THE UNIVERSITY OF ZAMBIA

AN ASSESSMENT OF THE IMPACT OF PARTNERSHIP IN EDUCATIONAL PROVISION TO VULNERABLE HIV/AIDS-AFFECTED CHILDREN IN CHONGWE DISTRICT

BY

HARRISON SAINAN DAKA

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2005

DECLARATION

I HARRISON SAINAN DAKA ..... do declare that this dissertation represents my own work which had not been submitted for a Masters degree at this or any other university.

Signature:.....

APPROVAL

This dissertation of Harrison Sainan Daka is approved as fulfilling the requirement for the award of the degree of Master of Education by the University of Zambia.

1. Sign: ..... Date: 24/05/2006
2. Sign: ..... Date: 24.05.2006
3. Sign: ..... Date 24/05/06

ABSTRACT

This study highlights the impact of partnership in educational provision to vulnerable HIV/AIDS – affected children in Zambia. It was conducted in Chongwe District in Lusaka Province. Chongwe District has four chiefdoms and is occupied by soli speaking people. Part of chief Nkomesha's area was used as the study site. Quantitative and qualitative research methods were used for data collection. The researcher used a questionnaire, Focus Group Discussions and interviews as data cellection instruments. The District Commissioner, District Education Board Secretary, Education Officers, Health workers, community leaders, World Vision area Manager and the Communities participated in the questionnaire, Focus Group Discussion sand /or interview exercises. The questionnaire and Focus Group Discussion document had close and open-ended questions while interviews were unstructured. The respondents were therefore free to express their views.

The findings of the study revealed that partnership in educational provision to vulnerable HIV/AIDS-affected children had a positive impact. The partners contributed to nutrition, health care, shelter and clothing ofthe vulnerable children, motivating them to continue with education.

The guardians and Orphans and Vulnerable Children (OVC) cited lack of provision of life-skills and psycho-social care .Bad morals like beer drinking by boys and early involvements in sexual relations by girls were things that contributed to school dropout.

Poor implementation of government policy was also found to be affecting vulnerable children's access to education. This was evidenced by unfulfilled promises, e.g. vulnerable children were not a priority in as far as the distribution of education materials and enrolments are concerned, even if written policy stated so. There was also government's failure to distribute educational materials to basic schools.

The study ended up recommending that the government should improve the funding to basic schools as a solution to the main problem of charging pupils through Parent Teacher Associations (P.T.A.). The study discovered that providing life- skills training to vulnerable children would best address the problem of continual dependence on Non Governmental Organisations (NGO). In addition to this, households headed by grandparents, children and chronically ill guardians should be empowered with livestock restocking for selfsustainance. It was also recommended that NGOs should concentrate on rural areas where no other NGO operated from.

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TABLE OF CONTENTS

PAGE

Declaration ii

Approval iii

Abstract iv

Acknowledgment v

List of tables ix

Acronyms x

Definition of terms xi

CHAPTER ONE: INTRODUCTION 1

Background 1

Origins of Education in Zambia 2

Role of government in Education 2

Impact of decline of Zambia's Economy 3

Cost- sharing in Educational Provision 3

Situation of HIV/AIDS in Zambia 4

Impact of HIV/AIDS on vulnerable children 5

Partnership in Educational Provision 5

Statement of the problem and Objectives 7

Research questions 7

The purpose of the study 8

Significance of the study 8

CHAPTER TWO: LITERATURE REVIEW 9

Literature review 9

CHAPTER THREE: METHODOLOGY 20

Theoretical orientation 20

Research design 21

Ethical considerations 22

Research instruments 22

Study population 23

Study Sample and Sampling procedure 24

Data collection tools/procedure 25

Data analysis and interpretation 28

CHAPTER FOUR: FINDINGS OF THE STUDY 30

Background information on the communities 30

Types of Household heads 30

Access to Education 32

Nutrition 35

Health 37

Psycho- social support 39

External support and life skills training 40

CHAPTER FIVE: DISCUSSION OF THE FINDINGS **43**

Introduction 43

Reasons for more widow headed households 43

Drop outs 44

Psycho- social care 48

Nutrition 48

Training in life – long skills 50

Summary 51

CHAPTER SIX: CONCLUSIONS RECOMMENDATIONS 54

Conclusions 54

Recommendations 56

BIBLIOGRAPHY 59

APPENDIX A – Household Questionnaire 64

APPENDIX B – Focus Group Discussions 68

APPENDIX C – Sheets for data entry from questionnaire 72

LIST OF TABLES

TABLE		PAGE
1.	Names of the villages and number of households	24
2.	Types of Households	31
3a	Access to Education	33
3b	Access to Government and Community Schools	34
4a	Children having normal meals in one week	35
4b	Children that ate before going to school	36
4c	Combined number of children that ate before going to school	37
5	Children who were sick and accessed medical treatment	38
6	Households which received psychosocial counseling	39
7	Households which received external support and life- skills Training	41
8	Relationship between percentage of ADP and non- ADP contributing to Variables affecting access to education by OVC	52

ACRONYMS

ADP	-	Area Development Programme
CIP	-	Chronically Ill Patients.
EFZ	-	Evangelical Fellowship of Zambia
GER	-	Gross Enrolment Ratio
IHAA	-	International HIV/AIDS Alliance
IMF	-	International Monetary Fund
IRI	-	Interactive Radio Instruction
MOE	-	Ministry of Education
MOH	-	Ministry of Health.
OVC	-	Orphaned and Vulnerable Children.
PACWA	-	Pan Africa Conference for Women Association
REPSSI	-	Regional psycho- social Support Initiative
WVZ	-	World Vision Zambia

DEFINITION OF TERMS

Community School – A school whose infrastructure is built by the community and is run by the community in providing resources like finances for teachers

Cost – sharing – Where government contributes a share while the remaining is contributed by the parents and beneficiaries.

Donors - These are countries that sponsor or assist government in its educational activities. They are now known as co – operating partners.

Education – A deliberate, systematic and sustained effort of transmitting, evoking or acquiring knowledge, skills, attitudes, intellect, values and other outcomes.

Government school – Government builds infrastructure and sponsor all activities in running the school.

Normal meal – This refers to content of the meal and how many times per day.

Orphan – This is a child aged between 0 – 18 who has lost either one parent (single orphan) or both parents (double orphan). An orphan can also be either paternal (father dies) or maternal (mother dies).

Pandemic – A wide spread disease outbreak affecting the population of an extensive area of the world.

Partnership – The involvement of other sectors in providing formal education.

Primary Care givers – These are the heads of the households. They can be grand parents, uncles, brothers or sisters.

Private schools – Institutions which run formal education on profit basis.

Psychosocial support – This is an ongoing process of meeting the physical, emotional, social mental and spiritual needs of children, all of which are essential elements of meaningful and positive human development.

Secondary Caregivers – People who visit the OVC and give them necessary psycho – social support.

Vulnerable – A child is said to be vulnerable if he/she is between 0 – 18 and is not able to access basic materials and needs. This is a result of losing parents due to HIV/AIDS.

CHAPTER ONE

INTRODUCTION

Background

One scourge that has left many people disadvantaged, vulnerable, and impoverished is not a disease but mass illiteracy, caused by exclusion from opportunities for education. This has been due to failure by most governments to formulate and implement national policies, which should address such issues (Watkins 1999). Such a crisis happens to millions of children who are denied their only chance to gain the literacy and numeral skills that they need in order to escape the poverty trap.

The main purpose of education is to provide everybody not only the privileged few but also the majority of the under-privileged, mainly the vulnerable, such as the HIV/AIDS-affected children with relevant skills, knowledge, attitudes and ideas which will enable them to live more fulfilling, productive and satisfying lives. Therefore, education is the greatest engine of personal development (Watkins 1999) and an educated person will have more opportunities.

Despite the leaders having the knowledge of what education does to their people, in most rural areas of the developing countries, people suffer from inadequate

facilities and opportunities. Bishop (1989; 209) stated that 'for all practical purposes, they are beyond the reach of formal education'.

The Origins of Education in Zambia

Education had existed in Northern Rhodesia, now Zambia, for as long as human societies had lived here. The form of education was traditional education, which varied from one tribal society to another depending on custom and environment (Snelson, 1990).

When tradition education was offered, the orphans had equal access with other children for they were incorporated into the extended families and as the old saying goes 'an orphan learns as parents teach their own children.' This type of education was focused on giving life-long skills like trapping animals, social obligations like respecting elders and initiation ceremonies where physical endurance hygiene and sexual behaviour were taught to children. When Zambia got independence, most of these were to be done by the Government.

The Role of Government in Education

Education is a right for each individual and the government is the custodian of the human rights of all individuals (MOE, 1996). It is also government responsibility to educate its citizens for human capital formation and democratization. In this case then, the Government has the following roles.

(i) **Developer:** The government through different ministries should develop different areas related to education. Some of these include developing of roads and health structures. If this is left to the private sector the costs can be high when using them and the vulnerable children may not access them.

(ii) **Equalizer:** The government should equalize the opportunity for people in accessing education especially for the poor (especially orphans) thereby narrowing the gap between the poor and the rich.

(iii) **Defense and security:** Help people go about attain social interaction without fear.

Impact of Decline of Zambia's Economy

Since the government has a bigger role to play in providing education and the distribution of resources, the economy of the country can affect this obligation. In Zambia, the state of the economy has undergone different phases in a declining manner. A lot of factors have contributed to this and some of these include; the closing of the Zimbabwe trade route (1965), the rise in oil prices(1973), and the falling of copper prices(1975).This caused a reduction in national resources going to education.

Cost - sharing in educational provision

Due to the limited availability of public resources and the declining economy, the government of Zambia had to introduce the concept of cost-sharing in the

provision of education at different levels (Boarding fees in secondary schools in 1987 and increase in tuition fees for the University of Zambia in 1993). This meant that the parents and the beneficiaries were to contribute towards the provision of education in terms of uniforms, transport, building of infrastructure, paying of teachers at community schools and the provision of other materials like books, pens and pencils. This was because the government budgetary allocations alone could not be sufficient enough to ensure quality education. It also reduced the education spending from 5 or 6% in the mid eighties to 2.5% of the GDP (Oxfam JCTR 2000).

Situation of HIV/AIDS in Zambia

As the government of Zambia is trying to provide equal access to education, the HIV/AIDS pandemic has had its own effects.

It is estimated that 1.7 million people are living with HIV/AIDS (CSO, 2003). Furthermore, prevalence of opportunistic infections is also increasing as the immunity of those living with the disease decreases, placing great pressure on an already strained health care system.

Some factors that have precipitated the spread of HIV/AIDS in Zambia are multiple sexual relations, low condom use, early sexual activity (especially among females), high poverty levels and low socio-economic status of females. Women

say that they can preferably die of AIDS in 10 years time than of hunger in 10 days time (World Vision Zambia, 2004).

So the government diverts some resources to the purchasing of ARVs and other HIV/AIDS programmes.

Impact of HIV/AIDS on vulnerable children

As very often is the case with war and other major calamities, it is the women and children that suffer most. This is clearly also the case with the AIDS epidemic in Zambia. Orphans are perhaps the most tragic manifestation of the HIV/AIDS epidemic.

A research carried out by World Vision showed that 32% of the children in a given population were orphans (World Vision Zambia, 2004).

Partnerships in Educational Provision

In order to achieve its fundamental goal (ensuring that every eligible individual can have access to education), the Ministry of Education had to restore partnerships in educational provision (MOE, 1996). Partnership was to be between the government and non-governmental organizations, the private sector, local communities, religious groups, and families.

The government would work with these partners in different ways. For example;

(i) **Interactive radio instruction:** This was a radio programme which allowed pupils through a mentor to learn using the radio. This was to be done anywhere e.g., under a tree or a church building. The government

provided radios and sponsored programmes on the radio. This programme was commonly referred to as TAONGA MARKET.

(ii) **The private sector**: In order to encourage the private sector participation in education, the Ministry provided incentives by way of access to curriculum, educational materials and training of personnel. It should be noted that though these were alternatives to government schools, in most cases they were costly and only the well to do managed to access them.

(iii) **Community schools**: This was another option to give chance to those not taken on in government schools or those who had had no opportunity at some time (over-age).In this case, the community provided labour, finances and other materials for the maintaining of the school infrastructure and teachers.

(iv) **Donor aid**: More than twenty bilateral and multi-lateral donors provided aid for education and training in Zambia in 2005. A significant number of donors provided aid for basic education (grade 1 – 9), e.g., Japan has helped through the building of basic schools.

(v) **Non-Governmental Organisations**: The organisations helped in different ways, e.g., buying of uniforms, paying of school fees, providing nutrition and health care, e.g., FAWEZA and E.F.Z.

Statement of the problem

As the demand for education from vulnerable HIV/AIDS-affected children was increasing the impact of partnership involvement in educational provision to them had not been assessed. As a result there had been no proper coordination among partners and also between partners and the Government.

Objectives

(i) To assess the policies of education concerning vulnerable children which were being implemented in schools.

(ii) To identify the variables which children and the communities considered to be hindering their access to education.

(iii) To assess whether the child policy addressed the special needs of HIV/AIDS-affected children.

(iv) To assess the impact of partners' assistance to vulnerable children's access to education.

(v) To assess the type of support that was being given to vulnerable children by partners.

Research questions

(i) Did vulnerable children have the first priority in school enrolment?

(ii) Did vulnerable children have a priority in receiving educational material support from government?

(iii) Was the child policy addressing the special needs of HIV/AIDS-affected children?

(iv) Did the involvement of partners have any impact in the provision of education to vulnerable children?

(v) Did children supported by partners have an advantage over those not supported?

(vi) What type of support did partners give to vulnerable children?

The purpose of the study

The purpose of the study was to assess the impact of partners' involvement in the provision of education to HIV/AIDS-affected children so as to recommend ways of how they could coordinate with each other as well as with the Government.

Significance of the study

This study might inform the Ministry of Education, Non-Governmental Organisations and Religious Organisations the factors that could improve vulnerable children's access to education, meet the severity of this challenge and provide more effective, holistic support to children within their families and communities. It would assist the decision-makers to formulate an OVC national policy, which should be holistic in addressing their needs.

CHAPTER TWO

LITERATURE REVIEW

A number of investigators have been interested in trying to isolate the variables responsible for hindering vulnerable children's access to education. Some variables suspected to affect vulnerable children's access to school are noted below.

A research carried out by Bishop in 1989 in Kenya showed that drop-out numbers in rural schools were higher than enrolment rates. The research showed further that the drop-out rate was 90%. The reasons for these high rates of drop-outs were not found solely in the quality and alleged incompatibility of teaching and educational structures but the root problem lay in the socio-economic conditions of the people concerned, that is; in their poverty state. As a result, they were unable to pay school fees, older children were withdrawn to tend the cattle or to work on the family holdings. Children were weary of long journeys to and from school on empty stomachs (this is in line with a saying that, 'when the stomach is full, the foot is fast' and the opposite is true) and were also sick due to malnutrition. In the case of girls, most were withdrawn from school to act as child-nurses to the younger children while their mothers worked on the family plot.

i. Health

Research has shown that malnutrition (nutrient deficiency) produces damage to the central nervous system, adversely affecting a child's ability to read, write, do simple sums and to think clearly and logically (MOH, 1998). This means that malnutrition results in early drop-out from the educational system.

ii. Water/sanitation

It was evident in Zambia, especially in urban areas, that the less privileged people had a problem with access to education due to different factors, which included access to water. This resulted in many school going children spending most of their time fetching water (especially in the morning) instead of going to school while those who had water in their houses just woke up and prepared to go to school. A research carried out by the Ministry of Health, showed that adequate sanitation was very low in rural areas compared to urban areas at 37% and 66% respectively (MOH, 1992). This showed that both in urban and rural areas, a certain group of people (less privileged) lacked access to good sanitation and water resulting in the school going children sacrificing education with daily chores at home.

iii. Clothes

Bishop (1989) showed that the poor had been discriminated against in as far as access to education was concerned due to major resources which resulted into failure to buy clothes or uniforms for their children.

In Zambia, despite the government's announcement that no child would be excluded from school on the grounds of not having a uniform (MOE, 1998:70), most children especially in rural areas where this was applicable (in urban areas in all government schools up to Middle Basic School pupils wear uniforms) drop out of school due to lack of good clothes. World Vision Zambia in 2004 in a research conducted in Petauke District showed that most children stopped school due to lack of good clothes. They said they felt ashamed of their clothes which were torn. In addition, though Primary education was free, the drop-out rate was still high because most children from less privileged homes shifted their priorities from education to means of survival, forcing many to seek petty employment.

Research has shown that if such children were given good clothes or uniforms, they would go back to school. Evangelical Fellowship of Zambia through Pan-African Christian Women Alliance (PACWA) department mobilized its member churches and managed to return to school 7, 590 vulnerable children (E.F.Z., 2004) through the provision of clothes. This was done to make sure the HIV/AIDS affected children were educated to reduce the risk of HIV infection by increasing their knowledge, awareness skills and opportunities.

iv. Property transfer

Traditionally in Zambia, the family elders used to meet and assign a relative to care for an orphaned child. The ability in terms of resources (capacity) of families to do this is becoming strained. Currently most children are cared for by grandparents and these face orphaning for another time when their grandparents die (Foster, 1996).

A research carried out by World Vision Zambia (2004:25) showed that, 'when a man dies, the relatives to the deceased mostly grab all valuable items, leaving the widow and the children with less valuable or no items'. This has had adverse affects on the children's access to education for the items collected were to assist them meet the daily needs.

In most cases the loss of inheritance had been due to parents not writing a will so that their children could have a legal right. Since most of the valuable goods or items were grabbed, the children were left in a poor state and as a result, they began to work at young ages. That was in accordance with the research carried out in urban Burundi in 2001 by Save the Children UK, which revealed that children in HIV/AIDS affected households began work at a tender age.

v. **Birth certificates**

Birth certificates are very important documents especially to orphans who might have lost both parents. This is because they can be used as proof of birth during school enrolment. The Regional Psycho-Social Support Initiative (REPSSI) revealed that most vulnerable children in Chikankata in the year 2004, were denied access to school enrolment due to lack of birth certificates (REPSSI, 2004). The worst affected were the child-headed households.

In other countries like Zimbabwe, research showed that many orphans/vulnerable students could not be allowed to sit for national examinations due to lack of birth certificates (IHAA, 2003).

vi. **Psycho-social support**

Most programmes for OVC focused on material support and meeting children's physical needs. Relatively, little or no psycho-social support was given to such children which led to most children remaining mentally affected such that they could not perform well at school. The loss of a parent is a traumatic and stressful experience and early intervention is vital.

The HIV/AIDS affected children were worst off due to stigma. Denial when a parent was dying and a sense of shame linked to an AIDS death

were particularly harmful for children. So stigmatization and discrimination must be dealt with so as to reduce the stress and trauma.

The research done by REPSSI in 2002 showed that despite providing food and clothes to vulnerable children, their commitment to school attendance was low. It was then revealed that the major problem was that these children (especially orphans and HIV/AIDS-affected) never underwent psycho-social support, which is an essential element of meaningful and positive human development. A research by World Vision Zambia in 2004 showed that 89% of the orphans never received psycho-social support even from the religious groups.

Most of the above factors had been attributed to the HIV/AIDS pandemic. This pandemic was first known as part of witchcraft in Zambia and later known as the disease of prostitutes and the rich. It was also perceived as something away from the religious groups and respectable homes but now everyone is affected if not yet infected.

Research has also shown that most parents who died of HIV/AIDS were men and the paternal orphans to maternal orphans ratio was 6:1 (World Vision, 2004) demonstrating that children are left without a bread winner. The issue of vulnerable children as a result of HIV/AIDS in Zambia was a problem, which automatically needed a response through putting up a

national policy which was to address such a crisis, continuous sensitization in communities and coordination among partners and with the government.

In Zambia, the government had so far carried out certain activities so as to help solve the above problem through the National Orphaned Vulnerable Children (OVC) Policy. The findings and information in this research would help formulate a policy which was to be an answer to the problem. Some of the things which the government has done include the following:

i. Pronouncement of free education from grades 1 to 7. This seemed to have increased access of vulnerable children to school though the impact was being investigated.

ii. Another policy which research has shown was that, 'government's priority is increasing and promoting access to educational training opportunities by all groups especially vulnerable ones ...' (Kelly, 1999: 11). In this policy, the government resolved that, 'priority in educational provision and in the distribution of educational resources will be in favour of whatever is more likely to benefit the poor and vulnerable' (MOE, 1996: 72). This was expected to have yielded much if the resources were enough and were given to vulnerable children. World Vision Zambia, 2004, showed that some school managers just kept the books and pens to be distributed to

vulnerable children in their offices and sometimes distributed equally to everyone without considering the vulnerability of the children.

iii. The government had also signed a lot of international declaration commitments, for example:

a) In Dakar, it committed itself that by 2005, all school-going children would be in school. Estimates showed that there had been an increase in the enrolment rate though the goal had not yet been reached.

b) The commitment of the Millennium Development Goals (MDGs), that by 2015, the nation would have achieved Education For All. This was expected to bear much fruit since more basic schools were being constructed though much needed to be done in sensitizing the people in the rural areas on the importance of education.

c) It signed the United Nation General Assembly Special Session (UNGASS) on Orphans and Vulnerable Children. This commitment was the one leading to the formulation of National Child policy which was to include the issues of OVC. This policy was supposed to have been formulated by 2003 and implemented by 2005. This type of a policy was expected to be holistic for it was to include other departments like Health, Community Development, Home Affairs and Education. The information and findings in this research would contribute to what was expected.

d) The GO GIRLS SECURE YOUR FUTURE TODAY PROGRAMME which was launched in October, 2004 also would help return to formal education the young girls who had stopped school or had got married. The discovered challenge of this was infrastructure and human resource.

Considering all the above critical issues of HIV/AIDS and high poverty levels, the government alone could not manage to provide education to all including the vulnerable HIV/AIDS affected children. This required the involvement of partners. Some of them, who had already started, included;

i. **Evangelical fellowship of Zambia**: This organisation started to work with its member churches in 2002 through sensitization. By December 2003, 73, 000 vulnerable children were supported in different ways like providing uniforms, clothes, counseling, paying school fees and buying school shoes (EFZ 2004).

ii. **FAWEZA**: This organisation had been assisting school girls in counseling, providing financial assistance and organizing extra lessons (tuitions) for them and paid the tutors (Foster, 1996).

iii. **The community**: Since the introduction of cost-sharing, the communities had been greatly involved in the provision of education to their children.

They had been involved in providing labour in the moulding of bricks, digging and transferring of river and building sand, providing untrained teachers and paying them (even in government schools) where there were fewer teachers (World Vision Zambia, 2004).

Many other NGOs including World Vision Zambia had been involved and their assistance had been recognized.

It is evident from the literature given that HIV/AIDS had contributed adversely to the lives of most children in Zambia and other parts of the world. Due to this crisis, it was also vital that the National child policy was revised in order to address the needs of vulnerable HIV/AIDS – affected children.

Since many organisations had come to assist such children, there was need for assessing their impact in educational provision so as to give an idea to decision – makers as to what needed to be improved upon and put up guidelines through the National Child Policy.

This research assessed the impact that World Vision Zambia had made in providing education to vulnerable HIV/AIDS – affected children. The organization in 2005 worked in 23 districts in Zambia and was one of the Non-profit making organisations. It had an OVC wing under the Models

of Learning (MOL) department. It took a holistic position in the provision of basic needs to vulnerable children and the community, including access to education.

CHAPTER THREE

METHODOLOGY

In this chapter, the researcher offers a detailed outline of the theoretical elements guiding the research as well as the methods used in data collection.

Theoretical orientation

The purpose of the theory was to help the researcher sort out and be guided on how the research would be. This research took a combination of phenomenological approach, where one used the concept of trying to see what the believer/affected sees (in this case the believers being the vulnerable children and primary caregivers who participated in the research). The researcher tried to 'bracket' or abstain from ones' own views or value – judgment about vulnerable HIV/AIDS affected children. As it was impossible to completely 'bracket out' ones' value judgment, the researcher tried at all cost to minimize ones' preconceptions in order to try and get a fresh look at phenomena under study.

The other approach used was interpretive approach. From this approach, the researcher realized that the research participants could not be studied in isolation, hence, the researcher used the concept of 'part' while the community as the 'wholes'. In order for one to understand what was studied, the researcher related 'building bridges' what the research participants stated with what was seen in the community. In the researcher's writing, there are no direct quotations of the words of the respondent or recording of interviews.

Research design

The research took the form of a survey and used a combination of qualitative and quantitative approaches. The two approaches differ in their methods of data collection and the ways in which data is analysed and reported. The quantitative approach is also known as scientific, positivistic and hypothetic-deductive. This means that the first is a hypothesis. A hypothesis is a tentative, testable statement which usually connects two concepts. The hypotheses or working hypotheses derived from it, are then tested in various ways to see whether they hold good in different combinations of circumstances (Basu , 1988).

In qualitative research, on the other hand, the process of collecting and reflectively analyzing the data, triggers the leap of inductive thought.

This survey employed a combination of the two approaches (qualitative and quantitative). It should be mentioned that the quantitative method was dominantly used as compared to the qualitative approach because data in form of tables, percentages, frequencies and graphs during data analysis were used to determine the impact of partnership in educational provision. The quantitative method relied mainly on the questionnaire. A summary sheet was prepared for entry of all information. Then chi-square test and t-test were used to determine the reliability and validity of the data and its significance.

The information from Focus Group Discussions (FGDs), observations and interviews were followed by commentary highlighting the themes and sub-themes of the importance of the study. This was followed by careful analysis and evaluation in light of the basic questions of the study before making conclusions.

Ethical considerations

During the research, certain ethical issues were looked at, and these included; participants' right to privacy, dignity, self-determination and the researcher's right to know. This means the researcher followed a certain code of conduct or set of principles during the research to ensure that the participants enjoyed their rights to privacy, dignity and self-determination.

Another thing which the researcher assured the respondents, was their right to confidentiality and anonymity and this was respected. The researcher explained to them that they were to remain anonymous and this was done during the filling in of the questionnaires that they had to choose any name (not true name).

Research instruments

The research was carried out over a series of visits in communities. The data was collected by questionnaires, focus group discussions (bearing in mind the advantages of focus group discussions where consensus views are revealed and richer responses are generated by allowing participants challenge one another's views) and interviews. Individual interviews were carried out with some

stakeholders like health workers, education officers, PTA executive members and community leaders to supplement information gathered by questionnaires and seek clarification on emerging issues. During interviews, the researcher did not interrupt the interviewee accidentally but paid attention to tone of voice, facial expression, gestures and hesitation in answering. Respondents reacted or behaved in different ways. Some were excited while others tended to be nervous at the beginning of the interviews.

Study population

Chongwe District has four chiefdoms. Of these chiefdoms Nkomesha chiefdom was selected because it was the area where World Vision Zambia (partner) was operating. In the Nkomesha chiefdom, there are many village communities but only the area where the community health workers were working from(around chief Nkomesha's palace, which is 20 kilometers from Great East Road) was used so as not to have a problem in identifying households which were HIV/AIDS affected. For the purpose of obtaining a relatively comprehensive picture of the situation, the study sampled four village communities within the Area Development Programme (ADP) and four village communities outside the Area Development Programme (non-ADP). The rationale behind confining the study to only eight communities was what the time and resources available could permit.

Study sample and sampling procedure

In order to draw a sample of four village communities from each area, those surrounding the rural health centre were chosen from the ADP area and those adjacent to the ADP area were also chosen so as to make sure that both areas experienced the same conditions like; distance to the health centre, landscape and soil fertility. In each village community, only households which were HIV/AIDS-affected were picked. To do this, simple random sampling was employed. At the second stage, stratified sampling was employed to come up with two strata, single and double orphaned households. 40 households from each area were selected to take part in answering the questionnaire(see Table 1).

Table 1:Names and number of households

VILLAGE	LOCATION	NO. OF HOUSEHOLDS
1.Kampekete	ADP	10
2. Lobolola	ADP	10
3. Muyoba	ADP	10
4. Nkomesha	ADP	10
5. Chikwela	NON-ADP	10
6. Kakubo	NON-ADP	10
7. Libuko	NON-ADP	10
8. Mwantalasha	NON-ADP	10
TOTAL		80

The selection of interviewees was random based but on whether they were stakeholders like agricultural officers, health workers, education officers, ADP staff members and/or those in the executive of Parents and Teachers Association (PTA). Most of them were committed during the research but those available in each department were interviewed. The district commissioner, district voluntary, Counseling and Testing (VCT) coordinator and the ADP manager were also interviewed as key informants.

Data collection tools and procedure

(a) Focus group discussions.

These were conducted before survey questionnaires and interviews. This was because there were some questions in the questionnaire that required information from the focus group discussion. The composition of focus group discussion was as follows:

(i) **Community leaders**: All headmen/women of the selected village communities, church leaders, health workers, teachers, community health workers and a leader from Home Based Care (HBC).

(ii) **Secondary care givers**: This comprised Home Based Care group members and Orphan and Vulnerable Children (OVC) care members. Such were available only in the ADP area and so no

focus group discussion of this group was conducted in non-ADP area.

(iii) **Primary care givers**: This comprised guardians, like grandparents, uncles, aunts, mothers, fathers, brothers and sisters. It was made sure that each type of household was represented.

(iv) **OVC group**: Two groups were first met at different times. These groups were boys of age 7-18 and girls of age 7-18. Each group consisted of 13 children. The groups were representative of different types of vulnerability like maternal/paternal orphans, single/double orphans and chronic illness of parents. Also OVC coming from a variety of households e.g. grandparent headed, widow/widower headed, uncle/aunt headed and sister/brother headed. Group composition included both in and out of school OVC. Only one child per vulnerable household was selected so as to avoid fear in some.

After conducting separate discussions with each of the OVC group, the two were combined so as to clarify the conflicting issues of whether boys or girls drop out of school early. The OVC groups particularly were not onerously long. Quiet members were prompted and encouraged to participate.

Some stories which emerged from the focus group discussions, were followed up and written up as short case stories. This made the research more interesting.

(b) Questionnaire

The questionnaire was the main research instrument used to collect quantitative data from households. A structured questionnaire was used to solicit information from respondents. A total number of 80 questionnaires were administered to households selected during sampling. The researcher administered the questionnaires from household to household with the help of the community leaders for identification of households. This resulted in 100% response rate.

(c) Interview

The researcher used unstructured interview questions, which allowed room to ask broad questions in any order considered appropriate. Questions also gave the respondent room to answer freely and amplify the

responses. The respondents were interviewed in their offices and homes (in case of PTA executive members).

The interviews were done during the same time of administering the *questionnaire but after focus group discussions. The questions in the* interview were in addition based on issues that emerged from focus group discussion and partly from questionnaires. The research was first done in the ADP area and later in the non-ADP.

Data analysis

The data collected was coded and categorized into major variables. The researcher considered two categories of variables namely independent and dependent. The independent variables were partners in education provision, which included World Vision Zambia (in this research), the church and the community. The dependent variables were vulnerable children's access to education, health care and psycho-social care. During data analysis, the researcher wanted to know how the independent variables shaped the dependent variables.

All data were analysed by the researcher. The statistical package for social scientists (SPSS) was utilized to generate tables of frequencies and percentages from the questionnaires. Data collected through interviews and focus group discussions were coded into themes and grouped into categories. The Most

significant categories of themes were then compared with the results from the SPSS analysis for purposes of triangulation. This is done in the discussion chapter. From the analysis of data collected the researcher assessed the impact of partnership in educational provision to vulnerable HIV/AIDS-affected children.

CHAPTER FOUR

FINDINGS OF THE STUDY

The first section of this chapter covers the background information on the communities. The remaining sections cover the findings of the study which are presented in descriptive and table form which incorporate frequencies and percentages.

Background information on the communities.

This study was conducted in Chongwe District in Lusaka Province. Chongwe District has four chiefdoms, namely Nkomesha, Bundabunda, Mpansha, and Shikabeta . Part of Nkomesha's chiefdom was used as study site. Eight Village communities were chosen to make the sample. The sample consisted of 10 households from each of the 8 Village communities. Four Village communities were from the ADP area and 4 others from the non-ADP area.

Types of household head

Data collected from the 80 questionaires revealed the type of households of the HIV/AIDS affected children (see Table 2).

Table 2: Types of Households and number of households

	CHILD		WIDOW		WIDOWER		OTHER ADULT		ELDERLY		CHRONICALL ILL	
	NO.	%	NO.	%	NO.	%	NO.	%	NO.	%	NO.	%
ADP AREA	3	04	16	20	1	01	11	14	4	05	5	06
NON-ADP AREA	1	01	12	15	1	01	10	12	12	15	5	06
TOTAL	4	05	28	35	2	02	21	26	16	20	10	12

According to the survey of 40 households in the ADP area, 3 were headed by children which represented 04%, 16 by widows representing 20% and 1 by widowers which represented 01%. The other household heads were other Adult headed (uncle, aunt, older sister or brother) which were 11 (14%), Elderly headed were 4 which represented 05% and the chronically ill headed were 5 (06%).

In the non-ADP area, the following were the representations; child headed was only 1 (01%), widow headed were 12 (15%), widower headed was only 1 (01%), other adult headed were 10 (12%), Elderly headed were 12 (15%) and chronically ill headed were 5 (06%).

In total, 5% of the households were child headed, 35% widow headed, 26% other adult headed, 20% elderly headed 12% by the chronically ill and 2% widower headed.

In comparison, in the ADP area, there were more widow headed (40%) as compared to non –ADP area (30%) and on the other hand, in non-ADP area, there were more elderly headed (30%) as compared to ADP area (10%). In general, more households were widow headed (35%) than widower headed (02%).

Access to education

For school attendance of children aged between 7 and 18, the results are shown in table 3 a below.

Table 3a: Number of Children Aged between 7 and 18 with to education.

	ADP AREA		NON-ADP AREA		COMBINED	
	FREQ.	%	FREQ.	%	FREQ.	%
GIRLS IN SCHOOL	62	87	67	92	129	90
BOYS IN SCHOOL	75	91	47	81	122	87
TOTAL CHILDREN IN SCHOOL	**137**	90	**114**	87	**251**	88
GIRLS OUT OF SCHOOL	9	13	6	08	15	10
BOYS OUT OF SCHOOL	7	09	11	19	18	13
TOTAL CHILDREN OUT OF SCHOOL	**16**	10	**17**	13	**33**	12
TOTAL NUMBER OF CHILDREN	**153**		**131**		**284**	

The total number of children between 7 and 18 involved in the research were 284. Out of these, 153 were found in the ADP area and 131 in the non-ADP area and 251 were attending schools while 33 were not attending school.

In the ADP area, 137 children which represented 90% were attending school as compared to 114 (87%) in the non-ADP area.

In the ADP area more boys (91%) were attending school than girls (87%). In the non-ADP area, the opposite was true where 92% of the girls were attending school as compared to 81% of the boys.

In general, more girls (90%) now attended school than boys (87%).

Comparing the number of children who were in attendance in government and community schools, the following were the findings that are tabulated in table 3b.

Table 3b: Number of pupils with access to government and community schools

	ADP		**NON-ADP**	
	Frequency	**Percentage**	**Frequency**	**Percenta**
Number of pupils attending government school	111	81	80	70
Number of pupils attending community schools	26	19	34	30
TOTAL	**137**		**114**	

It was revealed that in the ADP area, out of 137 children that were attending school, 111 (81%) were attending school in government schools while 26 (19%) were in community schools.

In the non-ADP area, out of 114 children attending school, 80 (70%) of them were attending school in government schools and 34 (30%) were in community schools. Therefore more children in the ADP area (81%) attended school in government schools than in the non-ADP area (70%).

Nutrition

The children on whom the research was carried out on nutrition were the school-going children aged between 7 and 18. During the focus group discussion, a normal meal was refered to as having two meals a day (lunch and supper) comprising Nshima and relish like vegetables, kapenta, beans or meat. The research just considered the normal meals one week prior to the research time. The following were the findings;

Table 4a: Number children that had normal meals in one week out of those that didn't

	ADP AREA		NON- ADP AREA	
	Frequency	**Percentage**	**Frequency**	**Percentage**
Children with normal meals	104	76	26	23
Children without normal meals	33	24	88	77
TOTAL	**137**		**114**	

Information obtained showed that in the ADP area, out of 137 children, 104(76%) had had normal meals in one week prior to research while in the non-ADP area only 26(23%) out of 114 children had had normal meals in one week prior to research.

The research further tried to find out the number of children who used to eat before going to school. The following were the findings;

Table 4b: Number of children that used to eat before going to school

	ADP AREA		NON- ADP AREA	
	Frequency	**Percentage**	**Frequency**	**Percentage**
Children that ate	81	59	22	19
Children that did not eat	56	41	92	81
TOTAL	**137**		**114**	

It was revealed that in the ADP area 81(59%) children used to eat before going to school and 56(41%) never used to eat. In non-ADP area, it was revealed that only 22 (19%) of children out of 114 children used to eat before going to school as compared 92 (81%) that never used to eat.

Combining the results above from both non-ADP area and ADP area, the following were the findings;

Table 4C: Combined number of children that used to eat before going to school.

	NUMBER	PERCENTAGE
Those that used to eat	104	41
Those who didn't eat	147	59
TOTAL	**251**	100

Out of the total children (251) who were attending school, it was revealed that 104 (41%) used to eat before going to school and 147 (59%) never used to eat.

Health

This section of the study required respondents to give the names of children that were sick three months prior to the research and accessed medical treatment at the rural health centre or from traditional medical practioners. The study also required them to indicate those who did not access medical attention due to lack of financial resources or neglect on the part of the guardian.

Table 5: Children who were sick and accessed medical treatment.

		ADP AREA		NON-ADP AREA	
		Frequency	**Percentage**	**Frequency**	**Percentage**
Children who accessed	Government clinic	36	90	10	25
	Tradition	1	03	09	23
Children who did not access		3	07	21	52
TOTAL		40		40	

For the children who were sick, it was found that the total number was the same in both areas. In ADP area, out of 40 children who were sick, 37 accessed medical treatment of which 36 (90% of the total children) accessed medical treatment from the health centre while only 1 (3% of the total children) accessed medical treatment from the tradition practioners.

In the non-ADP area, out of 40 children who were sick, only 10 (25%) accessed medial treatment from the health centre while 9(23% of the total children) accessed from the tradition practioners.

From the data, it is clear that in the ADP area, most children (90%) accessed medical treatment from health centres as compared to 25% in the non-ADP area. The research further showed that 21 (52%) of the children who were sick did not

access medial treatment in the non-ADP area while only 3 (07%) did not in the ADP area.

Psycho-social support

This section gives the number of households which received psycho-social support and not individual children. This is so because psycho-social support was supposed to have been given to the whole household. The findings are shown in table 6 below.

Table 6: Number of households which received psychosocial support.

		NON- ADP AREA		NON- ADP AREA	
		No	**%**	**No**	**%**
Households which received	Community care givers	11	27.5	1	03
	Religious leaders	8	20	17	42
	Both groups	11	27.5	0	00
Households which did not receive		10	25	22	55
TOTAL		40		40	

The two groups which were involved in providing psycho-social support (counseling) were the community caregivers, which comprised the Home Based

Care (HBC) of the Arch-diocese of Lusaka Roman Catholic volunteers and the Orphan and Vulnerable Children (OVC) were groups from World Vision. The other groups were the religious leaders who mostly provided spiritual help.

The research revealed that out of 40 households in the ADP area, 30 of them received psycho-social counseling from the two groups mentioned above. It showed that 11 (27%) of the households received psycho-social counseling from both the community care givers and religious leaders, 8 (20%) were provided only by religious leaders while 11 (27.5%) were provided by community care givers only.

In the non-ADP area, no household was provided psycho-social counseling from both groups, only 1 (03%) household received psycho-social counseling from the community care givers and 17 (42%) of 40 households received psycho-social counseling from the religious leaders. The type of counseling that was given did not include psycho-social support care as much because most of them were not yet trained in both areas though a few were trained in the ADP area and the process was still going on.

External support and life skills training

This section looked at the type of external support which households of vulnerable HIV/AIDS-affected children received and the groups providing such support. Research revealed that World Vision Zambia was the main external

supporter in the ADP area. They provided assistance in terms of food, clothes, water and sanitation (putting up of boreholes, building of toilets and houses for OVC), uniforms, school fees, shoes and medical care. The other support was from the churches like Roman catholic, Gospel church and Seventh Day Adventists were the OVC belonged to. This was mostly the case in the non-ADP area. The type of support offered by the church was in form of clothes, uniforms, shoes, paying of school fees and school books. The responses are tabulated in table 7 below.

Table 7: Households which received external support and, life skills training

	ADP AREA		**NON- ADP AREA**	
	Frequency	**Percentage**	**Frequency**	**Percentage**
School support	10	25	04	10
Medical support	5	13	0	00
Other support	18	45	4	10
Life skills training	2	05	00	00
TOTAL	**35**	**88**	**8**	**20**

The table above shows that 40 households 35 (88%) households in the ADP area received external support. The support was in form of school (25%), medical (13%) others (45%), which included food, clothes and shelter. The households

whose children received life skills training considered in this research as revealed from the focus group discussion were carpentry, blacksmithing, and tailoring/knitting. 5 (12%) of the households revealed that they did not receive any external help not even from the government in form of books and pencils for their children. Research revealed that in 2005, the government did not provide educational materials to the area under study.

From the non-ADP area, out of 40 households only 8 (20%) households received external support coming from the churches where the households belonged to. The support was in form of school (10%) and others (10%).

Comparing the two areas, more external support was provided in the ADP area (88%) and less help in the non-ADP area (20%). There was no medical support provided in the non-ADP area and only 13% was provided in the ADP area. Considering life skills training, non was provided in the non-ADP area while only 2 children in different households were provided in ADP area which only represented 5% of the households.

CHAPTER FIVE

DISCUSSION OF THE FINDINGS

Introduction

This chapter discusses the findings of this study and highlights the main factors that affected the vulnerable HIV/AIDS-affected children's access to education. These factors are discussed in relation to the responses in questionnaires, interviews and focus group discussions. The discussion also incorporates the interview responses for purposes of triangulation.

The two areas under study were adjacent to each other in such a way that people had to walk equal distance to the health center and lived on similar landscape and soil fertility.

Reasons for more widow headed households

According to the survey, 35% of the households were widow headed compared to only 02% widower headed. It therefore showed that there were more deaths of fathers than mothers. Since fathers were the sole breadwinners, this left most children vulnerable and lacking basic material needs.

The findings of this study were similar to the findings by the research done by World Vision Zambia in 2004 in Sinazongwe District where 63% of the orphans were paternal and only 12% maternal. This gives a ratio of 6:1 paternal orphans to maternal orphans.

There had been a lot of questions as to why such a trend existed. In case of urban areas, women had been alleged to be murdering their spouses so as to inherit the wealth together with the children. This had never been proved for it was simply an allegation. The researcher found out that two men in the area under study had more than one wife. This meant that if such a man died, more than one woman was widowed. For example if a man had four wives, it meant leaving behind four widow headed households instead of one. The second reason was that most men involved themselves in extra marital affairs (having more than one sexual partner). In the case where the man was infected with any STIs, HIV/AIDS inclusive, and there was less or no use of condoms, there was re-infection resulting to loss of immunity and the man died early.

Children drop out from school

It is vital for children's future that they attend school. Education is important for their psychosocial development. School can provide children with a safe, structured environment, the emotional support, and the opportunity to learn how to interact with other children. It also reduces children's risk to HIV/AIDS infection by increasing their knowledge, awareness, skills and opportunities.

However, children affected by HIVAIDS are less likely to attend school due to various reasons. From research, it was found out that 90% of the HIV/AIDS-affected children in the ADP area were attending school compared to 87% in the

However, children affected by HIVAIDS are less likely to attend school due to various reasons. From research, it was found out that 90% of the HIV/AIDS-affected children in the ADP area were attending school compared to 87% in the non-ADP area. The results showed that more children in the ADP area were attending school. Focus Group Discussions and interviews revealed that in the ADP area, there were a lot of sensitization on the importance of education. This resulted in many guardians taking their children to school. It was also due to a lot of external support in form of clothes, uniforms, shoes and food supplements given to HIV/AIDS-affected households by World Vision. This also increased the number of children who had stopped to restart or continue school. The things which these households received if not provided were mentioned by the primary care givers and OVC as what contributed to drop out.

Research revealed that this was due to the declaration by the government of free primary education. Children who had stopped were later taken back to school. This was the reason that 30% of the children attending school in non-ADP were in community schools while only 19% in ADP. During the interviews with education officers in the ADP, it was revealed that many children at lower level (grades 1-3) opted to attend community schools where food was given. As they reached upper level (grade 4-7), parents transfered such children to government schools. The reason was that in community schools the quality of education was low due to untrained teachers employed in such schools. This was evident in the

age group of those in community schools in the ADP which was between 7 and 10. In non-ADP, those above age were many in community school because most of them started when they were above age after the declaration of free education.

It was also revealed that some girls who were already in marriage were also attending school both in community schools and government schools. This was due to the recent programme of GO GIRLS SECURE YOUR FUTURE which encouraged many young married girls to go back to school. It was revealed that even the husbands of such girls were for the idea though research did not go into details to have statistical data.

Concerning absenteeism and later drop out, it was revealed that children living with family members who were ill, with grandparents or in child-headed households often never used to go to school consistently because they had too many households duties. Girls were likely to be withdrawn from school to care for sick parents/guardians and younger siblings, and to help with domestic chores and household responsibilities. Those who managed to go to school never had time to do their homework because of chores which they needed to do at home. This was similar to the case in Malawi where there was free primary education. Their

priorities shifted from education to survival, forcing most of them to seek employment (International HIV/AIDS Alliance, 2003).

In addition, it showed that most children drop out of school when they reached Grade 8. This was because at this level they were required to pay fees and buy uniforms. From those in ADP, this was not the case because they were paid for and uniforms and shoes were bought for them by World Vision (Partner).

In general it was found out that both OVC and non-OVC tend to stop going to school at between 14 and 16 years. Girls do so due to early involvement in sexual relations resulting in early unwanted pregnancies. Girls who became pregnant used to feel shy to go back to school though the policy encouraged them to continue learning. In the case of boys, they involved themselves in other acts like beer drinking and later stopped schooling. The researcher discovered that in all communities visited, there were many taverns at an average spacing of 100m from each other.

It was also revealed that most of the people were aware of free primary schooling for children especially in 2005. The distribution of these resources was not priotised to vulnerable children but given equally to all children. Research also discovered that enrolment was according to age only and not the vulnerability of the child as stated in the National Education Policy. It was revealed that most children at primary level wore uniforms and those without uniforms felt out of

place and dropped out of school without being chased. This was common to vulnerable children. In Zimbabwe, the research done by IHAA in 2003 also revealed that children naturally found it offensive to be told to wear uniforms by teachers.

The difference between girls and boys out of school was not much. Results showed that in the ADP area, 13% of girls and 09% boys were out of school while in non-ADP area, 08% of girls and 19% boys were out of school.

Psycho social care

Many programmes for orphans and vulnerable children focus on material support and meeting their physical needs. It is a natural fact that the loss of a parent is a traumatic and stressful experience. Early intervention is vital. When their parents/guardians become ill or die, children feel immense emotional distress and grief. They can show their pain by crying. These difficulties may prevent such children from attending school or performing well.

The research showed that in the ADP area, 75% of the children received counseling from either community care givers and/or religious leaders while in the non-ADP area, only 45% of the children received counseling. It was revealed that the type of counseling available did not include psycho-social support because most of them were on spiritual needs. It is therefore important that training of community leaders, Home Based Care and teachers be provided. If

such were trained, children would be helped so much because children would never feel accepted wherever they are i.e. at school or at home. It was revealed that most OVC attended religious meetings regularly.

Nutrition

Normal meals in this research refered to two meals a day comprising Nshima with Kapenta or vegetables or beans at both lunch and supper. Very few households used to have breakfast with either porridge or food which had been left over the previous day. This was what came up in the focus group discussion. This was because HIV/AIDS – affected households had agricultural production reduced or stopped altogether. This was because when parents died, the children were left under the care of widows or grandparents. The grandparents were too old to earn a living and the widow if infected used to experience a lot of opportunistic diseases.

Table 4a shows the number of children who had normal meals a week before the research. It was shown that in the ADP area, 76% had normal meals while the figure is 23% in the non-ADP area. The ADP used to receive nutrition support from World Vision. The problems of not having normal meals corresponded with the deaths of widower headed (02%) households. It was also revealed that households where there were orphans tended to be larger than non-OVC households which led to problems of food supply.

Considering the children who had meals before going to school, it was shown that out of 251 children, only 104 (41%) took meals. This also affected their school attendance negatively.

It was discovered that most of those who had meals before going to school were those who attended school in the afternoon. This had an effect on dropout because children who were hungry or malnourished were less likely to attend school. If they went to school, they found it more difficult to concentrate and learn.

Concerning street children, it was revealed that in households where there was no food, the children mostly used to move away in the morning to visit friends in households where there was food. They could be there until they had had their meals with such households. Children normally used to move from household to household and were encouraged by their guardians. In addition, the children whose households were near the colleges or boarding schools, used to go to such institutions during lunch and supper to pick up left overs. So instead of going to school, they preferred to go to such places. Their guardians had even accepted the situation and appreciated them because they helped in lessening the burden at home in terms of access to food. If such children were in urban areas, they were to be referred to as street children. Some slept hungry (no supper). It was revealed that due to drought in the 2004 to 2005 rainy season, the situation had worsened.

Training in life-long skills

Orphans, vulnerable children and affected households often could not improve their economic situation because they had lost their inheritance and lack of access to education, training, and income generating opportunities. Children who did not receive primary and basic education were not likely to receive vocational training or further education. Many parents died before passing on to their children the skills and knowledge that would allow them to continue with their farming or economic activities. This affected their households income, food security and nutrition.

The research showed that in the ADP area there was a lot of external support given (88%) and only 05% of this in form of training in life-long skills. This meant that the vulnerable HIV/AIDS-affected households would ever be dependent on the donations from World Vision. If this NGO phased out, the problems would continue. However the primary care givers and the OVC desired that skills such as carpentry, blacksmithing, tailoring and knitting be offered. This could help them to be self-dependent. It was recommended that such training skills be offered in each community especially during weekends and also during holidays so as not to disturb those in school.

Summary

Deliberation of the discussion found out that partnerships in educational provision to vulnerable and HIV/AIDS-affected children had an impact. In order to test that the two results from ADP and non-ADP were sufficiently different, the t- test

could be used. If the t-value calculated approaches zero, then the independent variable (partners in this case in ADP) had no affect or impact on children's access to education. The t-value obtained will be compared to the critical t-value, from t-distribution to test for significance or impact of partners in the provision of education to vulnerable children. In this case percentages will be used and not number of children because in the ADP area 153 children were covered while 131 in the non-ADP area were covered. The four factors have been selected in this survey as the ones which contributed to children's access to school. These are nutrition, access to health care, external support and psycho-social care. The table below shows how the t-value could be found.

Table 8: Relationship in percentage of ADP and non-ADP of factors contributing to access of children to school

Factor	**ADP**	**NON-ADP**	**DIFFERENCE** **d**	**d^2**
Nutrition	76	23	53	2809
Health care	90	25	65	4225
External support	88	20	68	4624
Psycho-social care	75	45	30	900
mean (x)	82.25	28.25	$\sum d = 216$	$\sum d^2 = 12558$

N = number of factors = 4

$(\sum d)^2 = 216 \text{ X } 216 = 46656$

$N\sum d^2 = 4 \text{ X } 12558 = 50232$

Using the formula $t = \dfrac{\sum d}{\sqrt{\dfrac{N\sum d^2 - [\sum d]^2}{N-1}}}$

$$t = \frac{216}{\sqrt{\dfrac{3576}{3}}}$$

$$= \frac{216}{\sqrt{1192}}$$

$$= 6.257$$

$$t = \underline{6.257}$$

The degree of freedom (df) is calculated as N-1,

Therefore df = 4-1

= 3

From the critical t- value table at df = 3 (here two-tailed since the difference is non-directional) at 00.5 our observed t-value of 6.257 exceed the value of the table (3.182). The difference is therefore highly significant which shows that partners contributions were worthwhile.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

The purpose of the study was to assess the impact of partnership in providing education to vulnerable HIV/AIDS-affected children in Chongwe District. The investigation was carried out in the area where World Vision (Partner) was operating from, known as Area Development Program and the adjacent community where World Vision did not operate from, known as non-ADP. Qualitative and quantitative research methods were used and questionnaires, focus group discussions and interviews were used as data collection tools. The collected data were analysed and the results were expressed in frequencies and percentages and then triangulated with interview responses in the discussion. This resulted in the following major findings of the study:

i. The pronouncement of free primary education by the government had increased the access of school age children in schools especially the vulnerable HIV/AIDS – affected children.

ii. The government had not fully been funding the basic school in form of grants.

iii. The vulnerable children were not a priority in the distribution of education materials from the government and during enrolment in grade one.

iv. The school managers did not have access to the National Education Policy document so as to guide and implement the policies affecting the vulnerable children in schools.

v. The Parents and Teachers Association charged the pupils some money towards school projects and renovations. Most of the guardians refused to pay (70%) and only a few (30%) agreed to pay.

vi. Children dropped out of school not only as a result of failure to pay fees or buy uniforms (for those above grade 7) but also due to bad morals like beer drinking and sexual immorality.

vii. Children absented themselves from school in search of food or taking care of the younger children (in case of girls).

viii. Most of the communities were not trained in offering psycho-social care to OVC.

ix. Some OVC were not taken to health centres due to failure by the guardians to raise consultation fee and money for medication while others was due to negligence.

x. Some households moved from non-ADP area to ADP area so as to be part of those receiving help. This had resulted to over population in the ADP communities.

xi. There was nothing much that had been done in providing life-long skills to children in the ADP area while completely nothing had been done in the non-ADP area.

Recommendations

The findings of the study prompted the proposal of the following recommendations:

i. The government should improve the funding to basic schools and grants should be released on time.

ii. The distribution of educational materials and enrolment of grade one by school authorities should be given priority to vulnerable children as stipulated in the National Education Policy document.

iii. The P.T.A. should charge the guardians to contribute and not per child because those large households with a lot of children who were OVC may not pay for each child.

iv. There was need for the community and school authorities to teach school going children the importance of education and behavioural change.

v. The community and the partners should find a way of paying for OVC at health centres so as to increase their access to medical care.

vi. The partners should increase the number of households receiving livestock and seed packs especially those which were headed by grandparents the chronically ill and children.

vii. There was need for partners to build capacities of communities/community care coalition to care for OVC and their households.

viii. There was need for partners to train traditional leaders, teachers and religious leaders in psychosocial care for OVC.

ix. There was need to introduce life-long skills training in both ADP area and schools so as to equip the youths to help sustain themselves. The government should first introduce this so that other partners could easily contribute.

x. Educational support by partners to vulnerable children should be extended up to tertiary level of education by the partners.

xi. ADP areas should be expanded by partners so as to cater for large areas.

xii. New NGOS should concentrate on rural areas where other already existing *NGOs were not operating*

xiii. There should be a shift by partners from providing only foodstuffs and clothes to things which should sustain the community even after they were phased out. Such should include; livestock restocking, putting up of boreholes, building of houses and toilets, providing of agricultural inputs, hammer mills and training the youths in life-long skills like carpentry, blacksmithing, tailoring and knitting. There was need to develop agricultural technology which should be less laborious for the aged to manage.

xiv. The government should formulate and implement the OVC policy, which must address their issues holistically. If such becomes part of the child policy, OVC should be a separate section clearly stating commitment to it.

xv. The National Education Policy document should be made available to all school managers for guidance and also there should be consistent implementation of the policy.

The above recommendations can be summarized in the following framework.

Conceptual theoretical framework: Factors that increase education access to vulnerable children.

1.0 *Enabling conditions (by the government) through policy formulation.*

1.1 OVC enrolment a priority.

1.2 Free medical services to OVC.

1.3 Supply of curriculum materials to all schools.

1.4 Prioritise distribution of educational materials to OVC

2.0 *Provision of other variables (from partners)*

2.1 Adequate food supply.

2.2 Easy access to health care.

2.3 Provision of social security.

2.4 Enough clothes.

2.5 Easy access to clean water.

2.6 Provision of psycho-social support.

3.0 *Outcomes*

3.1 Increase in access to education and attainment of skills and knowledge.

3.2 Reduction in poverty level and overdependence.

3.3 High levels of democracy and human development.

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APPENDIX A : HOUSEHOLDS QUESTIONNAIRE

THE UNIVERSITY OF ZAMBIA

SCHOOL OF EDUCATION

DEPARTMENT OF EDUCATIONAL ADMINISTRATION AND POLICY STUDIES

Questionnaire on Access to Education by Vulnerable Children

Dear respondent

I am a postgraduate student at UNZA. You have been selected to participate in providing information to this research which is part of my studies. This information is purely for academic purposes. You are requested to respond to the questions as truthfully as possible.

1. Name of village .....
2. Name of respondent .....
3. Status of respondent in the household .....
4. Type of household head .....

Widower ..... Widow ..... Child ..... other adult ..... Elderly ..... Chronically ill .....

5. Total number of children in the household .....

For each child in the household please answer the following:

CHILD'S NAME	GENDER F/M	AGE YEARS	IS THE CHILD CURRENTLY GOING TO SCHOOL? IF YES, TICK THE TYPE			GRADE COMPLETED	
			Govt	*Community*	*IRI*	*IN*	*OUT*
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12							

6. Do you pay for your children who are in grade 1 – 7? Yes/No
7. If no, why? .....
8. Which children didn't go to school at least a day in last 2 weeks? Give names .....
9. Has any adult member of the household been bed – ridden for more than 3 weeks in the last 3 months? Yes/No
10. If yes, who? .....
11. Which children have been sick in the last 2 months? (Given their names) .....
12. Which of these went for medical treatment and where? (Give their names).

CHILD'S NAME	WENT FOR MEDICAL TREATMENT		WHERE		
			HEALTH CENTRE	NGO	TRADITION MEDICINE
1. 2. 3. 4. 5.					

13. Has the household received medical support? Yes/No
14. Which children (give names) have received normal meals in the last week? (Primary care givers in focus group will define content and frequency of meals)

    .....

    .....
15. Do your school going children eat before going to school? Yes/No
16. If yes, what do they eat? .....
17. Does the household belong to any religion? Yes/No
18. Which children (give names) attend the religion services regularly? .....

    .....

    .....
19. Do the religious leaders come to provide spiritual counselling to OVCs? Yes/No
20. Apart from the religious leaders, has this household been visited by community caregivers to provide counselling to OVCs? Yes/No
21. If yes, how often?

    a) Never ..... b) Weekly ..... c) Monthly .....

    d) Longer than a month .....
22. Has the household received any other support? Yes/No
23. If yes, please state. .....
24. Which children are receiving/have received the following skills and knowledge?

CHILD (NAME)			
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			

APPENDIX B : FOCUS GROUP DISCUSSIONS

Focus group discussion guide for community leader (Head. Men/women, church leaders, health workers and teachers)

What is the major cause of death in the community?

Education

Are all school aged children attending school?

What prevents children from attending school? Prompt about OVC.

Are girls more likely than boys to be out of school? If so why? Prompt about early marriages and tending of animals.

Which children show high absenteeism from school? Prompt about OVC.

Is there any other form of education provided to children apart from going to school? Prompt about life-long skills

Health

What support are you as community leaders providing to OVC households?

What support are OVCs receiving?

Who is providing this support?

Does a community group coordinating OVC care exists?

What resources is the coordinating group able to access? How are these resources accessed? Any problems or hindrances?

What are the main differences in OVC care and support between the ADP and outside the ADP.

Do you experience children moving up and down without being cared for? Prompt the issues of street children. Those who do not spend much of the time at the homes.

FOCUS GROUP DISCUSSION GUIDE FOR PRIMARY CARERS (GUARDIANS) GROUP

Education

Are all school aged children attending school?

What prevents children from attending school?

Are girls more likely than boys to be out of school? If so why? Prompt about early marriages and tending of animals.

What help is available to keep children in school?

Apart from going to school, what other type of education do they receive?

Health

When a child is ill does she/he go for medical treatment?

Is there any difference between OVC and non–OVC in accessing health services? (Non-OVC are the less vulnerable).

What prevents some children from accessing health services.

Nutrition

What does a normal meal for a child consist of in this community and how many meals in a day? This is then incorporated into the household survey questionnaire.

What impact has HIV/AIDS had on the amount of food that households have?

How do OVC households cope in providing food for all the children?

Psycho-social support

What types of psycho-social support do the children in your care receive? Probe counselling, recreational activities, spiritual, succession planning.

Skills and knowledge

What are the 3 major skills needed? (Excluding literacy and numeracy). If group gives more than 3 then the group ranks the most important 3. These are then incorporated into the household survey questionnaire.

External support

What external support do you receive?

How often?

Who provides this external support

FOCUS GROUP DISCUSSION GUIDE FOR SECONDARY CARERS (HOME VISITORS) GROUP

Education

Are all school aged children attending school?

What prevents children from attending school? Prompt about OVC.

Are girls more likely than boys to be out of school? If so why? Prompt about OVC.

What help is available to keep children in school?

Health

When a child is ill does she/he go for medical treatment?

Is there any difference between OVC and non–OVC in accessing health services?

What prevents some children from accessing health services.

Nutrition

What impact has HIV/AIDS had on the amount of food that households have?

How do OVC households cope in providing food for all the children?

Psychosocial support

What types of psycho-social support do you give to OVC? (Probe counselling, life skills, recreational activities, spiritual, succession planning).

What training have you been given in the provision of psycho-social support?

External support

What external support do you receive? How often?

Who provides this external support?

FOCUS GROUP DISCUSSION GUIDE FOR OVC GROUPS

OVC definition

What makes some children more needy and requiring special care and support?

Education

Do all school age children in this community attend school?

What prevents a girl/boy from attending school? Discuss on boys if in boys groups or girls if in girls group.

Which type of children is more likely to be out of school?

What help have you receive to stay in school?

Which skills do you desire to be equipped with?

Health

Where do you go for treatment when you are sick?

Is there any difference between OVC and non-OVC in accessing health care?

What prevents some children from accessing health care?

Nutrition

How many meals do you eat on a normal day?

What do you eat on a normal day?

Is this different from before you became an orphan?

Do you go to sleep feeling hungry? How often?

Psycho-social support

What recreational activities are you engaged in?

Have you received any life skills training?

Does anyone apart from relatives visit you? If so who and how often?

What do the visits consist of?

Do you belong to any group or club?

APPENDIX C: SHEETS FOR DATA ENTRY FROM QUESTIONNAIRES.

Number and percentage of Households receiving external support.

	ADP AREA		NON-ADP AREA	
	NO	**%**	**NO**	**%**
School support				
Medical support				
Other support				
Life skills training				
TOTAL				

Care needs to be taken to avoid double/triple counting of households receiving external support. When analyzing the data ensure that tabulation is done in terms of;

School support only

Medical only

Others only

School and medical

School and other

Medical and other

All 3

The total of the above gives you the total of households receiving external support apart from life skills training.

Number and percentage of Households receiving psycho-social support.

		ADP AREA		NON-ADP AREA	
		NO	%	NO	%
	Community care givers				
Households which Received	Religious leaders				
	Both groups				
Households which did not receive					
TOTAL					

Care needs to be taken to avoid double counting of households receiving psycho-social support. When analyzing the data ensure that tabulation starts with both, then religious leaders only lastly community care givers only.

Children who had normal meals in the past one week.

	ADP AREA		NON-ADP AREA	
	Frequency	Percentage	Frequency	Percentage
Children with normal meals				
Children without normal meals				
TOTAL				

Children who where sick in the last three months and accessed medical treatment.

		ADP AREA		NON-ADP AREA	
		Frequency	Percentage	Frequency	Percentage
Children who accessed	Government clinic				
	Tradition				
Children who did not access					
TOTAL					

Types of households

	CHILD		WIDOW		WIDOWER		OTHER ADULT		ELDERLY		CHRONICAL ILL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
ADP area												
Non-ADP area												
TOTAL												