in children's services: critical issues and key ingridients. *Child Abuse and Neglect,* **31**, pp.55-69.
HUBLEY, J., S. TILFORD and J. WALLEY. 2010. *Planning, implementing and managing interventions. In John Walley and \jogn Wright (Eds) Public Health an action gude to improving health.* Oxford: Oxford University Press.
HUDSON, B. 1997a. *Collaboration in social welfare: a framework for analysis. In Hill, Michael (Ed) The Policy Process, 2nd Edition.* A pearson Education Company.
HUDSON, B. 1997b. *Michael Lipsky and street level bureaucracy : a neglected perspective. In Hill. Michael (Ed) The Policy Process.*2nd Edition.
HULME, D. and M. EDWARDS. 1997. NGOs, states and donors too close for comfort.
HUSSEIN, M. H. et al. 1966. Who misses out with school based health programmes? A study of schistomiasis control in Egypt. *Trans. R. Soc. Tro. Med. Hyg* **90**, pp.362-365.
INSITUTE FOR POLICY RESEARCH AND SOCIAL EMPOWERMENT. 2007. Learning from experience: re-examining community based organisations as agents of implementation of national HIV/AIDS response.
INSTITUTE OF MEDICINE. 1990. *Medicare: A Strategy for quality assurance, Volume 1.* Washington D C: National Academy Press.
INTERNATIONAL, H. A. 2006. Why social pensions are needed now.
ISOLDE, B. et al. 2009. Is education the link between orphanhood and HIV/HSV-2 risk among female adloescents in urban Zimbabwe? *Social Science and Medicine,* **68**, pp.1810-1818.
JAMES, R. and MALUNGA. 2006. The rise and pitfalls of civil society networks in Malawi. International NGO Training and Research Centre.
JENKINS-SMITH, H. C. and P. A. SABATIER. 1993. The Study of Public Policy Processes. In P. A. Sabatier & H. C. Jenkins-Smith (Eds.), Policy Change and Learning: An Advocacy.
KANCHEDZERA, G. 2003. From multi-party system to full democracy: The real challenge for Malawi. *The Courier ACP-EU,* **201**.
KANG, M. et al. 2009. Maternal versus paternal orphans and HIV/STI risk among adolescent girls in Zimbabwe. *AIDS Care,* **20**(2), pp.214-17.
KASCHULA, S. 2011a. Using people to cope with the hunger: social networks and food transfers among HIV/AIDS afflicted households in KwaZulu-Natal, South Africa. *AIDS behaviour,* **15**, pp.1490-1502.

KASCHULA, S. 2011b. Using people to Cope with the hunger:social Networks and food transfer amongst HIV/AIDs afflicated households in KwaZulu-Natal,South Africa.

KASIRYE, I. and E. HISALI. 2010. The Socioeconomic impact of HIV/AIDS on education outcomes in Uganda: School enrollment and schooling gap in 2002/2003. *International Journal of Educational Development,* **30**, pp.12-22.

KENDALL, N. and C. O'GARA. 2007. Vulnerable children, communities and schools: lessons from three HIV/AIDS affected areas. **37**, pp.5-21.

KHAILA, S. and C. CHIBWANA. 2005. Ten Years of Democracy in Malawi: Are Malawians getting what they voted for. Afrobarometer Working Paper No. 46, Cape Town, Accra, and Michigan: Idasa, CDD, and Michigan State University. .

KIMANI-MURAGE, E. W. et al. 2010. Food security and nutrition outcomes among urban poor orphans in Nairobi, Kenya. *Journal of Urban Health: Bulletin of the New York Academy of Medicine,* **88 (supple 2)**.

KING, G. and K. MEYER. 2005. Service integration and coordination: a framework of approaches for the delivery of co-ordinated care to children with disabilities and their families. *Child care, health and development,* **32**(4), pp.477-492.

KINGDOM, J. 1984. *Agenda, alternatives and public services.* Boston: Little Brown & Company.

KIRBY, D., A. OBASI and Laris, B. A. 2006. The Effectiveness of sex education and HIV education intervention in schools in developing countries. In WHO, Preventing HIV/AIDS in young people, A Systematic review of the evidence from developing countries. WHO Technical Report Series 930.

KISHINDO, P. 1994. Family planning and malawian male. *Journal of Social Development in Africa,* **9**(2), pp.61-69.

KLASSEN, A. et al. 2010b. Perfromance measurement and improvement frameworks in health, education and social services systems: a systematic review. *International Journal for quality in Health Care,* **22**(1), pp.44-69.

KRUEGER, R. A. 1994. *Focus groups. A practical guide for applied research.* Sage Publications.

KUHANEN, J. et al. 2008. Junior-headed households as a possible strategy for coping with the growing orphan crisis in northern Namibia. *African Journal of AIDS Research.* *,* **7**(1), pp.123-132.

KWENDA, C. M. 2009. How Zimbabwean AIDS orphans negotiate their personal identities within their personal identities within the fields of home and school in a stigmatised society. Pedagogy, Culture and Society, 17, 279-294.

LACEY, A. and D. LUFF. 2009. Qualitative data analysis. National Institute for Health Research.

LACEY, A. and D. LUFF. 2007. Qualitative data analysis. National Institute for Health Research.

LAGARDE, M. and N. PALMER. 2011. *Impact of user fees on access to health services in low and medium income countries (Review).* John Wiley and Sons.

LAURA, R., G. SIMON and G. P. GEOFF. 2010. Sexual risk among orphan adolescents:is country-level HIV prevalence an important factor? **22**(8), pp.927-938.

LEATHERMAN, S. et al. 2010. The role of quality improvement in strengthening health systems in development countries.*International Journal of Quality in Health,* **22**(4), pp.237-243.

LEE, T. et al. 2002. Families, Orphans and Children under Stress in Zimbabwe. *Evaluation and Program Planning,* **25**(4), pp.459-470.

LEGARD, R., J. LEWIS and K. WARD. 2003. *In-depth intervews. In Ritchie, Jane and Lewis, Jane (EDs) Qualitative research practice: A guide for social science students and researchers.* London: Sage Production Ltd.
LEGER, A. S., H. SCHNIEDEN and J. P. WALSWORTH-BELL. 1992. *Evaluatinf Health Services' Effectiveness.* Milton Keynes: Open University Press.
LEICHTER, H., M. 1979. *A comparative approach to policy analysis: Health Care policy in fofur nations.* London: Cambridge University Press.
LEVERS, L. ed. 2006. *Focus Group and Related Rapid Assessment Methods: Identifying Psychoeducational HIV/AIDS Interventions in Botswana in Fischer C. T. (Eds) Qualitative Research Methods for Psychologists.* London: Academic Press.
LEWIS, J. and J. RITCHIE. 2003. *Generalising from Qualitative research. In J. Ritchie & J. Lewis (Eds.), Qualitative research practice : A guide for social science students and researchers.* . London: Sage.
LIAMPUTONG, P. 2007. *Researching the vulnerable.* London: Sage Publications Ltd.
LINCOLN, Y. S. and E. G. GUBA. 1985. *Naturalistic inquiry* Sage.
LIPSKY, M. 1993. *Street-levl bureaucracy: an introduction. In Hill, Michael (Ed) The Policy Process.* 2nd Edition ed.
LITTRELL, M. et al. 2011. The influence of orphan care and other household shocks on health status over time: a longitudinal study of children's caregivers in rural Malawi. *AIDS care: Psychological and socio-medical asepects of AIDS/HIV,* **23**(12), pp.1551-1561.
LOEWENSON, R. et al. 2008. Review of links between external formal support and community household support to orphans and vulnerable children in Zimbabwe.
MADHAVAN, S. and N. TOWNSEND. 2007. The social context of children's nutritional status in rural South Africa. *Scandinavian Journal of Public Health,* **35 (supple 69)**, pp.107-117.
MALAWI GOVERNMENT. 1998c. National Decentralisation Policy.
MALAWI GOVERNMENT. 2000a. The National Gender Policy.
MALAWI GOVERNMENT. 2002b. Malawi Essential Health Package. Ministry of Health and Population.
MALAWI GOVERNMENT. 2003. National HIV and AIDS Policy.
MALAWI GOVERNMENT. 2003b. *National HIV and AIDS Policy.* Lilongwe.
MALAWI GOVERNMENT. 2004b. *Rapid assessement analysis and action plan: Orphans and other vulnerable children:.*
MALAWI GOVERNMENT. 2005. *National Plan of action for orphans and other vulnerable.* Lilongwe.
MALAWI GOVERNMENT. 2006a. Food Security Policy.
MALAWI GOVERNMENT. 2006b. *Guidelines for education support for orphans and other vulnerable children.* Lilongwe.
MALAWI GOVERNMENT. 2006d. *Malawi Poverty and vulnerability assessement: investing into our future.* Lilongwe.
MALAWI GOVERNMENT. 2008c. Policy formulation and coordination guidelines.
MALAWI GOVERNMENT. 2009c. Education Sector Implementation Plan: Towards quality education; implementing the national Education Sector Plan 2009-2013.
MALAWI GOVERNMENT. 2010c. OVC National Plan of Action.
MALAWI GOVERNMENT. 2011. Malawi Health Sector Strategic Plan 2011-2016.

MANGOMA, J., M. CHIMBARI and E. DHLOMO. 2008. An enumeration of orphans and analysis of the problem and wishes of orphans: the case of Kariba, Zimbabwe. *Journal of Sical Aspects of HIV/AIDS Research Alliance,* **5**(3), pp.120-8.

MANSFIELD, S. 2006. Keeping a critical reflexive research journal. University of Dundee.

MARCH, J., G and J. OLSEN, P. 1997. *Institutional perspective on political institutions. In Hill,M (Ed). The policy process. .* 2nd edition ed. Printice Hall.

MARSHALL, C. and G. B. ROSSMAN. eds. 2006. *Designing Qualitative Research.* Califonia: Sage Publications.

MASLOW, A. 1954. *Motivation and Personality* New York: Harper.

MASLOW, A. H. 1987. *Motivation and Persinality.* New York: Harper and Row

MASTWIJK, S. 2000. Social security systems in Malawi - a conclusive report on the conditions for and constellation and capacity of informal social security systems: implications and recommendations.

MATHAMBO, M. M. and H. V. DOCTOR. 2002. Matriliny, Patriliny and wealth flow variations in rural Malawi. *African Socialogical Review,* **6**(2), pp.71-97.

MATTESSICH, P. W., B. A. MURRAY-CLOSE and B. R. MONSEY. 2001. *Collaboration: what makes it work.* 2nd Edition ed. Fieldstone Alliance.

MAXWELL and CARDWELL. 2008. The COPING Strategies Index: A tool for rapid measuerement of household food security and the impact of food aid programs in humanitarian emergies. USAID and CARE.

MAXWELL, R. J. 1992. Dimensions of quality revisited:from thoughts to action. *Quality and Safety in Health Care,* **1**, pp.171-177.

MCPHERSON, M., F. 2008. Can a developing country support warefare needs of orphans and other vulnerable children affected by HIV and AIDS in Africa?

MEYRICK, J. 2006. What is good qualitative research? A first step towards a comprehensive approach to judging rigour/quality. *Journal of Health Psychology,* **11**(5), pp.799-808.

MILLER, C. 2007. Children Affected by AIDS:A review of the literature on orphaned and vulnerable children.

MILLER, C., T. MAXTON and R. KATHRYN. 2008. Impact evaluation report: external evaluation of the mchinji social cash trasfer pilot.

MILLER, M., CANDACE et al. 2007a. Emerging health disparities in Botswana:Examining the situation of the orphans during the AIDS epidermic. *Social Science and Medicine,* **64**, pp.2476-2486.

MISHRA, V. and S. B.-V. ASSCHE. 2008. *Orphans and Other Vulnerable Children in High HIV-Prevalence Countries in Sub-Saharan Africa.*
. Maryland, USA.

MKANDAWIRE, P. 2011. Vulnerability of adolescents to HIV/AIDS in Malawi. Electronic Thesis and Dessertation Repository.

MMARI, K. et al. 2006. Risk and protective factors for HIV among orphans and non-orphans in Tanzania: A quantitative analysis.

MOGOTLANE, S. M. et al. 2010. A situation analysis of child headed households in South Africa. *Curationis,* **33**(3), pp.24-32.

MOHINDRA, K., S et al. 2010. Panya voice: A participatory poverty and health assessment among a marginalised south Indian tribal population. *MBC Public Health,* **10**(149).

MONASCH, R., J. BOEMA and J. TIES. 2004. Orphanhood and children patterns in Sub-Saharan Africa: an analysis of national surveys from 40 countries. . *AIDS,* **18**(2), pp.s55-s65.

MONASCH, R. and J. T. BOEMA. 2004. Orphanhood and children patterns in Sub-Saharan Africa: an analysis of national surveys from 40 countries. **18 supplement 2**, pp.s55-s65.

MORGAN, D. L. ed. 1998. *The Focus Group Guidebook.* Califonia: Sage Publications, Inc.

MUHWEZI, W., WINSTONS, D. MUHANGI and F. MUGUMYA. 2009. Inta-household differences in health seeking behaviour for orphans and non-orphans in an NGO-supported and non-supported county of Luwero, Uganda. *African Health Science,* **9**(2).

MUNTHALI, A. and S. J. ALI. 2000. Adaptive strategies and coping mechanism: the effect of HIV and AIDS on the informal social security system in Malawi.

MUNTHALI, A. C. 2002 *Adaptive strategies and coping mechanisms of the families and communities affected by HIV/AIDS in Malawi*.

NAMIBIA NGO FORUM. 2009. making the difference: The 'BIG' in Namibia, Basic income grant coalition.

NARAYAN, D. et al. 2000. *Voices of the poor: can anyone hear us?* Oxford University Press.

NATIONAL STATISTICAL OFFICE. 2008. *Preliminary population and housing census*. Zomba.

NATIONAL STATISTICAL OFFICE AND UNICEF. 2008. *Multiple Indicator Cluster Survey: Monitoring the situation of children and women*. Zomba: NSO.

NATIONAL STATISTICS OFFICE. 2004. *Demographic and Health Survey.* Zomba: NSO.

NATIONAL STATISTICS OFFICE. 2005. *Integrated Household Survey 2004-2005.* Zomba: NSO.

NATIONAL STATISTICS OFFICE. 2010. Malawi Demographic Health Survey.

NATIONAL STATISTICS OFFICE and UNICEF. 2008. Multiple Indicators Cluster Survey: Monitorin the situation of women and children.

NEHER, A. 1991. Maslow theory of motivation: A critique. *Journal of humanistic Psychology,* **31**, pp.31-89.

NGWIRA, N., S. BOTA and M. LOEVINSOHN. 2001. HIV/AIDS , AGRICULTURE AND FOOD SECURITY IN MALAWI.

NSHAKIRA, N. and N. TAYLOR. 2008. Making externa resources flows through communities work better for vulnerable children: the experiences, concerns and suggestions on inititives and care-giving households in Uganda.

NTATA, P., T,R. 2007. Equity in drug access to ARV drugs in Malawi. Sahara Journal, 2007, 4(1), pp 564-74..

NYABANYABA, T. 2009. Factors influencing access and retention in secondary schooling for orphans and vulnerable children and young people: Case studies from high HIV and AIDS prevalence Lesotho.

NYAMBEDHA, E., OTIENO, W. SIMIYU and J. AAGAARD-HANSEN. 2001. Policy implications of the inadequate support systems for orphans in Western Kenya. *Health Policy* **58**, pp.83-96.

NYAMUKAPA, C. and S. GREGSON. 2005. Extended family's and women's role in safeguarding orphans' education in AIDS-afflicted rural Zimbabwe. *Soc. Sci. Med.,* **60**(10), pp.2155-67.

NYAMUKAPA, C. A., G. FOSTER and S. GREGSON. 2003. Orphans' household circumstances and access to education in a maturing HIV epidemic in eastern Zimbabwe. *Journal of Social Development in Africa,* **18**(2).

NYAMUKAPA, C. A. et al. 2008. HIV-associated orphanhood and children's psychosocial distress: theoretical framework tested with data from Zimbabwe. *American Journal of Public Health. ,* **98**(1), pp.133-141.

NYONATOR, F. K. et al. 2005. The Ghana Community-based Health Planning and Services Initiative for scaling up service delivery innovation. *Health Policy Plan.,* **20**(1), pp.25-34.

OLEKE, C. et al. 2007. Constraints to educational opportunities of orphans: A community –based study from Northern Uganda. . *AIDS Care. ,* **19**(3), pp.361-368.

OPERARIO, D. et al. 2008. Orphanhood and completion of compulsory school education among young people in South Africa: Findings from a National Representative survey. *Journal of Research on Adolescence,* **18**(1), pp.173-186.

OPERARIO, D. et al. 2007. Prevalence of parental death among young people in South Africa and risk for HIV infection. . *Journal of Acquired Immune Deficiency Syndromes. ,* **44**(1), pp.93-98.

OPERARIO, D. et al. 2011. HIV infection and sexual risk behaviour among youth who have experienced orphanhood: systematic review and meta-analysis. *Journal of International AIDS Society,* **14**(25), pp.14-25.

OVRETVEIT, J. 1992. *Health services quality.* Blackwell scientific publications.

OVRETVEIT, J. 1998. *Evaluating health interventions.*

PALERMO, T. and A. PETERMAN. 2009. Are female orphans at risk for early marriage, early sexual debut and teen pregnancy? Evidence from Sub-Saharan Africa. *Studies in family planning,* **40**(2), pp.101-112.

PALYS, T. 2008. Purposive sampling. In Lisa M. Given (Ed) The sage encyclopedia of qualitative research methods.

PANPANICH, R. et al. 1999. Are orphans at increased risk of malnutrion in Malawi? *Ann. Trop. Paediatr,* **19**(3), pp.279-285.

PARKER, E. M. and S. E. SHORT. 2009. Grandmother Coresidence, Maternal Orphans and School Enrollment in Sub-Sahran Africa. *Journal of Family Issues,* **30**(813).

PARSON. 1995. *Public Policy; An introduction to the theory and practice of policy analysis.* Massachussetts: Edwards Elgar Publishing.

PASCOE, S. J. S. et al. 2010. Increased risk of HIV-infection among school-attending orphans in rural Zimbabwe. *AIDS Care:Psychological and Socio-medical Aspects of AIDS/HIV,* **22**(2), pp.206-220.

PATTON, M. 1990. *Qualitative evaluation and research methods.* 2 ed. Sage Publications.

PATTON, M. Q. ed. 2002. *Qualitative Research & Evaluation Methods.* 3rd edition ed. Califonia: Sage Publications Ltd.

PHILLIPS, C., C. PALFREY and P. THOMAS. 1994. *Evaluating health and social care.* London: MacMillan.

PHIRI, K. 1983. Some changes in matrilineal family systems among the chewa of Malawi since the ninenteeth centrury. *Journal of African History,* **24**, pp.257-274.

PHIRI, M. A. R. 2007. Children in need of special protection based survey, Ministry of Women and child Development.

PLAN. 2008. Reversed Roles and Stressed Souls: Child Headed Households in Ethiopia.

POPE, C. and N. MAYS. 2006. *Qualitative research in health care.* Blackwell.

POPE, C., S. ZIEBLAND and N. MAYS. 2000. Qualitative Research in health care: Analysisng qualitative data. *BMJ,* **320**, pp.114-116.

PORTER, R. W. and I. HICKS. 1998. *Knowledge Utilization and the Process of Policy Formation: Towards a Framework for Africa*. Health and Human Resources Analysis for Africa (HHRAA), USAID.

PULLUM, T. W. 2008. *Orphanhood in Malawi, 2004-2006*.

REEVE, J. 2005. *Unserstanding motivation and emotions.* 4th ed. John Wiley and Sons Inc.

RENZETTI, C. M. and R. LEE. 1993. *Researching sensitive topics.* London: age Publication Ltd.

RICHTER, L., J. MANEGOLD and R. PATHER. 2004. *Family and Community Interventions for Children Affected by AIDS* [online]. Cape Town South Africa: Human Science Research Council.

RICHTER, L. and L. SHERR. 2008. Demographic evidence of family and household changes in response to the effects of HIV/AIDS in Southern Africa: Implications for efforst to strengthen families.

RICHTER, L. M. and C. DESMOND. 2008. Targeting AIDS orphans and child-headed households? A perspective from national surveys in South Africa, 1995-2005. . *Aids Care,* **20**(9), pp.1019-28.

RIDDE, V. and F. MORESTIN. 2010. A scoping review of the literature on the abolition of user fees in health services in Africa. *Health Policy Planning,* **26**, pp.1-11.

RITCHIE, J. 2003. *The application of qualitative methods to social research. In Ritchie, Jane and Lewis, Jane (EDs) Qualitative research practice: A guide for social science students and researchers.* London: Sage Productions Limited.

RITCHIE, J. and J. LEWIS. eds. 2003. *Qualitative research practice.*

RITCHIE, J. and L. SPENCER. eds. 1994. *Qualitative Data Analysis for Applied Policy Research. In Bryman A and Burgess G (Eds) Analysing Qualitative Data.* New York: Routledge.

RITCHIE, J., L. SPENCER and W. O'CONNOR. 2003. *Carrying out qualitative analysis. In Ritchie, Jane and Lewis, Jane (EDs) Qualitative research practice: A guide for social science students and researchers.* London: Sage Publications Ltd.

RIVERS, J. et al. 2010. The imoact of orphanhood on food security in the high-HIV context of Blantyre, Malawi. *Food and Nutrition Bulletin,* **31**(3).

RIVERS, J., E. SILVESTRE and J. MASON. 2004. Nutritional and Food Security Status of Orphans and Vulnerable Children. IFPRI.

ROBERTSON, L., S. GREGSON and G. GARNETT. 2010. Sexual risk among orphaned adolescents: in country-level HOV prevalence and important factor? *AIDS Care.,* **22**(8), pp.927-938.

ROBSON, S. and S. B. KANYANTA. 2007. Moving towards inclusive education policies and practices? Basic education for AIDS orphans and other vulnerable children. *International Journal of Inclusive Education,* **11**(4), pp.417-430.

ROBY, L., JINNI and A. SHAW, STACEY. 2008. Evaluation of a community-based orphan care program care program in Uganda. *Families in Society,* **89**(1).

ROSENBERG, A., K. HARTWIG and M. MERSON. 2008. Government-NGO collaboration and sustainability of orphans and vulnerable children Projects in Southern Africa. *Evaluation and Program Planning,* **31**, pp.51-60.

ROWAN, J. 1999. Ascent and secent in Maslow's theory. *Journal of humanistic Psychology,* **39**.

RUBIN, H. J. and I. S. RUBIN. 1995. *Qualitative interviewing: the art of hearing.* Sage Publications.

RUBIN, H. J. and I. S. RUBIN. 2005. *Qualitative interviewing, the art of hearing data.* Second ed. Sage Publications.

SACMEQ. 2011. http://www.sacmeq.org/education-malawi.htm.

SALA, M. A. 2009. The quality of food, clothing and shelter provided to orphaned children under foster care in Kibera slums in Kenya. *East African Journal of Public Health,* **6**(3), pp.312-316.

SCHROEDER, E.-A. and T. NICHOLA. 2006. The adoption of HIV/AIDS orphans and food security in rural Ingwavuma, South Africa. *The International Journal of Technology Management and Sustainable Development,* **5**(2), pp.173-187.

SEALE, C. 1999. Quality in qualitative research. *Qualitative Inquiry,* **5**, p465.

SHARMA, M. 2005. Orphans in Malawi: Prevalence, outcomes and targeting of services.

SHAW, C. D. and I. KALO. 2002. *A Background for national quality policies in health systems.* Copenhagen: WHO.

SHERR et al. 2008. A Systematic review on the meaning of the concept 'AIDS Orphan: confusuin ove definition and implications on care. *AIDS CARE,* **20**(5), pp.527-536.

SIBALE, B. and T. NTHAMBI. 2008. Mid term review of the National Plan of Action for orphaned and other vulnerable children.

SIKOSANA, P., L,N and Q. DLAMINI, Q,D. 1995. Health sector reform in Sub-Saharan Africa, WHO, Geneva.

SKINNER, D. et al. 2004. Towards Defining Orphaned and Vulnerable Children. *AIDS and Behavior,* **10**(6), pp.619-626.

SKOVDAL, M. et al. 2010. Building Orphan competent communities: expereiences from community based capital cash transfer initiated in kenya. *Health Policy Planning*, pp.1-9.

SMART, R. 2003. Policies for Orphans and Vulnerable Children: A Framework for Moving Ahead. [online]. Available from: http://www.google.co.uk/search?hl=en&rlz=1T4SKPB_enGB314GB314&q=rOSE+sMART+policies+for+orphans+and+vulnerable+children&btnG=Search&meta=.

SSEWAMALA, F., M et al. 2010. Effet of economic assets on sexual risk-taking intentions among orphaned adolescents in Uganda. *American Journal of Public Health,* **100**(3).

STAPLES, L. H. 1990. Powerful ideas about empowerment. *Administration in social work,* **14**(2), pp.29-42.

STATHAM, J. 2000. *Outcomes and effectivenss of family support services*. London: Institute of Education

STEPHENS, N. 2007. Collecting Data from the elites and ultra elites: telephone and face-to-face interviews with macroeconomics. *Qualitative Research,* **7**(2), pp.203-216.

SWAP SUPPORT GROUP. 2004. The sector-wide approach: organising principle for bilateral development cooperation.

TAMASANE, T. and J. HEAD. 2012. The quality of materail care provided by grandparents for their orphaned grandchildren in the context of HIV/AIDS and poverty: A study of Kapanong municiplity, Free State. *Journal of Social Aspects of HIV/AIDS,* **7**(2), pp.76-84.

TONES, K. and S. TILFORD. 2001. *Health Promotion: Effectiveness, efficiency and equity.* Cheltenham Nelson Thornes Ltd.

TURNER, N., E and R. PINKETT, D. 2000. An asset-based approach to community buiding and community technology.

UEYAMA, M. 2007. Mortality, morbidiy and schooling outcomes among orphans: evidence from Malawi.

UGANDA, T. R. O. 2004. The National orphans and other Vulnerable Children Policy: Hope Never Runs Dry. Ministry of Gender, Labour and Social Development Kampala.

UNAIDS. 2010. UNAIDS Report on the Global AIDS epidemic. Joint United Nations Programme on HIV/AIDS.

UNAIDS, F. UNICE and USAID. 2004. Children on the Brink 2004: A Joint Report of new Orphans Estimates and Framework for Action. [online]. Available from: http://pdf.dec.org/pdf_docs/PNACY333.pdf.

UNAIDS and UNICEF. 2004. The framework for the protection, care and support of orphans and vulnerable children living in a world with HIV/AIDS.

UNAIDS, UNICEF and USAID. 2002. Children on the Brink 2002: A Joint Report on Orphans Estimetes and Programm Strategies, . [online].

UNAIDS, UNICEF and USAID. 2004. Children on the Brink 2004: A Joint Report of new Orphans Estimates and Framework for Action. [online]. Available from: http://pdf.dec.org/pdf_docs/PNACY333.pdf.

UNDP. 2005. *Malawi Human development report 2005; reversing HIV and AIDS in Malawi*. Lilongwe.

UNDP. 2008. United Nations Development Assistance Framework: Malawi 2008-2011.

UNDP. 2011. Human Development Report.

UNICEF. 2004 *Care for Children affected by HIV/AIDS : the urgent need for international standard, improving protection for children without parental care*. Unpublished.

UNICEF. 2005. Guide to monitoring and evaluation of the national response for children orphaned and made vulnerable by HIV/AIDS.

UNICEF. 2008a. *The Evidence Base for Programming for Children Affected by HIV/AIDS in Low Prevalence and Concentrated Epidemic Countries*.

UNICEF. 2008c. *Getting in line: coordinating responses of donors, CSO and governmeemt for children affected by HIV/AIDS*. Nairobi, Kenya: UNICEF Eastern ans Southern African Regional Office

UNITED NATIONS. 2001. *General Assembly Resolution adopted by the General Assembly S-26/2.: Declaration of Committement on HIV/AIDS.* New York.

UNY, I. W. 2008. Factors and motivations contributing to community volunteers' participation in a nursery feeding project in Malawi.

USAID and CATHOLIC RELIEF SERVICES. 2008. Education Programming for Orphans and vulnerable Children affected by or Vulnerable to HIV. Moving beyond school fees and uniforms.

VAILLANCOURT, D. 2009. Do Health Sector Wide approach achieve results? Emerging eveidence and lessons from six countries, World Bank Independent evaluation Group working paper 2009/4.

VAN DER HEIJDEN, I. and S. SWARTZ. 2010. Bereavement, silence and culture within peer-led HIV/AIDS-prevention strategy for vulnerable children in South Africa. *African Journal of AIDS Research,* **9**(1), pp.41-50.

WAGT, A. D. and M. CONNOLLY. 2005. Orphans and impact of HIV/AIDS in Sub-Saharan Africa. *Food, nutrition and Agriculture,* **34**, pp.24-31.

WAKHWEYA. 2008. Children thrive in families. Family centred model of care and support for orphans and vulnerable children.

WALLERSTEIN, N. and E. BERNSTEIN. 1988. Empowerment education: Freire's ideas adapted to health education. **15**.

WALLIS, A., V. DUKAY and C. MELLIS. 2010. Power and Empowerment:fostering effective collaboration in meeting the needs of orphans and vulnerable children.

WALT, G. 1994. *Health Policy an Introduction to Process and Power.* Johanesburg: Witwatersrand University Press.

WALT, G. and L. GILSON. 1994. Reforming the health sector in developing countries: the role of policy analysis. *Health Policy and Planning,* **9**(4), pp.353 -370.

WALT, G. et al. 1999a. Health sector development: from aid coordination to resource management. *Health Policy and Planning,* **14**(3), p20070218.

WALT, G. et al. 1999b. Managing external resources in health sector: are there lessons for SWAp? *Health Policy and Planning,* **14**(3), pp.273-284.

WATT, D. 2007. On becoming a qualitative researcher: The value of reflexivity. *The Qualitative Report,* **12**(1), pp.82-101.

WATTS, H. et al. 2007. Poorer health and nutritional outcomes in orphans and vulnerable *Tropical Medicine and International Health,* **12**(5), pp.584-593.

WATTS HELLEN, B. L., CONSTANCE NYAMUKAPA AND SIMON GREGSON. 2005. Orphan crisis in Zimbabwe: rising incidence and magnitude http://iussp2005.princeton.edu/download.aspx?submissionId=51851.

WHITE, S. 2007. Malawi country gender profile.

WHITTEMORE, R., S. K. CHASE and C. L. MANDLE. 2001. Validity in qualitative research. *Qualitative Health Research,* **11**(4).

WHO. 2008a. *Guidance on developing quality and safety strategies with a health system approach*.

WHO. 2012. World Health Statistics.

WOOD, K., E. CHASE and P. AGGLETON. 2006. "Telling the truth is the best thing": Teenage orphans' experiences of parental AIDS-related illness and bereavement in Zimbabwe. . *Social Science and medicine. 2006 Oct; 63(7): 1923-1933*.

WORLD BANK. 1997. *Confronting AIDS:Public priorities on a global epidemic.* New York: Oxford University Press.

WORLD BANK. 2009. *Conditional cash transfers: reducing present and future poverty.* Washington DC: World Bank Publication.

WORLD BANK and UNIVERSITY OF DAR-ES-SALAAM. 1993. The economic impact of fatla adult illness in Sub-Saharan Africa. Workshop Report, Tanzania.

WORLD HEALTH ORGANISATION. 2007. *Management for health services delivery*. *In:* WHO (Ed.) Geneva: WHO.

YAMANO, T. and T. S. JAYNE. 2005. Working-Age Adult Mortality and Primary School Attendance in Rural Kenya. *Economic Development and Cultural Change,* **53**(3), pp.619-653.

YAMANO, T., T. S. YAYNE and M. MCNEIL. 2002 *Measuring the impacts of prime-age adult death on rural households in Kenya*. Unpublished.

APPENDICES

Appendix A : Orphans Demographic and socioeconomic information

Orphan Type	Identity	Category	Age	orphan Gender	Years of education	Orphan Duration	Location	Household Income	Household Composition
Double	RKOP	Double orphan	13	female	9	14	Semi-urban	Ganyu	4
Paternal	RTOP	Paternal Orphan	14	female	10	4	Semi-urban	Ganyu	6
Maternal	OZOP	Orphan, Maternal	16	female	11	10	Semi-urban	ganyu, small business	5
Double	MKOP	Double Orphan	16	male	11	4	Semi-urban	Farming	5
Double	DMOP	Double Orphan	16	male	10	6	rural	Farming	3
Maternal	VMOP	Double Orphan	15	female	7	6	rural	Ganyu	4
Maternal	EWOP	Maternal Orphan	16	male	6	4	Semi-urban	Ganyu	2
Double	VCOP	Double Orphan	14	male	6	5	Semi-urban	Ganyu	2
Double	ANOP	Double Orphan	14	male	5	6	Semi-urban	Ganyu	5
Paternal	PDOP	Paternal Orphan	16	male	10	10	Semi-urban	Ganyu	5

Orphan Type	Identity	Category	Age	orphan Gender	Years of education	Orphan Duration	Location	Household Income	Household Composition
Paternal	CCOP	Paternal Orphan	14	female	8	5	rural	Ganyu	6
Double	CNOP	Maternal Orphan	16	female	8	12	Rural	ganyu, small business	4
Double	SJOP	Paternal Orphan	14	male	4	3	Semi-urban	Ganyu	6
Maternal	TPOP	Maternal Orphan	13	female	5	4	Rural	Ganyu	5
Double	TCOP	Double Orphan	14	female	8	5	Semi-urban	Farming	3
Paternal	OBOP	Paternal Orphan	14	male	11	2	rural	Farming	5

Appendix B : Caregivers Demographic and Socioeconomic Information

Identity	Category	Age	Gender	Orphan care Duration (Yrs)	Income	Household Assets	Household Composition
MMCR	Maternal Caregiver	47	female	8	rely on charity	small house, small land	5
PJCR	Grandmother Caregiver	62	male	10	rely on charity	small house, small land	5
EMCR	Maternal grandmother	61	female	9	ganyu	small house, small land	10
SCCR	Grandmother Caregiver	69	female	2	farming	Small house, Pets, small radio	5
WLCR	Maternal Caregiver	38	female	5	ganyu	Small house, Utencils	8
JKCR	Paternal Caregiver	61	male	3	ganyu	small house, small land	3
AMCR	Grandmother Caregiver	71	female	1	rely on charity	Small house, small garden	5
SCCR	Paternal Caregiver	62	male	7	farming	small house, small land	2
MPCR	Paternal Caregiver	50	male	4	employment	House, Bicycle, livestock, radio, land	3
EKCR	Maternal Caregiver	69	female	4	ganyu	small house, small land	6
EDCR	Maternal Caregiver	34	female	3	farming	Small house, small garden	8
RCCR	Maternal Caregiver	43	female	4	farming	Small house, Goat, small land	7

Appendix C: Information Sheet for District and Service Providers Focus Group Discussion.

INFORMATION SHEET – FOCUS GROUP DISCUSSIONS
(District & Community Service providers)

Location number.....................................
Focus group number................................
Date…………………………………………

Title of Study: A Study of child-related policies, services and wellbeing of orphans in Malawi
Principal Investigator: Esmie Tamanda Kainja, MPH Nutrition

1. Introduction

We have invited you here today in order to hear your views and experiences on the effects of services offered by different stakeholders on the wellbeing of orphans and their families. The research is done by Esmie Tamanda Kainja (Principal investigator) who is registered as a PhD student of University of Leeds, in the United Kingdom. In this scenario, Esmie is playing a dual role: First as a senior employee of Ministry of Women and Child Development in Malawi, which is responsible for coordinating orphan care policy and service implementation to orphans; and secondly as a researcher under University of Leeds. The PhD is funded by the Commonwealth Secretariat based in the United Kingdom.

Do not worry if your views differ from others in the group. There is no right or wrong answer and we would like to hear everyone's views. The discussions will be conducted in Chichewa language.
Before you decide whether or not to take part, we have provided some basic information for you to read and understand why the study is being carried out and what it will involve. You are free to ask questions about this study at any time. If you agree to take part in this study, you will be asked to give your consent through the audio tape recorder and this will be separated from the interview data.

2. What is the purpose of the research?

The study seeks to assess how selected child-related policies and services address the needs of orphans.

3. Who is conducting the research?

The research is carried out by Esmie Kainja from the Ministry of Women and Child Development with the help of other researchers.

4. Why have I been chosen?

You have been chosen because you are involved in providing services that help to improve the wellbeing of orphans in Blantyre district.

5. Do I have to take part?

Taking part in this study is completely voluntary. It is up to you to decide whether or not to take part. You are free to leave the study before the interview, during the interview and after the interview without giving a reason and this will not affect the service you receive. If you withdraw from the study, the information you give will be destroyed and will not be used.

6. What will happen to me if I take part in the study?

You will take part in focus group discussions that will focus on your experiences on to how child-related services provided to orphans are helping to meet the needs orphans. The discussions will take 1-1.5 hours and will be taped to ensure that no important information is lost. Your name will not appear in written form or on any recording at any time. Any publication of this study will not use your name or identify you personally. The tapes will be destroyed after the research has been assessed.

7. How will the results of the research be used?

This study will help to identify gaps and challenges in the policies and delivery of orphan care services and make recommendations for improving quality of services and support to orphaned children. The recommendations will also assist to strengthen the national orphan care program in the Ministry of Women and Child Development. The findings will also help to write a PhD thesis to be submitted to the University of Leeds, UK. A summary of findings of the research will be communicated back to you through the District orphan care committee meeting after the submission of the thesis.

Further information

If you have further questions about the interview and the study, please contact:

Esmie Tamanda Kainja,
Deputy Director of Child Development,
Ministry of Women and Child Development,
Gemini House, Floor 5,
Private Bag 303,
Lilongwe.

Telephone: 265 770411

Appendix D: Information sheet for Policy Makers and Service Providers

PARTICIPANT INFORMATION SHEET
(In-depth Interviews with Policy makers & Service providers)

Title of Study: A Study of policies, services and wellbeing of orphans in Malawi

Principal Investigator: Esmie Tamanda Kainja, MPH Nutrition

1. Introduction

You are being invited to take part in a research which seeks to get your views and experiences on how child related policies and services are influencing the wellbeing of orphans. The research is done by Esmie Tamanda Kainja (Principal investigator) who is registered as a PhD student of University of Leeds, in the United Kingdom. In this scenario, Esmie is playing a dual role: First as a senior employee of Ministry of Women and Child Development in Malawi, which is responsible for coordinating orphan care policy and service implementation to orphans; and secondly as a researcher under University of Leeds. The PhD is funded by the Commonwealth Secretariat based in the United Kingdom.

Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. We have provided some basic information for you to read and understand why the study is being carried out and what it will involve. You are free to ask questions about this study at any time. If you agree to take part in this study, you will be asked to sign the consent form. You will get a copy of the consent form to keep.

2. What is the purpose of the research?

The study seeks to assess how selected child-related policies and services address the needs of orphans.

3. Who is conducting the research?

The research is carried out by Esmie Kainja from the Ministry of Women and Child Development with the help of other researchers.

4. Why have I been chosen?

You have been chosen because your job and the organisation you are working with have a great influence on how policies and services are delivery to orphans in Malawi.

5. Do I have to take part?

Taking part in this study is completely voluntary. It is up to you to decide whether or not to take part. You are free to leave the study before the interview, during the interview and after the interview without giving a reason and this will not affect the service you receive. If you withdraw from the study, the information you give will be destroyed and will not be used.

6. What will happen to me if I take part in the study?

You will be interviewed about your experiences related to how child-related policies and services provided to orphans by different stakeholders are helping to meet the needs orphans. The interview will take 1-1.5 hours and will be taped to ensure that no important information is lost. Your name will not appear in written form or on any recording at any time. Any publication of this study will not use your name or identify you personally.

All information including direct quotations will be anonymous and will be treated with strict confidence. The recorded information will be used for purpose of the research and will be listened to by the researchers only. The tapes will be destroyed after the research has been assessed.

7. How will the results of the research be used?

This study will help to identify gaps and challenges in the policies and delivery of orphan care services and make recommendations for improving quality of services and support to orphaned children. The recommendations will also assist to strengthen the national orphan care program in the Ministry of Women and Child Development. The findings will also help to write a PhD thesis to be submitted to the University of Leeds, UK. A summary of research findings will be presented to you through the National Steering Committee meeting and to National Technical Working Group Committee meeting to policy makers and service providers respectively after submission of PhD thesis.

Further information

If you have further questions about the interview and the study, please contact:

Esmie Tamanda Kainja

Deputy Director for Child Development

Ministry of Women and Child Development

Gemini House, Floor 5

Private Bag 303

Lilongwe

Telephone 265 770411

Appendix E: Information Sheet for Orphans and Caregivers

PARTICIPANT INFORMATION SHEET
(In-depth interviews with service users - Orphans & Caregivers)

Title of Study: A Study of child related policies, services and wellbeing of orphans in Malawi

Principal Investigator: Esmie Tamanda Kainja Masters in Public Health Nutrition

1. Introduction

I would like you to take part in a research which seeks to get your views and experiences on how services offered to you by different stakeholders are influencing your wellbeing. The research is done by Esmie Tamanda Kainja (Principal investigator) who is registered as a PhD student of University of Leeds and it is funded by the Commonwealth Secretariat based in the United Kingdom.

Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. I will read out some basic information so that you can understand why the study is being carried out and what it will involve. You are free to ask questions about this study at any time. If you agree to take part in this study, you will be asked to give your consent. You will be free to speak the language you are comfortable with, either English or Chichewa

2. What is the purpose of the research?

The study seeks to assess how selected child-related policies and services address the needs of orphans. The information which you provide about policies and services to orphans will in the long term influence changes in the implementation of services by service providers. This likely to result in improved services to orphans.

3. Who is conducting the research?

The research is carried out by Esmie Kainja from the Ministry of Women and Child Development with the help of other researchers.

4. Why have I been chosen?

You have been chosen because you are accessing services that seek to improve the wellbeing of orphans.

5. Do I have to take part?

Taking part in this study is completely voluntary. It is up to you to decide whether or not to take part. You are free to leave the study at any time and without giving a reason and this will not affect the service you receive.

6. What will happen to me if I take part in the study?

You will be interviewed about your experiences related to how services provided by different stakeholders are helping to meet your needs. The interview will take 1-1.5 hours and will be taped to ensure that no important information is lost. Your name will not appear in written form or on any recording at any time. Any publication of this study will not use your name or identify you personally.

All information will be known by other people. The recorded information will be used for purpose of the research and will be listened to by the researchers only. The tapes will be destroyed after the research has been assessed.

7. How will the results of the research be used?

This study will help to identify gaps and challenges in the policies and delivery of orphan care services and make recommendations for improving quality of services and support to orphaned children. The recommendations will also assist to strengthen the national orphan care program in the Ministry of Women and Child Development. The findings will also help to write a PhD thesis to be submitted to the University of Leeds, UK.

Further information

If you have further questions about the interview and the study, please contact:

Esmie Tamanda Kainja

Deputy Director for Child Development

Ministry of Women and Child Development

Gemini House, Floor 5

Private Bag 303

Lilongwe

Telephone 265 770411

Appendix F: List of policy makers

Organisation	Organisation Type
UNICEF	Donor
WHO	Donor
FAO	Donor
USAID	Donor
HIV Department	Government
Ministry of Health	Government
Ministry of Labour	Government
High Court	Government
Ministry of Education	Government
Ministry of Economic Planning & Dev	Government
Ministry of Gender, Children and Community Services	Government
Law Commission	Government
Ministry of Agriculture	Government
National AIDS Commission	NGO
Children NGO Coalition	NGO
OXFAM	NGO

Appendix G: List of service providers

Organisation	**Organisation Type**
World Vision International	NGO
PACT Malawi	NGO
CONSOLE home	NGO
Eye of the Child	NGO
Ministry of Education	Government
Ministry of Youth and Culture	Government
Save the children	NGO
Ministry of Labour	Government
Ministry of Health	Government
Ministry of Gender and Child Development	Government
NOVOC	NGO
NAPHAM	NGO
Plan Malawi	NGO
Malawi Intefaith Association	NGO
Coalition on Child Rights	NGO
Coalition of women with HIV	NGO

Appendix H : Interview Guide for Orphans 13-16 years

Part One: General Issues

Introductions

Thank the participant for their time

Explain the purpose of the research

Explain why the participant has been chosen and importance of their contribution

Reinforce ethical issues on confidentiality and others

Re-establish consent of participant

Opening question aims at putting participants at ease:

Switch on the audio recorder

Tell me something about your community

What do you like best about your community?

What do you like least about your community?

Part Two: Guiding questions

A. Needs of orphans and services offered

1. Can you describe to me the things you do in any typical day?

Probes:

-What sorts of domestic chores do you do and how much time do you take to finish the activities?

-Are you involved in any paid work outside your household and what type of work do you do?

-Do you go to school? If yes, what level are you in?

If not, what are the reasons?

-Who prepares food for you?

-Who provides these things: clothes, food and school materials?

-Who do you play with?

2. Remember the last time you were sick, what did you do?

Probes:

-Where did you get help?

Who helped you?

-What did they do?

-Were you satisfied with the help you received?

3. Think about an imaginary orphan living in your community, what common problems do they face?

Probes:

-In what way do you think other children of your age are experiencing the same problems?

-What problems are similar to the ones you face?

4. What would you prefer your best day to look like?

Probe:

-What often stops your best day from being the best day?

5. Look at a picture of services that are available for orphans. Ask the participant to identify the help orphans normally get?

Probes:

-What help do you get?

-Who provide the help? (Community, family, government and other organisations)

-What exactly do they do to help you?

-What help do you like most and what are the reasons?

-What help do you like least and what are the reasons?

B. Effect of services on the needs

6. On the help that you receive, tell me the ways in which the support is meeting your needs?

Probes:

-Can you give an example of how the help has changed your life in the following areas: education, child abuse, health, economic and material support?

-Are you satisfied with the help you receive?

-Do you think there is any new additional help that you wish should be provided?

-Are there other orphaned children you know who are not receiving any help? What are the reasons?

C. Service Implementation process

7. What can you say about how the help is given to you?

Probes:

-How do you know about any help that is available for your needs?

-How do those who provide support know about your needs?

-What is good about the way the help is given to you?

-What problems do you face with the way the help is given to you?

D. Concluding questions

8. If you were to meet the big boss responsible for children in the Ministry of Women and Child Development, what key message would you tell him/her about improving how support and services are given orphaned children?

Probes:

-What service would you want to continue and what are the reasons?

-What services would you want to stop or change and what are the reasons?

Part Three: Personal Data

Age…………………………………………………….

Sex…………………………………………………….

Length of stay in the area……………………………

Level of education……………………………………

Interview number...

Appendix I : Interview Guide for Policy makers

Part One: General Issues

Introductions

Thank the participant for their time
Explain the purpose of the research
Explain why the participant has been chosen and importance of their contribution
Reinforce ethical issues on confidentiality and others

Ask the participant if she/he has any question about the study

Part Two: Guiding questions

A. Needs of orphans and policies affecting them

1 Malawi has a high prevalence of orphans. What do you see as the most critical needs of orphans?
Probes:
-Types of needs-Education, Socio-economic, health and child abuses
- Identify the most critical needs and causes
-How do orphans and families cope with the challenges?

3. There are many policies that affect orphans, what do you thinks are the key policies that address the needs of orphans?
Probes:
- Policies related to Education, Socio-economic, health and child abuse
- Gaps are identified in the policies
- Coordination of policies with the National Policy on Orphans and other Vulnerable children
- The link between national and international & regional policies on orphans

2 Service providers and their roles on policy

3. What do you think are the key organisations that are having influence on orphan care policies?

Probes –
-Types of partners: government, donors, non-governmental organisations, community participants;
-Roles of partners: policy making, funding, lobbying, disseminating
-What is the influence of partners on orphan related policies?
-Coordination of stakeholders: what coordination mechanisms exist, which structures, committees, operational plans, communication systems are functional and why

4. Policy guidance on service provision

4. What is your opinion on how policies guide the implementation of services to orphans?
Probes: Accessibility of service, targeting/selection criteria, coverage, equity, implementation approach, resource management

5. In your opinion, what factors influence orphan related policies?

a) What is the existing strength?
b) What are existing challenges?
c) What are existing opportunities?
d) What threats?
-What lessons have you learnt about policy and service implementation to orphans?

5. Concluding question

5. If you were given chance to improve policy delivery to orphans, what would you do?
Probes
-What aspects of the policies that are working well and what are the reasons?
-What aspects of the policies that are not working well and what are the reasons?
6. What strategies would you use to effect the recommendations?

Personal Data

Sex…………………
Organisation number…..

Appendix J : Interview Guide for Service Providers

Part One: General issues

Introductions

Thank the participant for their time

Explain the purpose of the research

Explain why the participant has been chosen and importance of their contribution

Ask the participant if he /she has any question about the study.

Part Two: Guiding questions

B. Needs of orphans and policies affecting them

1. Malawi is known with a high prevalence of orphans. What needs do orphans face during their daily living?

Probes:

-Types of needs-Education, Socio-economic, health and child abuses
- Identify the most critical needs and causes
-How do orphans and families cope with the challenges

1b.What do you see as the most important needs of orphans and what are the reasons?

1c. How do orphans and families cope with the challenges?

2. There are many policies that affect orphans, what do you thinks are the key policies that address the needs of orphans?
   Probes:
- Policies related to Education, Socio-economic, health and child abuse
- Gaps are identified in the policies
- Coordination of policies with the National Policy on Orphans and other Vulnerable children

C. Type of service providers and their roles on orphan care

3. What do you know as the key stakeholders that are having influence in the implementation of services to orphans?

Probes:

-Types of partners: government, donors, non-governmental organisations,
-What services does your organisation offer,
- How important is the service?

- Roles of partners: providing leadership, funding, resource mobilisation lobbying, disseminating
  - -What are your views on the roles of your organisation and others?
  - -What influence are the roles of partners on orphan care?
  - -In what way is your organisation influencing service implementation

4. What is your opinion on the coordination of orphan care stakeholders?
Probes:
- What coordination mechanisms exist (structures, committees, operational plans & communication systems?)
-How functional are coordination structures, plans
-Which committees are working, what are the reasons and why are others not functional?

D. Service implementation processes

5. What are your views on how services are implemented to orphans?
Probes:
-What are your views on the following approaches used to deliver services to orphans: integrated services, school based, community based and household based
-How functional are the approaches
-How are orphans selected to benefit the services?
- How is service delivery integrated by different partners?

6. In your opinion, what factors influence service implementation to orphans?
Probes:
a) What is the existing strength?
b) What are existing challenges?
c) What are existing opportunities?
d) What threats?
-What lessons have you learnt in the process of implementing these services?

b) Effects of services to orphans and their families

7. In what way do you think the needs of orphans are met by your services?
Probes:
-How do orphans and caregivers access the services?
-Is there evidence of utilisation of services?
-What is your opinion on the quality of services?
-Are there any new services needed by orphans, why are they not provided?
-Do you think there are other orphans who are not receiving services, why not?

c) Concluding question

8. In general, if you were given a chance to improve service provision to orphans, what would you do?
Probes:
-On the following: services, service provision and policies affecting orphans

-What aspects of service provision is working well, what are the reasons
-What aspects of service provision is not working well, what are the reasons

9. What strategies would you use to effect the changes?

10. Is there anything you want us to discuss about service provision to orphans?

Personal Data
Sex…………………
Organisation number……..

Appendix K: Focus Group Guide for Community participants

Question guide for District implementing partners & Community Based Organisations
Part One: General issues
Introductions
Welcome participants and introduce research team
Explain the purpose of the discussions
Explain why the participant has been chosen and importance of their contribution
Establish ground rules
Introduction of participants

Ask the participants if they have any question about the study.

Part Two: Guiding questions
Needs of orphans and policies affecting them

From your experience of working with orphans, what do you think are the most critical needs of orphans?
Probes:
-Types/areas of need: Educational, socio-economic, health and child abuses
-Differences between the needs orphans and non- orphans and the reasons
-Identify the most critical needs and causes
-Solutions orphans and caregivers find to the challenges

There are many policies that affect orphans, what do you see as the key policies that address the needs of orphans?
Probes:
Policies related to the following areas: Education, Socio-economic, health and child abuse
Gaps on the needs identified in the policies
Coordination of policies with the National Policy on Orphans and other Vulnerable children

Type of service providers and their roles on orphan care

From your experience of implementing services to orphans in this district, who do you think are key stakeholders who provide services to orphans?
Probes:
What services does your organisation offer to orphans?
-What are your views on the roles and the influence these partners on orphan care?
-What specific roles does your organisation play on orphan care and what influence are they making
-Types of partners: government, donors, non-governmental organisations,
- Type of roles: providing leadership, funding, resource mobilisation lobbying, disseminating;
- Examples of tangible milestones and achievements

4. What is your opinion on the coordination of orphan care stakeholders?

Probes:
- What coordination mechanisms exist (structures, committees, operational plans & communication systems?)
How were the coordination mechanisms established?
-How functional are coordination structures,
-Which committees are functional, what are the reasons and why are others not functional?

Service Implementation process

5. What are your views on how services are implemented to orphans? Or what are your views on policy guidance on service implementation?
Probes:
-Delivery approaches (integrated, prescribed services), school based, community based, household based)
-Which approaches are functional what the reasons are?
-Selection beneficiaries & targeting strategies
-Coverage (equity issues, distance, cost)

6. In your opinion, what factors influence service implementation to orphans?
Probes:
a) What is the existing strength?
b) What are existing challenges?
c) What are existing opportunities?
d) What threats?
-What lessons have you learnt in the process of implementing these services?

Effects of services to orphans and their families

7. Do you think the needs of orphans are met by your services, in what way?
Probes:
-How do orphans and caregivers access the services?
- What evidence do you see that the orphans and caregivers are utilising the services?
-What is your opinion on the quality of services that orphans and caregivers receive?
-Are there any new services needed by orphans, why are they not provided?
-Do you think there are other orphans who are not receiving services, why not?

Concluding question

8. In general, if you were given a chance to improve service provision to orphans, what would you do?
Probes:
-What change in the policies?
-What change in service provision by stakeholders?

9. What strategies could be used to effect the changes?

10. Is there anything you want us to discuss about service provision to orphans?

Appendix L: Chichewa Interview Guide for orphans 13-16 years

Gawo loyamba

Malonje
Kuthokoza pochita chidwi kukhala nawo pa kafuku-fuku.
Kufotokozera cholinga cha kafuku-fuku.
Kufotokozera chifukwa chiyani asankhidwa kuchita nawo kafuku-fuku komanso kufunika kwa maganizo awo.
Kufotokozera kuti maganizo awo asungidwa mwa chinsisi.
Kupempha kuti abvomere kapena kukana kukhala nawo pa zokambilanazo.

Funso la kalambula bwalo
Kuyatsa chida chotengera mawu.
Tandiuza zimene ukudziwa za mudzi uno.
Ndi chiyani chimene chimakusangalatsani kwambiri m'mudzi muno?
Ndi chiyani chimene sichikusangatsani m'mudzi muno?

Gawo lachiwiri: mutu wa nkhani

A. Zosowa za ana amasiye ndi thandizo lomwe amalandira

1. Ungandiuze zinthu zimene umachita pa moya wako wa tsiku ndi tsiku kuyambira m'mawa pamene wadzuka kufikira nthawi imene umapita kukagona?

Mafunso otsatira

- Ndi ntchito zanji za pakhomo zimene umagwira ndipo zimakutengera nthawi yotalika bwanji kuti umalize ntchitozo?
- Kodi umagwira ntchito yolipidwa kwa anthu ena? Ndipo ngati umagwira ntchito, umagwira ntchito yotani?
- Umapita ku sukulu? Uli kalasi yanji? Ngati supita ku sukulu, chifukwa chiyani supita?
- Amakuphikira chakudya ndani?
- Ndani amakupatsa zobvala, chakudya, ndi zofunika ku sukulu?
- Umasewera ndi ndani?

2. Nthawi imene unadwala, unachita chiyani kuti uchire?

Mafunso otsatira

- Unapeza kuti thandizo?
- Anakuthandiza ndani?
- Anachita chiyani kuti akuthandize?
- Kodi unakhutira ndi thandizo limene anakupatsa?

3. Taganizira za ana amasiye amene ukuwadziwa. Kodi ana amenewa amakumana ndi mabvuto zanji?

Mafunso otsatira

- Kodi ana ena amasiye a msinkhu wakowo, ukuganiza kuti akukukumana ndi mabvuto ngati amene wafootokozawa?
- Ndi mabvuto ati amene iwe umakumana nawo amene ana ena amasiye amakukumana nawonso?

4. Kodi ungakonde kuti moyo wako wa tsiku ndi tsiku uzikhaka wotani?

Mafunso otsatira

- Kodi ndi chiyani chimene chimasokoneza kuti masiku ako asamakhale achisangalalo?

5. Yang'ana pa chithunzi chojambula. Sankha zitsanzo za mathandizo amene ana a masiye amalandila pa moyo wawo?

Mafunso otsatira

- Umalandira thandizo lanji?
- Amapereka thandizo ndi ndani?(Boma, banja, mabungwe, anthu a m'mudzi)
- Amachita chiyani cheni cheni chimene chimakuthandiza?
- Ndi thandizo lanji limene umasangalala nalo kwambiri? Chifukwa chiyani?
- Ndi thandizo lanji limene susangalala nawo? Chifukwa chiyani?
- Ukakhala ndi nkhawa kapena zodandaula, umapanga chiyani?

B. Zotsatira za thandizo lomwe ana amasiye amalandira

6. Kodi thandizo lomwe umalandira likukwaniritsa bwanji zosowa za pamoyo wako?

Mafunso otsatira

- Kodi thandizo lomwe umalandira lasintha bwanji maphunziro , umoyo, chitetezo ku nkhanza kapena zosowa zina za moyo wako?
- Kodi ukukhutitsidwa bwanji ndi thandizo lomwe ukulandira?
- Kodi pali thandizo lina limene sukulandira pakali pano lomwe ukadakondwa kuti udzilandira?
- Kodi alipo ana ena amasiye ngati iweyo amene sakulandira thandizo? Chifukwa chake ndi chiyani?

D. Ndondomeko yoperekera thandizo kwa ana amasiye

7. Kodi maganizo ako ndi otani pa ndondomeko zimene zikutsatidwa pokupatsa iwe thandizo?

Mafunso othandizira kuyankha mafunso ofunikira pa kafuku-fuku

- Umadziwa bwanji za thandizo la ana amasiye limene lilipo?
- Kodi anthu othandiza ana amasiye amadziwa bwanji za zosowa za ana amasiye?
- Kodi chimene chimakusangalatsa ndi chiyani pa m'mene thandizo limaperekedwera kwa iwe?
- Ndi zobvuta zanji zimene umaziona/umazidwiwa pa m'mene thandizo limafikira kwa iwe?

E. Mafunso omaliza

8. Ngati utakhala ndi mwayi wolankhula ndi akulu akulu a boma pa nkhani yokhudza kusamalira ana amasiye, kodi ungawauze chiyani choti boma kuti lichite kuti ntchito yosamalira ana amasiye iziyenda bwino.

Mafunso otsatira

- Ndi thandizo liti ungakonde kuti lipitirire? Chifukwa chiyani?
- Ndi thandizo liti ungakondwe kuti lithe? Chifukwa chiyani?

9. Kodi pali nkhani zina zokhudza thandizo la ana amasiye zimene ungafune kuti tikambirane?

Gawo lachitatu : Kudziwana ndi munthu oyankha mafunso

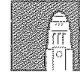
Zaka zakubadwa ……………………………………………………………………………
Mamuna kapena mkazi …………………………………………………………………….
Nthawi yomwe wakhala mderalo ………………………………………………………..
Kalasi imene ali ku sukulu ……………………………………………………………..
Nambala ya Interview ……………………………………………………………………

Appendix M : Ethical Approval from Nuffield Institute of International Health and Development, Leeds.

Faculty of Medicine and Health
Research Office

Room 10.110, Level 10
Worsley Building
Clarendon Way
Leeds LS2 9NL

T (General Enquiries) +44 (0)113 343 4974
F +44 (0)113 343 4373
E FMHRO@leeds.ac.uk



UNIVERSITY OF LEEDS

Mrs Esmie Tamanda Kainja
Nuffield Institute of International Health and Development
Leeds Institute of Health Sciences
University of Leeds
101 Clarendon Road
LEEDS LS2 9LJ

08 March 2010

Dear Esmie

Re ref no: **HSLT/09/010**

Title: **A study of selected child-related policies, services and wellbeing of orphans in Malawi**

I am pleased to inform you that the above research application has been reviewed by the Leeds Institute of Health Sciences and Leeds Institute of Genetics, Health and Therapeutics (LIHS/LIGHT) joint ethics committee and following receipt of the amendments requested, I can confirm a favourable ethical opinion on the basis described in the application form, protocol and supporting documentation at submitted at date of this letter.

Please note, this approval is granted on condition that evidence of renewed ethical approval from Malawi will be submitted to the committee on the expiration of existing Malawian approval which is on 21.02.2011.

Please notify the committee if you intend to make any amendments to the original research as submitted at date of this letter.

I wish you every success with the project.

Yours sincerely

Laura Stroud

Professor Alastair Hay/Mrs Laura Stroud
Chairs, LIHS/LIGHT REC

Appendix N : Ethics approval from Health Sciences Research Committee in Malawi

Telephone: + 265 789 400
Facsimile: + 265 789 431
e-mail doccentre@malawi.net
All Communications should be addressed to:
The Secretary for Health and Population

In reply please quote No. MED/4/36c
MINISTRY OF HEALTH
P.O. BOX 30377
LILONGWE 3
MALAWI

22nd February 2010

Esmie Tamanda Kainja
University of Leeds
Dear Madam,

RE: Protocol #728: A Study of selected child-related policies, services and wellbeing of orphans

Thank you for the above titled proposal that you submitted to the National Health Sciences Research Committee (NHSRC) for review. Please be advised that the NHSRC has **reviewed** and **approved** the above titled study.

- **APPROVAL NUMBER** :**NHSRC/728**
  The above details should be used on all correspondence, consent forms and documents as appropriate.
- **APPROVAL DATE** : **22nd February 2010**
- **EXPIRATION DATE** :This approval expires on **21st February 2011**
  After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the NHSRC secretariat should be submitted one month before the expiration date for continuing review.
- **SERIOUS ADVERSE EVENT REPORTING** :All serious problems having to do with subject safety must be reported to the National Health Sciences Research Committee within 10 working days using standard forms obtainable from the NHSRC Secretariat.
- **MODIFICATIONS**: Prior NHSRC approval using standard forms obtainable from the NHSRC Secretariat is required before implementing any changes in the Protocol (including changes in the consent documents). You may not use any other consent documents besides those approved by the NHSRC.
- **TERMINATION OF STUDY**: On termination of a study, a report has to be submitted to the NHSRC using standard forms obtainable from the NHSRC Secretariat.
- **QUESTIONS**: Please contact the NHSRC on Telephone No. (01) 789314, 08588957 or by e-mail on doccentre@malawi.net
- **Other:**
  Please be reminded to send in copies of your final research results for our records as well as for the Health Research Database.

Kind regards from the NHSRC Secretariat.

FOR CHAIRMAN, NATIONAL HEALTH SCIENCES RESEARCH COMMITTEE

PROMOTING THE ETHICAL CONDUCT OF RESEARCH
Executive Committee: *Dr.C.Mwansambol (Chairman), Prof. J. Mfutso Bengo (Vice Chairperson)*
Registered with the USA Office for Human Research Protections (OHRP) as an International IRB
(IRB Number IRB00003905 FWA00005976)

Appendix O: Informed Consent Form for Focus Group Discussions

Location Number….………
Participant No……………………
Age……………………………….
Sex……………………………….
Education qualification……………

Consent Form for Community based participants`

Project Title: A Study of child-related policies, services and wellbeing of orphans in Malawi

Name of Principal Investigator: Esmie T. Kainja, MPH Nutrition
Please tick in the box

1 I confirm that I have understood the information about the study.
I have had the opportunity to ask questions, and I am satisfied with the answers. ☐

2. I understand that my participation is voluntary and that I am free to withdraw three days before the interview or during the interview or 1 week after the interview without giving any reason. ☐

3. I understand that the information I give will be used for the purpose of the research only. I am willing to have my voice recorded through the audio recorder and to use my information as a direct quotation in the reports, provided I am not identified personally with the voice and the quotation. ☐

4 I agree to take part in the above study ☐

Name of participant Date Signature

____________________ ______________ __________________

Name of researcher Date Signature

____________________ ______________ __________________

1 copy for participant; 1 copy for researcher

Appendix P: Informed Consent Form for In-depth Interviews for policy makers and service providers

Organization Number…..………
Participant Number……………………
Age…………………………………
Sex………………………………….
Education qualification…………….

Consent Form for Policy makers and Service Providers

Project Title: A Study of child-related policies, services and wellbeing of orphans in Malawi

Name of Principal Investigator: Esmie T. Kainja, MPH Nutrition

Please tick in the box

1 I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to ask questions, and I am satisfied with the answers. ☐

2 I understand that my participation is voluntary and that I am free to withdraw at three days before the interview or during the interview or 1 week after the interview, without giving any reason, without my legal rights being affected. ☐

3 understand that my identity will remain anonymous. I am willing to have my voice recorded through the audio recorder and to use my information as a direct quotation in the reports, provided I am not identified personally with the voice and the quotation. ☐

4 I agree to take part in the above study ☐

Name of participant	Date	Signature
______________________	______________	__________________

Name of researcher Date
Signature

______________________ ______________ __________________

1 copy for participant; 1 copy for researcher

Appendix Q: Informed Consent Form for Child and Caregiver

Location Number…...………………..
Child's Number……………………..
Child Sex……………………………
Child Age……………………………
Caregiver Number…………………
Caregiver Sex……………………..

Consent Form for child and Caregiver

Project Title: A Study of child-related policies, services and wellbeing of orphans in Malawi
Name of Principal Investigator: Esmie T. Kainja, MPH Nutrition

Please tick in the box

1 I confirm that I have understood the information about the study. I have had the opportunity to ask questions, and I am satisfied with the answers. ☐

2 I understand that my participation is voluntary and that I am free to leave three days before the interview or during the interview or 1 week after the interview without explaining the reasons and that this will not affect the service I receive. ☐

3 I understand that my name will not be known. I am willing to have my voice recorded through the audio recorder and to use my information as a direct quotation in the reports, provided I am not identified personally with the voice and the quotation. ☐

4 I am willing to take part in the study. ☐

<u>For children 13-17 years old who live with a parent or guardian</u>

5 As the parent/guardian I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions. ☐

6. As the parent/guardian of (child number)________________ I agree for him/her to take part in the
above study and understand that he/she can withdraw at any time. ☐

Name of participant	Date	Signature
____________________	____________	______________
Parent/Guardian	Date	Signature
____________________	____________	______________
Name of person taking consent	Date	Signature
____________________	____________	______________

1 copy for participant; 1 copy for researcher

Appendix R : Needs of orphans' codes adopted from Maslow's hierarchy of needs

Number	Code	Explanation/meaning
1	Need	What orphan and caregivers required or wanted to meet a deficiency or gap in one's life and the behaviour or action they took to show to try to meet the need
2	Physiological need	- Life threatening need: When orphans express food inadequacy and having problems to find food and water -The action taken to find food and water
		-The need for shelter, clothes and beddings to keep and maintain the body temperature -The action taken to keep the body normal body temperature and internal body systems
3	Security need	Security of health: Sickness, health seeking behaviour efforts and limitations
		Security of body: Orphan's need for protection from the following abuses; physical, emotional and sexual.
		Security from child labour: The need to be protected from child labour and strategies used to find money
		Financial security: The need for money and reliable means of finding money
4	Love and belonging	The need for love, affection, belonging to a group or family and having friends and able to play with friends
5	Esteem need	Self-esteem: The need for self-value including self-respect, confidence
		Esteem of others: The need to be valued by others, including, importance, appreciated, accepted
6	Self-actualisation	The need to do something and realise full potential

Appendix S : Policy and Services Codes Based on the Conceptual Framework

Number	Code	Explanation/meaning
1	Policy	Series of goals, objectives, practices and regulation that provide a framework for activity or action
2	Service	Ability to understand a person's needs and able to take action to meets those needs
3	Accessibly	Providing services within distance, cost and timeliness barrier
4	Acceptability	Delivering services by taking into account user's preferences and culture. These can be views about the service itself or the way it is delivered to users (process)
5	Coordination	The manner in which different players are organised and work in harmony towards a common goal
6	Comprehensiveness	The ability to provide broad and diverse strategies and services for needs. For example giving multiple services where there are more needs.
7	Continuity	The ability to provide a service without any disruption as long as the need exist.
8	Equity	Providing equal or unequal services for needs regardless of gender, location, socioeconomic status. Provide more service if the needs are more, or equal services if needs are equal. E.g. service to selected people in a house or area.
9	Efficiency	The potential to provide services in a cost effective manner and avoid waste. That is using strategies to getting more output from same input, such as money, time. For instance group supervision, poor coordination leading inefficiency
10	Effectiveness	The capacity to deliver services that result in improved outcomes , based on a particular need

Appendix T : Policy Document Analysis Template.

Title of document	Background information (context)	Service types	Evaluation elements on quality of policy			
	Title, year, host, user		Coordination	Equity	Accessibility	Comprehensiveness
		Food				
		Education				
		Health				
		Protection				
		Psychosocial				

Appendix U : List of Malawi Government Child-Related Policy Documents Reviewed

Sector theme	Name of Policy	Year	Child focus areas
Food	National food security policy	2006	food security (quantity)
	National nutrition policy & Strategic plan	2007	Nutritious food security
	National fertilizer strategy	Undated	Strategies for promoting food production
Education	National education sector Implementation plan (NESP)	2009	Provision of Education; pre primary, primary, secondary and tertiary
	OVC Education support	Undated	Provision of school fees & learning materials
	School health and nutrition guidelines	2009	Coordination of school health & nutrition
	School health & nutrition strategy	2008	Health and nutrition in schools
	Early childhood development policy	2006	Integrated community based child care services
Health	Malawi Health sector strategic plan	2009	Provision of health services
	National standards for youth friendly health services	2006	Child friendly health services
	National HIV/AIDS policy	2003	HIV and AIDS services
	Integrated management of childhood illnesses	2006	Management of childhood illnesses
	National water policy	2005	Provision of safe water and sanitation
	National Sexual and Reproductive Health Rights Policy	2009	Sexual and reproductive health services
Coordination	National Orphans & vulnerable children policy	2003	OVC and orphan care services
	National Plan of Action on OVC	2005	Coordination Child care Services
	National Plan of Action on OVC, extended version	2010	Coordination of Child care Services
	National Gender policy (draft)	Undated	Equal opportunity is all aspects of society
	Gender in Public Budgeting guidelines and checklist	Undated	Gender based financial allocation for service
	National youth policy	2007	Services available for

			10-17 year old children
	National Decentralization policy	1998	Participation in democratic processes
	Local Government Act	1998	Participation in democratic processes
	Guidelines for the care, protection and support of orphans and other vulnerable children	2006	Care, protection and support of vulnerable children
	Minimum standards and regulations for the establishment and management of children homes and orphanages	2006	Children homes and orphanages standards
Child Protection	Child Care, Protection & Justice law	2010	Child justice & Alternative child care
	Draft National child labour policy	2011	Protection & rehabilitation of child labour
	Child labour National Action plan for Malawi	2008	Child labour implementation strategy
	The Constitution of Republic of Malawi	2000	Rights of children
Economic & Material	Malawi Growth and Development strategy	2006	National Socio-economic development agenda
	National Social Support policy	2010	Provision of welfare support
	National Housing policy	2010	Provision of shelter, and infrastructure services

Appendix V : Linkage between service users needs, services and policies

Service Users Needs (Maslow's Theory Classification)	**Services**			**Policies**	
	Quality of Care element	**Responsive Factors**	**Non Responsive Factors**	**Responsive Factors**	**Non Responsive Factors**
Physiological Poor food quality, inadequate food quantity, poor water quality, lack of shelter, clothing and beddings.	Accessibility	Service available close to households & affordable services	Lack of policy, long distances, access costs (transport/fees)	Functional policy dissemination strategies	Limited circulation of policy documents.
Security Poor health and limited access to health services, physical & sexual abuse, property grabbing, child labour, financial insecurity.	Equity	Need based services	Lack of needs assessment capacity, limited technical skills & corruption	Availability of equitable access strategies and guidelines	Inadequate services, limited equitable services provision guidelines on the basis of age, location or gender
Love and belonging Need to be loved or accepted, depression,	Coordination	Existence of coordination structures	Lack of connectedness of service levels, lack of resources, lack of transparency among service providers & non functional coordination structures	Government instituted policy structures, established roles for stakeholders, resource sharing agreements and policy implementation guidelines	Limited Government coordination leadership, lack of policy alignment and stakeholders implementation structures, conflicting policy guidelines and lack of monitoring/evaluation of policy impacts

stigmatisation. **Self Actualisation** Lack of access to education					
	Comprehensiveness	Provision of cash, community based child care services	Non holistic services, limited resources & overdependence on donors.	Coherent policy vision and implementation strategies	Absence of key policy documents and guidelines & lack of holistic policies
	Effective	Empowering services	Lack of ownership & poor coordination		
	Efficiency	Join planning and monitoring arrangements	Corruption, poor governance, limited technical capacity, poor monitoring systems and limited access to information		
	Continuity	Coordination of partners and referral services	Over dependence on donor resources. Limited resources mobilisation strategies		
	Acceptability	Addressing priority needs	Lack of timely, coordinated, comprehensive & continuous services		