SOCI-ECONOMIC FACTORS AFFECTING ORPHANS: A CASE STUDY OF HIV/AIDS ORPHANS IN KIBERA SLUMS, NAIROBI

BY

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DECLARATION

This thesis is my original work and has not been presented for a degree in other university or any other award.

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DEDICATION

To my wife Cecilia A. Onyango and children, Noel A. Onyango and Enoch A. Onyango all who tolerated my long absence during the course of the study. To my mother Rose Aluoch for her consistent prayers and encouragement.
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GLOSSARY OF ABBREVIATIONS

AIDS ........................................ Acquired Immune Deficiency Syndrome.
CBO ........................................ Community Based Organizations.
CHWs ....................................... Community Health Workers.
FGD .......................................... Focus Group Discussions.
GDP ........................................ Gross Domestic Product.
GOK .......................................... Government of Kenya.
HIV .......................................... Human Immunodeficiency Virus.
NASCOP .................................. National AIDS/STD Control Program.
NGO .......................................... Non Governmental Organization.
SAPs ........................................ Structural Adjustment Program.
SPSS ........................................ Statistical Package for Social Sciences.
UN .............................................. United Nations.
UNAIDS ..................................... United Nations Program on HIV/AIDS.
USAID ......................................... United States Agency for International Development.
WHO .......................................... World Health Organization.
DEFINITION OF KEY TERMS

For the purpose of this study, key terms have been defined as follows;

Support Systems. These refer to various structures within the community which facilitate the activities relating to assistance of orphans within the community.

Social Networks. Refers to any form of relationship or alliances that develop out of social interests and which can be used to assist HIV/AIDS orphaned children.

Cultural Institutions. Refers to the traditional mechanisms that are available for the care and provision of HIV/AIDS orphans.

HIV/AIDS Orphans. Refers to children under the age of 16 years who either one or both parents are deceased as a result of HIV/AIDS.

Double Orphans. Refers to children who both parents (mother and father) are deceased.

Paternal Orphans. Refers to children who have lost their father as a result of HIV/AIDS.

Maternal Orphans. Refers to children who have lost their mother as a result of HIV/AIDS.

Coping Mechanisms. Refers to the ways and means through which orphans in the study contribute to earning their livelihood. These include schooling, food, clothing, health care, shelter and the status of orphans in the adopting household.

Chang’aa. Refers to an illicit locally brewed liquor which is common among most Kenyan communities.

Orphanhood. Refers to the state of being bereaved of one or both parents and the situation created by such bereavement (Hunter, 1990).
This descriptive cross-sectional study aimed at examining the socio-economic conditions under which HIV/AIDS orphaned children live in Kibera slums of Nairobi, investigate and describe peoples attitudes towards orphanhood, as well as the various forms of support systems and coping mechanisms for dealing with orphanhood in the study area. Purposive sampling was used to select the institution while the study subjects were identified using snowballing method. Data was collected using both interview guides and structured questionnaires, focus group discussions and observations. The data were entered, cleaned and analyzed using SPSS statistical package. Chi-square tests were done to establish association between various variables. The finding suggested that 57% of orphaned children were HIV/AIDS associated, of which 60.5% were paternal and 37.7% were maternal. The majority of the orphans 98% were going to school, while 2% had either stopped or never went to school. Among the age category 6-10 years, more females 53.3% than males 48.6% had stopped at one stage. Of the double orphans, 53.5% had difficulty in access to education ($\chi^2 = 0.539$, df= 1, p< 0.05). Gender had an influence in access to education, more females 67.4% double orphans than males 32.6% experienced difficulties ($\chi^2=0.507$, df=1, p<0.05) while among the single orphans gender is not a significant factor although majority of the disadvantaged are females 78.2%. Among the paternal orphans, more females 94.4% than males find it difficult while among the maternal orphans more females 70.3% than males 29.7% find it difficult, the disadvantaged are girls ($\chi^2=3.950$, df=1, p<0.0468). About 66% of the orphans find it difficult to access health services, 72% were females and males 54.4%. The attitude of the people towards children has changed significantly, 60% of the orphans indicated that they were treated differently among these, 70.8% females than males 29.2% reported being treated differently. About 80% of the respondents had no knowledge of Social Institutions within the study area 10% mentioned 3-4 community-based organizations though they were not sensitive to the needs of orphaned children. Cultural institutions on the other hand, were trying everything possible within their means to support orphaned children as registered by 56.8% single orphans being supported by surviving parent and 29.7% supported by uncle or aunt. The main coping mechanism for orphaned children was involvement in income-generating activities as registered by 72%, In other cases 25.5% females double orphans had partners who supported them at times ($\chi^2=1.891$, df=1, p<0.05). On the basis of the findings, it was concluded that modern living conditions in which people are forced to depend on resources outside the community, coupled with the escalating levels of poverty, were responsible for the changes in the people’s attitudes and support for orphaned children. This has affected the orphaned children negatively, most particularly their access to education, food, clothing and health care. It is, therefore, recommended that policies designed to improve orphaned children access education should strive to improve their household living conditions. Non-governmental organizations such as churches, as well as the department of Social Services, should sensitize people about the declining support for HIV/AIDS orphaned children, as well as empowering orphaned children themselves.
CHAPTER ONE

INTRODUCTION

1.0 Background Information

The state of orphanhood is not new in African societies, indeed African culture in general possessed structures which took care of orphaned children by fully integrating them into community life. This was made possible due to the fact that children in the traditional settings were regarded as belonging to the community and not only to their parents. Consequently, they looked upon the entire community for support and protection (Kayongo and Onyango, 1984). The support systems offered various forms of assistance such as cultural, economic and social in nature (Hunter and Williamson, 1998).

Suda (1997) notes that the kin based support system served to ensure that the death of one or both parent did not necessarily spell destitute for orphans or other family members. These support systems had potential to reduce the number of destitute children in the family or community. Such children were not left to cope on their own or turn to the streets to beg or taken to institutions. However, socio-economic changes have made the situation of orphanhood more problematic than it was in the past, making it an issue of concern to national governments as well as the international community. The problems associated with modern economic conditions and the diminishing functions of the extended family system in caring and protecting orphaned children, leave such cases with little or no safety nets (Berger, 1977; Kayongo and Onyango, 1984; Kilbride and Kilbride, 1993; ROK, 1994).
The problem of orphanhood is exacerbated by the increased incidence of high adult mortality rates due to AIDS as a major killer of the productive members of households. It is expected to leave the world with a large numbers of orphans (UN 1990; UNICEF 1994; ROK 1997). These orphaned children will be found not only in the poor urban areas of Sub-Saharan Africa but also in the rural areas. In Kenya, the number of orphaned children has been estimated at 890,000 and the prevalence rates have been rising rapidly (UNAIDS, 2000). Further more with the definition of HIV/AIDS orphaned children as a child under 16 who has lost the mother to AIDS, the number of AIDS orphans has probably reached over 900,000 today in Kenya and will increase to 1.5 million by 2005 (ROK, 2001). These devastating sequence of events should, therefore be seen as a challenge to the health and social sectors within the community that face the task of basic care provision of social services (World Bank, 2000).

1.1 The AIDS Situation in the Slums.

The slum dwellers, like many other people around the world, are becoming affected by the AIDS epidemic at an alarming rate. According to NASCOP (1999), one of the worst impacts of AIDS death of young adults is the increase in number of orphans who may lack proper care and supervision they need at this critical period of their lives, indicating a tremendous strain on social systems to cope with such a large number of orphans.
1.2 Rationale of Study

1.2.1 Statement of the problem

Although orphanhood is not a new phenomenon, this situation has raised concern across many nations. The reason being the projected number of orphaned children expected to be left without appropriate care. Furthermore, the few responsible members of the community who could assist fear taking additional responsibility because of the large number of orphaned who could be in urgent need of assistance. With orphans projected to comprise up to a third of the population under the age of 15 years, the outgrowth of HIV/AIDS pandemic will create a lost generation, under-educated and less healthy youth the traditional caring mechanism will not be able to cope with the ever-increasing demands of long term care (Manguyu, 1991; Barnett and Blaikie, 1992; UN, 1994, Forsythe and Rau, 1996; Johnston et al., 1999). Worse still, a proportion of these orphans are HIV positive, with a short life span and are therefore not “attractive” for assistance. The ability of those remaining behind and the community to care for this large number of orphans is highly doubtful. This is because most of those affected are young and productive people who are also parent of very young children, leaving a large number of orphans to be cared for by other members of the family who in most cases are incapable both economically and socially (Poonawala and Cantor, 1991).

There is also concern that if these orphaned children are not cared for, they may end up in the streets where they will be exposed to conditions that may make them vulnerable to HIV infection, among other risks. Therefore, the problem associated with orphaned children require urgent remedial measures.
1.2.2 Research Questions

• What are the socio-economic factors that are a constraint to better care for orphans?
• Are orphaned children able to access education and medical services without difficulties?
• Are there specific support systems available to these children?
• How do they cope with their situation?

1.2.3 Justification

Apart from road accidents and other diseases which account for the majority of adult deaths, the problem of AIDS is set to leave various communities with large number of orphans. Bearing in mind that children are the most valuable resources of any nation, research is therefore needed to define the needs of the children and, most importantly, the need of orphans in order to give them a meaningful future. This would enable the affected nations to replace the skillful and productive young adults who are lost due to AIDS and other causes. The extended families can no longer bear the burden of caring for the large number of orphans. There are quite a number of Non-Governmental Organizations (NGOs) and Community Based Organizations (CBOs) engaged in providing assistance to orphans. However, due to lack of appropriate information and guidance in the provision of community-based interventions coupled with the problem of poor funding from donors, such assistance have been rendered ineffective. Orphans in this area are most likely to face the double tragedy of being orphaned and residing in a poor community. Therefore, while the extended family members could be willing to assist, their ability to cope may be further
hampered by the harsh environment. In addition, the problem of uncared-for orphans could lead to a sharp increase in children being infected with HIV and this could put on added strain on healthcare services. This situation could lead to a sharp reversal of progress in survival efforts and serious health implications for maternal and child health service.

1.3 Null Hypotheses

1. Orphaned children do not face difficulties in access to education and medical services.
2. There are no adequate and efficient social networks and cultural institutions for supporting orphans.
3. Orphaned children do not face severe socio-economic problems in coping with their situation

1.4 Study Objectives

1.4.1 General Objectives

To investigate and describe the socio-economic factors affecting orphans in the study area.

1.4.2 Specific Objectives

1. To determine the level of access to and availability of education and health services to orphaned children,
2. To assess the social networks and cultural institutions for supporting orphans in the study area.
3. To identify the existing coping mechanisms adopted by orphaned children.
4. To describe the situation of orphanhood in the study area.

1.5 Significance of the Study

This study will be useful in providing information to the donor community and more importantly, policy makers and the communities themselves to enable them formulate a broad strategy within which resources could be channeled more effectively.

The government, policy making bodies Non-Governmental Organizations and Donors could also use the study to formulate and design strategies that could alleviate the suffering of orphaned children. Health research institutions could also base on these findings to institute intervention programs that could improve the living conditions of orphans so that they are not left vulnerable to preventable health hazards. Finally, social workers could also use the report to understand the difficulties faced by orphaned children and to be able to effectively monitor their progress.

1.6 Scope and Limitation of the Study

Due to lack of adequate time and financial resources this study could not carry out a full-scale survey of households within the study area to establish the state of prevalence of orphanhood. Because of the nature of the study population (orphans) who fall under the category of difficult to trace information rich cases (Patton, 1987), this study found it equally impossible to adopt a random sampling strategy to get respondents. The study, therefore, adopted purposive sampling method in which the snowballing or chain sampling strategies were used to get respondents.
CHAPTER TWO

LITERATURE REVIEW

1.1 Situation of Orphanhood in the world

The state of orphanhood all over the world is increasing as a result of conflicts, diseases and accidents (Urassa et al., 1997). UNICEF estimates that there will be over 20 million children who would have lost one or both parents by the year 2010. A further 11 million will be found in Sub-Saharan Africa where conflicts, diseases and poverty are taking toll. These children will be the first to lose support of extended families, attending school and to an extent medical care. Orphaned children losing both parents are even less likely to get any form of assistance (UNICEF, 2004).

World Bank (2004) reports that the death of one or both parents will trigger a lot of sociological, economic and psychological effects on the orphaned child, they may become vulnerable to a number of problems ranging from malnutrition due to scarcity of food to the weak position they occupy in the household distribution process. Their education inevitably may suffer as they may be faced with heavy domestic responsibilities or lack of resources for school fees or to buy books and school uniforms. They may suffer the loss of physical and social security as well as parental attention and supervision, their situation may also worsen when they are forced to tire on the streets. Ntozi (1997) similarly reported that the problem of orphans was mostly due to civil strife present in many countries in the region and high adult mortality rates. However in the last decades the number of orphans has increased
dramatically because of AIDS pandemic (World Bank, 2002). HIV/AIDS directly affects the socio-economic backbone of families, the most vulnerable being the adult members that bring in an income to sustain these families. UNAIDS (2002) report states that there are 42 million people infected with HIV/AIDS worldwide, 29.4 million (70%) being in the Sub-Saharan Africa. Among these, 58% are women aged between 15 and 49 years. This implies that large numbers of small children are going to be left behind with no one to provide for them upon the death of their parents. It is also estimated that the majority of such cases will be found in both urban and rural areas of Sub-Saharan Africa (UNICEF, 2002).

Preble (1990) had projected that between 1.5 and 2.9 million additional deaths due to AIDS of women aged 15 to 49 years will increase the number of orphans to between 3.1 and 5.5 million accounting for 6 to 11 percent of all children under 15 years for ten high seroprevalent countries of East and Central Africa. This situation, if not controlled, will be a great challenge to the society as a whole and what will be of concern to governments and other organizations is who is going to face the problem of provision and care for these orphans. This problem should be looked at against the background of the fact that most governments in the developing world have reduced their budgets on the provision of social services (Poonawala and Cantor, 1991). Apart from the immediate impact AIDS has on individuals, those who survive for example children and the elderly people, have to struggle to cope with the loss of loved ones and caretakers. According to UNICEF (1994), AIDS is robbing nations as well as families of their able bodied workers who are also parents of young children. For instance, in Malawi, the income lost already amounts to 7% of the
nations gross domestic produce (GDP). In fact, the United Nations estimates that in high fertility countries in east Africa, for every mother dying of HIV/AIDS, three children are orphaned (UN, 2002). The impact of HIV/AIDS, therefore, threatens to undermine development efforts depleting workforce and striking many sectors of the economy.

2.1.1 The Situation of Orphanhood in Kenya

UNICEF (2002) estimated that there are over 1 million children under the age of 15 years left orphaned by AIDS in Kenya. Forster et al., (1997) emphasize that if the trend is not checked, the number of orphans due to AIDS is projected to increase drastically by the year 2005. According to the National AIDS/STDs control program (NASCOP, 1998), 200,000 Kenyans are expected to die of AIDS and this number is expected to increase to 300,000 a year by 2005 unless a cure is found. Furthermore, half of the beds in hospitals are occupied by people suffering from AIDS-related illnesses. The report also indicates that a further 1.5 million people in the country are infected and living with HIV/AIDS. Most of these people still look healthy and are not aware of their serostatus (NASCOP 1998). In addition, the escalating poverty levels seem to increase the incidences of the epidemic. Currently, Kenya has the third highest number of HIV/AIDS orphans in the world estimated at 890,000, with Nigeria being first with 1 million orphans and Ethiopia second with 990,000 respectively (UNAIDS, 2002). Such estimates show the urgency with which the problem of orphans need to be addressed. The continuing increase in the number of disadvantaged children is set to outstretch the traditional caring mechanisms of accommodating orphans. Forsythe and
Rau (1996) project that the extended family will no longer be adequately prepared to meet the orphans needs for education, health, clothing and nutrition. In some cases, children are living completely outside any family structure, either in orphanages or in the streets (Forsythe and Rau, 1996).

2.1.2 Impacts of AIDS

The impacts of HIV/AIDS is manifested by reduced size and experience of the labour force, increased health care expenditure, raised costs of labour and reduced savings and investments. It is different from other diseases because it strikes people in the most reproductive age groups and is essentially 100 percent fatal. The effects of AIDS will be felt by individuals and their families (ROK, 2001).

2.1.2.1 Support Systems for Orphaned Children

The support and protection of orphans cannot be left to individual households and extended family system alone. This is especially because the extended family systems are declining as a result of modern economic and social changes (Whisson, 1964, Kayongo and Onyango, 1984; Kilbride and Kilbride, 1993). Other scholars have pointed out that this large number of orphans far more outstrip the meager resources the traditional caring institutions could manage to provide (Cattel, 1986; Barnett and Blaikel, 1992; ROK, 1994; Forsythe and Rau, 1996). This means that if public and private efforts are not strengthened, the traditional
support systems, such as the extended health care infrastructures, will be overwhelmed and rendered insufficient to meet demands for long-term care (Poonawala and Cantor, 1991).

The implication of the above argument is that supporting orphaned children will require resources, which may not be available in many developing countries. The AIDS crisis, for instance, is already making enormous demands on the scarce resources, which further worsens the efficiency of the already underdeveloped health care and social services. In addition, debt and low prices of exports from these countries have led to dwindling economic resources (UNICEF, 1990).

This economic problem, coupled with the implementation of the structural adjustment programs (SAPs), has made governments drastically reduced their budget on social services (Poonawala and Cantor, 1991). Furthermore, the AIDS epidemic is crippling those segments of society most relied upon to rejuvenate economies, for example productive adult and their children. Most non-governmental organizations (NGOs), because of their direct link with people at the grassroots, have insight into the type of programs needed and desire by the local community and this connection could be crucial for effective delivery of services. However, lack of information on the implication for involvement, appropriate guidance in providing community-based interventions, and lack of financial resources, have rendered the non-governmental organizations ineffective in addressing the problems facing various communities.

Coupled with under funding and other related problems, most NGOs have implemented projects without sufficient co-ordination or direction. In the past, donor commitment has
been on a small scale and directed to specific projects. However, the spread of HIV/AIDS infection will require a broad strategy under which resources can be more effectively focussed (Poonawala and Cantor, 1991). This focus need to formulate a way through which families and communities affected can be given assistance (UN, 1990). The most urgent problem faced by those concerned with the fate of children orphaned by AIDS is finding and supporting appropriate caretakers for orphans (Poonawala and Cantor, 1991). Forsythe and Rau (1996) further argue that the desire to ensure their survival is weighed against the household economics factors since these have ingrained influence on the ability of the households to adopt in cases of crisis.

2.1.2.3 Economic Impacts of HIV/AIDS on Orphans.

According to study by UNESCO (1995), the most immediate and visible impact of HIV/AIDS on orphans is on education, which is already seen and felt. Most of the children infected at birth have not lived to enroll in schools, some of the children enrolled have dropped out of school in order to earn money for their families and to look after their ill relatives. When someone becomes sick with AIDS, it is usually the women who care for the sick person, young girls may have to stay home from school to help the mother together with other children. the family may exhaust its savings to pay for drugs and funeral expenses and in some cases they may even be forced to sell land. The implication is that the families become poorer, children’s education may suffer and the standard of living of the entire family declines (NASCOP. 1999).
CHAPTER THREE

MATERIALS AND METHODS

3.0 Description of the Study Area

3.1 Study Area

The study was conducted in Kibera, an urban slum area in Nairobi, the capital city of Kenya (Appendix viii and ix). The slum was purposively selected being the largest in Kenya (GOK/MOH, 1996). It is in the southwest of Nairobi province, six kilometers from the city centre. Its boundaries are Golf Course on the North, Langata on the south, Nyayo high-rise Estate on the east and Jamhuri Estate on the west. Administratively Kibera falls under Ward 45 of the city of Nairobi. It is the largest slum, not only in Kenya but also in East and Central Africa. It is also a Government land with temporary occupation licenses.

The slum was originally a military reserve from 1912 to 1928. The British Colonial Government had set it aside for settlement of Sudanese ex-soldiers who had served in the army for at least 12 years. Cartel Land Commission then recommended gradual eviction with compensation. This recommendation was not however effected by 1952 emergency declaration and when many people moved to Nairobi in search of employment, they settled in the area. After independence, the government took a leading role in development of the area and the city boundaries were extended to include Kibera. Subsequently in 1969 the government regarded Kibera area a state land and plans for its development were drawn up (Clark, 1970).
3.1.2 Geographical Characteristics

Nairobi has the highest urban population in Kenya, where more than 50% live in absolute poverty. Its informal settlement of Kibera has a population of approximately 286,739 (Nairobi cross-sectional suurvey, 2000). The slum is divided into 9 villages consisting of Makina, Lindi, Kisumu Ndogo, Silanga, Laini Saba, Soweto, Mashimoni, , Gatwikira and kianda, with population density highest in Laini Saba, Gatwikira, Mashimoni and Kisumu Ndogo.

3.1.3 Housing Condition

The houses are built closely together in rows. They are mainly mud walled and iron-roofed. The rent per room ranges from Kshs. 500, in Laini Saba to 2000 in various parts of Mashimoni.

3.1.4 Water supply and sanitation

The shortage of water in the slum is a common problem and was critical at the time of the study. Nairobi City Council supplies water to the slum. Standing water taps are owned by individuals and 75% by women’s groups. From these sites, water is obtained at a cost of Kshs.5 per 20-litre jerrican. A few households have water tanks and collect rainwater from the roof. Though highly polluted , Nairobi Dam serves as another source of water for many of the slum residents. A few plots possess pit latrines. However the number of these in all the area visited was negligible.
3.1.5 Health Services

There are many privately owned clinics and nursing homes. There are also a few clinics managed by NGO. City Council Clinics and Government health facilities are also available and these serve as referral centres. These include Kenyatta National Hospital, Ngong Dispensary, Langata Health Center, Dagoretti Corner Dispensary and Otiende Health Center. There are also a number of medicine men and traditional birth attendants (TBAs) within the slum.

3.1.6 Educational Institutions.

There are many privately owned nursery and primary schools within the slum. Some of the schools such as Kikoshep and Raila Educational Center cater for the children orphaned as a result of HIV/AIDS. Some of the schools are church based. Olympic Primary School caters for majority of the slum children. There are also a number of City Council and NGO schools at the periphery of the slum.

3.1.7 Economic Activities

Several income-generating activities are carried out along the roadside. There are two open-air markets and many privately owned shops and kiosks. A metropolitan household survey of 677 respondents in Kibera in 1989 showed the following sources of income: employment 37%, vegetable growing 0.3%, and small-scale business 20.4%. Some 42.4% of the
respondents surveyed had no source of income (GOK, 1990). With the economic crisis at the time of the survey, these figures may have dramatically changed.

The choice of Kibera was necessitated by several reasons, which include the following:

- Kibera is one of the largest informal settlements in Nairobi and therefore expected to have high prevalence of HIV/AIDS and also being a check point for most track drivers enroute north and southwards respectively (Nairobi cross-sectional survey, 2000).
- The researcher had prior knowledge of the area and also had interest in highlighting the possible difficulties orphans face through documentation.
- Kibera has one of the highest poverty-stricken areas of urban informal settlement.

3.2 Target Population

The study population was the orphaned children who were residing in Kibera Division of Nairobi District, Kenya

3.2.2 Inclusion Criteria

1. All orphaned children aged 6 years to 16 years specifically those whose parents were suspected to have died of HIV/AIDS and residing within the study area.

2. Any member of the community who was a caretaker of the orphaned children who was willing to participate in the study.

3. Key informants from the community (Religious Leaders, Administrators, Social Workers, Teachers, Women Groups, etc) who were willing to participate in the study.
3.2.3 Exclusion Criteria

- Any person who was neither orphaned aged above 16 years nor a member of the community under study.
- Any orphaned child or a member of the community who was not willing to participate in the study.

3.2.4 Sample Size Determination

This was calculated using the formula:

\[ n = \frac{z^2pqD}{d^2} \]

as used by Fisher et al. (1998).

Where,

- \( n \) = the desired sample size (N > 10,000)
- \( z \) = the standard normal deviate, usually set at 1.96 which corresponds to the 95% confidence level.
- \( p \) = the proportion of target population estimated to have a particular characteristic. In this case estimates for Nairobi was not known therefore 50% or 0.5 was used.
- \( q = 1.0 - p \)
- \( d \) = degree of accuracy desired, set at 0.05 level.
- \( D \) = desired effect = 1 (where there were no replications or comparisons)

Therefore,

\[ n = \frac{(1.96)^2(0.5)(0.5)(1)}{0.05^2} = 384 \]
3.2.5 Ethical Consideration

The clearance to carry out the research was obtained from the Ministry of Education after approval from the Kenyatta University Ethics Committee. Further clearance was obtained from the chief of the area and the manager and Head of Raila Educational Center. Informal consent was obtained from the study subjects before the interview. The code of ethics in conducting the research was adhered to, to ensure that the research does not harm the safety, dignity or privacy of the respondents.

3.3 Study Design

The design of the study was descriptive cross-sectional whose purpose was to provide information on the socio-economic difficulties orphans face and also suggest ways of tackling these difficulties in order to reduce their suffering both within the study area and in the Republic of Kenya. Socio-economic factors were made meaningful by reference to measurable concepts such as source of income, educational level, occupation property owned, love and acceptance. Difficult situation was measured by reference to other measurable concepts such as the ability to acquire learning materials such as books, uniforms, frequency of school attendance and ease to get medical attention when orphans become sick. Frequency of sickness was taken to mean the number of times one becomes sick. Quite frequently, when one becomes sick four times or more in a month, not quite frequently (sometimes) when one becomes sick on average two times a month and rarely
once a month. Discrimination in this study was taken to mean different kinds of treatment as described by the orphans and the key informant.

The first phase of the study involved the use of structured interviews to collect quantitative data, with closed questions for both orphans and caretakers (Appendix ii and iii). The second phase of this research involved conducting key informants interviews with elderly people of the community, members of staff at Raila Educational Center and the Catholic parish within the study area (Appendix vi). The purpose of the interviews with the elderly people was to confirm some information on what were considered to be gray area in the community’s understanding an orphaned child, how the community handled or took care of orphans and the changes that have taken place. Staff of the Educational Center, especially the head of the orphan institution was interviewed to provide information on the possible causes and magnitude of orphanhood within the study area. Church leaders on the other hand, were interviewed to give the position of the church on the problem of orphanhood, that is if there are any efforts the church has initiated or is supporting to address the problem of orphanhood within the study area.

After key informant interviews, in-depth interviews were conducted using interview guides for orphans and their caretakers (Appendix iii and iv). The phase also involved conducting focus group discussions (FGDs) to obtain qualitative data and explore some of the issues that emerged during the in-depth studies and needed some clarification. During this phase, questions pertaining to attitude of the community towards the situation of orphanhood, the social and cultural institutions available in the study area and any efforts they make to
address the situation of orphaned children. What orphans do in coping with their situation, and suggestion on how they could be assisted, were asked (Appendix iv and v).

3.3.1 Sampling Method

Because of the nature of the study, random or stratified sampling could not be used as this would have needed a longer time to obtain the targeted sample size. Therefore, the study adopted the purposive sampling strategy where the snowballing method, and informants from the Educational Center’s records and Ministry of Local Government children’s department were used to get the required number of orphans and their caretakers. In using the snowballing or chain sampling method, a field assistant from within the community and other key informants were used to identify the respondents who, in turn were requested to identify people within the community with the same problem, that is “information rich-cases”, for in-depth study. Snowball sampling is an approach for locating information-rich informants or critical cases. It is useful in finding difficult to trace population such as the orphans (Patton, 1987). In all, 220 respondents were interviewed using questionnaires (Appendix ii and iii).

3.4 Method of Data Collection

Data collection was done by the Principal Researcher and Research Assistants. A total of four Research Assistants were recruited and trained for the study. The training took one week and basically involved understanding and filling of the questionnaires, discussion
guides, interviewing and observation techniques to be used in the selection of the study subjects. Pre-testing of the data collection instruments was done before the actual survey was carried out to ascertain feasibility of the study instruments. Each of the four Research Assistants administered a questionnaire to each orphan as identified by the key informants. Pre-testing was meant to determine whether the questions were acceptable, answerable, analyzable and applicable and to enable the interviewers discern, alter or detect any questions which were being misinterpreted or were too sensitive to be asked without offending the orphans, thus coming up with a good final questionnaire. The pre-testing institutions were, however, not later selected for the actual survey. Data were collected by various methods namely: structured questionnaires, key informants interviews, focus group discussions and observations.

3.4.1 Data Collection Instruments

The study employed both quantitative and qualitative data collection techniques. The instruments administered for collecting data from the field included questionnaires, key informants interviews, focus group discussions, interview guides for both orphans, caretakers and community leaders and observations. The administration of the various research instruments is described below.
3.4.1.1 Questionnaires

These were administered by the Principal Researcher and the Research Assistants to orphaned children aged 16 years and below and caretakers who were willing to participate in the study. Some 220 questionnaires were administered, 200 for orphans and 20 for their caretakers (Appendix ii and iii).

3.4.1.2 Focus Group Discussions

These were conducted by the Principal Researcher and the Research Assistants. A total of three focus group discussions were held, two sets of group discussion guides were used in this study, one for women of different socio-economic backgrounds and community leaders and another for children (Appendix iv, v and vi). The purpose was to collect views of participants in relation to various themes on the topic of support systems for orphaned children. Such themes included the present attitude of people towards orphaned children, and the explanations for such attitude, how the cultural and social institutions operate within the study area to help HIV/AIDS orphaned children and the coping mechanisms orphans adopted to cope with their situation.

3.4.1.3 Key Informant Interviews

These were carried out by the Principal Researcher in the company of Research Assistants who helped in locating the key informants. Key informants were people knowledgeable about the situation of orphanhood and who occupy influential positions within the study
area (Appendix vi). These included elderly people, church leaders, teachers and staff members of the Raila Educational Center. Ten key informants were interviewed this way one person at a time. The elderly gave insight on the past situation of orphanhood, the changes that have taken place, and the contrast between how the orphans were supported in the past and in the present. Staff at the center gave information on the prevalence of orphanhood in the area and the possible causes of the situation. Church leaders, on the other hand, were interviewed to give the position of the church as far as the question of support for orphaned children was concerned. They also gave their contribution on issues concerning how the community handles orphaned children and widows and the effort the church is making to create awareness on the need to support orphans.

3.4.1.4 Observations

These were made by the Principal Researcher with the aim of getting information on the respondents' behavior, actions and a full range of human interactions that explain the situation of orphanhood. This was done through home visits to some of the identified typical orphanhood situations and to observe various issues such as the household division of labor and disciplinary measures taken by caretakers. This method was also used to gather information on how the community integrates orphaned children into social life and how they interact with other people. In addition, the method was used to get information on the physical conditions of the environment in which orphans lived, for instance housing conditions, hygiene standards and their health condition as could be seen from their appearance, as well as confirming information by key informants.
3.5 Data Management and Analysis

Data collection in the field was continually supervised and the quality controlled by the Principal Researcher, the raw data from the questionnaires were coded and entry done using Statistical Package for Social Sciences (SPSS) data entry program.

Subsequently, data was cleaned and analysis done using SPSS version 10.0 statistical computer package and other simple calculations were performed using hand-calculators. After data entry, tables were produced by the computer and information presented in the text in form of frequencies and percentages. Cross tabulation was done to establish the relationship between variables and the Pearson’s Chi-square test used to test for associations. Other information from key informants, in-depth studies, focus group discussions were analyzed using qualitative methods. Level of significance was fixed at 0.05 (p=0.05). The study findings are presented using tables, pie charts, bar diagrams and histograms and other findings in qualitative form were presented as text. Statistical test of association and significance were given where applicable.
CHAPTER FOUR

RESULTS

4.1 Respondents Socio-economic and Demographic Characteristics

A total of two hundred and twenty (220) orphans and their caretakers were interviewed, 200 (90%) were orphans and 20 (10%) were caretakers. The educational attainment of the caretakers is contrary to what was expected, only 10% had completed secondary education compared to 35% with primary education. About 40% of the caretakers had attended formal schooling up to secondary as compared to 15% with no formal schooling (Table 2 and Appendix vii).

Table 2: Education Level Attained by Caretakers.

<table>
<thead>
<tr>
<th>Education Level</th>
<th>Frequency</th>
<th>Percent %</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illiterate</td>
<td>3</td>
<td>1</td>
<td>15.0</td>
</tr>
<tr>
<td>Primary</td>
<td>7</td>
<td>35</td>
<td>50.0</td>
</tr>
<tr>
<td>Lower secondary</td>
<td>8</td>
<td>40</td>
<td>90.0</td>
</tr>
<tr>
<td>Upper secondary</td>
<td>2</td>
<td>10</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Among the households surveyed, 80% were self-employed, 15% earned salary or wages and 5% were involved in chang'aa brewing. Such information points to the fact that the level of income among the sample population is very low (Fig 1).
Fig 1: Caretakers Source of Livelihood

Most of the orphans were Luo 112 (56%), followed by Kikuyus 33 (16.5%), Luhyas 21 (10%), Kamba 17 (18.5%), Nubian 6 (3%), Kisii 3 (1%) and Mixed i.e. those orphaned children whose parents were not from the same ethnic groups 8 (4%). These figures are presented in Table 3.

Table 3: Distribution of Orphans by Ethnic Group

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Frequency</th>
<th>Percent %</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Luo</td>
<td>112</td>
<td>56</td>
<td>56.0</td>
</tr>
<tr>
<td>Kikuyu</td>
<td>33</td>
<td>16.5</td>
<td>72.5</td>
</tr>
<tr>
<td>Luhyas</td>
<td>21</td>
<td>10.5</td>
<td>82.5</td>
</tr>
<tr>
<td>Kamba</td>
<td>17</td>
<td>8.5</td>
<td>91.5</td>
</tr>
<tr>
<td>Mixed</td>
<td>8</td>
<td>4</td>
<td>95.5</td>
</tr>
<tr>
<td>Nubian</td>
<td>6</td>
<td>3</td>
<td>98.5</td>
</tr>
<tr>
<td>Kisii</td>
<td>3</td>
<td>1.5</td>
<td>100</td>
</tr>
<tr>
<td>Total</td>
<td>200</td>
<td>100%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
In terms of sex of respondents, 132 (66%) were females and 68 (34%) were males as shown in Table 4.

Table 4: Distribution of Orphans by Sex

<table>
<thead>
<tr>
<th>Sex</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>68</td>
<td>34</td>
<td>34.0</td>
</tr>
<tr>
<td>Females</td>
<td>132</td>
<td>66</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>200</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

The distribution of orphans by age is shown in Table 5. Two age groupings were considered, 6-10 years and 11-16 years. These were 97 (48.5%) and 103 (51.5%) in the age groups respectively.

Table 5: Distribution of Orphans by Age

<table>
<thead>
<tr>
<th>Age</th>
<th>Frequency</th>
<th>percent</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>6-10 years</td>
<td>97</td>
<td>48.5</td>
<td>48.5</td>
</tr>
<tr>
<td>11-16 years</td>
<td>103</td>
<td>51.5</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>200</td>
<td>100%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Out of these, 31 (45.6%) were males and 72 (54.5%) females of age category 11-16 years, 37 (54.4%) males were of age category 6-10 years and 60 (45.5%) females as shown in (Table 6).
Table 6: Distribution of Orphans by Age and by Sex

<table>
<thead>
<tr>
<th>Age</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percent %</td>
</tr>
<tr>
<td>6-10 years</td>
<td>37</td>
<td>54.4</td>
</tr>
<tr>
<td>11-16 years</td>
<td>31</td>
<td>45.6</td>
</tr>
<tr>
<td>Total</td>
<td>68</td>
<td>100%</td>
</tr>
</tbody>
</table>

Of the 200 orphans 86 (43.43%) were double orphans, 71 (35.86%) were maternal orphans and 41 (20.71%) (Table 7)

Table 7: Distribution of Orphans by Parental State and by Sex

<table>
<thead>
<tr>
<th>Parental State</th>
<th>Males %</th>
<th>Females %</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Double orphans</td>
<td>15.65</td>
<td>27.78</td>
<td>43.43</td>
</tr>
<tr>
<td>Maternal orphans</td>
<td>14.65</td>
<td>21.21</td>
<td>35.86</td>
</tr>
<tr>
<td>Paternal orphans</td>
<td>3.03</td>
<td>17.68</td>
<td>20.71</td>
</tr>
</tbody>
</table>

Of these, 31 (15.65%) males and 55 (27.78%) females were double orphans and 29 (14.65%) males and 42 (21.21%) females were maternal orphans. Of the paternal orphans, 6 (3.03%) were males and 35 (17.68%) females.

4.2 Access to Education

Access to education was also assessed in terms of whether the orphans were going to school at one time or stopped, following the parent’s death. One hundred and ninety six (98%) were going to school, while 2 (1%) had stopped, only 2 (1%) never went to school (Table 8)
Table 8: Assessment as to Whether Orphans were going to School or Stopped at One Stage

<table>
<thead>
<tr>
<th>State</th>
<th>Frequency</th>
<th>Percent %</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Going to school</td>
<td>196</td>
<td>98</td>
<td>98.0</td>
</tr>
<tr>
<td>Not going to school</td>
<td>2</td>
<td>1</td>
<td>99.0</td>
</tr>
<tr>
<td>Not schooled</td>
<td>2</td>
<td>1</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>200</td>
<td>100%</td>
<td>100.0</td>
</tr>
</tbody>
</table>

When analyzed by sex, 32 (47.1%) males and 65 (49.2%) females stopped going to school at one stage (Table 9).

Table 9: Assessment as to whether orphans Stopped Going to School at One Stage by Sex

<table>
<thead>
<tr>
<th>State</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percent %</td>
</tr>
<tr>
<td>Stopped</td>
<td>32</td>
<td>47.1</td>
</tr>
<tr>
<td>Never stopped</td>
<td>36</td>
<td>52.9</td>
</tr>
<tr>
<td>Total</td>
<td>68</td>
<td>100%</td>
</tr>
</tbody>
</table>

Majority in the age category 6-10 years 50 (51%) stopped going to school at one stage in comparison to 47 (45.6%) in the age category 11-16 years (Table 10).

Table 10: Assessment as to whether the orphans Stopped Going to School at One Stage by Age

<table>
<thead>
<tr>
<th>State</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percent %</td>
</tr>
<tr>
<td>Stopped</td>
<td>50</td>
<td>51</td>
</tr>
<tr>
<td>Never stopped</td>
<td>47</td>
<td>48.5</td>
</tr>
<tr>
<td>Total</td>
<td>97</td>
<td>100%</td>
</tr>
</tbody>
</table>
Of the age category 6-10 years, 18 (48.6%) males and 32 (53.3%) females stopped going to school at one stage. Of the age category 11-16 years, 14 (45.2%) males and 33 (45.8%) females stopped at one stage (Table 11).

Table 11: Assessment as to whether the orphans Stopped Going to School at One Stage by Age and Sex.

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th></th>
<th>Females</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percent %</td>
<td>Frequency</td>
<td>Percent %</td>
</tr>
<tr>
<td>Stopped</td>
<td>18</td>
<td>48.6</td>
<td>32</td>
<td>53.3</td>
</tr>
<tr>
<td>Never stopped</td>
<td>19</td>
<td>51.4</td>
<td>28</td>
<td>46.7</td>
</tr>
<tr>
<td>11-16 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stopped</td>
<td>14</td>
<td>45.2</td>
<td>33</td>
<td>45.8</td>
</tr>
<tr>
<td>Never stopped</td>
<td>17</td>
<td>54.8</td>
<td>39</td>
<td>54.2</td>
</tr>
<tr>
<td>Total</td>
<td>68</td>
<td>34%</td>
<td>132</td>
<td>66%</td>
</tr>
</tbody>
</table>

Those who find it difficult to access education was analyzed, 102 (51%) orphans found it difficult irrespective of whether they were double or single orphans (Table 12).

Table 12: Assessment of Access to Education

<table>
<thead>
<tr>
<th>Access to education</th>
<th>Frequency</th>
<th>Percent %</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficult</td>
<td>102</td>
<td>51</td>
<td>51.0</td>
</tr>
<tr>
<td>Not difficult</td>
<td>98</td>
<td>49</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>200</td>
<td>100%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

When this was analyzed further to determine the type of orphans experiencing difficulties to access education, 46 (53.5% double orphans and 55 (48.2%) single orphans encountered it difficulties ($\chi^2=0.539, df=1, p<0.05$) (Table 13).
Table 13: Relationship between Access to Education and being HIV/AIDS Orphan

<table>
<thead>
<tr>
<th>State of Orphanhood</th>
<th>Not difficult to access</th>
<th>Difficult to access</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq.</td>
<td>Percent</td>
<td>Freq.</td>
</tr>
<tr>
<td>Double orphans</td>
<td>46</td>
<td>53.5%</td>
<td>40</td>
</tr>
<tr>
<td>Single orphans</td>
<td>55</td>
<td>48.2%</td>
<td>59</td>
</tr>
<tr>
<td>Total</td>
<td>101</td>
<td>50.5%</td>
<td>99</td>
</tr>
</tbody>
</table>

The relationship between access to education and being an orphan of a given sex category indicates that 15 (32.6%) male double orphans and 31 (67.4%) female double orphans experienced difficulties ($\chi^2=0.507, df=1, p<0.05$). Being an orphan of a given sex had an influence in access to education i.e. 31 (67.4%) females the majority being the double orphans as shown in (Table 14).

Table 14: Relationship between Access to Education and being an Orphan of a Given Sex Category (Double Orphans)

<table>
<thead>
<tr>
<th>Sex</th>
<th>Difficult to access</th>
<th>Not difficult to access</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq.</td>
<td>Percent</td>
<td>Freq.</td>
</tr>
<tr>
<td>Males</td>
<td>15</td>
<td>32.6%</td>
<td>16</td>
</tr>
<tr>
<td>Females</td>
<td>31</td>
<td>67.4%</td>
<td>24</td>
</tr>
<tr>
<td>Total</td>
<td>46</td>
<td>53.5%</td>
<td>40</td>
</tr>
</tbody>
</table>

When both parents are dead, the gender of the child is a factor that influences whom among the orphans experience difficulties. About (21.8%) males and (78.2%) females find it difficult to access ($\chi^2=5.486, df=1, p<0.05$).
Table 15: Relationship between Access to Education and Being an Orphan of a Given Sex Category (Single Orphans)

<table>
<thead>
<tr>
<th>Sex of single orphans</th>
<th>Difficult to access</th>
<th>Not difficult to access</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq.</td>
<td>Percent</td>
<td>Freq.</td>
</tr>
<tr>
<td>Males</td>
<td>12</td>
<td>21.8%</td>
<td>25</td>
</tr>
<tr>
<td>Females</td>
<td>43</td>
<td>78.2%</td>
<td>34</td>
</tr>
<tr>
<td>Total</td>
<td>55</td>
<td>48.2%</td>
<td>59</td>
</tr>
</tbody>
</table>

Among the single orphans (paternal and maternal) being an orphan of a given sex is not a significant factor although majority of the disadvantaged are females (Table 15) of the single paternal orphans, 1 (5.6%) males and 17 (94.4%) females encountered difficulties ($\chi^2 = 3.480, df=1, p<0.05$). But girls are more disadvantaged (Table 16).

Table 16: Relationship Between Access to Education and being an Orphan of a Given Sex (Paternal and Maternal Orphans)

<table>
<thead>
<tr>
<th>Attributes</th>
<th>Difficult to access</th>
<th>Not difficult to access</th>
<th>Significant Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paternal Orphans</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males</td>
<td>1 (5.6%)</td>
<td>7 (28%)</td>
<td>$\chi^2 = 3.480, df=1, p&lt;0.05$</td>
</tr>
<tr>
<td>Females</td>
<td>17 (94.4%)</td>
<td>18 (72%)</td>
<td></td>
</tr>
<tr>
<td>Maternal Orphans</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males</td>
<td>11 (29.7%)</td>
<td>18 (52.9%)</td>
<td>$\chi^2 = 3.950, df=1, p&lt;0.05$</td>
</tr>
<tr>
<td>Females</td>
<td>26 (70.3%)</td>
<td>16 (47.1%)</td>
<td></td>
</tr>
</tbody>
</table>

This could be attributed to the fact that some girls are considered as house help assisting in duties at home and in some cases even get to school late because they have to carry out household chores and set things ready each day before they go to school. Where there were maternal orphans, 11 (29.7%) males and 26 (70.3%) females found it difficult. Majority of the disadvantaged were girls ($\chi^2 = 3.950, df=1, p<0.05$) (Table 16, Above).
4.3. Health Problems and Services

This was to help with the information on health problems, frequency of sickness and access to medical services. Of the 200 respondents interviewed, 124 (62%) had experienced some form of sickness in the recent past from the date of the survey (Table 17).

<table>
<thead>
<tr>
<th>Health problems</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cumulative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Been sick</td>
<td>124</td>
<td>62</td>
<td>62.0</td>
</tr>
<tr>
<td>Not been sick</td>
<td>76</td>
<td>38</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>200</td>
<td>100%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

The data was further analyzed to ascertain the frequencies of sickness i.e. how often one became sick in the past three months, 87 (43.5%) orphans fell sick quite frequently, 8 (41%) not quite frequently and 31 (15.5%) rarely fell sick. Among these, 24 (35.3%) male fell sick quite frequently, 28 (41.2%) not quite frequently, 16 (23.5%) rarely fell sick (Fig 2). Of the females, 63 (47.7%) fell sick quite frequently, 54 (40.9%) sometimes and 15 (11.4%) rarely fell sick (Fig 3).
4.4. Access to Medical Treatment/Services

About 132 (66%) reported that they experience difficulties to access health services while 68 (34%) had no difficulties (Fig 4).

Fig 4: Access to Medical Treatment/Services

Among these, 37 (54.4%) males find it difficult while 31 (45.6%) had no problem. Of the females, 95 (72%) find it difficult while 37 (28%) had no problem (Fig 5).
Majority of the age category 11-16 years 72 (69.9%) found it difficult to access medical treatment/services while 31 (30.1%) had no problem. Of the age category 6-10 years 60 (61.9%) find it difficult while 37 (38.1%) had no problem (Fig 6).
4.4.1 Relationship Between being an Orphan and being able to Get Medical Services

This was to investigate whether being an orphan contributed significantly in affecting access to medical treatment/services. Out of 200 respondents, 132 (66%) find it difficult while 68 (34%) had no problem. Among these 62 (47%) double orphans encountered difficulties and 70 (53%) single orphans find it difficult. About 132 (66%) of the orphans find it difficult ($\chi^2=2.501, \text{ df}=1, p<0.05$) being an orphan significantly affect access to medical services (Table 18).
Table 18: Relationship between being an Orphan and being able to Get Medical Services

<table>
<thead>
<tr>
<th>Access to Medical</th>
<th>Double orphans</th>
<th>Single orphans</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq.</td>
<td>percent</td>
<td>Freq.</td>
</tr>
<tr>
<td>Difficult</td>
<td>62</td>
<td>47</td>
<td>70</td>
</tr>
<tr>
<td>Not difficult</td>
<td>24</td>
<td>35.3</td>
<td>44</td>
</tr>
<tr>
<td>Total</td>
<td>86</td>
<td>43</td>
<td>114</td>
</tr>
</tbody>
</table>

4.4.2 Coping Mechanism Adopted by Orphans

In addition it was noted that of the 200 respondents, 19% admitted involvement in commercial sex. About 20.9% of the double orphans and 17.3% of the single orphans admitted being involved in such activities. A Chi-square analysis shows that being an orphan influences engagement in sex ($\chi^2 = 0.365, df=1, p<0.05$). Among the double orphans, the number of females having boy friends 25.5% exceeds that of boys 12.4%. A Chi-square analysis shows that sex category is significant ($\chi^2 = 1.891, df=1, p<0.05$). This could be attributed to the basic needs that cannot be given by the caretakers and are therefore provided by the boyfriend. This was also revealed during the focus group discussions where most respondents cited example of girls engaging in sexual relations in order to meet other needs.

4.4.3 Community Attitude to Treatment (Discrimination) of HIV/AIDS Orphans.

Of the 200 orphans interviewed 120 (60%) felt that they were handled differently from other children (Fig 7). In terms of sex, among those who felt discriminated against, 35 (29.2%) were males and 85 (70.8%) were females (Fig 8).
Fig 7: Treatment/Discrimination as Observed by Orphans

Fig 8: Assessment of Treatment/Discrimination by Sex
4.5 Support Systems

This was to investigate the support system available to these orphans and its relationship with the magnitude of the social and economic problems they face. Of the 200 respondents interviewed, 57% double orphans stayed with their uncle/aunt, 20.9% with brother/sister, 20.4% with grandmother, 1.2% others (Table 19).

Table 19: Person(s) Supporting Double Orphaned Children

<table>
<thead>
<tr>
<th>Persons supporting double orphans</th>
<th>Frequency</th>
<th>Percent %</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brother/Sister</td>
<td>18</td>
<td>20.9</td>
<td>20.9</td>
</tr>
<tr>
<td>Uncle/Aunt</td>
<td>49</td>
<td>57</td>
<td>77.9</td>
</tr>
<tr>
<td>Grandmother</td>
<td>18</td>
<td>20.9</td>
<td>98.8</td>
</tr>
<tr>
<td>Others</td>
<td>1</td>
<td>1.2</td>
<td>100</td>
</tr>
<tr>
<td>Total</td>
<td>86</td>
<td>100%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Among the single orphans, 75 (65.8%) stayed with the parent, 3 (2.6%) with brother/sister, 21 (18.4%) with uncle/aunt, 14 (12.3%) with grandmother and 1 (0.9%), (Table 20).

Table 20: Person(s) Supporting Single Orphaned Children

<table>
<thead>
<tr>
<th>Persons supporting single orphans</th>
<th>Frequency</th>
<th>Percent %</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surviving Parent</td>
<td>75</td>
<td>65</td>
<td>65.8</td>
</tr>
<tr>
<td>Brother/Sister</td>
<td>3</td>
<td>2.6</td>
<td>68.4</td>
</tr>
<tr>
<td>Uncle/Aunt</td>
<td>21</td>
<td>18.4</td>
<td>86.8</td>
</tr>
<tr>
<td>Grandmother</td>
<td>14</td>
<td>12.3</td>
<td>99.1</td>
</tr>
<tr>
<td>Others</td>
<td>1</td>
<td>0.9</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>114</td>
<td>100%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Among the male double orphans, 5 (16.1%) stay with brother/sister, 18 (58.1%) with uncles/aunt, 8 (25.8%) with grandmother.
Of the females double orphans, 13 (23.6%) stay with brother/sister, 31 (56.4%) with uncle/aunt, 10 (18.2%) with grandmother and 1 (1.8%) with others (Table 21).

Table 21: Person(s) Supporting both Double and Single Orphaned Children by Sex.

<table>
<thead>
<tr>
<th>Persons supporting</th>
<th>MALES</th>
<th></th>
<th>FEMALES</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Double orphans</td>
<td></td>
<td>Frequency</td>
<td>Percent %</td>
<td>Frequency</td>
</tr>
<tr>
<td>Brother/Sister</td>
<td>5</td>
<td>16.1</td>
<td></td>
<td>13</td>
</tr>
<tr>
<td>Uncle/Aunt</td>
<td>18</td>
<td>58.1</td>
<td></td>
<td>31</td>
</tr>
<tr>
<td>Grandmother</td>
<td>8</td>
<td>25.8</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>Others</td>
<td>-</td>
<td>-</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>31</td>
<td>100%</td>
<td></td>
<td>55</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Persons supporting</th>
<th>MALES</th>
<th></th>
<th>FEMALES</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Single orphans</td>
<td></td>
<td>Frequency</td>
<td>Percent %</td>
<td>Frequency</td>
</tr>
<tr>
<td>Parent</td>
<td>21</td>
<td>56.8</td>
<td></td>
<td>54</td>
</tr>
<tr>
<td>Brother/Sister</td>
<td>-</td>
<td>-</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Uncle/Aunt</td>
<td>11</td>
<td>29.7</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>Grandmother</td>
<td>5</td>
<td>13.5</td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>Others</td>
<td>-</td>
<td>-</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>37</td>
<td>100%</td>
<td></td>
<td>7</td>
</tr>
</tbody>
</table>

Among the male single orphans, 21 (56.8%) stayed with parents, 11 (29.7%) with uncle/aunt, 5 (13.5%) with grandmother. Of the females single orphans, 54 (70.1%) stay with parents, 3 (3.9%) with brother/sister, 10 (13%) with uncle/aunt, 9 (11.7%) with grandmother (Table 21 above).

In terms of age, the double orphans of age category 11-16 years, 31 (63.3%) stay with uncle/aunt, 9 (18%) with brother/sister, 8 (16.3%) grandmother and among the age category 6-10 years, 9 (24.3%) stay with brother, 15 (48.6%) with uncle/aunt and 10 (27%) with grandmother. For the age category 11-6 years single orphans, 35 (64.8%) stay with their parents, 11 (20.4%) stay with uncle/aunt, 5 (9.3%) grandmother, 2 (3.7%) with
brother/sister. For the age category 6-10 years 40 (66.7%) stay with parent, 10 (16.7%) with uncle/aunt, 9 (15%) with grandmother and 1 (1.7%) with brother/sister.

4.4.2 Coping Mechanism Adopted by HIV/AIDS Orphans

A significant number 72% of orphans reported being involved in various income generating activities which enable them to help the caretakers meet their household financial obligations and at the same time acquire some personal effects they may be in need of. In other cases, 45% orphaned children indulged in sexual activities to get money. Most orphaned children (72%) within the study area fetch water for people, wash clothe and cars, work as has house help and even sell vegetables, most of these are done to maintain themselves in school and in a number of situations also help their caretakers. Of the 200 respondents interviewed, 124 (62%) had experienced a form of sickness. 87 (35.5%) orphans quite frequently fell sick, to cope with the illnesses orphaned children and their caretakers resorted to buying tablets from the community drug retailers and kiosks, in some cases wait for the visits by volunteer medical teams operating within the area. Among the orphans who engaged in income generating activities, the dominant group reported vegetable selling and in some cases fetching water for people.
CHAPTER FIVE

DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1 Discussion

In this study, orphaned children were identified as children under the age of sixteen years whose either one or both parents are deceased. During the key informant interviews, in-depth interviews, and focus group discussions, informants were able to categorize the level of needs of various orphaned children. For instance, the most needy were identified as double orphans, that is, children whose both parents were deceased, maternal orphans, children whose mothers are deceased then paternal orphans children whose fathers were deceased (Appendix 5 part B). Maternal orphans were considered more vulnerable than paternal orphans because when the mother dies, the father marries another woman who might mistreat them.

The key informants explained that members of the community were encouraged to assist children under difficulties and in situations where there were irresponsible parents, family members prevailed upon them to take care of their children. For instance, 57% of the double orphans stayed with uncles and 75 (65.8%) single orphans stayed with their parent. A study carried out by Urassa et al., (1997) in Tanzania also showed that the extended family system appeared to absorb and care for the orphans with minor adaptations, such as involvement of maternal and paternal relatives. It was explained that orphaned children had different needs depending on their age. For instance, with the death of a father, the child faces problems when he/she reaches school going age because mothers can only afford to feed them, while
a child below school going age needs the mothers attention more than the fathers. Interviews with key informants, FGD and in-depth interviews show that the attitude of the people of Kibera especially Mashimoni, have changed significantly in relation to the situation of orphanhood as compared to what was there in the past. To a large extent, the change is attributed to the forces of modernity originating from outside but reinforced by some cultural traits within the community. This is coupled with high levels of poverty within the study. The above argument is closely related to the information gathered from quantitative data where only 10% of the respondents stated that peoples attitude towards orphans was positive and that they were willing to assist but could not owing to economic constraints. About 85% of the respondents argued that people have negative attitude towards HIV/AIDS orphans. When probed further, they asserted that such people refuse to help when approached and are not friendly. One informant declared, “Those who have refused to help, in fact, do not want people to know about it”.

About 80% of reported knowledge of social institutions within the study area that specifically assists HIV/AIDS orphaned children. However these groups are faced with a lot of problems, ranging from social to financial problems and the increasing numbers of orphans. The implication of the above sequence of events is that efforts need to be enhanced to support HIV/AIDS orphaned children. Such efforts will need to take into consideration some of the cultural traits that militate against voluntary support. For instance, key informants and in-depth interviews revealed that the efficiency of some community-based organizations started earlier has been affected by individualism and greed.
The majority of the caretakers interviewed in-depth, (60%) were women some of whom were ailing. Increased the vulnerability and suffering of orphans. Similarly, a study by Ntozi (1997) argues that orphans with surviving mother suffer more from financial problems than those with fathers. To further strengthen this observation, key informants in the study pointed out that orphans without fathers face a lot of problems with schooling because the mothers can only afford to feed but not to sustain them in school.

The fact that female headed households face financial problems, as was also observed by Nalugoda et al., (1997) could be traced to the traditional household division of labor where men were expected to go out and fend for the family. Women especially in the urban areas find it difficult to adjust immediately to the role of the husband in the event of the husbands death. This is particularly the case now when livelihood is to a greater extent, determined by modern economic conditions, a challenge they are least prepared to face.

Among the orphans studied, 51% reported a lot of problems with schooling. Nalwanga and Segendo, (1987) also found lower rates of school attendance by children who had lost a parent in Rakai District of Uganda.

UNICEF (2002) postulates that many orphans in Sub-Saharan Africa risk never completing basic schooling due to limitations in the resources that characterized such households within the region. As a response to this challenge, a number of governments, including those of Malawi and Uganda, have put measures in place to support education for orphans. Such policies include free primary education (UNICEF, 1999). The Kenya Government also has such policy (ROK, 2002) however it has not had any meaningful impact on the educational
sarcity, rooted in national and international politics, economic and public health. However, part of this discrimination could be due to the bad relationship that existed between the biological parents of the orphans and the present caretakers. Bledsoe (1988) has observed that orphaned children fostered in other families received worse treatment than the biological children in the same family, trends which point to the disadvantages of HIV/AIDS orphaned children.

The solution as Nalugoda et al., (1997) proposes, lies in the developing of feasible interventions with community-based support systems which focus on the most vulnerable households and extended family with inclusion of the orphans themselves. In Uganda, the strength of the women’s support networks have shown significant progress (Obbo, 1995). Ntozi et al., (1999), in their study about the role of the extended family in orphan care in northern Uganda, found that the extended family support for orphaned children has been overburdened by the AIDS epidemic. The result is that some care is being provided by the older orphans, who are too young for the responsibility. Quite a good number of households within the study area were found to be dependent on orphan’s labor and their initiatives to boost the household’s income-generating activities. For instance, some of the orphans were found to be involved in income generating activities such as fetching water, washing clothes and sex. Observed in the study area possibly because economic constraints have weakened the moral power of the members of the community under study. Some members of the extended family find it difficult to share the scarce resources they have with orphans.
The role of friends and neighbors concern for the welfare of orphans seemed to be unsustainable in the study area. A study carried out by Ntozi (1997) on the problem of orphans in Uganda revealed that friends and neighbors did not participate much in the orphan care decision-making process. Other sources of assistance for orphans households covered in this study did not feature very prominently apart from assistance by caretakers themselves and, to a lesser extent, members of the extended family. In some cases households with orphans did not show any evidence of having received or having any connection whatsoever with either social or cultural institutions within the study area. Urassa et al., (1997) noted that outside support is generally lacking or very limited to orphans in Tanzania. A study carried out by Ouko (1999) discovered that such groups, which are credit schemes on a merry-go-round basis, have potential to support orphans and widows but do not do so at the moment. Similarly, (ROK, 2001) also known as the Poverty Reduction Strategy Papers for the period 2001-2004 targets such group for income generating projects to ensure sustainability in orphan households. However in general, the informants stated that they only received support during funerals and nothing else after the mourning period. The cost of illness, expensive funeral rites and lack of employment among the people were cited as being responsible for low household property levels in Kibera (Mashimoni). Hunter and Williamson (1998) attributed the poverty observed in households living with orphans to the cost of illness and funeral expenses. Obbo (1995) also observed that prolonged nursing would usually have drained the family's resources. This was equally true in households with orphaned children in Kibera (Mashimoni) where a number of the
caretakers indicated that the property they had was sold to meet the medical and funeral expenses of the deceased.
5.1.1 Conclusions

From this study the following conclusions were drawn:

(1) Areas where orphaned children were most disadvantaged was access to education needs 51% and medical services 66%.

(2) Gender had an influence in access to education, more females 78.2% than males 21.8% experienced difficulties. More females 72% than males 28% experienced difficulties in access to medical services.

(3) The attitude of the study population towards orphans was found to have changed, 60% orphans felt that they were handled differently from other children.

(4) The changing living conditions negatively affect the survival prospects of orphaned children.

(5) Cultural institutions within the study area were found to be undermined by poverty though doing everything to support orphans.

(6) The extended family system is gradually weakening as a result of larger social, cultural and economic transformation that are taking place in contemporary Kenya.

(7) Social institutions are in place though their programs are not adjusted to respond to the needs of the orphaned children.

(8) In coping with their situation, orphaned children adopted various coping mechanisms such as involvement in income generating activities e.g. fetching water, washing clothes and commercial sex.
5.1.2 Recommendations

(1) Policies designed to address educational problems orphaned children face, need not look at education in isolation but also take into consideration the household living conditions of orphans.

(2) Policies designed to address health issues need also to formulate health schemes that are aimed adequately providing health services to the orphaned children.

(3) Alternative source of funding through school and church based programs should be used inorder to discourage orphans involvement in income generating activities

(4) Non-governmental organizations such as religious organizations working within the study area should educate members of the community on the need to assist orphaned children

(5) The problem of orphanhood should be seen in political and macroeconomic context, the government should formulate HIV/AIDS policy and allocate funds to provide basic needs such as food, clothing through church based programs.
Areas for Further Study/Research

(1) There is need to carry out a study on how social institutions could be used in intervention programs so as to design a community based support systems for orphaned children.

(2) There is need to carry out a full-scale survey to determine the rate of prevalence of HIV/AIDS orphanhood within the study area.

(3) There is need to carry out a full-scale survey to estimate the number of HIV/AIDS orphans residing within the study area to be able adequately plan for their needs.
REFERENCES


APPENDIX I

INFORMATION CONSENT

A QUESTIONNAIRE TO ASSESS THE IMPACT OF HIV/AIDS ON ORPHANS WITHIN THE URBAN SETTING OF NAIROBI.

This questionnaire is aimed at finding out the impact of HIV/AIDS on orphans. The information obtained therein is confidential and will be used only for the purpose of the study.

The purpose of the study has been explained and all that it involves and I have accepted to be interviewed.

Interviewee................................................. Date............................................

Investigator............................................... Date.............................................
APPENDIX II

QUESTIONNAIRE

A STUDY ON THE SOCIO-ECONOMIC IMPACT OF HIV/AIDS ON ORPHANS

AREA SURVEYED: DIVISION.........................

INTERVIEWER...........................................

STRUCTURE NUMBER.................................

(Please put a tick or fill in where necessary)

A. RESPONDENTS BACKGROUND

1. Sex..............1. Male [ ] 2. Female [ ]

3 Age............

4 Mother tongue/Tribe..........


B. LIVING CONDITIONS, BASIC NEEDS AND SUPPORT FOR EDUCATION

SECTION 1: School needs and support

5. which of your parents is alive.......1. Father [ ] 2. Mother [ ] 3. None [ ]

(b) If any, is the parent employed/working............1. Employed [ ] 2. Not employed [ ]

© If any, do you stay with your parent(s).......1. Yes [ ] 2. No [ ]

(d) If ‘No’ with whom do you stay?...........

(e) If any of your parent(s) died, at what age were you?.........
6. How many children are you in your family?

(b) Do all of you stay together with the same parent/person? 1. Yes [ ] 2. No [ ]

© If ‘No’ with whom do the others stay?

7. Have you ever attended school (Nursery/Primary)? 1. Yes [ ] 2. No [ ]

8. Are you currently attending school? 1. Yes [ ] 2. No [ ]

(b) If ‘No’ what is the highest level of school you attended? 1. Nursery [ ] 2. Primary [ ]

© If ‘Yes’ could there have been a time you stopped going/changed school? 1. Yes [ ] 2. No [ ]

(ii) What major reason stopped you going/made you change the school?

1. No one to pay fees [ ] 2. Did not like school [ ] 3. Physical mental problems [ ]

4. School rejected me [ ] 5. Others [ ] (specify)

(iii) Do you think the reason for stopping/changing the school is now solved?

1. Permanently Solved [ ] 2. Temporarily solved [ ] 3. Don’t know [ ]

9. Are there school items you used to get when both parents were alive that you feel are no longer provided?

1. Yes [ ] 2. No [ ]

10. If you are attending school, who meets your school related expenses?


5. Religious groups [ ] 6. NGOs [ ] 7. Self Friends [ ] School [ ]

11. If you have brothers/sisters are they going to school? 1. Yes [ ] 2. No [ ]

If ‘Yes’ who meets their school-related expenses? (Use opinions in 10 above).

If ‘No’ what is the reason for them not going to school?

1. They don’t like [ ] 2. No one to assist [ ]
SECTION 2: AVAILABILITY OF DAILY BASIC REQUIREMENTS

12. Do your family own any property (Plots/houses/business) which can support you? ……
   1. Yes [ ] 2. No [ ]

If ‘Yes’ do you benefit from the property? ……… 1. Yes [ ] 2. No [ ]

If you don’t benefit explain why …………………………………………

13. Were your parents legally married to each other?
   1. Yes [ ] 2. No [ ] 3. Don’t know [ ]

14. Describe the kind of treatment/support you get from the person you stay with………..
   1. Friendly and adequate [ ] 2. Friendly but not adequate [ ] 3. Adequate but not friendly
   4. Discriminative and inadequate [ ] 5. Valueless [ ]

15. Do you get support from any other place, different from your parent? ……(specify)
   1. None [ ] 2. Uncle [ ] 3. Aunt [ ] 4. Grandparents [ ] 5. NGOs [ ] 6 Religious groups [ ] 7. Others [ ] (specify) ……………………..

(b) What kind of support do you get from the above? …………………………………………

16. If you don’t get support from anywhere, have you ever thought of asking for support from any person or any group? ……………………. 1. Yes [ ] 2. No [ ]

(b) If ‘Yes’ can you name the group or relationship with the person from whom you sort help …………………………………………

©What reason, if any, did they give for not being able to assist you? ……………………

17. If you have attempted to ask for support from any group, what was your reason for choosing the group(s) and not others, if any …………………………………………
MEDICAL NEEDS AND SUPPORT

18. Have you ever been sick in the past three (3) months?............ 1. Yes [ ] 2. No [ ]
(b) Do you normally ever go for treatment or advice when you fall sick?............
1. Yes [ ] 2. No [ ]
© If ‘No’ why?...1. Money [ ] 2. Fear [ ] 3. Don’t know [ ]
(d) If ‘Yes’ do you encounter any problem getting advice/treatment?... 1. Yes [ ] 2. No [ ]
(ii) State the problem.................................

20. Do you suffer any form of medical problem which needs constant medical support?....... 1. Yes [ ] 2. No [ ]
(b) If ‘Yes’ do you ever get that support/treatment without difficulty? 1. Yes [ ] 2. No [ ]
© If ‘No’ what is the reason for not getting that attention?......................... 1. Finance [ ]
2. Don’t know [ ]
(b) Is there a person or group supposed to support you in this bit don’t do so?............. 1. Yes [ ] 2. No [ ]
(ii) What is the reason for them not doing so?.................................

21. Is there any problem you encounter when seeking medical treatment? State........................................

22. Whenever you are sick who takes care of your needs?.........................
1. Parents [ ] 2. Friends [ ] 3. Good Samaritans [ ] 4. No one [ ]

23. Have you heard of HIV/AIDS?.......... 1. Yes [ ] 2. No [ ]
25. Do you have boyfriend/girlfriends?............ 1. Yes [ ] 2. No [ ]

(ii) If 'Yes' is any of your relatives/parent aware about them?......... 1. Yes [ ] 2. No [ ]

(iii) If 'Yes' do they like your friend(s)? (explain)...........................................

(iv) Do you have any special reason for having a boyfriend/girlfriend? 1 Yes [ ] 2. No [ ]
State the reason.................................................................................................

24. Do you get any form of assistance from the friend(s) when you are sick?............
1. Yes [ ] 2. No [ ]
APPENDIX III

INTERVIEW GUIDE FOR CARETAKERS

(A) Biographical data:

Age of respondent .........................................................

Marital status .................................................................

Educational level for respondent ...............................

Religious affiliation ......................................................

Occupation .................................................................

Household size/number of people staying in the household and relationship to the household head.

(Indicate male/female)

Census number .............................................................

(B) Source of income and subsistence activities:

-What are the household subsistence activities? (Kind of money)

-Assistance from outside including remittance from working family members and any other donations, gifts from the community members.

(C) Education:

-Do orphaned children of school going age under your care go to school? (Give details)

-Who made the decision to take/not to take them to school? (Probe how decision was reached)

-How many times have they missed school in a term. Give reasons.

-Give suggestions on how education for orphans under your care can be best provided.
(D) Orphans access to health care:

- How often do they fall ill
- Where do you take orphaned children for treatment when they are sick? (Give reasons)
- Problems you face in providing health care for orphans and how do you solve those problems.
- Give suggestions on how the health needs of the orphaned children you stay with can be properly catered for.

(E) Food and clothing for orphans

- Do you face any problems in providing food for the orphaned children?
- Who else helps you to feed the orphans? Explain.
- Apart from you who else gives the clothing?
In case of serious clothing problem, who else do you approach for assistance?

(F) Social institutions

What are the social institutions available in the area and which has given assistance of any nature for the orphans you are staying with. (Give names, school, church bodies, youth groups, women groups, etc).

(G) Cultural institutions and support for orphaned children:

- Who made the decision to accommodate the orphan in the household? (Probe how the decision was reached).
- Do other relatives of the orphaned children you are staying with give assistance? If no, probe reasons.
- Any other assistance received from the community, neighbors, extended family, etc. (probe any kind of assistance given).

- How are orphaned children looked upon?

(H) Summary:

- Do you see any difference between the orphan(s) in question and your biological children? (Coping Mechanism).
APPENDIX IV

FOCUS GROUP GUIDE FOR ORPHANS

(A) Problems faced in school:
- School and money payment.
- School attendance and feeding at home:

(B) Different treatment at home:
- How is it done in provision of food and acquisition of basic needs.

(C) Coping strategies:
- Selling vegetables and other activities done.
- How the money is used.
- Who decides how the money is used?

(D) Assistance within the community:
- Do you ask any assistance from home?
- Why?
- What assistance?
- How do people react when approached for assistance?

(E) Psychological effects of parents death:
- What are the feelings?
- How/when do they manifest themselves?
- How do you overcome them?
(F) HIV/AIDS information availability:

-Have you ever had about HIV/AIDS? (Probe from source).
APPENDIX V

FOCUS GROUP GUIDE FOR COMMUNITY LEADERS

(A) Definition of an orphaned child.
- Who is considered an orphaned child?
- Who among the orphans of various categories is more vulnerable?

(B) Views about orphaned children indulging in paid labor within the community:
- How often do orphaned children work for people within the community?
- Why do they go to work for people?
- How do they use the money they get from the work?

(C) Supporting orphans:
- How were orphaned children supported in the past?
- Is there any difference between the past and the present mode of assisting orphans?

(D) Discrimination at household level and the question of orphan headed households.
- Why do some orphaned children stay alone while there are members of the extended family network?
- Why do some caretakers discriminate against orphaned children within the community?

(E) Orphan’s education and HIV/AIDS information:
- How can orphaned children be assisted to gain access to education and HIV/AIDS information?
APPENDIX VI

INTERVIEW GUIDE FOR KEY INFORMANTS

(A) Knowledge about orphanhood:

- Whom do you consider to be a vulnerable child?

- Who is an orphan according to your definition?

(B) How would you see the position of a child who:

- Has lost both parents.
- Has lost the mother but not the father.
- Has lost the father but not the mother.
- Whose parents are still alive but not able to take care of him/her?
- Whose parents are still alive and who has been sent to stay with other relatives?
- Has the person’s understanding of orphaned children changed?
- What are the changes?
- How do you define orphans today?

(C) Support for orphans:

- How were such orphaned/vulnerable children supported in the past?
- Who was responsible for their protection?
- Have there been changes in the way orphans were taken care of kin the past?
- What are the changes and how have they affected orphaned children?
- Have people’s attitudes towards orphans also changed?
- What do you consider as constraints to better care for orphans?
(D) Summary:

- Approximately how many orphans do you think there are in the area?

- Among them how many are due to HIV/AIDS?
APPENDIX VII

Table 1. Biographical information of caretakers interviewed in-depth

<table>
<thead>
<tr>
<th>House No</th>
<th>Age of Caretakers</th>
<th>Education Level</th>
<th>Household Size</th>
<th>No. of Orphans</th>
<th>Relations to Orphans</th>
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<tbody>
<tr>
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<td>4</td>
<td>2</td>
<td>Uncle/aunt</td>
</tr>
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<td>27</td>
<td>Lower secondary</td>
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<td>38</td>
<td>Primary</td>
<td>4</td>
<td>3</td>
<td>Mother</td>
</tr>
<tr>
<td>4</td>
<td>28</td>
<td>Lower secondary</td>
<td>5</td>
<td>4</td>
<td>Mother</td>
</tr>
<tr>
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<td>23</td>
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<td>3</td>
<td>2</td>
<td>Mother</td>
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<td>12</td>
<td>2</td>
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<td>2</td>
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<td>6</td>
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<td>3</td>
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<td>4</td>
<td>Father/step Mother</td>
</tr>
</tbody>
</table>

Key:

Father/step mother – Refers to maternal orphans who stay with their stepmother and are

by their biological father.
Upper Primary - Refers to caretakers who attained primary education beyond class 4 but never had access to secondary education.

Lower primary – Refers to caretakers who attained primary education but never went beyond class three.

Upper secondary – Refers to caretakers who accessed secondary education up to form three and above.

Lower secondary – Refers to caretakers who accessed secondary education but did not reach form three.
APPENDIX VIII

BOARD OF POSTGRADUATE STUDIES
KENYATTA UNIVERSITY

Our Ref: 157/7169/2001 DATE: 4th April, 2003,

Your Ref:

The Permanent Secretary,
Ministry of Education, Science & Technology,
P.O. Box 30040,
NAIROBI.

Dear Sir/Madam,

RE: RESEARCH AUTHORIZATION:

I write to introduce Mr. Paulicap Onyango Owino who is a Postgraduate Student of this University. He is registered for a Master of Public Health & Epidemiology (M.P.H.E) degree programme in the Department of Zoology.

Mr. Owino intends to conduct research for a project entitled, "Socio-Economic Impact of HIV/AIDS on Orphans within an Urban Setting in Nairobi".

Any assistance given to him will be highly appreciated.

Yours faithfully,

J.K. LANGAT
FOR DIRECTOR, BOARD OF POSTGRADUATE STUDIES

C.C.: Registrar (Academic)
Director, BPS - to see on file
Dean, School of Pure & Applied Sciences.
Chairperson, Zoology Department.