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**APPLICATION OF COMMUNITY PARTICIPATION PARADIGM IN
THE CARE OF CHILDREN ORPHANED BY HIV AND AIDS IN
KIBERA DIVISION, NAIROBI, KENYA.**

BY

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**A THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE
REQUIREMENTS FOR THE DEGREE OF DOCTOR OF
PHILOSOPHY IN THE DEPARTMENT OF TEXTILE, FAMILY AND
CONSUMER SCIENCES, SCHOOL OF ENVIRONMENTAL AND
HUMAN SCIENCES, KENYATTA UNIVERSITY**

NOVEMBER, 2004

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DECLARATION

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



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DEDICATION

This thesis is dedicated to my family:

*To my loving mother and parents-in-law, and in memory of my late father,
Stanley Nyaata Mwanacha.*

To my dear sisters, and in memory of my late brother, Steve Mwanacha.

To my loving husband, Lazaro Akunga Kimang'a.

To my adoring children, Lawrence Okeyo, Robert Moseti and Allan Maseese.

ACKNOWLEDGEMENTS

My sincere appreciation goes to my supervisors, namely Prof. Olive Mugenda and Dr. Lucy Ngige, for their enormous input and dedication, which culminated in the realization of this study. I thank them particularly for their academic guidance, encouragement and intellectual support throughout the study. They have been my mentors and have continually shown interest in my academic endeavours. Foremost, I particularly thank the Almighty God.

I am indebted to many other individuals and organizations without whose assistance and contribution this thesis would not have become a reality. I sincerely wish to thank them all for their support throughout this research study. I also wish to thank my colleagues in the Department of Family and Consumer Sciences for their continued support and understanding during my entire research study period.

Further, I thank my husband, Mr. Lazaro Akunga Kimang'a, for his continued motivation, understanding and support throughout this study. Most importantly, he encouraged me to keep on working even when things were rough. He has been a great source of inspiration and strength throughout the entire research study period. My special thanks also go to my children, Lawrence, Robert and Allan, for their understanding during the entire time I worked on this thesis. They were occasionally denied motherly love and attention at a time they indeed needed them. My special thanks also go to my mother, parents-in-law, my late brother, sisters, friends and all other relatives for their prayers, support and encouragement during the course of my study.

I further give my special thanks to individuals and organizations that supported me in various ways. In particular, I would like to thank Dr. Abel Mugenda, Dr. Daniel Muia and Mr. J. Kihoro for their contribution in data analysis and editing my work. I also recognize the assistance accorded to me by the Ministry of Education, Science and Technology, the Children's Department, the Nairobi provincial administration and the Nairobi City Council.

Last but not least, I am grateful for the communities where I conducted my research, particularly Kibera Community Self Help Group (KICOSHEP), for their assistance in identifying children orphaned by HIV and AIDS and their caregivers. Additionally, many thanks go to the caregivers and the orphaned children for participating in this study, particularly for opening up and pouring their hearts out to tell the very sad stories of their lives. Without their cooperation, this study would not have been possible. Similarly, many thanks go to the community leaders and community care programme leaders for their willingness to participate in the study.

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
CBOs	Community Based Organizations
CBS	Central Bureau of Statistics
CESA	Comprehensive Education Sector Analysis
CNSP	Children in Need of Special Protection
FGD	Focus Group Discussion
FHI	Food for the Hungry International
GOK	Government of Kenya
HACI	Hope for African Children Initiative
HIV	Human Immuno-deficiency Virus
ILO	International Labour Organisation
KCO	Kenya Country Office
KICOSHEP	Kibera Community Self Help Group
MOH	Ministry of Health
NACC	National AIDS Control Council
NASCOP	National AIDS and Sexually Transmitted Infections Control Programme
NGOs	Non Governmental Organizations
P.IDX	Participation Index
PAR	Participatory Action Research
PLWA	People Living with HIV and AIDS
REEEP	Rural Education and Economic Enhancement Programme
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNCRC	United Nations Convention on the Rights of Children
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Education Fund
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WCRP	World Conference on Religion and Peace
WHO	World Health Organization

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ABSTRACT

Literature reviewed indicates that community care programmes have been initiated to support children orphaned by HIV and AIDS. These children suffer from various problems, including loss of family, depression, malnutrition, lack of access to education and healthcare; loss of property and inheritance; abuse and increased exposure to HIV and AIDS. However, there is no information on gender relationship in their needs, care, and problems faced. There is also no information on community participation in the care programmes assisting orphaned children, and the success of these community programmes in meeting orphan needs. Neither is there any information on the relationships between the orphans being supported by these community care programmes and those without any support, issues that this study sought to address. This study applied community participation paradigm in community care programmes providing care to HIV and AIDS orphans in Kibera Location, Nairobi, Kenya. This paradigm emphasizes and strengthens the role of the community in community programmes. It emphasizes that involvement of the community members in planning and implementation of these programmes enhances ownership and therefore leads to success of these programmes. The study is also supported by the double ABCX model, which describes factors that account for differences in family capability to achieve a new level of balance at both the individual family and the family-community level over time after a situation affecting the family occurs. The study therefore sought to establish community participation in care programmes, as well as the success of these programmes in meeting the needs of orphans. A random sample of 219 orphans and caregivers (55 from a community care programme and 164 not under the programme); 11 community leaders and 13 community care programme leaders in Kibera Location, Nairobi, was surveyed using interviews and focus group discussions. The findings of this study showed that orphan needs for food, clothing, medical care, shelter, education and psychosocial support are not adequately provided for. Findings further showed that the orphans experienced a number of problems, including hunger, inadequate shelter and clothing; being overworked, beaten and quarrelled. The results further indicate that very few caregivers were involved in community care projects. For instance, only 5% of caregivers were involved in planning the activities of community care programmes, while only 2.7% are involved in decision-making. Additionally, very few (17.3%) of caregivers were involved in carrying out activities of the community care programmes, which mostly involves reaching out to orphans and offering home based care and support. At the same time, only 6.8% of caregivers made contributions towards supporting community care programmes. Overall, 56.2% of the caregivers felt that community care programmes were not sufficiently meeting orphan needs, hence not successful, while only 8.2% felt that the programmes were successful in meeting needs of orphans. The rest, 35.6%, felt that the needs of orphans were fairly sufficiently met. There were significant relationships between gender of orphans and assistance required in school fees, with more girls requiring support in school fees. Significant relationships were also observed between orphans in and out of the project and problems of hunger, inadequate clothing and being overworked. The majority of orphans out of the project were overworked. Correlation results show success of community care programmes and, the number of orphans, support provided, needs and problems of the orphans and problems experienced by caregivers. Community participation variables also showed significant relationship with success of community care programmes. The study findings further show that the number of HIV and AIDS orphans and number of problems experienced by caregivers are predictors of success of community care programmes. Based on the findings of this study, there is a need for programmes designed to assist orphans to have an integrated approach towards assisting orphans, thereby striving to

provide for all their needs adequately and checking against any abuses. There is also a need to design programmes to support caregivers and communities affected particularly those without any assistance. In addition, it is important to involve the communities and in particular caregivers in the activities of the community care programmes. It is also important to establish home based care support programmes, establish orphan support networks and advise and encourage parents who are infected with HIV and AIDS to engage and discuss with their children about their future.

CHAPTER ONE

INTRODUCTION

1.1 Background information

Community participation in programmes has been said to be a prerequisite factor in the attainment of development goals. Participation, as pointed out by Mbithi (1974), is an active process whereby beneficiaries influence the direction and execution of development projects rather than merely receive a share of project benefits. Thus, community participation is a means of involving people in planning and taking actions aimed at improving their living conditions.

Participation therefore is seen as dynamic and, to a certain extent, spontaneously generated as a phenomenon serving the self-motivated goals of members of the community. Bwalya (1985) states that the conventional wisdom of local level participation in development is that, first, it increases the quality and relevance of decisions; secondly, it increases the chances of success and mobilization; and lastly, the above, in turn, tend to motivate a sense of self-reliance, and wider and more efficient use of resources. It is further pointed out by Oyugi (1985) that community participation promotes the success of programmes, and without it, programmes are bound to fail. Participation is, therefore, an active process in which participants take initiative and action that is stimulated by their own thinking and deliberation and over which they can exert effective control.

According to Mbithi (1974), participation denotes an intimate involvement whereby people critically influence decisions about how, when and in what form they acquire benefits. Thus, it implies power transfer to target groups and is meant to create the target groups' initiative and tap their potentialities in problem solving. In one way, Jorgenson (1977) argues that the only viable method of solving crisis within communities is to instil a sense of community feeling in them so that they can cater for their own needs. Full participation of

communities in planning and implementation of the programme activities is the key element to the strategy. The foregoing argument seems to be based on the principle that the stronger the participation of beneficiaries in all aspects of the programme, the more successful a programme is likely to be.

Community level programmes have been initiated to address many social problems including assisting children orphaned by HIV and AIDS. Orphan-hood due to Human Immuno-deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) is an emergent social problem. This problem has created a stressful situation for the family and community in making provisions for their care and support. The orphaned children, who live with their caregivers or on their own, get support in form of food, clothing, shelter, education and medical care from these community programmes. Community participation in these care programmes would, therefore, bring about community cohesion and collectiveness in addressing the problems being faced by those caring for orphans. At the same time, participation in these programmes provides a platform for mobilization of resources and also discussion of issues for collective action.

Global statistics indicate that HIV and AIDS has now become a problem affecting all countries worldwide. By the end of 2003, the Joint United Nations programme on HIV and AIDS (UNAIDS) and the World Health Organization (WHO) indicate that HIV and AIDS, now the leading killer in Sub-Saharan Africa, has taken the lives of 16.3 million people since it was first reported in the early 1980s. The report also estimates that 87% of children living with HIV and AIDS in the world live in Africa. The number of orphans globally is 11.2 million, 10.7 million of whom live in Sub-Saharan Africa.

In Kenya, over 2.2 million people are living with HIV and AIDS, while 1.5 million have died of AIDS since it was first reported in 1984 (UNICEF, 2002). These deaths have left large numbers of orphaned children needing care and support. In a report by the United

Nations Children's Education Fund (UNICEF) (2002), estimates indicate that in 2002, there were 1.3 million orphans in Kenya and the figure is projected to rise to 1.78 million by 2005 and to 2.2 million by 2010.

According to a report by National AIDS Control Council (NACC) (2003), Nairobi is one of the areas with high HIV prevalence rates in the country. Orphans are distributed among areas roughly in the same patterns as HIV prevalence, such that the areas with the highest infection levels often also have the highest orphan rates. According to the UNICEF (2002) report, Nairobi has the largest number of children orphaned by HIV and AIDS. It is estimated that Nairobi has 68,882 orphans and this number is projected to rise to 134,377 by 2005 (Appendix D).

The increasing number of orphans has had a tremendous strain on social systems at family and community levels in providing for their care and support. At the national level, there is increased burden on society to provide services such as orphanages, healthcare and education for these children. Traditionally, members of the extended families adopted orphans, however, due to the increasing numbers of orphans, economic and social pressures, the extended family network has been overstretched and is no longer able to provide a safety net for the ever-increasing numbers of orphans (ACTION AID-Kenya, 1995; Barnett & Blaike, 1992). These children, as indicated by Hunter and Williamson (1997), suffer a catalogue of deprivations and vulnerabilities which include loss of family, depression, malnutrition, lack of access to education and healthcare, homelessness, loss of property, loss of inheritance, abuse, neglect and increased risk of HIV infection. While the extended family in Kenya has traditionally fostered orphaned children, the growing number of these children has already overwhelmed the traditional care structures in the country. Most communities are seemingly overwhelmed by the large numbers of orphans, and therefore can hardly provide adequate assistance.

Government authorities, Non Governmental Organizations (NGOs) and communities have come out in response to the needs of these orphans. While studies have been carried out to ascertain the needs of these children (GOK/UNICEF, 2000; HACI, 2002; Hunter & Williamson, 1997; Saoko & Mutemi, 1994; WCRP/UNICEF, 2002), information on community participation in these programmes and the associated care and support of orphans is scarce. This study therefore applied the community participation paradigm in care and support of children orphaned by HIV and AIDS, and also sought to establish the success of community care programmes in meeting the needs of these orphans.

1.2 Statement of the problem

From the foregoing, it appears that the role of communities in addressing the needs of orphans cannot be gainsaid. A study by Hope for the African Children Initiative (HACI) (2002) indicated that community contributions, which include both human and non-human resources, are required to initiate, build capacity and promote supportive conditions for the care programmes. Lack of these resources hampers the achievement of the programme goals. Equally important is community involvement in planning, decision-making and implementation processes in achievement of the set goals. The community members should also make contributions required to meet the set goals. Through their participation in the programmes, they are able to initiate programmes they want and can afford to sustain.

The more a community is involved, the greater the chance of success of their initiatives in caring for the orphans. This study therefore sought to apply the community participation paradigm in the care of orphans to establish the community's participation in these programmes. It also sought to find out the success of community care programmes in meeting the needs of orphans.

1.3 Purpose of the study

The purpose of this study was to apply the community participation paradigm in orphan care programmes to establish the community's participation in these programmes and also determine the success of community care programmes in meeting the needs of orphans in Kibera Location, Nairobi, Kenya.

1.4 Research objectives

The specific objectives of this study were to:

- a) Identify the socio-demographic and economic profiles of the caregivers and orphans.
- b) Identify the needs and problems of children orphaned by HIV and AIDS.
- c) Determine the care and support provided to the children orphaned by HIV and AIDS.
- d) Establish the nature of community participation in care and support of orphans.
- e) Determine the success of community care programmes.
- f) Determine the relationships between independent variables (socio-economic, care and community participation variables) and the dependant variable (success of community care programmes).

1.5 Hypotheses

The study hypotheses are as follows:

- a) There is a relationship between gender of orphans and their needs.
- b) Types of problems experienced by orphans are associated with their gender.
- c) Gender influences the form of assistance required by orphans.
- d) The needs of orphans are determined by whether the orphans are in or out of community care project.
- e) There is a relationship between orphans in and out of community care project and the type of problems they experience.

- f) The form of assistance required by orphans is associated with whether the orphans are in or out of community care project.
- g) The care provided to orphans by caregivers is related to whether the caregivers are in or out of community care project.
- h) The problems experienced by caregivers while caring for orphans are associated with caregivers being in or out of community care project.
- i) Caregivers' status of being in or out of community care project influences their attendance at community care programme meetings.
- j) There is a relationship between caregivers in and out of community care project and their involvement in planning community care programme activities.
- k) Caregivers' involvement in decision-making activities in community care programmes is determined by whether they are in or out of the project.
- l) There is a relationship between caregivers in and out of community care project and their participation in carrying out community care programme activities.
- m) Caregivers' other contributions towards community care programmes are determined by whether the caregivers are in or out of the project.
- n) There are differences between orphans and caregivers in:
 - Length of stay with caregivers.
 - Needs of orphans.
 - Needs not adequately met.
 - Problems experienced by orphans.
- o) There are differences between in and out of project orphans in:
 - Length of stay with caregivers.
 - Needs of orphan.
 - Needs not adequately met.
 - Problems experienced by orphans.

- p) The success of community care programmes is determined by the following factors: age, gender, education, marital status and occupation of caregivers; number of children, number of HIV and AIDS orphans, needs of orphans, care provided to orphans, problems of orphans, problems experienced by caregivers, caregivers' participation in planning, involvement in decision-making process, caregivers' attendance at meetings, caregivers' involvement in carrying out activities and contribution made to community care programmes.

1.6 Theoretical framework

This study is based on the community participation paradigm (Yeung & McGee, 1986), which was derived from a systems theory. The study is also supported by the Double ABCX Model, which was developed by McCubbin & Patterson (1983).

1.6.1 Systems theory

A system is an integrated set of parts that function to accomplish a set of goals. It consists of sub-systems, which are a A system set of components functioning together for a purpose, fulfilling the same conditions as a system and playing a functional role in a larger system (Deacon & Firebaugh, 1988). The sub-systems consist of inputs, throughputs and outputs. Specific forms of input entering the system are classified as resources and demands. Demands are either goals or events that require action. Goals are defined as value-based objectives that give direction and orientation to action. On the other hand, events are unexpected or low probability occurrences. In other words, inputs are comprised of matter, energy, and/or information entering a system in various forms to affect throughput (transformation) processes in the achievement of outcome or output. Throughput is defined as transformation of matter, energy or information by a system from input to output. It comprises planning and implementing. The transformation process includes decision-making and the process of evaluation in choosing or resolving alternatives. The final component of

the system is output. Deacon and Firebaugh (1988) define it as met demands. Output could be in form of the achieved goals.

1.6.2 Community participation paradigm

This paradigm is derived from a systems theory. It is divided into three parts, namely, input, throughput, or conversion, and output. In this paradigm (Yeung & McGee, 1986), the environment forms the input and this includes the infrastructure that is in place in the community, human resources, information and cultural factors, and any events, among others. The throughput focuses on the internal processes that a system undergoes to achieve completion so as to attain the set goals; it comprises planning and implementing of the activities to be undertaken. Throughput includes dynamic interaction between members of the community of ideas, knowledge, services and people that occurs through the facilitation of others in the community working towards a common goal. It includes decision-making and the process of attending meetings to discuss issues as they arise, and evaluation in choosing or resolving alternatives. The output comprises the results achieved; this includes the achievement of the set goals.

The paradigm emphasizes and strengthens the role of the community such that the community members are involved in planning and implementing projects to serve the community. It emphasizes the establishment of better collaboration and cooperation between agencies dealing with communities and the community members. It calls for readiness and acceptance in working together as partners of all stakeholders in decision-making leading to successful community participation and thereby achievement of the goals set.

1.6.3 The Double ABCX model

This model developed by McCubbin & Patterson (1983) describes factors that account for differences in family capability to achieve a new level of balance at both the individual family and the family-community level over time after a situation affecting the

family. The model has various components including:

Stressors: These are events and situations that arise from individual and community demands and the accompanying challenges in the family e.g. sickness and death.

Resources: These are assets and capabilities that a family has for meeting the demands and needs that arise. They could be personal, family and community resources, like education, finance, skills, relationships and community networks.

Perception: This includes the view, understanding and meanings attached to a situation by the family.

Adaptation: This is the family's capacity to adjust and manage the situation.

The model explains how some families manage situations. While not all events call for major changes in the family's pattern of life, some may call for major changes and hence reorganization of the family in response to a situation.

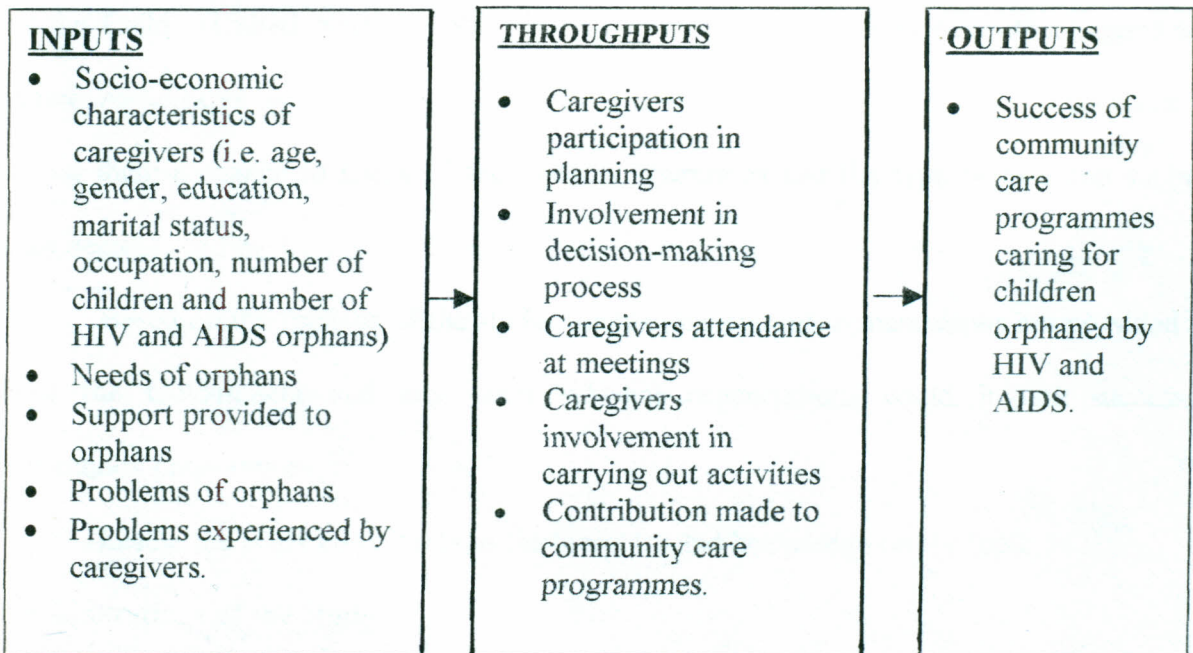
1.6.4 Conceptual Model

By use of the community participation paradigm sub systems of inputs (environmental factors), throughputs (transformation processes) and outputs (achieved results) and the double ABCX model of stressors (situations affecting the family) resources (human and materials for addressing the situation), perceptions (held by the family regarding the situation affecting them) and finally how the family will adopt to the new situation, a model was constructed. The model depicts a set of concepts and their relationships, and was characterized by **input, throughput** and **output**. The inputs consisted of the socio-economic characteristics of caregivers and orphans (i.e. age, gender education, marital status, occupation and number of children), needs of orphans, support provided to orphans, problems of orphans and problems experienced by caregivers. These inputs are used to affect throughput (transformation) processes in the achievement of outcome or output.

Throughput is defined as transformation of matter, energy or information by a system

from input to output. Throughputs are used to transform the inputs into the outputs and mainly comprise planning and implementing. In this study, the throughputs included community participation in planning, decision-making processes, attendance at meetings participation in carrying out activities and making contributions to community care programmes. The final component of the system is output. Deacon and Firebaugh (1988) define it as met demands. Output could be in form of the achieved goals, which, in this case, is success of community care programmes in meeting the needs of children orphaned by HIV and AIDS. Below is a diagrammatical presentation of a conceptual community participation model.

FIGURE 1: Diagrammatical presentation of a conceptualised community participation model



Source: Adopted from community participation paradigm by Yeung and McGee (1986), and systems theory by Deacon and Firebaugh (1988).

1.7 Significance of the study

This study identified the needs and problems faced by HIV and AIDS orphans. This information will be useful to the Children's Department and other organizations dealing with children for future planning of intervention programmes.

The results of the study will also increase awareness of the needs and problems faced by HIV and AIDS orphans and caregivers and the assistance they require among communities and agencies dealing with children, and motivates such organizations to act upon the information. The areas that need strengthening in the existing community care programmes are highlighted. These could be acted upon by the relevant authorities for improvement and/or to initiate others.

This study also promotes Article 12 of the United Nations Convention on the Rights of the Child (United Nations, 1989), which establishes children as subjects of rights and active participants in their own lives with views and information. This was achieved by giving them a chance to speak of their needs, aspirations and the type of care and support they need.

Based on the findings of the study, suggestions and recommendations are provided on how the Government and any other relevant organizations could initiate successful community programmes.

Lastly, the study contributes to the literature and knowledge on the topic.

1.8 Limitations of the study

The younger orphans, below five years of age, were not interviewed. This is because it was felt that the issues were too sensitive and could further traumatise them.

The study was to a certain extent exploratory and, therefore, suffered limitations in

terms of paucity of relevant literature. Equally, the findings of this study can only be generalized with caution, as it was to some extent a case study design.

1.9 Underlying assumption

The major assumption underlying this study was that children orphaned by HIV and AIDS were receiving some form of assistance from either relatives or any other form of structure or source.

1.10 Theoretical definitions of terms used

Caregiver: A person who provides for the needs of others and/or lives with them.

Child: All persons under the age of 18.

Community care programme: This is a programme initiated at community level intended to assist families and other community members in caring for orphans.

Community Leaders: These are persons who hold social positions and influence decisions that affect the community. These include religious leaders, chiefs, women group leaders, youth leaders, community based organizations (CBO) leaders and non-governmental organizations (NGO) leaders.

Community participation: This is active involvement of community members in initiating and implementing activities of programmes within their community.

HIV and AIDS orphan: A child under the age of 18 who has lost both parents due to HIV and AIDS.

Household: This is a group of persons living together under one roof. They are under the responsibility of the same household head and share a common source of income.

Orphan: A child under the age of 18 who has lost both parents.

Kiosks: These are small-scale shops.

Inputs: These are specific forms of matter, energy and or information that enter a system for transformation to achieve the desired results.

Throughput: These are the transformation processes that the input undergoes so as to achieve the desired results.

Output: These are the desired results.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter reviews literature on the conceptualisation of community participation in programmes, HIV and AIDS pandemic, the impact of HIV and AIDS, HIV and AIDS and children, and community care programmes for children orphaned by HIV and AIDS.

2.2 The conceptualisation of community participation in programmes

Community participation in programmes has been said to be a prerequisite factor in the attainment of development goals. According to the United Nations Task Force on Rural Development (1977), participation is defined as:

An active process in which the participants take initiative and action that is stimulated by their own thinking and deliberation, and over which they can exert effective control. The idea of passive participation, which only involves the people in actions, that has been thought out or designed by others is unacceptable.

This approach is a means of involving people in planning and taking actions aimed at improving their living conditions. The issue of people's involvement in development activities has taken centre stage in a development agenda. Timberlake (1985) argues that development agencies in Africa often without experience themselves, but involving people in their programmes, have succeeded to bring about development.

Participation denotes an intimate involvement whereby people critically influence decisions about how, when and in what form they acquire benefits (Mbithi, 1974). It implies power transfer to target groups and is thus meant to create the target groups' initiative and tap their potentialities in problem solving. This is the case mainly because it is the people who are well informed about their issues and have a better understanding of their needs. They should be involved in making all forms of decisions that entail management of the

programmes. As pointed out by Chitere (1980), delegation of authority to make decisions regarding the various activities of programmes they are required to undertake will permit them to tailor these activities to needs of communities and individual families affected. As such, one viable method of solving the orphan crisis is to instil a sense of community feeling in them so that they can cater for their own needs. Since the government's ability to cater for orphans is limited by inadequate finances, it is necessary to create motivation and concern in people through involving them so that they can cater for their orphans within their communities.

Mbithi (1974) further points out that participation includes involvement of the local people in project planning and implementation stages. Important in this regard is to involve the community in project planning and resource mobilization. Through discussions, the community members get to identify their needs and prioritise them, while at the same time looking at ways of addressing these needs. Through these discussions, community members determine the course of events of participation in the programme process. It is from this perspective that Chambers (1983) argues that one needs to tap local people's knowledge. Otherwise, plans and set activities, which are passed to communities to implement, make it difficult for them to identify the real priorities and hence adapt such plans and activities to local conditions. There is therefore need for participatory action between the people and the programme staff in formulating appropriate ways and means of attaining the goals, and the more the community is involved in planning, the greater the chance for success of the programmes. The overall picture, which emerges with regard to people's participation, is the issue of people's empowerment to determine their destiny.

The foregoing argument seems to be based on the principle that the stronger the participation of beneficiaries in all aspects of the programme, from planning to implementation, the more successful the programme is likely to be (Russel, 1983). On the

other hand, Chambers (1983) sees participation as tapping the local peoples knowledge and starting from what they know and what they have. Chambers's conception seems to recognise the fact that the community represents the single largest knowledge source not yet fully utilized and which cannot be simply ignored. Thus, development agencies that initiate community programmes need to open up to knowledge inputs from those people whom they set out to assist.

2.2.1 Levels of community participation

Participation in community programmes can be categorized into different levels. These levels of participation often have an implication for success and sustainability of the project. This is because high levels of participation are linked with success of projects. The basic criterion is the extent of control a community has over identification and management of its programmes. A report by FAO (2002) identified six levels of participation. The levels are:

- a) **Passive:** People participate by answering questions and they are basically told what is going to happen.
- b) **Consultative:** People express their views, which may be taken into account, but have no share in decision making.
- c) **Material incentives:** People participate in activities in order to receive something, like food. However, there is still no decision-making and participation often ends when the incentives end.
- d) **Functional:** People form groups and carry out activities to meet project objectives, but there is no involvement in choosing objectives, and minimal involvement in choosing activities. Some groups may in time become stronger and more self-reliant.

- e) **Interactive:** People participate in joint analysis and planning, while staff undertake joint decision-making.
- f) **Self-mobilization:** People take initiatives independently. They develop contacts with external institutions, where necessary, to access technical expertise and funding, but retain control over decision-making.

2.2.2 Benefits of participation in programmes

Participation can also be conceptualised as dynamic and to some extent spontaneously generated as a phenomenon serving the self-motivated goals of members of the community. This is particularly so if some of the advantages of participation in development are appreciated. Bwalya (1985) states that the conventional wisdom of local level participation in development is that: First it increases the quality and relevance of decisions; secondly, it increases the chances of success and of mobilization; and lastly, the above in turn tend to motivate a sense of self-reliance and wider and more efficient use of resources.

Chitere (1994) has argued that the need for participation of local people in development is underlined by a number of reasons. First, people tend to resist measures or suggestions that are imposed on them. Their involvement therefore makes them internalise the suggestions and further make any changes that are applicable to their conditions. Second, local participation is also needed because it permits mobilization of local resources and their use in achieving the set goals. Community resources, which may entail financial and material contributions, and their time and skills, are required to initiate, build capacity and promote supportive conditions for the care programmes. Community members should make contributions required to meet their set goals. As such, they are able to initiate programmes they want and can afford to sustain. Furthermore, when the community participates in all stages of a project, the opportunity to consider the financial consequences of various service levels is presented. This enables them to debate on the pros and cons of various options and

select the most appropriate system for their perceived needs. Third, participation permits growth of local capacities, which develop out of the establishment of a partnership between the programme staff and the community. Fourth, participation helps reduce the growing sense of lack of community which comes with the weakening social relationships in society and fifth, participation tends to reduce alienation which prevents members from identifying with their communities. Finally, participation ensures overall communication, control and planning and permits members to hold together and work toward attainment of the goals of their programme. This is so in that many organizations are held together by functional rather than normative integration and that it is felt that without participation, the programme would likely split and not effectively work to attain its goals. Community participation is therefore an attempt at people's involvement in issues that affect them and their development.

2.2.3 Challenges to participation in community programmes

In most organizations and development situations, as pointed out by Chitere (1980), planning of activities is done at higher levels, outside the community, a fact which leaves little or no room for these activities to be tailored to needs and constraints of local communities. When decision-making is done at other levels without involving the local community, the people responsible for implementing the programmes and other issues that may affect the programme pay little attention to involvement. In such a situation, people are not involved effectively in making decisions about activities of programmes, which they are required to implement. They are not even consulted about what they are required to do. The situation which prevails is one in which plans are formulated by the programme staff with set activities which are passed down to the communities to implement, a fact which as Mbithi (1974) has noted makes it difficult for communities to fit them in their reality.

Researches done by HADI (2002) and World Conference on Religion and Peace—(WCRP) and UNICEF (2002) show that community programmes assisting orphans are

characterised by lack of adequate resources, lack of knowledge and skills, lack of adequate facilitation and mobilization efforts, low community participation in the programmes and inflexible planning. These various organizational problems help understand why most community programmes have not worked effectively. This implies that any community programme should involve participation of people in identification of their problems and ways of addressing those problems. The people should be organized to develop their own administrative and development capacity. The community members should determine the course of events for participation in the programme process. This calls for participatory action between the people and any development agency in formulating appropriate ways and means of attaining the goals.

2.3 HIV and AIDS pandemic

The story of HIV and AIDS began in 1979 when doctors in the United States of America observed clusters of previously extremely rare diseases. This included a type of pneumonia carried by birds (*Pneumocystis carinii*) and a cancer called Kaposi's sarcoma. Subsequently, these cases increased rapidly and the first cases were among homosexual men. As a result, the disease was called Gay Related Immune Deficiency Syndrome (GRID). However, American scientists began to see cases among other individuals, initially mainly haemophiliacs and recipients of blood transfusions. Subsequently, the syndrome was identified among injecting drug users, and infants born to mothers who used drugs (Barnett & Whiteside, 2002). It was then apparent that this was not a gay disease and it was renamed "Acquired Immunodeficiency Syndrome" (AIDS).

The illness was later seen simultaneously in a number of countries outside the United States of America. AIDS has now become a problem affecting all countries worldwide. By the end of 2003, the joint United Nations programme on HIV and AIDS and the World Health organization estimated that over 42 million people were infected with HIV and AIDS.

The disease, now the leading killer in Sub-Saharan Africa, has claimed the lives of 16.3 million people since it was first reported in the early 1980's.

In Kenya, the first case was reported in 1984, and since then, the numbers of those infected have risen drastically. According to a report by National AIDS Control Council (NACC) (2003), 2.2 million Kenyan adults were living with HIV and AIDS while 1.5 million people in Kenya had died of AIDS since the epidemic started early in 1980s. Out of these, 1.41 million are adults and the remainder children. If no interventions are introduced, the cumulative number of deaths due to HIV and AIDS in Kenya may rise to 2.6 million by the end of 2005 with about 200,000 to 300,000 adult deaths per year by the same period.

Available data from National AIDS/STIS control Programme (NAS COP) (2003) shows that 80-90% of infections and resulting deaths are in the 15-49 year age group. Since this is the most economically productive segment of the population, these deaths constitute a serious economic burden. This is also the age when investments in education are just beginning to pay off. Additionally, these deaths also have severe consequences for children since most people in this age group are raising young children. According to the orphan programming report in Kenya by United States Agency for International Development (USAID) and UNICEF (2000), areas with very high infection levels border Lake Victoria, and form a corridor from there to Nairobi. Medium levels of infection can be found adjacent to the highly infected lakeside districts to the north and southeast of Nairobi; around Mombasa (Coast) and on the Ethiopian border to the north. Lower levels of infection are found in most northeast, northwest and the Tanzania border districts. Orphans are distributed among areas in the same patterns as HIV prevalence such that the areas with the highest infection levels often have the highest orphan rates.

The proportions of infected adults and children and the number of orphans have increased and will continue to increase rapidly over the next five years (USAID/UNICEF,

1999). Currently, there are estimated to be 1.3 million orphans in Kenya. These numbers are projected to rise to 1.7 in 2005 and 2.2 million in 2010 (UNICEF, 2002). This is about 20-24% of all children. Most communities have been overwhelmed by the large numbers of orphans and can hardly provide any assistance. Furthermore, communities help orphans initially but they get drained, tired and give up (GOK/UNICEF, 2000).

2.4 Impact of HIV and AIDS

One of the worst impacts of AIDS is death of young adults, which has resulted in an increase in the number of orphans. This has led into tremendous strain on social systems at family and community levels to cope with such a large number of orphans. Many of these children go without adequate healthcare and education, thereby increasing the burden on society to provide services such as orphanages, healthcare and education. AIDS will also have a significant impact on population size. It is estimated that with AIDS causing increased deaths, the total population of Kenya could decrease by 3.6 million by 2005 (ROK-NACC, 2000). This is due to the combined impact of AIDS deaths and fewer births because of a smaller reproductive age population since most of the infections resulting to deaths occur in the reproductive age bracket of 15-49 years (World Bank, 2000).

The health sector is central to a successful response to the HIV and AIDS epidemic, since overall development of a country is dependent on the health of its people. HIV and AIDS has negatively impacted on the health sector by increasing the number of people seeking health services and increasing the overall cost of health-care in the country. In Kenya, substantial amounts of resources are needed to care for, and treat HIV and AIDS patients. The strategic plan by NACC (2000), estimates that the cost of hospital care for all HIV and AIDS patients, using a low-cost scenario, would rise to Kshs.3.7 billion in 2010 from Kshs.480 million in 1990. The high-cost scenario was projected to rise to Kshs.11.2 billion by the year 2010.

Individuals, families and businesses have also felt the economic impact of HIV and AIDS through decrease of labour and income, and increase in costs. HIV and AIDS have also had a multiple negative impact on education. It has affected the demand for education, supply of education, quality of education, content and process of education (World Bank, 2000).

2.5 HIV and AIDS and children

The prolonged illness, increased probability of losing both parents, and the stigma associated with HIV and AIDS increase the chances that the orphaned children will be denied their rights. The economic impoverishment that accompanies HIV and AIDS illness and death has serious implications for children's access to basic needs such as food, shelter, health, clothing and education. The impact of HIV and AIDS on orphans and other vulnerable children is substantial for the children themselves, the families that step in to take care of them and the communities in which they live. Not only do children lose the security and safety of their immediate families, they frequently end up taking adult responsibilities at a very early age. They provide care for ill or dying parents, take over farm and household work, care for younger siblings and work to earn money for basic necessities. As such, orphans are forced to leave school, have less access to health-care and become vulnerable to malnutrition as family resources dwindle (FHI, 2001). Children are impacted adversely by HIV long before they lose their parents; they are stigmatised, discriminated against, they drop out of school to help care for and engage in labour to earn money to support their parents and siblings. The increasing rise in AIDS-related deaths and the number of children affected by HIV and AIDS threaten the survival and perpetuation of certain families and communities. The growing demand for care and support of orphans and vulnerable children at the community level has strained traditional coping mechanisms.

Additionally, as reported by Hunter & Williamson (1997), orphaned children suffer a catalogue of deprivations and vulnerabilities, including loss of family, depression, malnutrition, lack of access to education and health-care, homelessness, loss of property, loss of inheritance, abuse and neglect and increased risk of HIV infection. While the extended family in Kenya has traditionally fostered orphaned children, the growing number of these children has already overwhelmed the traditional care structures in the country. Most communities are overwhelmed by the large numbers of orphans and can hardly provide any assistance. Thus orphans miss out on education, health care, growth, development, nutrition, shelter and a right to a humane standard of living due to the unaffordable human and social costs needed to provide adequate care and support.

Children have to bear the trauma of seeing their parents weaken day by day due to HIV and AIDS and finally die. With such trauma, as pointed out in a report by GOK/UNICEF (2001), children become withdrawn, have low self-esteem and are depressed. Some children keep away from their parents in fear of contracting their infections. They even refuse to eat food presented to them by their parents. As a result of severed parent-child relationship before death, many parents with HIV and AIDS are unlikely to prepare their children for their deaths. This has a very strong implication for the fostering arrangements that should be made by parents living with HIV and AIDS. In most cases, parents of such children died even without writing a will. This anomaly left the children in very difficult circumstances with their relatives when it came to estate distribution.

Orphans run a greater risk of being malnourished and stunted than children who have parents to look after them. In most cases, children who have been orphaned by AIDS may also not receive the health care they need. This is because as pointed out in a report by GOK/UNICEF (2000), it is sometimes assumed that they are infected with HIV and their illnesses are untreatable. Increasingly, children whose parents are dead accumulate even

greater burdens of responsibility as head of households when a grandparent or other guardian or caregiver dies. Furthermore, orphans enduring the grave social isolation that often accompanies AIDS when it strikes a family are at a far greater risk than most of their peers of eventually becoming infected with HIV. Often emotionally vulnerable and financially desperate, orphaned children are more likely to be sexually abused and forced into exploitative situations, such as prostitution, as a means of survival.

A situational analysis on orphans in Kenya carried out by the Government of Kenya (GOK) and UNICEF (2001), indicates that AIDS has diminished families' capacity to grow food or even earn money to buy it even while both parents are alive, and the death of the parent further worsens the situation. As a result, children consume less food and what food they do eat is less nutritious. In the same study, it is pointed out that relatives who took in orphans were themselves lacking sufficient food for their own families. Most of the children were reported to have one meal per day.

The same study further pointed out that many HIV and AIDS orphans and vulnerable children were dropping out of school and some of them never start school at all. Many caregivers were reportedly not able to pay school fees, meet the cost of school uniforms, books and other related expenses. In a study by Ferguson and Johnston (1997) in Rusinga Island, it was found out that there is a greater tendency for AIDS afflicted households to be associated with male drop-out in primary school (56%) compared to 39% in non-afflicted households. In this case, boys were expected to participate in economic activities such as fishing to augment household income and to provide for school expenses for younger siblings. These findings are consistent with those of a study by Saoke & Mutemi (1994), who found that 40% of orphans had dropped out of school due to lack of money.

While most orphans are likely to drop out of school, the girl child is more vulnerable to loss of educational opportunities during parental illness and after death. There is greater

reluctance on the part of relatives to support girls in school after parental loss (Ferguson & Johnston, 1997). In many communities, girls are deemed culturally more suited to providing home-based care for ill parents and to perform household duties.

Children orphaned and infected with HIV and AIDS are also at risk of being discriminated against the regular school system. For example, infected children residing in Nyumbani, a home for abandoned children in Nairobi, were being denied an opportunity to join public schools in the neighbourhood (Daily Nation, January 6, 2004; WHO/UNICEF, 1994). These children were also likely to have limited access to health services than were other children due to its high costs. In a study by Soake & Mutemi (1994), it was pointed out that 100% of caretakers of HIV and AIDS orphans identified access to medicines as one of the most difficult.

While the extended family continues to play a significant role in supporting children orphaned by HIV and AIDS, care and support for orphans has primarily focused on addressing their material needs and little is done about their psychosocial well-being. On the other hand, the growing demand for care and support of orphans at the community level has strained traditional coping mechanisms. Economic and cultural pressures have seen the extended family deprive widows (Soake & Mutemi, 1994) and orphans (Ferguson & Johnston, 1997) of their inheritance. In their study, Ferguson & Johnson (1997) found that 18.9% of adolescent children orphaned by HIV and AIDS in Rusinga Island had lost land and fishing boats following parental death. In patrilineal cultures, orphaned children and particularly boys from single mothers are often denied their property rights (GOK-MOH, 1997). In some cases, the extended family will take in orphans with the motive of later denying them their inheritance (Soake & Mutemi, 1994). Extravagant traditional bereavement

practices also contribute to the loss of family property. Amongst the Luo and Luhytraditions, for instance, tribute to the dead entails the slaughter of a cow and other domestic animals in a homestead to feed the mourners.

A host of cultural practices and the limited educational opportunities available to the girl orphan predispose her to sexual abuse and exploitation within and outside the family. In some parts of Busia, young virgins including orphans have been raped in AIDS cleansing rituals perpetuated by miracle healers (Daily Nation, September 22, 1999). As the problem escalates, the Rural Education and Economic Enhancement Programme (REEEP) has organized AIDS awareness campaigns to curb ritual cleansing and provides counselling for school girls who are victims of the rituals (Daily Nation, September 22, 1999).

Needs of orphans, just like other children, vary with their age and sex. Children orphaned by HIV and AIDS have the same needs as children orphaned by other causes. However they are traumatized, these children suffer additional discrimination and stigma that is attached to HIV and AIDS. Increasingly, children whose parents are dead accumulate even greater burdens of responsibility as head of household when a caregiver dies. Families, communities and governments face an enormous burden for the care of orphans. There is therefore need to make stronger commitment and sustainable efforts to assist these children.

The problem of how to care for the increasing numbers of orphans and vulnerable children will be a long-term issue for Kenya. Even if HIV prevalence levels off now, deaths of those already infected with HIV and the number of orphans will continue to increase for years to come.

2.6 Care programmes for children orphaned by HIV and AIDS

The community, through various ways, has responded to the need to support children orphaned by HIV and AIDS. Traditionally, whenever there was death or illness of a parent(s) in most Kenyan communities, assistance was assured through networks within extended

families. These traditional community coping mechanisms are now inadequate because of the large numbers of orphans and other vulnerable children involved, as well as the very difficult financial conditions associated with poverty. With these ever increasing numbers of children needing care, families and communities have responded in various ways. Assessments done on orphan care and support in Kenya (GOK/UNICEF, 2001; HAI, 2002; WCRP/UNICEF; 2002) indicate that there are various forms of care for orphans, these include:

- i) Community based care and support.
- ii) Institutional care.

I. Community-based care and support

Community-based care takes many forms. This includes:

- a) Informal fostering.
- b) Formal fostering and adoption.
- c) Communal fostering.
- d) Extended family.
- e) Community care.

Informal fostering: This is a form of care whereby orphaned children are taken in to live with neighbours or other families. It is an informal arrangement at a community level and it may come to an end at any time and, in such a case another foster parent may be sought. Such informal arrangements destabilize the children as they keep moving from one caregiver to another. The foster family lives with the children and is responsible for their provisions. They sometimes receive support from other well-wishers.

Formal fostering and adoption: In this form of care, fostering or adoption is done by families and is arranged through social and welfare services. Through such arrangements, the children are adopted legally and stay with the foster family, which

cares for the child and provides for all their needs.

Communal fostering: Communal fostering entails orphan family groups living in a community or communal setting with foster mother or house parents. In such cases, a certain number of the children are accommodated together under the care of a suitable foster mother. The foster mother with support from the community manages the home as a family unit and is responsible for the children entrusted to her.

Extended family: This is a case whereby the orphans live with grandparents, aunts or uncles or other relatives. Studies show that orphans in Kenya are still largely being absorbed by the extended family (Saoke & Mutemi, 1994; USAID/UNICEF, 1999). The extended family network is singled out as the most ideal informal care structure for children orphaned by HIV and AIDS (GOK-MOH, 1997; Saoke & Mutemi, 1994). The government's policy is that communities should be persuaded to care for these orphans to avoid their stigmatisation, exploitation and alienation (MOH, 1997). In addition, the extended family provides orphans with opportunities for social and cultural continuity as they adjust to the challenges of orphan-hood. However, with increased economic and social pressure, which is rapidly transforming most of the communities, care must be taken since the extended family network is already showing signs that it can no longer adequately take care of orphans.

The fact that HIV and AIDS infection levels in Kenya are highest among women and men in the 20-24 and 30-39 age groups (NASCO, 1999) respectively, means that more children are living with caregivers who are too old or too young (e.g. young aunts, uncles, or siblings or in a household headed by another child). These groups of people may be too impoverished to provide adequately for the orphans. The extended family system is not infinitely inelastic. In private, some caregivers express dismay about having to restart families late in their lives with the attendant loss of

personal freedom and anxiety about meeting the financial and emotional needs of small children (USAID/UNICEF, 1999). Often the adults themselves are traumatized by multiple deaths within their families just as are the children.

This situation weakens the support orphans can receive from extended families particularly in the most affected communities. Saoke & Mutemi (1994) found that grandmothers cared for 41.8% of orphans. Orphans in such households are likely to have no access to basic needs such as adequate food, health, education and shelter. Further, grandparents often find themselves unable to control and discipline adolescents under their care (Topouzis & Hemrich, 1995). As the pressure on the extended family mounts, orphans are increasingly forced to take care of their younger siblings thus heading their families. Child-headed families constitute 5% of all family types in Kenya (GOK-MOH, 1999). The extent to which orphans' needs are met in these households and the impact of increased household responsibilities on children are issues that need to be addressed in programmes designed to benefit orphans.

Despite the significant contribution of the extended family in supporting children orphaned by HIV and AIDS, several constraints limit the quantity and quality of care that orphans can receive. There are indications that the growing population of orphans and the difficult economic situation in the country has stretched

KICOSHEP in Kibera is an example of such a programme. This is a community self-help project initiated at community level to assist those affected by HIV and AIDS. The centre provides VCT services, medical services, home-based care and support to those infected and affected by HIV and AIDS, and support to AIDS orphans. In this centre, the AIDS orphans are registered and after assessment of their educational background, they are either placed in the community school within the centre or are placed in the formal schools where their education is supported. Within the centre, they are provided with lunch, clothing, and food such as beans, maize and flour when available. In some needy cases, shelter through rental housing is provided. Visitations are also made to the families living with orphans by the social welfare officers to offer counselling and home-based care and support.

household resources, rendering the extended family network largely incapable of adequately meeting the needs of orphans. Studies indicate that although these orphans are absorbed within the extended family, they are discriminated against in the distribution of household resources such as food and education; they are also allocated heavier workloads than are the biological children in the same household (ACTION AID-Kenya, 1995; Barnett & Blaike, 1992; Saoko & Mutemi, 1994). In some cases, HIV and AIDS orphans are not allowed to share shelter, utensils or interact with their cousins.

The geographic concentration of the HIV and AIDS epidemic implies that orphans are likely to be cared for by impoverished families and communities (Hunter & Williamson, 1997). A study conducted in Korogocho, one of the six main slum areas in Nairobi, revealed that 68.4% of the households taking care of HIV and AIDS orphans depended on petty trade as their source of livelihood (ACTION AID-Kenya, 1995). These findings show the fragile nature of the extended family as a support mechanism for orphans and call for efforts aimed at the economic empowerment of households and community participation in provision for the needs of orphans. In some communities with high HIV prevalence rates, the ever-increasing numbers of orphans have overwhelmed the members of the community. In Bondo District, for instance, the growing population of orphans has led the community to become habituated; they see orphan-hood as a normal situation and therefore show no sympathy or serious thought for them (Nyambedha, 1999).

Community care: Various forms of community-based care systems have been developed at the community level to assist orphans and families affected by HIV and AIDS. The Government of Kenya, and both local and international organizations such as non-governmental organizations, faith-based organizations and community-

based organizations have initiated these programmes. The programmes are often organized and managed by the organizations responsible with assistance from the community members.

Community-based support for families and children affected by HIV and AIDS has been viewed as the best alternative for care in many countries. As the number of orphans grows, communities are creating volunteer structures to offer assistance to those families caring for orphans. In a study by HACI (2002), it was established that groups of community members have organized themselves to identify vulnerable children, develop resources through local fundraisings and set up day care centres supporting the children. Other non-governmental organizations, both local and international, have also initiated programmes at community level to assist the children orphaned by HIV and AIDS in provision of their needs. The children, get support in form of food, clothing, shelter, support for education and medical care from the community programmes. In some programmes, the orphaned children and their families are registered and visit the centre for the provisions such as food, clothing and support in education. Most of these programmes rely on volunteers from the community to undertake their activities.

Community mobilization efforts encourage local leaders to protect the property and inheritance rights of widows and orphans, organize cooperative childcare and orphan visitation programmes, and to provide financial assistance support. Communities often rally around activities to provide care for the children. They are motivated not only by compassion and some by religious conviction but also by the recognition that they and or their children may require such help in the future. The more the community is involved, the greater the chance of success of their community initiatives in caring for children, and hence the need for this study to

establish the participation of community members in the community care programmes and the effect on success of the programmes. A most important benefit of community mobilization is the sense of empowerment it provides, that it is possible to have some control over what happens.

Community programmes have also been faced with a number of constraints. A study by HADI (2002) revealed that most community care programmes raise incomes through members' contributions and small income generating activities. Very few receive external funding. Most of them have no long-term planning and lack capacity for the way forward. In some of the programmes, the membership is quite low thereby limiting their capacity to reach out to many orphans.

Findings in the same study further revealed that networking and collaboration with other community care programmes is minimal while most of them existed as closed entities. Assistance offered by most of the programmes was of an ad hoc nature, with little effort at strategic and long term planning, while supervisory systems of the programme activities were also found to be weak and needed strengthening. Additionally, the majority of the community care programmes had no regular meetings to share the progress of the projects and discuss other administrative matters. These community care programmes are faced with some constraints, which include unemployment, poverty and poor health status among caregivers, unnecessary professionalism of approaches, unclear responsibilities of the community members, and lack of knowledge in community organization and counselling. The programmes are severely faced with limited resources and are overwhelmed by children in need. In the low-income areas, like slums, care of orphans is affected by lack of access to services, poor infrastructure and poverty, among others. Caregivers are also found to

be spending 90% of their time securing food, which means neglect of the orphans' other basic needs (USAID/UNICEF, 1999).

A report on orphan programming (USAID/UNICEF, 2000) indicates that, so far programmes have reached only a tiny fraction of the most vulnerable children indicating a need for these intervention programmes to be brought to national scale. This will require development of alternative funding resources including community and voluntary resources. The intervention programmes must be sustainable, meaning that the progress must rely and involve family and community based initiatives and at the same time meet the orphan needs. This, in turn, requires that families and communities work together and be able to support themselves economically.

In light of the growing population of HIV and AIDS orphans and given that the extended family is currently taking care of most orphans, supporting communities through the community programmes and empowering them remains the most cost-effective option of handling the orphan crisis. Organizations working with orphans must recognize and enhance the potential of communities to take care of orphans and involve them for the success of the programmes.

II. Institutional care

This form of care entails keeping orphans in institutions such as orphanages and children's homes. The children live in the institutions and are provided with their basic needs such as food, clothing and shelter, while some institutions offer education. In most of the institutions, the children are kept until the age of 18 (WCRP/UNICEF, 2002), while a few others keep them until 21 years of age, after which they are reintegrated back into society. It is hoped that at this age, they have some form of training, are mature and are able to settle on their own.

Critics of institutionalization of children argue that this is not the best option of caring for children (GOK-MOH, 1997). Such homes have been found to separate orphans from their social environments and family members, particularly their siblings. When these children are put in institutions, there is a likelihood of losing their identity. Further, they may not be able to safeguard their inheritance. As such, when they are eventually reintegrated into society, they may find difficulties fitting in the society, knowing and adjusting to their relatives and following up on their inheritance, which may have been taken by their relatives. Furthermore, as indicated in a study by WCRP/UNICEF (2002), institutionalizing children focuses on assisting the child and not the family unit, which may further create dependency. Moreover, institutionalization is less likely to be holistic in meeting the economic needs of households or the psychosocial needs of children. Besides, assisting the orphan in the family calls for partnership with the caregivers, while in some instances, support offered through income generating activities enables them to care for the orphans.

Despite consensus that institutionalisation care is not the optimal support system for HIV and AIDS orphans (MOH, 1997; WHO/UNICEF, 1994), the increasing number of orphans who are abandoned by the extended family have no choice but to turn to institutions for support. Infected orphans have difficulties gaining acceptance in existing children's homes and are often neglected. The increasing number of HIV and AIDS positive mothers and relatives who abandon babies for fear that they are infected has led to the establishment of homes, such as, Nyumbani and New Life Home, which care for a very limited number of abandoned and orphaned children. Institutions that specifically care for HIV and AIDS orphans may encourage communities that are actively involved in caring for orphans to abdicate their responsibility. In the long run, such institutions must strive to empower the extended family to re-absorb these children.

2.7 Summary of literature review

HIV and AIDS have affected all aspects of social and economic life in Kenya. It has had negative impacts on health, education, and agriculture and lead to the deaths of young adults, which has resulted in an increase in the number of orphans. This has resulted in tremendous strain on social systems at family and community levels to cope with such large numbers of orphans. AIDS has further impoverished families by decreasing household labour and income, increased medical and funeral expenses and affected the demand for education, supply of education, quality of education, and content and process of education.

Children orphaned by HIV and AIDS suffer from various problems. These include loss of family, depression, malnutrition, lack of access to education and health-care, homelessness, loss of property and inheritance, abuse and increased exposure to HIV and AIDS. Once adults fall ill and cannot work, available resources are used for treatment while other family members divert time to provide care to the sick. Children often take over adult work responsibilities at a very early age. They provide care for ill or dying parents, take over farm and household work, care for younger siblings and earn money for basic necessities. HIV impacts children long before they lose their parents; the children are stigmatised, discriminated against, and drop out of school to help care for and engage in labour to earn money to support their parents and siblings. How children cope in such situations is an important issue to document. Although studies have been done to establish the situation of these children, there is no information on gender differences in their needs, care and support problems faced and the extent to which their needs are met.

Community care programmes have been initiated at the community level to assist families and communities in caring for the orphaned children. These programmes assist caregivers taking care of orphans by provision of their basic needs. These provisions include food, support in education, shelter, medical care, clothing and psychosocial support. Whereas

studies have been done to ascertain their existence and the assistance they provide to orphans and caregivers, not much has been done to establish community participation in these care programmes and the success of community care programmes in meeting the orphan needs. Neither is there any information on the relationships and differences between orphans that are being supported with these community care programmes and those without any support, issues, which this study sought to address.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter covers the research design, study area, target population, sample and sampling procedures, data collection instruments and procedures, pre-testing of the instruments and data analysis procedures.

3.2 Description of research design

This was a cross-sectional survey research. In a survey research, data is collected from selected members of the population to determine the current status of that population with respect to one or more variables (Crazian & Raulin, 1993). A survey research design was chosen for this study because it is a good method when a large sample size is required. Furthermore, it provides information about the characteristics, experiences, and opinions in order to generalize the findings to a population that the sample is intended to represent. In this case, it would describe and explain the prevailing circumstances or conditions related to care of children orphaned by HIV and AIDS and yield data derived from self-reports of the respondents.

The study uses both quantitative and qualitative approaches in collecting and analysing the data. According to Dietrich & Kearns (1989), the quantitative approach is a scientific method of evaluation, which yields observations, or measurements that are numerical for various purposes. For example, the calculation of a statistic yields a single score that represents many scores. This approach is by nature structural, predetermined and specific (Gall, Borg & Gall 1999).

The qualitative approach, on the other hand, yields data, which are observations that can be classified into non-numerical categories (Dietrich & Kearns, 1989). This approach was

chosen because it focuses on naturally occurring ordinary events in natural settings and thereby allows the respondents to express themselves more freely. This approach yields data that are collected in close proximity to a specific situation and thus has a strong potential for revealing complexity and providing thick descriptions that are nested in real context (Miles & Huberman, 1994). Furthermore, qualitative data is well suited for locating the meanings people place on the events, processes, and structures of their lives; their "perceptions, assumptions, prejudgements, presuppositions" and for connecting these meanings to the social world around them (Miles & Huberman, 1994).

To the extent that quantitative and qualitative approaches compliment each other, both approaches were utilized in this study.

3.3 Selection of the study site

The study was carried out in Kibera Location of Kibera Division in Nairobi District. Nairobi District is the most densely populated urban area in the country and is grouped among the areas with high HIV prevalence rates in Kenya (i.e. between 20-29% for the 15-49 year olds) (USAID/UNICEF, 1999). According to the situation analysis (UNICEF, 1998), Nairobi has the most number of children in need of special protection (CNSP). Additionally, UNICEF (2002) indicates that Nairobi has the highest number (68,882) of children orphaned by HIV and AIDS in the country (Appendix D).

Nairobi District is divided into eight administrative divisions (i.e. Kasarani, Embakasi, Parklands, Central, Pumwani, Makadara, Kibera, and Dagoretti) (Appendix E). According to the Population and Housing Census report of 1999, Kibera has a total population of 2,143,254 people. It has the highest population density among all the provinces of Kenya with 3,079 persons per square kilometre. Kibera Division, where the study was undertaken, covers an area of 223.4 sq.km, with a population of 286,083 persons. It has 89,086 households and a density of 1,284 persons per sq.km. Kibera Division is further

divided into six locations, namely Kibera, Karen, Langata, Mugumoini, Nairobi west, and Sarangombe.

Kibera Location has a total population of 83,687 persons with 28,701 households. The location covers a total area of 1.7 sq. km. and has a density of 49,228 persons per sq.km. This location has four sub locations (i.e. Kibera, Makina, Silanga, and Lindi), within which, there are seven villages, namely Laini saba, Mashimoni, Makina, Kichinjio, Lindi, Kambi Nuru and Silanga. A study by Hunter and Williamson (1997) indicated that orphans are likely to be cared for by impoverished families and communities. Kibera Location is a low-income, unplanned settlement area (slum) whose residents are poor, overcrowded, and lack adequate basic facilities especially clean water and sanitation. Due to high poverty levels, the majority of the slum dwellers may not be able to provide for the needs of the orphans let alone their own children.

3.4 Target and accessible population

A target population includes all the members of a real or hypothetical set of people, events or objects to which researchers wish to generalize the results of the research (Mugenda & Mugenda, 1999). In this study, the target population comprised all caregivers and children orphaned by HIV and AIDS in Kibera Location.

Accessible population, on the other hand, refers to a more narrowly defined population that has the same characteristics as the target population from which a sample can be drawn. Hence, generalizations to the accessible population can be applied to the target population. In other words, as Gall, Borg, & Gall (1999) point out, it refers to all individuals who realistically could be included in the sample.

In this study, the accessible population comprised all caregivers and children orphaned by HIV and AIDS within the community care programme. According to the records accessed from the programme, the project has registered 676 orphans, out of which 507 have

been orphaned by HIV and AIDS. The programme, however, operates a support programme for 80 HIV and AIDS orphans, the rest 596, are on the waiting list to join the support programme. They however, get assistance once in a while when it is available.

3.5 Sample and sampling procedures

A sample is a small group selected from the accessible population. It is, however, large enough to represent the salient characteristics of the accessible population, and hence the target population. Sampling, on the other hand, is the process of selecting a number of individuals for a study in such a way that the individuals selected represent the large group from which they were selected. The purpose of sampling (Mugenda & Mugenda, 1999) is to secure a representative group which will enable the researchers to gain information about the population. In this study, two methods of sampling were used:

- i) Purposive sampling.
- ii) Stratified random sampling.

3.5.1 Purposive sampling

Purposive sampling is a sampling technique that allows a researcher to use cases that have the required information with respect to the objectives of the study (Mugenda & Mugenda, 1999). This technique was applied to get Nairobi District, Kibera Division and Kibera Location respectively, in which the units have the required characteristics. Within the location, a community care programme (KICOSHEP) was used to generate a sampling frame and identify the children orphaned by HIV and AIDS and their caregivers.

Nairobi District was purposively selected for the study. It is the most densely populated urban area and is grouped among the areas with high HIV prevalence rates in the country, between 20-29% for the 15-49 year olds (USAID/UNICEF, 1999). According to the situation analysis (UNICEF, 1998), it has the most number of children in need of special protection (CNSP), and the highest number (68,882) of children orphaned by HIV and AIDS.

In Nairobi District, Kibera Division and Kibera Location were purposively selected.

Kibera is a low-income, unplanned settlement area (slum) whose residents are poor, overcrowded, and lack adequate basic facilities especially clean water and sanitation. Due to high poverty levels, the majority of the slum dwellers may not be able to provide for the needs of the orphans let alone their own children. A study by Hunter & Williamson (1997) indicated that orphans are likely to be cared for by impoverished families and communities.

KICOSHEP is a community based non-governmental organization (NGO) operating in Kibera slums of Nairobi District. The programme begun in 1991 as a small clinic offering VCT services to people living with HIV and AIDS and other support services including family planning. Over the years, the clinic has grown to offer a wide range of prevention, treatment and capacity-building services. The project also runs a community school for the orphans and offers vocational training. Notable among these is home-based care for people living with AIDS (PLWA) and providing for the needs of HIV and AIDS orphans. All these services are provided through activities that enhance active community participation. Additionally, it provides assistance and strives to make placements for orphans within the community after parental death.

In Kibera Location, a community care programme, Kibera Community Self Help Project (KICOSHEP), was used as an entry point to access children orphaned by HIV and AIDS and their caregivers. Although there are other community care programmes in Kibera Location, they were found not to have clear cases of children orphaned by HIV and AIDS. The KICOSHEP care programme was selected because it had established registered children orphaned by HIV and AIDS.

3.5.2 Stratified random sampling

The goal for stratified random sampling is to achieve desired representation from various subgroups in the population (Mugenda & Mugenda, 1999). In stratified random sampling subjects are selected in such a way that the existing subgroups in the population are more or less reproduced in the sample. In this study, the orphan's list accessed from the

community care programme was stratified to various sub groups. First the lists were stratified to:

- Orphans in the project who numbered 80 (representing those who are under the support programme), and
- Orphans out of the project who numbered 427 (representing those who are registered with the project but not under the support programme, although they receive support once in a while when available).

Both categories of orphans (from the project and those not in the project) were enlisted for the study for comparison purposes. Within each list, further stratification was done on the basis of gender. This ensured that during sampling, boys and girls were equally represented in the study for comparative analysis. Random sampling was used within the strata because it gives an equal chance of inclusion of each unit in a defined population. It also yields data that can be generalized to larger populations (Gall, Borg & Gall 1999).

According to Prewitt (1974), for a survey research, a minimum total of 100 subjects and 20-50 in each minor subgroup whose results will be analysed are suggested. Further, Gall, Borg & Gall (1999) indicate that for further sub group analysis, larger group sizes yield statistically significant results.

From the list of 80 orphans in the project (under support in the project), there were almost equal numbers of boys and girls (i.e. there were 39 boys and 41 girls). From these lists, a simple random sampling technique was done to select about an equal number of boys and girls, which translated to 27 boys and 28 girls totalling 55 (67%) orphans for inclusion in the study. From the list of 427 orphans out of the project (registered with the project but not under support), 17 had moved out of Kibera and therefore were not available for the study. This left 410 orphans in the list, whereby 225 were boys and 185 girls. From these lists, 40% of the orphans were randomly selected. This translated to 90 boys and 74 girls. The total

sample of the study therefore, comprised 219 orphaned children, which included 55 out of 80 orphans from the programme, and 164 orphans out of 410 from those out of the programme. Through the orphans, their caregivers were identified and interviewed. Community care programme leaders were also included in the study to provide in-depth information on the community care programmes. These are those in charge of programmes in the area under study assisting in the care and support of children orphaned by HIV and AIDS. Records from the children's department at the divisional level indicated there were 13 community care programmes within Kibera Location. The leaders of these groups were identified and interviewed.

Community leaders are persons who hold social positions and influence decisions that affect the community. Through the local administration in the division, 34 leaders were identified and a stratified list was drawn which included 14 village elders, 8 women group leaders, 2 chiefs, 4 sub chiefs and 6 religious leaders. From these list, simple random sampling was used to get a random sample of 11 community leaders (i.e. four village elders, three women group leaders, one chief, one assistant chief and two religious leaders) for inclusion in the study.

3.5.3 Respondents

These are the cases or subjects included in the sample for data collection. In this study, these were children orphaned by HIV and AIDS, caregivers, community care programme leaders and community leaders.

i) Children orphaned by HIV and AIDS

The selected orphans were interviewed. The interviews were administered to 219-orphaned children (55 from the programme and 164 from out of the programme) who were between 5 and 18 years old. Those below 5 years old were not interviewed. It was felt that the issues were too sensitive and could traumatize them.

ii) Caregivers

These are persons who live with and care for orphans. Two hundred and nineteen (219) caregivers were identified through the orphans and the community care programme (KICOSHEP) and interviewed.

iii) Community care programme leaders

These include all leaders of community care programmes in Kibera Location supporting children orphaned by HIV and AIDS. There were 13 community care programme leaders within the location who were identified and interviewed.

iv) Community leaders

There were 11 community leaders (i.e. four village elders, three women group leaders, one chief, one assistant chief and two religious leaders) who were identified for inclusion in the study. Information from this group was obtained through a focus group discussion (FGD).

3.6 Data collection

3.6.1 Data collection tools

The data collection tools used included interview guide, focus group discussion guide and unstructured observation.

i) Interview guide

An interview is a face-to-face encounter with the subjects to collect information desired using a guide (Mugenda & Mugenda, 1999). Prewitt (1974) states:

When a particular piece of information is collected in a standardized form from a large number of units ... the result is quantifiable data ... the measurement adopted must be applied uniformly across the whole sample.

The interview guides were prepared after a literature review and planning exercise. Appropriate questions both for soliciting the relevant data (including probes) and for motivation of the respondents were developed. The questions were related to the main variables of the study so that the interview guides could achieve their main function. To

achieve this, use was made of certain techniques of interview guide construction, such as question sequence, beginning with more general broad questions and narrowing to specific points, that is, according to Oppenheim (1979) the "funnel approach."

In question writing, ambiguity and vagueness were avoided, as much as the construction of leading questions. Thus, as Harnett & Murphy (1985) would probably observe, attempts were made to avoid bias that might arise from "poorly worded interview guides..." Internal checks were applied by occasionally framing the same questions in different ways to gauge the respondents' reliability (i.e. consistency in repeating the same answers) on certain matters. Questions were also deliberately arranged to facilitate cross checking of information provided by respondents as Oppenheim (1979) states:

To ascertain validity ... a variety of techniques is employed usually known as across-checks; where independent source of information is required.

The interview guide was used as an instrument of data collection because of its high response rate and its ability to allow for probes. It also ensures the reduction of cheating by respondents as a well-trained interviewer can detect this. The interviewer can also strive to ensure the completeness of the responses for the various questions. It is also linked to a high degree of uniformity in interpretations of the questions. Oppenheim (1979), further points out that the interviewer can also maintain rapport and keep the respondent interested and responsive throughout the interview.

The technique also has inherent disadvantages. For instance, it is costly, which may arise from factors such as briefing, organizing and carrying out interviews. There may also be interviewer biases when the interviewer may give his/her own opinion and expectations. These were minimised partly by constantly addressing issues that arose and needed attention. Muia (1987) also quotes Chambers (1983) as saying that the interview guide "may embody concepts of the researcher than those of the subjects under study and thus impose meanings

on the subject's reality." Besides, data collection through the technique may take a long time unless proper arrangements are made. However, this was taken care of by making arrangements through the community care programme to access the respondents.

Despite all these shortcomings, the interview guide was preferred because of its richness and spontaneity of information collected. The unstructured open-ended questions, which were included, gave respondents room for self-expression where the need for this was crucial.

The interviews were used as a way of what Muia (1987) calls "widening the base of the research." Besides, probes and prompts that were in constant use helped to solicit as much truthful information from the respondents as possible, to increase the accuracy of the response. To strengthen the use of interview guide, simple observation process was employed to take note of observable data, and to verify some of the information given in the responses. As already mentioned, there were three interview guides:

a) Interview guide for caregivers

This interview guide was administered on the caregivers of the children orphaned by HIV and AIDS. It provided information on socio-economic and demographic characteristics, needs of orphans, problems of orphans, type of care given to orphans, constraints experienced, existing community care programmes and caregivers' participation in these programmes, and success of these programmes. The final part of the guide focused on suggestions on care for orphans. The interview guide consisted of both closed and open-ended questions. The closed questions helped collect specific responses from the respondents' while the open-ended questions collected respondents' own views and opinions on the issues. These yielded both qualitative and quantitative data.

b) Interview guide for orphans

This interview guide was administered to the orphans and covered the following sections: Interviewees' socio-demographic characteristics; needs of the orphans; problems experienced by the HIV and AIDS orphans; type of care and support provided; and suggestions on desired type of care. Interview with the orphans gave them an opportunity to express their feelings and views about issues that affect them (United Nations, 1989). From these interviews, both qualitative and quantitative data was obtained.

c) Interview guide for community care programme leaders.

This obtained information on care and support provided to the orphans, community participation; and suggestions on orphan care. This instrument yielded qualitative data.

ii) Focus group discussion guide

A focus group discussion (FGD) is a carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive, non-threatening environment. Generally, as Bogdan & Biklen (1982) observe, it is a good method particularly when the goal is to explain how people regard an experience, idea or an event. The groups as is indicated by Miles and Huberman (1994) are generally composed of 7 to 12 people who are unfamiliar with one another and have been selected because they share certain characteristics that are relevant to the question of the study. The interviewer creates a conducive environment, by asking focused questions in order to encourage discussion and the expression of differing opinions and points of view.

The advantages of this method are that it is socially oriented, studying participants in a natural real life atmosphere. The format also allows the interviewer the flexibility to explore unanticipated issues as they arise in the discussion. Besides, the method has low costs and potentially speedy results.

There are, however, certain disadvantages to this method. The method requires use of trained interviewers; the group can also vary a great deal and can be hard to assemble. The method also requires that it be carried out in an environment conducive to conversation (Bogdan & Biklen, 1982). These were taken care of by identifying and contacting participants in advance and making arrangements for a suitable place for the FGD.

The focus group discussion was held with community leaders to identify problems faced by orphans, support provided to orphans, community participation in orphan care programmes and suggestions on orphan care. This instrument yielded qualitative data.

All these various methods and tools were applied to the research so that their combined advantages could be tapped. Also, by triangulating the methods, data and data sources, the intrinsic bias that comes from single methods and observations was overcome. Thus, the data presented in this study was produced through the combined application of the collection methods outlined above, with adjustments, where necessary, to suit the context of this study. For instance, use was made of English or Kiswahili during the interviews, depending on the language the respondent was more familiar with. The instruments were developed both in English and Kiswahili and were conducted in the language with which the respondents understood and were most comfortable.

At the end of the study, the total number of respondents by tools/instrument and number of FGDs by respondents were therefore as indicated in Table 3.1:

Table 3.1 Number of tools/instruments by respondents

Instrument	In the project		Out of the project			
	SF	SS	SF	SS	TSF	TS
Orphan Interviews	80	55	410	164	490	219
Caregivers' interviews	80	55	410	164	490	219
Community programme leaders interviews	-	-	-	-	13	13
FGDs – Community leaders	-	-	-	-	34	11

Key

SF - Sampling Frame

SS - Sample Size

TSF - Total Sampling Frame

TS - Total Sample

FGDs- Focus Group Discussions

3.6.2 Pre-testing the instruments

The purpose of pre-testing the instrument is to ensure that items in the instrument are stated clearly and have the same meaning to all respondents. The respondents to which the instrument is pre-tested should not be part of the selected sample (Mugenda & Mugenda, 1999). During the pre-testing, the researcher is able to assess the clarity and the ease of the use of the instrument the researcher is also able to assess the time taken to administer the instrument, and adjust accordingly if, for example, it takes too long. Pre-testing in this study was done for a number of reasons. It was intended to reduce the problems of phrasing questions such as being vague, ambiguous, leading to being too technical and too abstract, which could be detected from the responses of the respondents, that is, were the answers to the questions telling us what we wanted to know, or did the questions need rewording. A number of questions were reworded after the pre-testing exercise so that the answers produced would not be incompatible with the way the derived data was going to be used, what Oppenheim (1979) calls "thinking a head."

The interview guide was also pre-tested to close some of the open-ended questions therein, turning them into multiple choice ones which would increase the pace of

administering the interview. In close association to these, the interview was pre-tested with the purpose of regulating the interview time to reasonable length that would not bore the respondents, with the possibility of non-response or carelessness, in answering the questions on the later part of the questionnaire. After pre-testing, the interview time was reduced by about 45 minutes to between 30 and 35 minutes.

For the purpose of the pilot study, the sample included five orphans, two community care programme leaders and five caregivers interviewed, and a focus group discussion was held with community leaders. The pre-testing was conducted in the neighbouring Sarangombe Location, which was not the study division. Its respondents, however, bore similarity to those in the main study. Important suggestions, omissions and corrections from the pre-testing exercise were incorporated in the final instruments.

3.6.3 Data collection procedure

A research permit was obtained from the Office of the President authorizing the collection of data. After the research permit was obtained, the researcher visited the research site to familiarize with the environment. The researcher then visited the Divisional Children's Department office at Kibera for notification of the study and sought assistance in identifying community care programmes assisting orphans in the research site.

KICOSHEP, a community care programme through which the respondents would be identified, was visited and consent for their participation and assistance during the study was sought. The researcher discussed with the leader of the community care programme (KICOSHEP) how the sampling for the orphans registered and being supported by the project (in the project) and for those registered and not receiving any support (out of the project) would be done, and the commencement of the study. Arrangements were made to make the children available in time for interviewing. Interviews were mainly conducted after school to avoid disrupting the learning programme for the children. Through the children and the

assistance from the community care programme staff, the caregivers to the children were identified and arrangements were made for interviews.

Before commencement of any interviews with the children and the caregivers, consent was sought from them to participate in the study. The nature of the study, procedure in administering the interviews, the estimated time, and the use of the study were specified. The respondents were further notified that their responses would not be individually identifiable, and that they were free to withdraw from participating from the study at any time if they wished and this would not affect their relationship with the community care programme. The subjects were also requested to answer the questions as honestly as possible. After this was done and consent for participation was granted, the researcher conducted one-to-one interviews with the children and caregivers at a place and time convenient to them. A good rapport to encourage the respondents to give accurate information was developed. The interviews were mostly held in schools, at home and at business premises and workplaces for the case of caregivers.

Completed interviews were reviewed on a daily basis. For a few cases of children and caregivers, the interviews were conducted in Kiswahili, as this was the language with which they were conversant.

After the one-to-one interviews with the caregivers and the children, the researcher then visited the other community care programmes in the study site and conducted interviews with the leaders. An interview guide was used to gather the required information from each respondent. This was edited and coded immediately after the interview.

Through the local administration and KICOSHEP staff, the selected community leaders were identified, notified and appointments made for the study. Consent was sought for their participation in the study, after which an appropriate time was set for a focus group discussion. A venue (a social hall), free from noise and convenient for the discussion, was

identified and prior arrangements were made for the meeting. During the meeting, the researcher facilitated the discussion, which was tape-recorded and transcribed later. The discussion lasted for about one and half hours, after which the participants were thanked.

3.7 Data analysis

Data was analysed using various statistical approaches. These included quantitative and qualitative approaches.

3.7.1 Quantitative approaches

Quantitative data was entered in the computer and processed using the Statistical Package for the Social Sciences (SPSS) and was analysed using both descriptive and inferential statistics. Godfrey (1977) has shown that descriptive statistics can reduce an indigestible mass of information into forms, which can be clearly appreciated. In other words, it makes the figures convey more vividly the information they represent. Descriptive statistics such as frequencies and percentages were computed for specific variables to describe the samples' characteristics and results.

Inferential statistics go beyond the descriptive statistics; they deal with estimation of population parameters and hypothesis testing. In this study, the focus is on relationships and associations between two or more variables and variations within them. The following tests were carried out: A statistical significance level of $\alpha = 0.05$ was used. If the calculated probability (p-value) $\leq \alpha$ the results are considered to be significant.

i) Chi-square test (χ^2)

Chi-square (χ^2) is a non-parametric statistical technique (Mugenda & Mugenda, 1999). This test is important because it establishes relationships between two variables both of which are categorical in nature. It is therefore a form of count occurring in two or more mutually exclusive categories. In this case, the non-parametric relationships between orphan boys and girls, and in and out of the project orphans, and their needs, problems and

the type of care provided were checked. Relationships between caregivers in and out of project and the support they provide to orphans, problems experienced and their participation in community care projects were also checked using chi-square test. A statistical significance level of $\alpha = 0.05$ was used.

ii) Fisher's exact test

This is a test for independence in a 2 X 2 table. The test is based on the hypergeometric distribution. This test is most useful when the total sample size and the expected values are small, and was used in cases where the number of cells with expected frequency < 5 should not exceed 20%. The exact probability of obtaining the observed result or one more extreme, if the two variables are independent and the marginals fixed is calculated. A statistical significance level of $\alpha = 0.05$ was used.

iii) T-test

This is a statistical test used to test whether there are significant differences between two means derived from two samples or groups at a specified probability level (Mugenda & Mugenda, 1999). According to Grimm (1993), there are two types of t-tests, these are independent samples t-test and dependent samples t-test (also known as a paired observations t-test or a correlated samples t-test). This study used both types of t-tests, paired samples t-test was used to determine whether there are differences between orphans and caregivers in the needs of orphans, problems experienced by orphans and the form of assistance required by orphans, while independent samples t-test was used to determine differences between in and out of project orphans in the needs of orphans, problems experienced by orphans and the form of assistance required by orphans. A statistical significance level of $\alpha = 0.05$ was used.

iv) Spearman rank correlation coefficient

Spearman rank correlation coefficient was used to measure relationships or associations between variables. This test is important because it indicates the strength and

direction or association between the variables, which included the independent variables (socio-economic, care and community participation variables) and the dependant variable (success of community care programmes). It is done when both variables are measured on an ordinal scale. The data may be converted to ranks for the application of Spearman rank correlation coefficient (Grimm, 1993). In this case, some of the original scores which were not in ordinal scale were ordered in ascending order and were assigned ranks accordingly which were then used in the analysis. Relationships between variables were tested, and a statistical significance level of $\alpha = 0.05$ was used.

v) Logistic regression

Logistic regression is a statistical procedure that allows use of information about one variable to predict the value of the second variable situations where the outcome variable is categorical (Mitchell, 1992). In this study, logistic regression was used to predict the success or failure of community care programmes. This statistical procedure is important since it indicates whether the socio-economic, care and support, and community participation variables are related to the success or failure of community care programmes. With logistic regression, the response variable is an indicator of some characteristic, that is, a 0/1 variable. A statistical significance level of $\alpha = 0.05$ was used.

3.7.2 Qualitative approaches

Qualitative data was collected through the open-ended questions and the in-depth interviews with the community care programme leaders and a focus group discussion with the community leaders. The data was classified, coded and analysed according to the objectives. Processing of qualitative data is an ongoing process, hence the data was processed on a daily basis whenever an interview was conducted (Miles & Huberman, 1994). The qualitative approach was used to generate themes and relationships at case level whereas the quantitative approach was used to validate them and relationships in the samples.

3.8 Measurement of variables

This section shows what the various variables were and how they were measured.

i) Dependent variable

A dependent variable is one, which is observed and measured in response to another variable (Grimm, 1993). It attempts to indicate the total influence arising from the effects of the independent variable. In this study, the dependant variable was success of community care programmes, which was measured by investigating the extent to which orphan needs are met through the community care programmes. It reflects the outputs in the hypothesized model of the study. Success of a programme is measured by the extent to which it has met its goals (Chitere & Mutiso, 1991). In this study, the goal is to adequately provide care and support to orphans and thus meet their needs. For community programmes, as pointed out by previous workers (Chitere & Mutiso, 1991; Mbithi, 1974; Muia, 1991), success is largely dependant on community members' participation; this involves planning, decision-making, implementation of programmes and making contributions. Participation therefore becomes an active process whereby beneficiaries influence the direction and execution of the projects rather than merely receiving a share of the project benefits. Programmes with little community participation are bound to fail after the sponsors withdraw. It is through participation that programmes are bound to become successful and hence meet their goals, which in this case was to meet the orphans' needs. Information on success of the programme was collected using question 26 of the caregivers' instrument (Appendix B).

ii) Independent variables

These are variables that are manipulated in order to determine their effect or influence on other variables (Grimm, 1993). They are also called predictor variables since they predict the amount of variation that occurs in other variables. In this study, the following were the independent variables.

a) Socio-economic and demographic variables

These included gender, age, marital status, education level, number of children and occupation. They were considered important in establishing whether they had any relationships with the needs and problems experienced in the care of orphans, and whether they were of any consequence on the care provided to the orphans. Also to be investigated was whether they had any effect on the participation of caregivers in the care programmes. Occupation was categorized into housewife, professional (e.g. nursing and teaching), small businesses (e.g. kiosks for different goods, barber shop, salon), large business (e.g. large shops for different goods), casual labourer (e.g. watchmen, maids, manual workers), not working and any other not included above. Data on these variables were collected by use of the caregivers' instrument (questions 1-7) and orphan instrument (question 1-3) (Appendix B).

b) Preparations prior to caring for orphans

This was considered important in establishing its relationships with the problems experienced by the caregivers. It was measured by use of caregivers instrument question 10 and 11 (Appendix B).

c) Orphan care variables

These were considered important in the study because the researcher wanted to investigate the needs of orphans, the type of care and support provided to orphans and the extent to which their needs were met. Additionally, it was important to find out the problems experienced by the caregivers and how they were solved. This information would also make it possible to compare the differences within and between the samples. This was measured by considering questions 12-22 of the caregiver instrument and questions 4-13 of the orphan instrument (Appendix B).

d) Community participation

This was measured by investigating whether the caregivers were involved in the community care programmes. Participation in community orphan care programmes was considered important in this study as it determined the extent to which community care programmes met the needs of orphans. This information was collected using questions 23-34 (Appendix B) and it focused on participation in planning, involvement in carrying out the activities of the programme, decision making and making contributions to the programme. The qualitative information was coded and analysed. The variables were measured as indicated below:

- **Community participation planning:** Was operationalized by whether the caregivers were involved in planning activities within the community care programmes.
- **Participation in decision-making process:** Was measured by whether caregivers were involved in making decisions in the community care programme.
- **Carrying out activities:** This was measured by whether the caregivers were involved in carrying out activities of the programmes.
- **Make any contributions:** Was measured by whether the caregivers made any contributions towards the community care programme.

e) Suggestions on orphan care

These were considered important in the study as they indicated how the existing programmes could be improved. These were measured by questions 35-38 in the caregivers' instrument and question 14 in orphan instrument (Appendix B).

CHAPTER FOUR

RESULTS AND DISCUSSIONS

4.1 Introduction

The purpose of this study was to apply community participation paradigm in care and support of HIV and AIDS orphans and to determine the success of community care programmes in meeting the needs of orphans. The results are presented and discussed under the following sub topics; social, economic and demographic characteristics of respondents; situation and care of HIV and AIDS orphans; participation in community care programmes; relationships between respondents and care practices variables; relationships between socio-economic, care practices, community participation variables and the success of community care programmes; and predictor variables of success of community care programmes.

4.2 Social, economic and demographic characteristics of respondents

This section will address the first objective, namely to identify the socio-economic and demographic characteristics of both caregivers and orphans.

4.2.1 Social, economic and demographic characteristics of caregivers

This section will discuss the social economic and demographic characteristics of caregivers. This will include their gender, age, marital status, education level, occupation, number of their children and number of HIV and AIDS orphans for whom they are caring.

4.2.1.1 Gender of the caregivers

Gender of the caregivers was considered an important variable. This is because ones gender can be viewed as resourceful in caring for orphans. Women have throughout history been the caregivers of their families and hence have experience in child caring. For instance, roles in most African communities were traditionally divided along the gender lines. Men were the breadwinners for their families while women provided care to the children and the

rest of the family members. However, with changing economic lifestyles, women are now engaged in activities outside the home. For example, they are taking up paid employment and thus contribute to the family kitty. It was therefore deemed necessary to find out the disparity in gender of the caregivers as this has implications on who is available to provide care and support to the orphans. The sample of caregivers composed of 219 subjects. The majority of the caregivers (68%) were women. Most of them, 72.7% were those under the community care project assisting orphans. Seventy (32%) of the caregivers were male (Table 4.1). A higher number of caregivers who were providing for the needs of the orphans they live with were women.

These findings are consistent with those of a study by GOK/UNICEF (2001) on the situation of HIV and AIDS orphans and other vulnerable children, which found that most caregivers of orphans were women. Additionally, in a study by Saoke & Mutemi (1994), it is noted that after parental death, orphans are often left under the care of aunties and elderly grandmothers.

Table 4.1

Frequency distribution showing gender of the caregivers

Gender	In the project		Out of the project		Total	
	No.	%	No.	%	No.	%
Male	15	27.3	55	33.5	70	32.0
Female	40	72.7	109	66.5	149	68.0
Total	55	100.0	164	100.0	219	100.0

4.2.1.2 Age of the caregivers

Age is an important factor as it has implications on the care of orphans. First, it is assumed that above 55 years of age, most people have grown-up children, may have retired and may not be active in economic activities. This may affect their resource base and they may therefore not be in a position to adequately care for orphaned children. On the other hand, younger people may have young children may be more suited to care for orphans as they can easily fit in and grow up with the family's children. Secondly, it would also be expected that the younger people are strong and still engaged in active employment and, hence, are more able to raise resources to care for orphans.

This study found that more than half of the caregivers (60.6%) were aged between 20-35 years old, while 31.0% were aged between 36-54 years old, with almost equal representation from caregivers both in the project and those out of the project (Table 4.2). This is not surprising given that these are the age brackets of most Kenyans who are in child bearing and rearing stages and who are actively engaged in economic activities. A few of the respondents (8.4%) were 55 years old and above.

Table 4.2

Frequency distribution showing age distribution of caregivers

Age of caregivers	In the project		Out of the project		Total	
	No.	%	No.	%	No.	%
20-35	34	63.0	95	59.8	129	60.6
36-54	16	29.6	50	31.4	66	31.0
Over 55	4	7.4	14	8.8	18	8.4
Total	54	100.0	159	100.0	213	100.0

Missing cases 6 (1=in the project, and 5=out of the project)

These results are consistent with those of a study by GOK/UNICEF (2001) in which it was established that orphans within urban areas live with relatives, the majority of whom were middle aged while those in the rural areas lived mostly with their grandmothers.

4.2.1.3 Marital status of caregivers

Marital status in this study was categorized into married, divorced, separated, widowed and single (never married). The findings of this study show that more than half of the caregivers (58.5%) were married. Married life is deemed indicative of responsible livelihood. This in itself becomes resourceful in a way of organizing the family and community in accessing of resources and managing the situation. Secondly, marriage is perceived to signify stability and hence a stable environment which can also be resourceful in the care of orphans. A few, 9 (4.1%) and 11 (5%) were divorced and separated respectively, while 27 (12.3%) were single (never married) as shown in Table 4.3.

Table 4.3

Frequency distribution showing marital status of caregivers

Marital status	In the project		Out of the project		Total	
	No.	%	No.	%	No.	%
Married	36	65.5	92	56.1	128	58.5
Divorced	3	5.5	6	3.6	9	4.1
Separated	2	3.6	9	5.5	11	5.0
Widowed	8	14.5	36	22.0	44	20.1
Single	6	10.9	21	12.8	27	12.3
Total	55	100.0	164	100.0	219	100.0

4.2.1.4 Education level of caregivers

The results of this study indicate that the educational level of the respondents ranged from no schooling to university levels. Education is a resource in the sense that the knowledge and skills one has may be used in the care of orphans. Secondly, education may have a bearing in the type of occupation one may be engaged in which may also have an implication on the mobilization of resources for care of orphans.

About one-third of the caregivers (34.9%) indicated that they had primary education level, while 39% had secondary school education level (Table 4.4). Thirty caregivers (13.8%) indicated that they had no schooling at all, with most of them being from out of the project. These results may be attributed to the fact that, the study area (Kibera Location), according to the Nairobi City Council's Social Services and Housing Department, is an area inhabited by low-income earning people, which may indirectly be a reflection of their education level. These results are consistent with those of a study conducted in Korogocho, a slum area in Nairobi, by ACTION AID-Kenya (1995), which showed that most of the people caring for orphans had low levels of education.

Table 4.4

Frequency distribution showing education levels of caregivers

Education level	In the project		Out of the project		Total	
	No.	%	No.	%	No.	%
No schooling	4	7.3	26	16.0	30	13.8
Primary school level	19	34.6	57	35.0	76	34.9
Sec. school level	24	43.6	61	37.4	85	39.0
College level	6	10.9	17	10.4	23	10.5
University level	2	3.6	2	1.2	4	1.8
Total	55	100.0	163	100.0	218	100.0

1 Missing case (out of the project)

4.2.1.5 Occupation of caregivers

The caregivers were asked to indicate their occupation. Occupation shows the economic activities the caregivers are engaged in and hence is an indication on the economic resources at their disposal for care of orphans. As shown below in Table 4.5, a diverse range of occupations was represented in the study sample. Sixty-one (28.2%) of the caregivers were in small businesses; 46 (21.3%) were housewives, while 38 (17.6%) were casual labourers respectively. The high percentages of caregivers in low paying professions could probably be due to their low education levels coupled with lack of employment opportunities. These findings are similar to those by ACTION AID-Kenya (1995), which indicated that the majority of households (68.4%) caring for orphans depended on petty trade as their source of livelihood. A few caregivers (6%) were engaged in other occupations, which included community service and religious activities.

Table 4.5

Frequency distribution showing occupations of caregivers

Marital status	In the project		Out of the project		Total	
	No.	%	No.	%	No.	%
Housewife	10	18.2	36	22.4	46	21.3
Professional	8	14.6	34	21.1	42	19.5
Small business	25	45.5	36	22.4	61	28.2
Large business	0	0	5	3.1	5	2.3
Casual labourer	5	9.1	33	20.5	38	17.6
Not working	5	9.1	6	3.7	11	5.1
Other	2	3.5	11	6.8	13	6.0
Total	55	100.0	161	100.0	216	100.0

3 Missing cases (out of the project)

4.2.1.6 Number of children belonging to caregivers

The caregivers were asked to state how many children of their own they have. The findings show that a total of 120 (54.8%) respondents had between one and three children, while 60 (27.4%) had between 4 to 6 children (Table 4.6).

Table 4.6

Frequency table showing distribution of number of children of caregivers

No. of children	In the project		Out of the project		Total	
	No.	%	No.	%	No.	%
1-3	29	52.7	91	55.5	120	54.8
4-6	16	29.1	44	26.8	60	27.4
Over 7	10	18.2	29	17.7	39	17.8
Total	55	100.0	164	100.0	219	100.0

The results further indicate that caregivers were living with and caring for children other than their own, a situation, which could be stressful on the family and community and calls for more resources in caring for them. One hundred and twenty of the caregivers (54.8%) cared for one to three children while 27.4% cared for four to six children. A few (17.8%) cared for seven children or more. These reportedly were relatives' children or orphaned children. In many communities, it is common to find people living with relatives' children for various reasons, like attending school, especially in the urban areas. Others have taken up orphans and are living with them.

4.2.2 Social, economic and demographic characteristics of orphans

The social, economic and demographic characteristics of orphans are discussed in this section and include gender, age and educational level of orphans.

4.2.2.1 Gender of orphans

The sample of orphans was composed of 219 subjects. As indicated, efforts were made to have about an equal gender representation in the study. However, there were more males (54.9%) than females (45.1%) from the out of project sample. Table 4.7 shows the results.

Table 4.7

Frequency distribution showing gender of orphans

Gender	In the project		of the project		Total	
	No.	%	No.	%	No.	%
Male	27	49.1	90	54.9	117	53.4
Female	28	50.9	74	45.1	102	46.6
Total	55	100.0	164	100.0	219	100.0

4.2.2.2 Age of orphans

The majority of the orphans (78.5%) as indicated in Table 4.8 were aged between 5-15 years old, out of which 59.8% were aged between 11-15 years old. This may be because at this age, most of the children are still dependants, in the care of caregivers and hence living with and being supported by the caregivers.

Table 4.8

Frequency distribution showing age of orphans

Age groups	In the project		Out of the project		Total	
	No.	%	No.	%	No.	%
5-10	5	9.1	36	22.0	41	18.7
11-15	48	87.3	83	50.6	131	59.8
15-18	2	3.6	45	27.4	47	21.5
Total	55	100.0	164	100.0	219	100.0

4.2.2.3 Education levels of orphans

The responses from the orphans indicated that the majority of orphans (69.7%) had primary school level of education (Table 4.9). This is expected since most of the orphans (78.5%) were aged between 5-15 years old, an age bracket within which children in Kenya attend primary school. Education is a resource, orphans with high education levels would use the knowledge acquired in addressing issues facing them.

Table 4.9

Frequency distribution showing education levels of orphans

Education level	In the project		Out of the project		Total	
	No.	%	No.	%	No.	%
No schooling	1	1.9	37	22.6	38	17.4
Primary school level	52	96.2	100	61.0	152	69.7
Sec. school level	1	1.9	26	15.8	27	12.4
College level	0	0	1	0.6	1	0.5
University level	0	0	0	0	0	0
Total	54	100.0	164	100.0	219	100.0

1 Missing case (in the project)

A few orphans, 38 (17.4%), on the other hand, reported that they had no schooling at all. This included the very young aged between five and six years old who may not be attending school. Nonetheless, as has been indicated in other studies (GOK/UNICEF, 2000; Saoke & Mutemi, 1994; USAID/UNICEF, 2000) after parental death, orphans may not be able to attend school due to lack of school fees and other school requirements. In some instances, it has been found out that relatives take orphans with a promise that they will care for them but actually they make them house helps (GOK/UNICEF, 2000). Only a few of the orphans (12.4%) had secondary school education. Secondary school education has been found to be expensive and unaffordable and not within reach for most caregivers. A study by

GOK/UNICEF (2001) on the situation of HIV and AIDS orphans and vulnerable children, established that orphans dropped out of secondary school education because caregivers found it expensive.

There was only one (0.6%) orphan out of the project with college level education while there was none with university level education. This would be expected since the sample was limited to children below 18 years, a limit within which in the Kenyan education system, a child would be completing secondary school. However, in real life experiences, it is possible to find children below 18 years attending colleges especially the polytechnics or community colleges for acquisition of skills after completion of primary school.

4.3.0 Situation and care of HIV and AIDS orphans

This section will address objectives two and three, which sought to identify the needs and problems of children orphaned by HIV and AIDS and determine the care and support provided to the children orphaned by HIV and AIDS.

4.3.1 Number of HIV and AIDS orphans living with caregivers

It was important to find out the number of children orphaned by HIV and AIDS that caregivers were living with and caring for. The situation of orphan-hood creates pressure in families and communities to raise extra resources for their care, a situation that may be strenuous for the family. The findings show that the majority of caregivers (80.2%) were living with 1-2 children orphaned by HIV and AIDS (Table 4.10). This may be because there is a tendency of relatives to share out orphans among themselves for care and hence the majority of respondents reported having one or two orphans. These findings are supported by studies by GOK/UNICEF (2001) and Saoko & Mutemi (1994) in which it is indicated that siblings are often shared out among relatives after parents die. The study further points out that once orphans are separated and live with different caregivers, they take a long time without visiting or seeing each other. This separation affects the children's psychosocial well-

being. In most cases, they suffer from anxiety and worry as they always think about their siblings' well being.

In Kenya, the number of orphans is steadily increasing. Available estimates indicate that there were 1.3 million orphans in 2002, up from 900,000 in the year 2000 (UNICEF, 2002). The estimates further indicate that this figure is projected to rise to 1.78 million by the year 2005 and 2.2 million by the year 2010. Studies have shown that relatives are caring for most of the orphans (Saoke & Mutemi 1994; GOK/UNICEF, 2001).

Table 4.10

Frequency distribution showing number of HIV and AIDS orphans living with caregivers

Number of orphans	In the project		Out of the project		Total	
	No.	%	No.	%	No.	%
1-2	44	81.5	122	79.7	166	80.2
3-4	7	13.0	30	19.6	37	17.9
Above 5	3	5.5	1	0.7	4	1.9
Total	54	100.0	153	100.0	207	100.0

12 missing cases (1-in the project; 11-out of the project)

4.3.2 Length of period caregivers have lived with orphans

The findings indicate that caregivers had lived and cared for orphans for a period of up to 6 years (Table 4.11). A few caregivers had lived with orphans for longer periods. This may be due to the fact that a few years back, before the HIV and AIDS epidemic took its toll, there were fewer orphans to be cared for and hence the few caregivers (18.7%) who had lived with orphans for over six years. However, as the orphan figures increased in the later years, the number of orphans needing care also increased, hence the increasing numbers of caregivers (44.4%) living with orphans for a period of less than three years.

Table 4.11

Frequency distribution showing the period of time caregivers have lived with orphans.

Period of time	In the project		Out of the project		Total	
	No.	%	No.	%	No.	%
Less than 3 years	19	36.5	69	47.3	88	44.4
3-5 years	22	42.3	51	34.9	73	36.9
6 years and above	11	21.2	26	17.8	37	18.7
Total	52	100.0	146	100.0	198	100.0

21 missing cases (3-in the project, 18-out of the project)

Further, the responses from the orphans' interviews on how long they had lived with caregivers were consistent with the caregivers' responses. The majority of orphans (75.7%) indicated that they had lived with their caregivers for a period of less than five years. The results further reveal that most of the 202 orphans (92%) lived with their relatives. This finding is not surprising given that it is the families and communities that are at the forefront of caring for orphans (GOK/UNICEF, 2000).

4.3.3 Prior arrangements made by caregivers to care for orphans

The findings of this study indicate that more than half of the caregivers 33 (60%) from the project and 95 (57.9%) out of the project had not made any prior arrangements to take care of the orphans (Table 4.12).

Table 4.12

Frequency distribution showing whether caregivers make prior arrangements before taking in orphans

Make prior arrangements	In the project		Out of the project		Total	
	No.	%	No.	%	No.	%
No	33	60.0	95	57.9	128	58.4
Yes	22	40.0	69	42.1	91	41.6
Total	55	100.0	164	100.0	219	100.0

In most instances, family members get together after the death of a relative and share out orphans for care, while in some cases relatives are given orphans to care for by other relatives/clan members without prior arrangements. It is after the children's arrival that the caregivers start making arrangements to accommodate them. Making prior arrangements is resourceful in managing the situation, such arrangements would include, preparation of accommodation and making provisions for other requirements such as clothing, school fees, and food. Prior arrangements would ease the stress caused by immediate arrival of orphans without any preparations at all. Studies conducted by GOK/UNICEF (2000) and Nyambedha (1999), indicate that most ailing parents do not discuss the future of their children, prepare wills, nor prepare the children for transition. This makes it difficult for them to trace their relatives and properties, thus making it more difficult for them to adjust and cope with the new family. Such situations traumatize children, as some of them do not know their relatives and/or property. Likewise, caregivers and their families get equally stressed when they have to make immediate plans for accommodating the orphans.

Some caregivers (41.6%) indicated that they had made prior arrangements before taking in the orphans. According to a report by HACI (2002), prior arrangements, which

should be made by ailing parents together with other family members, are very important. They should focus on preparing the child for transition and the future. For example, movement of the orphans, their care, and administration of property left behind should be addressed. Such arrangements enable both the orphans and their caregivers to prepare and adjust into the new situations with ease. When such arrangements have not been made as pointed out in a study by Ferguson & Johnston (1997), relatives who pretend that they will take care of orphans take the orphans' property and later abandon the children without anything to depend on. In worse circumstance, orphans have been disinherited of their land and other assets have been taken away by relatives. This has often put orphans in very difficult situations such as dropping out of school and engaging in labour to earn a living. In worse situations, some orphans move to live in the streets due to lack of shelter. In such situations, orphans often emotionally vulnerable and financially desperate are more likely to be sexually abused and forced into exploitative situations such as prostitution as a means of survival (Hunter & Williamson, 1997).

On whether they needed to have made prior arrangements before taking in orphans, most of the caregivers (67%) indicated that they needed to have made prior arrangements, particularly preparation of their family members to adjust to the new situation and make arrangements for other provisions. Other caregivers felt that they needed to prepare themselves psychologically, that is, understand the state of the HIV and AIDS orphans and how to assist them through the situation they are in. Researches (Hunter & Williamson 1997; Saoko & Mutemi, 1994) have indicated that HIV and AIDS orphans are traumatized and suffer from depression long before a parent dies mainly due to discrimination and long suffering endured while caring for their ailing parents. Most of them often take over adult responsibilities and provide care for sick parents, thus forcing them to drop out of school and other social activities. Stigma against HIV and AIDS further leads to stigmatisation and

social isolation of these children. On an individual level, the emotional, psychological, economic and physical impacts on a child are immeasurable; this calls for psychosocial support in addition to the provision of basic needs such as food, clothing and shelter.

The results from the orphans about their involvement in discussions with caregivers before living with them concurred with those of the caregivers. The results show that more than half of the orphans (52.8%) did not discuss their movement with their relatives prior to moving (Table 4.13). This indicates that in most cases, children were not consulted as to where they would like to live after their parents die. Most of the 47.2% of the orphans who mentioned that they discussed their movement with relatives prior to their moving were from those in the project. This may be because the community care programme provided a voluntary counselling and testing programme, among others. Through these programme, the members, particularly those infected with HIV and AIDS were encouraged to discuss the future with their children and other close relatives.

Table 4.13

Frequency distribution showing whether orphans discuss their movement before living with caregivers

Discuss movement	In the project		Out of the project		Total	
	No.	%	No.	%	No.	%
No	24	44.4	91	55.5	115	52.8
Yes	30	55.6	73	44.5	103	47.2
Total	54	100.0	164	100.0	218	100.0

1 missing case (in the project)

Asked whether they needed to have been involved in discussions prior to their movement, 95 of the orphans (43%) said they needed to have been consulted. This as pointed out is mainly because they are the ones affected and therefore would like to participate in

deciding whom they would like to live with rather than being shared out amongst relatives. In addition, they would also get to know the person they will be living with and also have time to prepare for their movement. According to article 12 of the United Nations Convention on the Rights of the Child (United Nations, 1989), children need to be involved in making decisions that affect them. This establishes them as subjects of rights and active participants in their own lives with views and information. Children need to be facilitated to express their own ideas and perceptions rather than being ignored and decisions concerning them made by others on their behalf (GOK/UNICEF, 2000).

One hundred and twenty four (57%) of the orphans, however, mentioned that they need not be involved in discussing their movement, they felt that they were still young and moreover, contribute nothing to their upkeep, hence have no say as to where they would like to live and with whom.

4.3.4 Type of care provided to orphans

It was important to establish the type of care provided to orphans by caregivers. This resource showed what provisions were made to orphans. The study findings reveal that caregivers provided food, clothing, shelter, education, medical care and psychosocial support as shown in Table 4.14.

Most caregivers provide food, clothing, shelter, education and medical care. However, a few caregivers (37%) provided psychosocial support. In a study by GOK/UNICEF (2001), it has been indicated that caregivers are engaged in economic activities to raise income to meet the basic needs of their household members and therefore lack sufficient time for provision of psychosocial support. It was further pointed out that the caregivers spent up to 90% of their time securing food, which meant neglect of the psychosocial needs of the children.

Table 4.14

Frequency distribution showing type of care provided to orphans by caregivers

Description of care	In the project		Out of the project		Total	
	No.	%	No.	%	No.	%
Food	55	100.0	164	100.0	219	100.0
Clothing	51	92.7	146	89.0	197	90.0
Shelter	49	89.1	158	96.3	207	94.5
Education	38	69.1	124	75.6	162	74.0
Medical	37	67.3	119	72.6	156	71.2
Psychosocial support	22	40.0	59	36.0	81	37.0

Number in the project (N_i) =55, Number out of the project (N_o) =164, Total (N) =219
Multiple responses were allowed.

During the study, one female caregiver from out of the project noted:

Where is the time to talk to children to find out what is troubling them; I leave very early to the market and come very late. I myself am very tired to start asking them if they are okay.

Caregivers may also not understand the importance of psychosocial support as one female caregiver in the project paused:

If a child has been given food and a place to sleep, what else does she/he need?

These findings concur with those of other researches (HACI, 2002; Saoke & Mutemi, 1994) which point out that most caregivers do not understand the need for psychosocial support to the HIV and AIDS orphans while others lack the skills to offer the support.

Psychosocial support, which includes counselling, talking with and listening to orphans and providing love and care to the orphans is of great importance to the HIV and AIDS orphans. It helps the child to overcome the trauma, depression, stigma and isolation experienced. Additionally, it helps the child come to terms with the death of the parents while adjusting to the new situation. Studies by previous workers (Ferguson & Johnston, 1997;

HACI, 2002; Hunter & Williamson, 1997) indicate that a child's vulnerability increases long before a parent dies. In poor households, HIV-related illnesses lead directly to household economic problems as adults fall ill and cannot work. Additionally, available resources are used for treatment while other family members divert time from productive activities to provide care to the sick. Children often take over adult work responsibilities and provide care for their sick parents, thus forcing them to drop out of school and other social activities. Denial of and stigma against HIV and AIDS further aggravates their social isolation in that children orphaned by HIV and AIDS suffer stigma, discrimination and isolation that are attached to HIV and AIDS. In a study by GOK/UNICEF (2000), it is pointed out that children orphaned by HIV and AIDS are often assumed infected with HIV since their parents died of AIDS and are therefore discriminated against. These situations are stressful for the orphans and would require psychosocial support.

The findings further show that out of the 100% of the caregivers who provided food, the majority of them (81%) provided it inadequately, like providing one meal a day, which was often not sufficient. In addition, 79.7% caregivers out of the 90% who reported that they provide clothing, made use of old repaired clothes donated by well-wishers and religious institutions, while some caregivers mentioned that they shared their clothes with the orphans. These results indicate that though caregivers provide the various forms of care to orphans, the care is limited and barely sufficient.

The findings also reveal that 188 of the caregivers (90.8%) out of the 207 (94.5%) of those providing shelter were living with orphans in small rented houses, mostly one or two roomed houses with mud walls and earthen floor. These houses, as reported by the caregivers, did not have good sanitation especially toilets and clean water. These sentiments were supported by community leaders who observed that orphans' living conditions were poor. For example, one male community leader stated:

You will get parents, children and other relatives living in a one-roomed house. this is not healthy.

The study was done in Kibera Location an informal settlement in Nairobi, which according to a study done by FHI (2001), is overcrowded and has inadequate basic facilities, especially clean water and sanitation. In the same study, it was further pointed out that the community has no access to electricity or flush toilets. They use pit latrines, which are usually inadequate for the population. As a result they are too far for some households necessitating inappropriate disposal of human waste. Such living conditions are unhealthy and could lead to disease outbreaks that would endanger lives, particularly of children.

Provision of education entailed paying school fees and providing school requirements such as books and uniforms. To be able to pursue education effectively, pupils require school fees and educational materials such as books. Only a few caregivers (27.8%), out of the 74% who indicated that they provided education were able to buy books and uniforms. These results are consistent with those of Ferguson & Johnston (1997) where it was found that some 30% of adolescents dropped out of school because of family poverty and inability to locate funds necessary for books, uniforms and school fees.

One hundred and fifty six (71.2%) of the caregivers mentioned that they provide medical care to the orphans. Further analysis on those providing medical care showed that only 54 (34.6%) take the children to hospital while another 49 (31.4%) buy medicine from the local shop. Fifty-three of the caregivers (34%), indicated that they asked for medicine from friends or neighbours when the orphans were sick, depended on traditional herbs and/or free medical camps organized once in a while by various organizations or just watched and sought help from God. Medical care in Kenya is costly and may not be afforded by caregivers due to their low economic status. A study by GOK/UNICEF (2001) on the situation of HIV and AIDS orphans and vulnerable children in Kenya showed that medical care was one of the

orphan needs that caregivers were not able to meet due to the high costs involved. Also, in some cases, children orphaned by HIV and AIDS may not receive the health care they need because it is sometimes assumed that they are infected with HIV and their illnesses are untreatable (GOK/UNICEF, 2000).

4.3.5 Needs of orphans

Establishment of the needs of orphans was considered important because this would establish the situation of HIV and AIDS orphans. Providing for their needs calls for more resources, a situation that in essence may create stress for the family and community. Table 4.15 shows the needs of orphans as mentioned by the caregivers.

Table 4.15

Frequency distribution indicating the needs of orphans as reported by caregivers

Description of the needs	In the project		Out of the project		Total	
	No.	%	No.	%	No.	%
Food	51	92.7	152	92.7	203	92.7
Clothing	48	87.3	145	88.4	193	88.1
Shelter	43	78.2	142	86.6	185	84.5
Education	48	87.3	140	85.4	188	85.8
Medical	37	67.3	122	74.4	159	72.6
Psychosocial support	22	40.0	70	42.7	92	42.0

$N_i = 55$, $N_o = 164$, $N = 219$

Multiple responses were allowed.

The majority of the caregivers mentioned food, clothing, shelter, medical care and education as the needs of orphans (Table 4.15). A few caregivers (42%) mentioned psychosocial support. One hundred and ninety three of the caregivers (88.1%) mentioned clothing as an orphan need, out of these, 57% of them reported that orphans wore torn clothes, which were mostly donations. Indeed a male caregiver from out of the project said:

The clothes are old beyond repair, they have been repaired severally until even you cannot tell the original colour of the dress.

On shelter, caregivers indicated that they needed well-constructed and spacious houses. This is not surprising in that most of the respondents indicated that they lived in small, one or two-roomed mud walled houses that were not safe and secure. Others felt that the rents demanded for the houses were high and unaffordable and hence required assistance in housing.

The responses from orphans about their needs (Table 4.16) showed that most of them mentioned food, clothing, shelter and education.

Table 4.16

Frequency distribution indicating the needs of orphans as reported by orphans

Description of the needs	In the project		Out of the project		Total	
	No.	%	No.	%	No.	%
Food	46	83.6	155	94.5	201	91.8
Clothing	51	92.7	151	92.1	202	92.2
Shelter	32	58.2	139	84.8	171	78.1
Education	43	78.2	141	86.0	184	84.0
Medical	28	50.9	107	65.2	135	61.6
Psychosocial support	17	30.9	58	35.4	75	34.2

$N_i = 55$, $N_o = 164$, $N = 219$

Multiple responses were allowed.

From the results, it is also evident that a few orphans (34.2%) mentioned psychosocial support as their need. Whereas earlier studies (Ferguson & Johnston, 1997; GOK/UNICEF, 2001; Hunter & Williamsion, 1997; Saoke & Mutemi, 1994) have strongly indicated that psychosocial support is necessary for the children orphaned by HIV and AIDS, the results from this study indicate that few children mention it as a need. These results are similar to those of the caregivers. This, perhaps, may be due to the fact that families felt a need to have

basic needs fulfilled first hence their high representation. This is consistent with study findings by GOK/UNICEF (2001), which indicated that food and education were seen as the most urgent needs for orphans while psychosocial needs were underscored.

Also, the majority of the orphans (84.8%) out of the project compared to 58.2% from the project indicated shelter as their need. This may be due to the inadequacy of shelter experienced within Kibera Location by especially those out of the project. Those in the project are assisted in provision of housing, for instance, in some needy cases; caregivers and orphans under the project are rented for houses.

The results on the nature of the needs show that the orphans lacked adequate and quality food. Some of the orphans noted that they rarely took supper. They noted that they drank porridge or black tea. A 13-year-old orphan girl out of the project noted:

I have very little to eat, I take strong tea for supper.

On the same note, a 14-year-old boy said:

Some days, I stay without food, when I am hungry, I beg from neighbours or beg in the streets.

Orphans further noted that they needed good clothing together with shoes, uniforms and secure homes. This is not surprising since most of the respondents lived in small, one or two-roomed mud walled houses that were not secure and safe.

4.3.6 Orphan needs not adequately met

From the study findings, most caregivers reported that education, medical care and clothing needs of orphans were not adequately met. Table 4.17 shows that 129 (58.9%) of the caregivers mentioned medical care, 133 (60.7%) mentioned education, while 118 (53.9%) mentioned clothing as needs not adequately met.

Table 4.17

Frequency distribution showing orphan needs not adequately met as reported by caregivers

Description of needs not adequately met	In the project		Out of the project		Total	
	No.	%	No.	%	No.	%
Clothing	27	49.1	91	55.5	118	53.9
Education	34	61.8	99	60.4	133	60.7
Shelter	13	23.6	58	35.4	71	32.4
Medical care	35	63.6	94	57.3	129	58.9
Food	13	23.6	45	27.4	58	26.5
Psychosocial support	20	36.4	59	36.0	79	36.1

$N_i = 55$, $N_o = 164$, $N = 219$

Multiple responses were allowed

These needs, as mentioned by caregivers were costly and hence unaffordable to many, especially those caregivers out of the project. During the interview, a male caregiver out of the project mentioned:

Sometimes, it is just impossible to raise money for fees and medical care, what is important is to try and provide food and a place for the child to live. The rest will only come if possible; if there is no fees, the children just stay at home.

These findings are supported by those of other studies (GOK/UNICEF, 2000; HACL, 2002), which found out that medical care is one of the needs inadequately met by caregivers. A few caregivers mentioned shelter, food and psychosocial support.

Orphans' reports of needs not adequately met were also consistent with the findings from the caregivers. Most of them indicated that their clothing, education and medical care needs were not adequately met (Table 4.18), while a few mentioned shelter, food and psychosocial support.

Table 4.18

Frequency distribution showing the distribution of orphan needs not adequately met as reported by orphans

Description of needs not adequately met	In the project		Out of the project		Total	
	No.	%	No.	%	No.	%
Clothing	32	58.2	93	56.7	125	57.1
Education	32	58.2	95	57.9	127	58.0
Shelter	16	29.1	63	38.4	79	36.1
Medical care	22	40.0	96	58.5	118	53.9
Food	26	47.3	51	31.1	77	35.2
Psychosocial support	11	20.0	64	39.0	75	34.2

$N_i=55$, $N_o=164$, $N=219$

Multiple responses were allowed.

Whereas 26.5% caregivers mentioned food as a need not adequately met, comparatively more orphans (35.2%) mentioned it as shown in Table 4.18. This may perhaps be because, the food provided and thought to be adequate by caregivers may not be found by the orphans to be so. Furthermore, it was indicated by the caregivers that although food was provided, it was usually inadequate and not of quality. In a study by GOK/UNICEF (2001) and Hunter & Williamson (1997), provision of adequate food to orphans has been pointed out as one of the challenges faced by caregivers.

When the orphans were asked how they coped with the needs that were not adequately met, 59 of them (47.2) out of the 57.1% who reported that their clothing needs were not met, mentioned that they made use of a few worn out clothes that had been repaired severally, a few, especially those within the project mentioned that they received donations. In terms of medical care, 56% of the 118 (53.9%) whose medical needs are not adequately met mentioned that they usually ask for medicine from neighbours and sometimes relatives as

put by a 12-year-old boy who noted:

When I am sick, I ask my neighbour to help me with medicine, my auntie says she has no money to take me to hospital.

Some orphans mentioned that they stay without medication and are only assisted when it gets very serious by well-wishers. Researches have indicated that medical care for orphans is an area that is not well provided for. Often, caregivers and organizations do not adequately provide for this need due to its high costs (GOK/UNICEF, 2000; HACI, 2002; USAID/UNICEF, 1999; WCRP/UNICEF, 2002). Lack of good medical care affects the health of a child, this, together with lack of adequate basic needs such as food and shelter further affects the growth and development of the child. In coping with the unmet need of education, the orphans noted that their caregivers try to seek assistance from the heads of schools or relatives in form of school fees while some noted that the orphans stay at home when it finally becomes impossible.

4.3.7 Problems experienced by orphans

The findings from this study show that the majority of the caregivers (69.4%) noted that orphans experienced problems. A further analysis shows that most caregivers 114 (52%) mentioned food, 101 (46%) mentioned education, while 99 (45%) mentioned medical care. The results from orphans also indicate that the majority of them 160 (73.1%) experienced problems while living with caregivers. From the orphans' responses, the nature of problems experienced as shown in Table 4.19 included being overworked (34.2%), lack adequate clothing (26.5%), experienced hunger (29.2%), and experienced school fees problems (26.0%).

Table 4.19

Frequency distribution showing nature of problems experienced by orphans as reported by orphans

Description of nature of problems	In the project		Out of the project		Total	
	No.	%	No.	%	No.	%
Beaten	2	3.6	18	11.0	20	9.1
Hunger	22	40.0	42	25.6	64	29.2
Quarrels	1	1.8	11	6.7	12	5.5
Fees problems	17	30.9	40	24.4	57	26.0
Inadequate shelter	5	9.1	20	12.2	25	11.4
Inadequate clothing	22	40.0	36	22.0	58	26.5
Lack of medical care	7	12.7	34	20.7	41	18.7
Overworked	4	7.3	71	43.3	75	34.2

$N_i = 55$, $N_o = 164$, $N = 219$

Multiple responses were allowed.

Other orphans expressed that they were not allowed to visit or have an outing with the rest of the family members, while some reported that they slept on the floor and covered themselves with a light sheet while the rest of the family members slept on beds. Additionally, some noted that they were chased outside at meal times and only came in to eat leftovers. A 12-year-old girl from out of the project said:

You eat the last after everyone has eaten, if the food gets finished, you stay hungry.

....*You have no time to read, instead you are given a lot of domestic work to do when the other children in the home are reading.*

Similarly, another 10-year-old girl from the project said:

...*When I am hungry and ask for food, I am told to remember that I have no parent to give me the food. In any case I know where their graves are.*

These responses were similar for both orphans' reports of needs for food and clothing

and reports of caregivers for the same. It is important to note that most of those experiencing problems of hunger, school fees and inadequate clothing were from those in the project and yet they were under a community project assisting orphans, indicating that the support received may be inadequate. The results further reveal that most of the orphans, 43.3% out of the 34.2% who indicated being overworked were from out of the project. This may be attributed to the fact that they lacked protection like those in the project.

Within the project, caregivers are counselled against child abuse while the children are sensitised about various forms of abuse and are informed to report any such occurrence to the project officers. According to previous researches (GOK/UNICEF, 2001; Nyambedha, 1999; Ferguson & Johnston, 1997), it is noted that orphaned children are often overworked by those offering care and support to them. It is further indicated that orphans are discriminated upon from the children of caregivers in terms of food, allocation of work and education support. In some cases, orphans pointed out that they start their daily chores as early as 4 a.m. to as late as midnight. The orphans further mentioned that housing is a big problem as the space is limited. This forces them and their caregivers to seek assistance in accommodation from neighbours and when this is not possible, they sleep outside the house as mentioned by the 13-year-old boy who said:

... When I have nowhere to sleep, I just sleep outside the house.

These findings concur with those of community programme leaders who observed that some orphans turn up at their centres having been badly beaten and hurt by their caregivers. At times they miss school because they have been undertaking domestic and other work outside the home. Similarly, community leaders noted that although caregivers are doing a commendable job in caring for orphans, they have not met their needs adequately. They reported that some children are seen on the streets begging food while others work in roadside “kiosks” owned by their caregivers, when they are meant to be in school.

The study findings further reveal the various ways orphans used to solve these problems. Most of the children noted that they went to look for casual jobs so that they could earn some money, while others said that they ended up begging on the streets or stealing. They also said that they shared their problems with teachers, neighbours, friends and some relatives; this was however done secretly because if caregivers found out, the orphans were beaten or punished thoroughly. The punishment, they said, could entail being denied food or chased from the house to spend the night out in the cold. The majority of the children who experienced non-support for school fees noted that they stayed at home and did not attend school, while those who lack adequate clothing mentioned that they use old worn-out clothes donated by community care programmes and other well wishers.

Further, some orphans reported that when the problems became too much, they ran away from home to seek refuge with neighbours or moved to live in the streets. Similarly, those who were overworked noted that they sometimes ran away from home when the situation became unbearable. Living on the streets exposed the children to more dangers such as sniffing glue, drugs and sexual abuse, among others. In a study by GOK/UNICEF (2001) it was pointed out that children living in the streets are more vulnerable to HIV and AIDS and all other forms of abuse.

4.3.8 Problems experienced by caregivers in caring for orphans

The majority of the caregivers (83.9%) reported that they experience problems while caring for orphans. The rest of the caregivers (16.5%) mentioned that they did not experience any problems. Experience of problems by caregivers may be strenuous to a family and even may destabilize the family, especially when prior arrangements were not made to take in orphans. Table 4.20 shows the areas in which caregivers experience problems while caring for orphans.

Table 4.20

Frequency distribution showing areas caregivers experienced problems while caring for orphans

Type of problem	In the project		Out of the project		Total	
	No.	%	No.	%	No.	%
Medical care	18	32.7	36	22.0	54	24.7
Food	15	27.3	44	26.8	59	26.9
Shelter	7	12.7	32	19.5	39	17.8
Clothes	15	27.3	37	22.6	52	23.7
Education	15	27.3	47	28.7	62	28.3
Psychosocial	12	21.8	14	8.5	26	11.9

$N_i = 55$, $N_o = 164$, $N = 219$

Multiple responses were allowed.

These findings indicate that most caregivers experienced problems in medical care (24.7%), food (26.9%), education (28.3%) and clothing (23.7%). Contrary to what would be expected, most of those experiencing problems were from the project, indicating that the support provided from the project is inadequate. On the other hand, caregivers within the project may be having higher expectations in terms of support from the project. At the same time, there is a possibility that they may be over reliant on the project to supply their needs fully, which may not be possible, and hence do not work towards meeting the needs of orphans and hence experience the problems.

The study findings further show that caregivers employed various mechanisms in addressing the problems experienced. The results show that the majority of the caregivers noted that they depended on other means such as asking for medicines from the neighbours and well-wishers, visited traditional medicine men or just ask the children to persevere

without any medicine at all. A few sought assistance from the community care programmes or visited a hospital.

The findings also show that out of the 26.9% who experienced food problems, the majority (67%) of them mentioned that they persevered with the little they managed to get, like providing one meal a day, preferably supper. The caregivers also mentioned that sometimes they got assistance from relatives, neighbours, friends and religious organizations. Provision of clothing was also an area in which caregivers experienced problems; the results indicate that the majority of caregivers (71%) of the 23.7% facing clothing problems relied on old donated clothes. The rest (29%) mentioned that sometimes they shared their clothes with the orphans. Caregivers also mentioned that they faced problems in meeting school requirements, including books and uniforms, which resulted in children being sent home from school. This, in most cases, compelled the children to engage in manual work so as to raise funds for buying the school materials.

4.3.9 Other assistance to orphans from the community

The study also sought to establish whether orphans received assistance from other members or organizations from the community. Assistance received was in itself resourceful to the family, as it contributed toward the provisions of orphans and therefore lightened the load of the caregivers in providing for orphans. The findings show that slightly more than half, 107 (54%), of the caregivers indicated that they received assistance from community members and other organizations in the community for support of orphans (Table 4.21).

Table 4.21

Frequency distribution showing whether caregivers received assistance for care of orphans

Receive assistance	In the project		Out of the project		Total	
	No.	%	No.	%	No.	%
No	13	23.6	78	54.5	91	46.0
Yes	42	76.4	65	45.5	107	54.0
Total	55	100.0	143	100.0	198	100.0

21 missing cases (out of the project)

The responses from orphans, however, indicated that more orphans, 147 (67.4%), compared to the caregivers above noted that they receive assistance from other members of the community and organizations (see Table 4.22).

Table 4.22

Frequency distribution indicating whether orphans received assistance

Receive assistance	In the project		Out of the project		Total	
	No.	%	No.	%	No.	%
No	4	7.3	67	41.1	71	32.6
Yes	51	92.7	96	58.9	147	67.4
Total	55	100.0	163	100.0	218	100.0

1 missing case (out of the project)

This disparity could be due to the fact that orphans may have received assistance without their caregivers' knowledge especially while away from home, for example, in school. Assistance received was mainly food, school fees, clothes and occasionally counselling from particularly the religious organizations and neighbours. A study by HACI (2002) shows that community care programmes and other individuals in society assist orphans and caregivers.

4.4.0 Participation in community care programmes

This section addresses objective four, which sought to establish the nature of community participation in care and support of orphans.

4.4.1 Caregivers' participation in community care programmes

It was important to find out the caregivers' participation in the community care programmes assisting orphans. Participation in community care programmes provides cohesion, and therefore a collective approach in addressing the problems being faced. It also in itself provides a forum for discussion and mobilization of resources and hence provides an avenue for psychosocial support to the caregivers. As such, participation enhances success of community projects since the people are able to identify their problems and seek solutions to the problems collectively, which further, according to Bwalya (1985) enhances mobilisation and quality decision-making. This could in turn result into more efficient use of resources.

The results as shown in Table 4.23 indicate that the majority, 184 (84%) of the caregivers, did not participate in the activities of the organization, most of whom were from those out of the project.

Table 4.23

Frequency distribution showing caregivers' participation in community care programme activities

Participation in activities	In the project		Out of the project		Total	
	No.	%	No.	%	No.	%
No	35	63.6	149	90.9	184	84.0
Yes	20	36.4	15	9.1	35	16.0
Total	55	100.0	164	100.0	219	100.0

This low level of participation as pointed out by Mbithi (1974) may be as a result of the fact that the programmes are normally started at community level without the involvement of the community members even though they are the beneficiaries. However, community leaders also observed that although members were requested to volunteer their services towards the community care programmes, only a few turned up. This as indicated by community programme leaders, is because the community members expected to benefit materially after they volunteered their services, for instance, get some food, clothes or any other items. Their involvement in the programme seems to be mainly driven by the incentives they receive. As indicated in a report by FAO (2002) this is participation for material incentives whereby people participate in order to get something. In this level, participation ends when the incentives end. Therefore, lack of these incentives demotivates them and leads to low participation. It was pointed out that caregivers mostly went to the community care programmes to seek for assistance. Chitere & Mutiso (1991) point out that community members from low socio-economic status are more concerned with their individual needs rather than collective participation in programmes, hence their participation in these programmes is bound to be low.

This low participation may be attributed to lack of time by the caregivers. In many cases, community functions (e.g. funerals, religious functions, visits) domestic and work-related activities draw upon people's time that there is no time to participate in community programmes. They are more concerned with their security and survival, a fact, which may make it difficult for them to create time for participation in community programmes.

4.4.2 Caregivers' participation in planning community care programme activities

The findings of this study showed that only 11 (5%) of the caregivers participated in planning activities of the community care programmes (Table 4.24). Involvement of people in planning activities is resourceful, as in the first place, people are the most important in

development programmes. Also as pointed out by Chitere & Mutiso (1991), community members are in a better position to plan the activities of community programmes. This is because they are better placed in identifying their problems, mobilizing resources for addressing the same. As pointed out by Yeung & McGee (1986), community participation in planning is vital to success of the programmes since it involves the community members in visualizing their needs, resources required and their role in mobilizing those resources for the success and sustainability of the programmes.

Table 4.24

Frequency distribution showing caregivers' participation in planning community care programme activities

Participation in planning	In the project		Out of the project		Total	
	No.	%	No.	%	No.	%
No	50	90.9	158	96.3	208	95.0
Yes	5	9.1	6	3.7	11	5.0
Total	55	100.0	164	100.0	219	100.0

Further, data showed that caregivers involved in planning were mainly engaged in planning visitations to orphans and sharing ideas on assistance required by orphans and the needy members of the society. These results concur with the responses from programme leaders who observed that community members were usually involved in undertaking light activities and not planning, which was usually done by the programme staff. One programme leader noted:

What do they know about planning; this is done by those who provide resources to start the programme.

From the foregoing, it is evident that caregivers are actually not involved in planning activities, a situation which according to a report by FAO (2002) deprives them an opportunity to reflect on issues affecting them and the best way of addressing them. This may impact negatively on the community care programme in that caregivers may not feel part of the process and hence not own the project, thereby not supporting it.

4.4.3 Caregivers' participation in attendance at meetings.

The results from this study as indicated in Table 4.25 show that very few of the caregivers (16%) attended meetings at the community care programmes, while the majority of them (84%) did not. The results further indicate that out of the 16% who attended meetings, very few caregivers 14 (39%) attended occasionally, 13 (36%) attended monthly, while 7 (21%) attended weekly. The rest (4%) attended quarterly.

Attendance at meetings by the caregivers is important as they get an opportunity to discuss progress of the programme, mobilization of resources and success of the programme. It is also through the meetings that the caregivers are able to participate in the review of activities and planning for the future.

Table 4.25

Frequency distribution showing caregivers' participation in attendance at meetings

Participation in planning	In the project		Out of the project		Total	
	No.	%	No.	%	No.	%
No	35	63.6	149	90.8	184	84.0
Yes	20	36.4	15	9.2	35	16.0
Total	55	100.0	164	100.0	219	100.0

4.4.4 Caregivers' participation in decision-making

Decision-making process involves defining the problems to be solved, seeking alternative courses, thinking through alternatives, selecting the best alternative to solve a problem, and finally accepting responsibility for the decision (Deacon & Firebaugh, 1988). It is a process of selecting one course of action from a number of possible alternatives in solving a problem or in meeting a situation. Involvement of caregivers in decision-making is resourceful in that they would draw on their community experiences. In any case, they are better placed, as they understand their problems better, mobilize resources and plan how they would effectively be used. The results from this study as indicated in Table 4.26 show that very few of the caregivers (2.7%) were involved in making decisions within the programmes. Those involved noted that they were involved in decisions that revolved around action plans and/or implementation of activities, and not in technical decisions involving planning programmes, and allocation and use of resources. This further clarifies the situation that their level of participation in community care programmes is low.

Table 4.26

Frequency distribution indicating caregivers' participation in decision-making activities

Participation in decision making	In the project		Out of the project		Total	
	No.	%	No.	%	No.	%
No	50	90.9	163	99.4	213	97.3
Yes	5	9.1	1	0.6	6	2.7
Total	55	100.0	164	100.0	219	100.0

According to Chitere & Mutiso (1991), it is important to involve members of the community in making decisions as this increases ownership of the project and hence

commitment to its success. Downward flow of information in the form of directives as noted by Leonard (1977), leads to a situation whereby the directives may not be readily adopted since they might not apply to local community conditions and consequently never work. This could drive away community people from the programmes, as they do not get to see results.

4.4.5 Caregivers' participation in carrying out programme activities

Participation of caregivers also involves use of their personal and family resources in implementing programme activities. The results of this study show that only 38 (17.3%) of the caregivers were involved in carrying out the community care programmes activities. The majority of the caregivers 181 (82.7%), most of whom were from out of the project, were not involved in carrying out programme activities. This may be attributed to the fact that they were not registered in a specific programme within the community. Activities carried out included caring for the orphans, preparing meals for orphans in schools, and participation in orphan activities such as fun days. Other activities mentioned included creating HIV and AIDS awareness within the community and volunteering in child protection issues, like reporting any cases of child abuse.

4.4.6 Caregivers' involvement in making contributions to community care programmes

The results indicate that a few caregivers made contributions toward community care programmes. The findings (Table 4.27) show that only 15 (6.8%) of the caregivers, most of whom were from the project, made contributions. This was perhaps because those from the project had been sensitised on the importance of mobilizing resources hence their contribution towards community care programmes. Contributions made included cash donations, material provisions of the orphans, such as clothes and food, offering voluntary visitations and home based care to orphans, spiritual guidance and counselling to the orphans.

It is however important to note that the study area is inhabited by low-income people, which may make it difficult for them to make contributions to the community programmes.

For instance, a community leader observed that:

Here people are very poor. It is already difficult for them to feed themselves and their children, how can they afford to contribute to an organization? They need help in caring for the children and orphans they already have.

Table 4. 27

Frequency distribution showing whether caregivers make contributions to community care programmes

Make contributions to organization	In the project		Out of the project		Total	
	No.	%	No.	%	No.	%
No	45	81.8	159	97.0	204	93.2
Yes	10	18.2	5	3.0	15	6.8
Total	55	100.0	164	100.0	219	100.0

4.4.7 Caregivers' suggestions on orphan care

Caregivers were asked to give their suggestions regarding alternative and responsible persons/organizations where orphans could be cared. The responses are as shown in Tables 4.28 and 4.29 below. From the results, eighty-one caregivers (37%) felt that orphans should be cared for at the household level because children were better cared for at this level by caregivers and other family members. According to past researches (HACI 2002; USAID/UNICEF, 1999; WCRP/UNICEF, 2002), it is argued that children retain their identity and safeguard their inheritance when they are cared for at household levels. Secondly, they are able to remain in touch with their siblings, relatives and other members of their family/communities, unlike when they are institutionalised and separated from their siblings and other family members.

Table 4.28

Frequency table showing caregivers' suggestions on orphan care

Places of care	In the project		Out of the project		Total	
	No.	%	No.	%	No.	%
Household	19	34.5	62	37.8	81	37.0
Community	9	16.4	30	18.3	39	17.8
Institutions	8	14.6	29	17.7	37	16.9
Others	19	34.5	43	26.2	62	28.3
Total	55	100.0	164	100.0	219	100.0

Caregivers further noted that care of orphans at household level is better because orphans are brought up within a family set-up, in which they are given close attention. Additionally, they feel loved and are more comfortable as it is a familiar environment.

Thirty-nine caregivers (17.8%) felt that orphans can be better cared for through community programmes. These are local programmes organized and managed by community members. They offer support, including food and clothes to orphans who visit the centres during the day but live with their caregivers. Some of these programmes provide other services like education and counselling to the children. Reasons given for this type of care are that the community programmes are better placed to mobilize resources for care of orphans from community members, and other organizations than individual caregivers. The caregivers further noted that the problem of orphans is not a problem of the immediate relatives alone, but for the whole community. The issue should therefore be addressed at community level with participation of all community members, particularly considering that the number of orphans has become increasingly unmanageable.

Other caregivers (16.9%) noted that orphans would be better cared for in institutions. Although efforts are being made to discourage institutionalisation of children

(GOK/UNICEF, 2000; WCRP/UNICEF, 2002), these caregivers felt that institutions are better placed since they have resources and the infrastructure to care for orphans. Furthermore, caregivers may be overwhelmed with the care of orphans and feel that they should be taken to institutions. Arguments against institutions point out that they are costly and cut off the children from their family ties, they are therefore not advocated for unless in special circumstances such as cases of HIV positive children that need specialised care and the very young ones that are abandoned (GOK/UNICEF, 2001). However, it is strongly argued that these children should be reintegrated back to their communities and reunified with their relatives later on. Other caregivers noted that orphans would be cared for anywhere as long as they are safe and their needs are met.

The findings regarding who should care for orphans (Table 4.29) show that most caregivers (66.2%) felt that everyone within the community should take care of the orphans. They argued that the orphan problem is everybody's responsibility and hence all members of the community should participate in their care. It was, however, noted that those offering care should be willing and not forced as this is likely to lead to mistreatment and abuse of the children. Other caregivers (14.8%) felt that friends and neighbours who are willing would care for orphans. The bottom line, nonetheless, as observed by both community leaders and programme leaders is that caregivers at all levels should be sensitive to orphan needs (i.e. be loving and caring), while at the same time strive to meet their basic requirements. In addition, all members of the community, including civil and religious organizations, should be sensitised and mobilized to support orphans in communities.

Table 4.29

Frequency distribution showing individuals/organizations that should care for orphans

Persons/organizations to care for orphans	In the project		Out of the project		Total	
	No.	%	No.	%	No.	%
Community based organizations	6	12.0	5	3.1	11	5.2
Everyone in the community	32	64.0	107	66.9	139	66.2
Relatives	8	16.0	21	13.1	29	13.8
Friends/neighbours	4	8.0	27	16.9	31	14.8
Total	50	100.0	160	100.0	210	100.0

9 missing cases (5 in the project, 4 out of the project)

In the orphan programming report by USAID/UNICEF (1999), it is indicated that orphan care is a family, community and state responsibility, no one individual or organization can undertake the challenge alone and achieve any significant results. The problem therefore requires a collective effort, as this would be a great burden for any one person to carry.

Regarding how community members would best organize themselves to support orphans, the results show that 9% of the caregivers suggested that community members should unite and work together as a team in caring for orphans at community level. This could be done by forming community-based organizations through which other community members can offer donations such as food and clothing to caregivers who care for orphans. Thirty percent of the caregivers indicated that orphanages could be build to cater for orphans. This may be due to the problems experienced in caring for orphans. Most communities are already overwhelmed with the provisions of care to the increasing number of orphans (GOK/UNICEF, 2001).

Other caregivers felt that communities should be loving, offer guidance to orphans, provide school materials, conduct fund raisings to assist in meeting the needs of orphans and

form strong support groups within communities for caregivers. Additionally, capacity of caregivers could be enhanced by availing themselves of micro financing for starting up small-scale businesses to generate incomes for support of the orphans.

4.4.8 Assistance required by caregivers

The results as indicated in Table 4.30 show that most caregivers (45.7%) wished to be assisted financially. The finances could assist them meet orphan needs according to their priorities. These results are similar to those of programme leaders who felt that they needed financial, technical and material support so as to effectively support more orphans in their communities. Other caregivers mentioned that they would like to be assisted with food, clothing and education costs.

Table 4.30

Frequency distribution showing assistance required by caregivers

Assistance required	In the project		Out of the project		Total	
	No.	%	No.	%	No.	%
Financial	28	50.9	72	43.9	100	45.7
Food	14	25.5	38	23.2	52	23.7
Clothing	15	27.3	32	19.5	47	21.5
Medical care	5	9.1	18	11.0	23	10.5
Sponsorship in education	21	38.2	55	33.5	76	34.7
Shelter	3	5.5	15	9.1	18	8.2
Security	1	1.8	2	1.2	3	1.4

$N_i=55$, $N_o=164$, $N=219$

Multiple responses were allowed.

The responses from orphans were similar to those of caregivers as shown in Table 4.31 below. Most orphans required assistance in clothing, school fess support, food and assistance in getting higher education.

Table 4.31

Frequency distribution showing assistance required by orphans

Assistance required	In the project		Out of the project		Total	
	No.	%	No.	%	No.	%
Clothes	18	32.7	43	26.2	61	27.9
Higher education support	7	12.7	48	29.3	55	25.1
Food	14	25.5	42	25.6	56	25.6
School fees	16	29.1	43	26.2	59	26.9
Medical care	6	10.9	33	20.1	39	17.8

$N_i=55$, $N_o=164$, $N=219$

Multiple responses were allowed.

4.5.0 Success of community care programmes

This section addresses objective number five, namely to determine the success of community care programmes, which was measured by the extent to which they meet orphan needs. The findings of this study show that most of the caregivers 123 (56.2%) noted that orphan needs were not met, while a few 18 (8.2%) felt that the community care programmes met the orphan needs quite sufficiently (Table 4.32).

Table 4.32

Frequency distribution showing success of community care programmes.

Extent of meeting needs	In the project		Out of the project		Total	
	No.	%	No.	%	No.	%
Not sufficiently	29	52.7	94	57.3	123	56.2
Fairly sufficiently	23	41.8	55	33.5	78	35.6
Quite sufficiently	3	5.5	15	9.2	18	8.2
Total	55	100.0	164	100.0	219	100.0

Community programme leaders similarly noted that due to lack of resources, they had not adequately met the needs of orphans. These results are consistent with those of HACI (2002) where it is pointed out that community programmes offering care and support to children orphaned by HIV and AIDS lack adequate resources and hardly meet the needs of orphans sufficiently. Additionally, their coverage was limited to only a few children. This is attributed to the large numbers of orphans and other vulnerable families needing assistance.

4.6.0 Relationships between respondents, care practices and community participation variables

To determine relationships between respondents and care practices and community participation variables, chi-square test (χ^2), Fisher's exact test and t-test were used.

Chi-square (χ^2) is a statistical technique, which attempts to establish relationships between two variables both of which are categorical in nature (Mugenda & Mugenda, 1999). It is a form of count occurring in two or more mutually exclusive categories. In this case, the non-parametric relationships between gender of orphans and, needs of orphans, problems of orphans and the type of care provided to orphans were checked. Similarly, relationships between orphans in and out of project and their needs, problems and type of care provided were also checked. Relationships between caregivers in and out of project and the support they provide to orphans, problems experienced and their participation in community care projects were also checked using chi-square test. A statistical significance level of $\alpha = 0.05$ was used. If the calculated probability (p-value) $\leq \alpha$, the results are considered to be significant.

Fisher's exact test is a test for independence in a 2 X 2 table. The test is based on the hyper geometric distribution. It is most useful when the total sample size and the expected values are small. The exact probability of obtaining the observed result or one more extreme, if the two variables are independent and the marginals fixed was calculated. This test was

used in cases where the sample size in a cell in a 2 X 2 table was 20 or less. A statistical significance level of $\alpha = 0.05$ was used. If the calculated probability (p-value) $\leq \alpha$, the results are considered to be significant.

T-test is a statistical test used to test whether there are significant differences between two means derived from two samples or groups at a specified probability level (Mugenda & Mugenda, 1999). According to Grimm (1993), there are two types of t-tests, these are independent samples t-test and dependent samples t-test (also known as a paired observations t-test or correlated samples t-test). This study used both types of t-tests. Paired samples t-test was used to determine whether there were differences between orphans and caregivers, while independent samples t-test was used to determine differences between in and out of project orphans in the needs of orphans, problems experienced by orphans and the type of care provided to the orphans. A statistical significance level of $\alpha = 0.05$ was used. If the calculated probability (p-value) $\leq \alpha$, the results are considered to be significant.

Hypothesis one: There is a relationship between gender of orphans and their needs.

The hypothesis tested postulated that there is a relationship between gender of orphans and their needs. Chi-square results (Table 4.33) show that there were no significant relationships between gender of orphans and their needs, implying that there were no unique needs associated with either boys or girls.

These findings indicate that needs of orphans have no relationships with their gender. This may be because the needs of orphans are the common basic necessities that are required for survival and growth by both boys and girls. As pointed out in a study by GOK/UNICEF (2001), orphaned children lack adequate basic needs, which under the rights based programming approach should be provided by such role holders as communities, governments and other agencies assisting children. These basic necessities include food, water, clothing, education, beddings, and medical care.

Table 4.33

Chi-square results showing relationships between gender of orphans and needs of orphans

Needs of orphans	χ^2	df	p-value
Food	0.04	1	0.85
Clothing	0.22	1	0.64
Education	0.72	1	0.39
Shelter	0.29	1	0.59
Medical care	2.68	1	0.10
Psychosocial support	1.26	1	0.26

Significant if $p \leq 0.05$

Hypothesis two: Types of problems experienced by orphans are associated with their gender.

The hypothesis tested postulated that types of problems experienced by orphans are associated with their gender. Chi-square analysis on the types of problems experienced by orphans while living with the caregivers revealed that there were no significant relationships between the orphan boys and girls as shown in Table 4.34.

Table 4.34

Chi-square results showing relationships between gender of orphans and types of problems experienced by orphans

Type of problem	χ^2	df	p-value
Beaten	1.18	1	0.27
Hunger	0.05	1	0.80
Quarrels	0.70	1	0.40
School fees	0.02	1	0.88
Shelter	1.26	1	0.26
Clothes	0.09	1	0.75
Medical care	1.15	1	0.28
Overworked	0.00	1	0.98

Significant if $p \leq 0.05$

These results indicate that there were no unique problems associated with gender of orphans. This is not surprising since the orphans are all living with caregivers in the same community and are faced with similar situations/problems. The findings of this study are consistent with those of other studies (GOK/UNICEF, 2000; HACI, 2002; WCRP/UNICEF, 2002), which indicate that orphans face similar problems of inadequate food, clothing, shelter, medical care and psychosocial support.

Hypothesis three: Gender influences the form of assistance required by orphans

The hypothesis tested stated that gender influences the form of assistance required by orphans. Chi-square analysis showed that there was a significant relationship between gender and the form of assistance required in school fees support ($\chi^2=3.96$, $df=1$, $p=0.04$) as indicated in Table 4.35. This implies that assistance required in school fees support was associated with gender of orphans.

There was however no significant relationship between boys and girls and the form of assistance required for clothing, food, medical care or getting higher education (Table 4.35), meaning that gender did not affect assistance required in these areas.

Table 4.35

Chi-square results showing relationships between gender of orphans and form of assistance required by orphans

Form of assistance	χ^2	df	p-value
Get higher education	1.87	1	0.47
School fees	3.96	1	0.04*
Clothing	0.53	1	0.47
Food	0.82	1	0.36
Medical care	1.00	1	0.31

Significant if $p \leq 0.05$

The study findings show that more girls (33.3%) as compared to 21.4% of the boys indicated that they wished to be assisted with school fees. This is not surprising in that it has already been shown that the unmet need of education is more prevalent for girls than boys. This, as mentioned by Ferguson & Johnston (1997) may be because there is greater reluctance on the part of relatives to support girls in school after parents die.

Hypothesis four: The needs of orphans are determined by whether the orphans are in or out of community care project.

The hypothesis tested postulated that the needs of orphans are determined by whether the orphans are in or out of community care project. Chi-square results (Table 4.36) show a significant relationship between orphans in and out of project and shelter need ($\chi^2=16.99$, $df=1$, $p<0.001$), and between orphans in and out of project and food need ($\chi^2=6.45$, $df=1$, $p=0.01$). This implies that shelter and food needs were associated with orphans in and out of the project. There were however no significant relationships between in and out of project orphans and clothing, education, medical care and psychosocial support needs.

Table 4.36

Chi-square results showing relationships between orphans in and out of project and needs of orphans

Needs of orphans	χ^2	df	p-value
Shelter	16.99	1	0.001*
Food	6.45	1	0.01*
Clothing	0.02	1	0.87
Education	1.86	1	0.17
Medical care	3.58	1	0.06
Psychosocial support	0.36	1	0.54

Significant if $p \leq 0.05$

The results show that the majority of orphans out of the project (84.8%) mentioned shelter as a need as compared to 58.2% of those in the project. This was possibly due to the fact that orphans in the project were assisted with provision of shelter. Through the project, orphans were placed under caregivers with appropriate housing. In addition, caregivers under the project in dire need of shelter were assisted in securing appropriate housing, whereas, caregivers out of the project could not have such assistance in housing and experienced housing problems. Saoko & Mutemi (1994) and GOK/UNICEF, (2001) report that shelter is a major problem facing caregivers.

There was also a significant relationship between orphans in and out of the project and food need. The results show that most orphans 94.5% from out of the project as compared to 83.6% from the project indicated food as their need. These results may be so because orphans out of the project did not get assistance, as do those in the project. It is important to note that there were also large numbers of those in the project needing food. This may be attributed to the fact that assistance received in food was not adequate. Furthermore, as has been pointed out in HABI (2002), the food received through caregivers is shared with other household members, and hence may not be adequate.

Chi-square results further show that there were no significant relationships between in and out of project orphans and clothing, education, medical care and psychosocial support needs. This implied that these needs were not associated to orphans in and out of the project. All orphans, whether in and out of the project required them.

Hypothesis five: There is a relationship between orphans in and out of community care project and the type of problems they experience.

The hypothesis tested stated that there is a relationship between orphans in and out of community care project and the type of problems they experience. The results are as shown in Table 4.37.

Table 4.37

Chi-square results showing relationships between orphans in and out of project and types of problems experienced by orphans

Types of problems	χ^2	df	p-value
Beaten	2.67	1	0.10
Hunger	4.12	1	0.04*
Inadequate clothing	6.89	1	0.001*
Overworked	23.73	1	0.001*
Quarrels	1.90	1	0.17
School fees	0.90	1	0.34
Shelter	0.39	1	0.53
Medical care	1.73	1	0.18

Significant if $p \leq 0.05$

Chi-square results show that there were significant relationships between orphans in and out of project and the problem of hunger ($\chi^2=4.12$, $df=1$, $p=0.04$), inadequate clothing ($\chi^2=6.89$, $df=1$, $p<0.001$) and being overworked ($\chi^2=23.73$, $df=1$, $p<0.001$). This implies that problems of hunger, inadequate clothing and being overworked were associated with orphans being in and out of the project. There were however, no significant relationships between in and out of project orphans and problems of being beaten, quarrelled, school fees, shelter and medical care.

The findings of the study show that 29.2% of the orphans experienced hunger problems. Surprisingly, most of those experiencing hunger problem were from the project where they were assisted with food. This may be because caregivers in the project may over rely on the project to provide sufficient food to orphans, which may not be the case.

The results further indicate significant relationships between in and out of the project orphans and clothing problem ($\chi^2=6.89$, $df=1$, $p<0.001$). The findings show that 26.5% of the orphans experienced a clothing problem, most of whom were also from the project. Similarly, orphans in the project may have higher expectations, which may not be adequately met. There was also a significant relationship between orphans in and out of project and the problem of being overworked ($\chi^2=23.73$, $df=1$, $p<0.001$).

From the findings, most of the orphans who reported that they were being overworked were from out of the project. Orphans out of the project were prone to being overworked because they were not aware of or did not have direct access to support systems like the children within the project, who had social workers who offered protection and support services to them and the caregivers. Most orphans within the project attended a community school operated by the project. As such, they spent most of their time away from home where they were likely to be overworked. Orphans out of the project, were likely to be allocated household and other duties, which could be too much for them. In some instances, they were called out of school to attend to domestic and other duties. These findings match those of studies conducted by Ferguson & Johnston (1997), Hunter & Williamson (1997), and Nyambedha (1999), which show that orphans are often removed from school by their caregivers to help with domestic duties at home. Some are engaged by the caregivers in their income generating activities to help raise income for the family's needs, while some are virtually taken in by caregivers to be house helps.

Also, in a study conducted by GOK/UNICEF (2001), it was found out that orphans living with caregivers worked for long hours, starting their domestic chores very early and sleeping late with no time for school or play. In some cases, it was pointed out that they were engaged in income generating activities before leaving for school in the morning. For example, orphans were reportedly sent to the market very early in the morning by their

caregivers to buy stock for their caregivers' kiosks, set up the stall, and wait till the caregiver comes to relieve them before they go to school, which could be as late as 2.00 p.m.

Chi-square tests on other types of problems experienced by orphans in and out of the project showed that there were no significant relationships (Table 4.37). This could be due to the fact that the orphans, even those in the project live with caregivers while being supported through the project. They also often experience similar problems of being beaten and quarrelled when not at the project. Also, caregivers both in and out of the project lack adequate resources to meet such orphans' needs as housing and medical care.

Hypothesis six: The form of assistance required by orphans is associated with whether the orphans are in or out of community care project.

The hypothesis tested postulated that the form of assistance required by orphans is associated with whether the orphans are in or out of community care project. Chi-square results show that there is a significant relationship between in and out of project orphans and assistance required in getting higher education ($\chi^2=5.99$, $df=1$, $p=0.01$). This means that assistance required in getting higher education was associated with being orphans in or out of the project. There were however, no significant relationships between in and out of project orphans and assistance required for clothes, food, school fees and medical care (Table 4.38).

Table 4.38

Chi-square results showing relationships between orphans in and out of project and forms of assistance required by orphans

Assistance required	χ^2	df	p-value
Clothes	0.86	1	0.35
Food	0.00	1	0.98
School fees	0.17	1	0.67
Medical care	2.38	1	0.12
Getting higher education	5.99	1	0.01*

Significant if $p \leq 0.05$

The findings show that the majority of orphans who required assistance in getting higher education were from out of the project. This is probably because most orphans out of the project were not supported in education and, as indicated, children dropped out of school due to lack of support in education. Also, higher education was costly and caregivers could find it difficult to afford.

Hypothesis seven: The care provided to orphans by caregivers is related to whether the caregivers are in or out of community care project.

The hypothesis tested stated that the care provided to orphans by caregivers is related to whether the caregivers are in or out of community care project. Chi-square results show that there were significant relationships between caregivers in and out of project and shelter ($\chi^2=4.18$, $df=1$, $p=0.04$). This implies that provision of shelter to orphans was associated with caregivers in and out of the project. There were however, no significant relationships between in and out of project caregivers and other forms of care provided (clothing, education, medical care and psychosocial support) as indicated in Table 4.39. This means that provision of these forms of care was not unique to caregivers in and out of the project.

Table 4.39

Chi-square results showing relationships between caregivers in and out of project and care provided to orphans.

Care provided	χ^2	df	p-value
Clothing	0.62	1	0.42
Shelter	4.18	1	0.04*
Education	0.90	1	0.34
Medical care	0.56	1	0.45
Psychosocial support	0.28	1	0.59

Significant if $p \leq 0.05$

Note: * Food was provided by all caregivers (in and out of the project); therefore χ^2 test was not relevant.

The findings of the study show that most (94.5%) of the caregivers provided shelter to orphans. A few (5.5%), the majority of whom were from the project, indicated that they did not provide shelter. These could be those who cared and provided for orphans during the day but did not offer accommodation. Through the project, it was possible for some caregivers to provide day care and meals to orphans while arrangements were made for accommodation elsewhere. A research conducted by GOK/UNICEF (2002) on gender, sexuality and HIV and AIDS in Kenya, revealed that due to shortage of adequate housing, caregivers/parents have made arrangements with neighbours, friends or relatives with adequate space to provide accommodation for their children.

Other forms of care showed no significant relationships, perhaps because caregivers in or out of the project are responsible for providing care to orphans in form of food, clothing, shelter, medical care, education and psychosocial support. Caregivers within the project get assistance but are fully responsible for providing care to orphans.

Hypothesis eight: The problems experienced by caregivers while caring for orphans are associated with caregivers being in or out of community care project.

The hypothesis tested postulated that the problems experienced while caring for orphans are associated to caregivers being in or out of community care project. As shown in Table 4.40, chi-square results show that there was a significant relationship between caregivers in and out of project and psychosocial support ($\chi^2=6.94$, $df=1$, $p=0.01$). There were, however, no significant relationships between in and out of project caregivers and problems of food, clothing, education, shelter and medical care. This implies that these problems were not unique to caregivers in and out of the project.

Table 4.40

Chi-square results showing relationships between caregivers in and out of project and types of problems experienced.

Problems experienced	χ^2	df	p-value
Food	0.00	1	0.94
Clothing	0.50	1	0.48
Shelter	1.29	1	0.25
Education	0.04	1	0.84
Medical care	2.57	1	0.10
Psychosocial support	6.94	1	0.01*

Significant if $p \leq 0.05$

The findings of this study show that there were significant relationships between in and out of the project caregivers and the problem of psychosocial support. Data indicated that the majority of the caregivers from in and out of the project mentioned that they did not experience the problem of provision of psychosocial support while caring for orphans. However, comparatively more caregivers from the project (21.8%) compared to only 8.5% from out of the project indicated that they experienced psychosocial problems. This finding is contrary to what would be expected, since psychosocial support is offered within the project. The majority representation of caregivers in the project experiencing psychosocial support problems could be attributed to the fact that they are sensitised to the psychosocial problems that children face and hence sensitive to the orphans psychosocial problems

Hypothesis nine: Caregivers status of being in or out of community care project influences their attendance at community care programme meetings.

The hypothesis tested postulated that Caregivers status of being in or out of community care project influences their attendance at community care programme meetings.

Chi-square results show that there was a significant relationship between caregivers in and out of project and attendance at meetings ($\chi^2=13.39$, $df=1$, $p<0.001$) as indicated in Table 4.41. This implies that attendance at meetings was associated with caregivers in and out of the project.

Table 4.41

Chi-square results showing relationships between caregivers in and out of project and attendance at programme meetings

Project caregivers	Attendance at meetings		
	No	Yes	Total
In project	31 (56.4%)	24 (43.6%)	55 (100%)
Out of project	145 (88.4%)	19 (11.6%)	164 (100%)
Total	176 (80.4%)	43 (19.6%)	219 (100%)

$\chi^2=26.81$, $df=1$, $p<0.001$

The results indicate that the majority (88.4%) of the caregivers out of the project did not attend meetings. The majority representation in this category may be attributed to not being enrolled in any specific project in which they would be called upon to participate. They were not likely to attend meetings in other projects. Attendance at programme meetings by community members is important since they are the direct beneficiaries. It is within these meetings that issues affecting the community members are raised and discussed. Further, the importance of the project, the tasks, roles, resource mobilization and the community's importance in participation in the project are discussed in such meetings.

Hypothesis Ten: There is a relationship between in and out of community care project caregivers and their involvement in planning community care programme activities.

The hypothesis tested postulated that there is a relationship between in and out of community care project caregivers and their involvement in planning community care programme activities. As shown in Table 4.42, there is no significant relationship between caregivers in and out of project and caregivers' involvement in planning activities ($\chi^2=2.54$, $df=1$, $p=0.11$).

Table 4.42

Chi-square results showing relationships between caregivers in and out of project and involvement in planning programme activities

Project caregivers	Involvement in planning activities		
	No	Yes	Total
In project	50 (90.9%)	5 (9.1%)	55 (100%)
Out of project	158 (96.3%)	6 (3.7%)	164 (100%)
Total	208 (95.0%)	11 (5.0%)	219 (100%)

$\chi^2=2.54$, $df=1$, $p=0.11$

This implies that involvement in planning activities was not associated with caregivers in and out of the project. The study findings show that the majority of the caregivers (95%) were not involved in planning programme activities. This is not surprising considering the fact that most caregivers were not involved in participation of programme activities, attendance at meetings and decision-making activities of the programme. These findings are supported by Chitere & Mutiso (1991), who point out that community

programmes become formalised and sometimes politicised with the effect that the majority of the beneficiaries become passive participants especially in the realm of decision-making. Moreover, caregivers mentioned that planning was done at a programme level by the staff while caregivers were offered available assistance, for example, food, clothing and shelter. Comparatively, more caregivers in the project (9.1%) as compared to 3.7% out of the project were involved in planning. This may be because they got assistance and thus were likely to be involved in the discussions of some of the issues faced and how they could be addressed unlike those who were not registered in any project.

Hypothesis eleven: Caregivers' involvement in decision-making activities in community care programmes is determined by whether they are in or out of the project.

The hypothesis tested postulated that Caregivers' involvement in decision-making activities within community care project is determined by whether they are in or out of the project. Fisher's exact test results show that there was a significant relationship between caregivers in and out of project and involvement in decision-making (Fisher's exact test = 0.004, df=1, $p < 0.001$) as shown in Table 4.43. This means that caregivers' involvement in decision-making in community care programmes was associated with caregivers in and out of the project. Fishers exact test was used because the χ^2 was not valid due to cells with expected frequency less than five were two out of four, which was 50%. The Fishers exact test was significant at $p=0.004$.

The study findings show that most of the caregivers (97.3%) were not involved in decision making. These findings would be expected considering that most of them were also not involved in planning and did not did they attend meetings. Furthermore, the results show that the majority of caregivers out of the project did not participate in the activities of programmes, hence the chances of them being involved in decision making were very slim. Most community programmes were also initiated and managed by the programme staff that

initiated programmes and made all decisions necessary with little involvement of community members or beneficiaries. According to a study by WCRP/UNICEF (2002), non-governmental organizations, some of which support orphans at community level, have organizational structures and staff that manage their programmes.

Table 4.43

Chi-square results showing relationships between caregivers in and out of project and participation in decision-making in community care programmes

In and out of project orphans	Participation in decision-making		
	No	Yes	Total
In project	50 (90.9%)	5 (9.1%)	55 (100%)
Out of project	163 (99.4%)	1 (0.6%)	164 (100%)
Total	213 (97.3%)	6 (2.7%)	219 (100%)

Fisher's exact test = 0.004, df=1, p<0.001

Hypothesis twelve: There is a relationship between in and out of community care project caregivers and their participation in carrying out community care programme activities.

The hypothesis tested postulated that there is a relationship between in and out of community care project caregivers and their participation in carrying out community care programme activities. Chi-square results show that there was a significant relationship between caregivers in and out of project and participation in carrying out programme activities ($\chi^2=26.27$, df=1, p<0.001) as shown in Table 4.44. This means that caregivers' participation in carrying out community care programme activities was associated with caregivers in and out of the project.

The research findings show that 148 caregivers out of the project (90.2%) did not participate in carrying out activities of the organization. This may be attributed to not being registered in any specific project and so not being involved in carrying out activities of community care programmes. Whereas these caregivers could have been receiving assistance from some organizations in the community, they could not be invited to participate in carrying out the activities of those organizations, unlike those in the project, who, due to their association could be involved in some activities within the organization.

Table 4.44

Chi Square results showing relationships between caregivers in and out of project and participation in carrying out community care programme activities

In and out of project caregivers	Participation in carrying out activities		
	No	Yes	Total
In project	33 (60.0%)	22 (40.0%)	55 (100%)
Out of project	148 (90.2%)	16 (9.8%)	164 (100%)
Total	181 (82.6%)	38 (17.3%)	219 (100%)

$\chi^2=26.27$, $df=1$, $p<0.001$

Hypothesis Thirteen: Caregivers' other contributions towards community care programmes are determined by whether the caregivers are in or out of the project.

The hypothesis tested postulated that making other contributions towards community care programmes is determined by caregivers' being in or out of the project. Chi-square results show that there is a significant relationship between caregivers in and out of project and caregivers making other contributions to the programme ($\chi^2=14.78$, $df=1$, $p<0.001$). This

means that making contributions to community care programmes was related to caregivers in and out of the project.

The findings show that the majority of caregivers (93.2%) from both in and out of the project do not make any other contributions to community care programmes. This may be because of lack of resources and the fact that their participation in the community care programmes is low. However, the results show that of the few who made contributions, most (18.2%) of caregivers were from the project as compared to only 3.0% from out of the project, probably because caregivers in the project may have been sensitised of the importance to contribute community programmes. According to Chitere & Mutiso (1991), community participation and resource mobilization leads to attainment of programmes goals.

Hypothesis Fourteen: There are differences between orphans and caregivers in:

- **Length of stay with caregivers.**
- **Needs of orphans.**
- **Needs not adequately met.**
- **Problems experienced by orphans.**

T-test results (Table 4.45) show that there were significant differences between orphans and caregivers in the number of problems experienced $t(132) = -2.43, p=0.01$, the number of orphan needs $t(216)=22.21, p<0.001$, and the number of orphan needs not adequately met $t(218)=-17.51, p<0.001$. This implies that orphans and caregivers were significantly different in the number of orphan problems experienced, the number of orphan needs and the number of orphan needs not adequately met. There were, however, no significant differences between orphans and caregivers in length of stay with guardians.

Table 4.45

T-test results showing differences between orphans and caregivers

Variable	N	Respondent	Mean	SD	T	P
Number of problems experienced by orphans	133	Caregiver	2.10	1.920	-2.43	0.02*
		Orphan	2.35	1.615		
Number of needs for orphans	217	Caregiver	4.70	1.360	22.21	0.001*
		Orphan	2.60	1.214		
Number of needs not Adequately met	219	Caregiver	0.92	0.834	-17.51	0.001*
		Orphan	2.69	1.637		
Length of stay with Caregivers	186	Caregiver	3.68	2.741	-0.78	0.44
		Orphan	3.78	2.743		

Significant if $p \leq 0.05$

There was a higher orphan group mean in the number of orphan problems experienced (orphans-2.35, caregivers-2.10) and the number of orphan needs not adequately met (orphans-2.69, caregivers-0.92), this indicates that these factors were more significant with the orphans than the caregivers. This could be due to orphans being better placed to express their problems and needs not adequately met than caregivers. It was observed that orphans reported that they are beaten overworked and discriminated against, facts that caregivers did not mention. Additionally, orphans mentioned that the caregivers are the cause of the problems they experience.

Caregivers, on the other hand, may perceive some of their actions towards orphans as discipline issues, while these may not be perceived as such by orphans. In a study by GOK/UNICEF (2001) on the situation of HIV and AIDS orphans and vulnerable children, it was reported that caregivers found it difficult to discipline orphans because the orphans were oversensitive and interpreted discipline as hatred. It was established that there was a gap between the orphans' expectations and the care that was being provided.

Additionally, whereas caregivers provided for the needs of orphans (i.e. food, clothing, education, medical care, shelter and psychosocial support), these were not adequately met, hence, the reason why orphans noted that they suffered from hunger and lack of fees among other needs not adequately met. However, orphans indicated that though the caregivers were providing for these needs they were inadequately met and hence their higher mean in unmet needs than that of the caregivers.

The results also show that there was a higher caregiver group mean in the number of orphan needs (orphans= 2.60, caregivers=4.70). This implies that the number of orphan needs were more significant to the caregivers than were to the orphans. Considering that it was the responsibility of the caregivers to provide for the care of orphans, they were more likely to know and understand the needs of orphans. Length of stay of orphans with caregivers was not significant, thus implying that there were no significant differences between the orphans and caregivers.

Hypothesis Fifteen: There are differences between in and out of project orphans in:

- Length of stay with caregivers.
- Needs of orphans.
- Unmet needs.
- Problems experienced by orphans.

As shown in Table 4.46, t-test results showed that there were significant differences between in and out of project orphans in number of needs ($t= 2.58$, $p=0.01$).

Table 4.46

T-test results showing differences between in and out of project orphans

Variable	Orphans	N	Mean	SD	T	P
Length of stay with caregivers	Out of project	152	3.70	2.735	-0.73	0.43
	In project	55	4.02	2.752		
No. of needs	Out of project	164	2.71	1.145	2.58	0.01*
	In project	55	2.18	1.376		
No. of unmet needs	Out of project	164	0.88	0.832	-1.17	0.13
	In project	55	1.04	0.838		
No. of Problems	Out of project	125	2.18	1.551	-0.37	0.29
	In project	35	2.29	1.467		

Significant if $p \leq 0.05$

This implies that orphans in and out of the project are significantly different in their number of needs. There were however, no significant differences between in and out of project orphans in length of stay with caregivers, number of unmet needs and number of problems experienced. This may be because the orphans in and out of project live with caregivers in a similar environment and face similar problems.

According to the results in Table 4.46, orphans in and out of the project showed significant differences in the number of needs ($t=2.58$, $p=0.01$). The results indicate that there was a higher group mean with the out of project orphans in number of needs (out of projects-2.71, in project-2.18). This implies that this variable was more significant with the out of the project orphans than those in the project. This may not be surprising since they were not under any community care programme, hence assistance received could be inadequate and, therefore, they had more needs than those in the project.

4.7.0 Relationships between independent variables (socio-economic, care practices, community participation variables) and dependent variable (success of community care programmes)

This section addresses objective number six, namely to determine the relationship between independent variables (socio-economic, care practices, community participation variables) and dependent variable (success of community care programmes). The section will discuss the results for both orphans and caregivers.

Spearman rank correlation coefficient was used to measure the strength and direction of association between the variables. It is used when both variables are measured on an ordinal scale. Data may be collected in the form of ranked data or it may be collected in other forms and then converted to ranks for the application of Spearman rank correlation coefficient (Grimm, 1993). In this case, some of the original scores which were not in ordinal scale were ordered in ascending order and were assigned ranks accordingly which were then used in the analysis. Relationships between variables were tested and the correlation coefficient was considered significant at the alpha level $\alpha = 0.05$.

The results are summarized as indicated in Table 4.47 for orphans and Table 4.48 for caregivers. The caregivers' participation index (P.IDX) was computed by summing up selected items that related to "community participation" in the questionnaire. The Spearman

rank correlation co-efficient results are presented in two categories, that is, the results for orphans and those of caregivers.

4.7.1 Relationships between socio-economic and care practices variables for orphans

The relationships between socio-economic and care practices variables for orphans are as shown in Table 4.47.

Table 4. 47

Table showing relationship between socio economic and care practices variables for orphans

	1	2	3	4	5	6	
Age of orphans	1						
Level of education	2	.37*	1				
Number of problems Experienced	3	.00	-.21*	1			
Number of needs	4	.04	-.09	.48*	1		
Number of met needs	5	-.09	.18*	-.26*	-.40*	1	
Number of unmet needs	6	-.11	-.13*	.16*	.29*	-.58*	1

$p \leq .05$

There was a negative relationship between education and the number of problems experienced by the orphans ($r = -0.21$, $p \leq 0.05$). This implies that children with high levels of education experience fewer problems and vice versa. This is probably due to the fact that children with high levels of education may be aware of alternative ways to seek assistance for their problems. Children with low levels of education are also likely to be younger and may have less experience in seeking help and handling problems. These findings could also be

attributed to children with higher levels of education spending more time in school than those with lower levels of education, which keeps them away from home where they likely experience most of the problems. Studies (GOK/UNICEF, 2001; USAID/UNICEF, 1999) have shown that children undertake heavy domestic duties and are overworked by caregivers to the extent that they hardly find time for play or studies.

The study findings further reveal a significant positive relationship between education levels and number of met needs ($r=0.18$, $p\leq 0.05$), denoting that orphans with high levels of education had more of their needs met. This could be attributed to orphans with higher education levels being in a better position to seek help to meet their needs. For instance, they may ask for food, clothing and medicines from neighbours when sick or prevail upon the head teacher to allow them attend school while arrangements are being made to pay school fees.

A positive significant relationship between number of needs and number of problems ($r = 0.48$, $p\leq 0.05$) was also noted, indicating that the more the needs an orphan has, the more the problems experienced. This is not surprising in that more orphan needs would require more resources, which as indicated, are limited, hence more orphan problems experienced. This study findings are supported in a report by USAID/UNICEF (2000) which pointed out that as the number of orphans and their needs have increased exponentially, communities and extended families that were a safety net for the orphans have overstretched their resources so that it has become difficult to care for orphans adequately. The current study also shows a significant positive relationship between the number of problems experienced and the unmet needs ($r = 0.16$, $p\leq 0.05$), implying that the higher the unmet needs, the more the problems an orphan experiences.

Significant negative relationships were also observed between the number of problems experienced and number of met needs ($r = -0.26$, $p\leq 0.05$). This denotes that

orphans with more problems have few needs met. This is not surprising bearing in mind that more problems would call for more resources to adequately meet the orphan needs.

The results further show a negative relationship between the number of needs and the met needs ($r = -0.40$, $p \leq 0.05$). This is not surprising in that more orphan needs with the already limited resources result to less needs being met. This is also why the results show a positive relationship between numbers of unmet needs and needs ($r = 0.29$, $p \leq 0.05$) implying that the more the needs the more they are unmet. These findings are supported by previous studies (Nyambedha, 1999; UNICEF, 2000) where it is pointed out that communities and families are overwhelmed by the number of orphans and their needs to a level that some of them have become complacent. Nyambedha further notes that some communities no longer regard orphans' plight as anything to worry about because it has been the norm.

There was no significant relationship between age of orphans and the number of problems experienced by orphans and between age of orphans and the number of needs. This implies that age of an orphan is not associated with the number of needs and number of problems experienced by the orphans. Ferguson & Johnston (1997) observes that orphans experience similar problems irrespective of their age. They lack basic needs such as food, clothing, shelter, medical care and psychosocial support. However, in some circumstances, some specific needs especially for the teenagers may increase as age increases.

4.7.2 Relationships between socio-economic, care practices, community participation variables, and success of community care programme.

This section discusses the results for caregivers (Table 4.48) and are presented under the following sub topics: relationships among the socio-economic variables; relationships between socio-economic care practices and community participation variables; and relationships between socio-economic care practices, community participation and success of community care programmes.

Table 4. 48 Table showing relationships between socio-economic, care practices, community participation and success of community care programmes

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	
Age of caregivers	1	1																
Education level	2	-.33*	1															
No. of children	3	.49*	-.28*	1														
No. of other children	4	.36*	-.29*	.26*	1													
No. of orphans	5	.33*	-.26*	.25*	.88*	1												
No. of support provided	6	-.17*	.12	.02	-.01	.09	1											
No. of orphan needs	7	.01	.08	.09	.17*	.15*	.37*	1										
No. of met needs	8	.01	.17*	-.23*	-.08	-.15*	-.13	-.13	1									
No. of orphan problems	9	.23*	-.03	.19*	.20*	.25*	.28*	.45*	-.44*	1								
No. of problems experienced	10	.20*	-.04	.16*	.24*	.27*	.21*	.46*	-.52*	.68*	1							
Participation in org activities	11	.10	.03	.08	.21*	.24*	.05	.19*	.11	.23*	.35*	1						
Attend meetings	12	.11	.03	.07	.26*	.26*	-.00	.18	-.03	.33*	.35*	.76*	1					
Participate in planning activities	13	.10	-.09	.02	.22*	.17	-.04	.03	-.07	.09	.14	.42*	.41	1				
Involved in making decisions	14	.03	-.04	.04	.04	.07	-.20	-.08	-.13	.00	.01	.27*	.30*	.19*	1			
Involved in carrying out activities	15	.19*	-.01	.11	.24*	.27*	.04	.21*	-.15	.40*	.38*	.83*	.73*	.49*	.26*	1		
Participation index	16	.09	.05	.03	.23*	.19*	-.05	.09	-.02	.17*	.29*	.84*	.92*	.54*	.36*	.87*	1	
Success of programmes	17	-.16	.05	-.21*	-.17*	-.23*	-.25*	-.31*	.41*	-.49*	-.58*	-.25*	-.34*	-.25*	-.20*	-.44*	-.22*	1

* p ≤ .05

4.7.2.1 Relationship among the socio-economic variables for caregivers

The results in Table 4.48 show a significant positive correlation between age and number of children ($r=0.49$, $p\leq 0.05$) and age and number of HIV and AIDS orphans ($r=0.33$, $p\leq 0.05$) this indicates that older caregivers have more children than younger caregivers. According to a study by Ondigi (2003), women in Africa tend to marry at a very young age, often by 16-18 years and an early start in childbearing too often results in many children. Also, older caregivers tended to have more orphans to take care of, perhaps because of their elderly age; they may be caring for their grandchildren and other relatives' orphans. Additionally, due to their age and life experiences, the older caregivers may be prevailed upon by community members and other relatives to care for orphans since it is felt that they are better placed to care for orphans than are younger caregivers.

Negative significant relationships were noted between education and age ($r = -0.33$, $p\leq 0.05$), education and number of children ($r = -0.28$, $p\leq 0.05$) and education and HIV and AIDS orphans ($r = -0.26$, $P\leq 0.05$). The negative relationship between education and age denote that older caregivers are less educated. This may be because the older persons may not have had a chance to attend school to high levels. It was also evident that the higher the education level the less the number of children. This is not surprising in that the educated may take more years in schooling thus these individuals marry and start child bearing later. They are also likely to keep smaller families. Generally, educated people tend to have fewer children probably because they understand the need to give the best to their children. The results indicate that education level of caregivers is negatively correlated to the number of HIV and AIDS orphans the caregiver is supporting ($r=-0.26$, $p\leq 0.05$). This denotes that the more educated people do not live with and care for orphans. A research by Nyambedha (1999) shows that HIV and AIDS orphans are most

likely taken care of by impoverished families, findings which were consistent with those of another study by ACTION AID (1995), which also pointed out that the poor tend to accept, and cater for HIV and AIDS orphans. The number of children and the number of HIV and AIDS orphans ($r=0.25$, $p\leq 0.05$) were also positively correlated implying that households with more children also had more orphans. This could be because orphans may easily be absorbed and catered for with the rest of the family children.

4.7.2.2 Relationships between socio-economic, care practices and community participation variables for caregivers

Education positively correlates with met needs ($r = 0.17$, $p\leq 0.05$) implying that caregivers with higher education levels are more likely to meet the needs of orphans. This could be due to the fact that the highly educated are in a better position to acquire better paying jobs that earn them higher incomes for support of orphans than the less educated people.

The study findings further show positive relationships between problems of orphans and age ($r=0.24$, $p\leq 0.05$), number of children ($r=0.19$, $p\leq 0.05$), number of HIV and AIDS orphans ($r = 0.25$, $p\leq 0.05$), number of orphan needs ($r = 0.45$, $p\leq 0.05$) and met needs ($r = -0.44$, $p\leq 0.05$). These correlations imply that caregivers with more HIV and AIDS orphans experience more problems. This is not surprising given that more children in a household and more HIV and AIDS orphans result to more demands. The number of needs of these children and orphans puts more pressure on the caregivers to seek ways of meeting their needs. However, with the high demands from the orphans and the limited resources, it is likely that the orphan needs may not be adequately met. Studies (GOK/UNICEF, 2000; Hunter & Williamson, 1997; UNICEF/USAID, 1999) have indicated that the increasing numbers of orphans have overstretched the families and community's resources that their needs can no longer be met at household level.

The results further show that the amount of support and care being provided to orphans was positively related to the number of problems experienced by orphans ($r=0.28$, $p\leq 0.05$). This denotes that orphans experience more problems when caregivers provide more support and care to them. This finding is contrary to other findings (HACI, 2002; WCRP/UNICEF, 2002) which points to more support to orphans leads to meeting orphan needs.

Other positive significant relationships were found between, problems experienced by caregivers in caring for orphans and; number of children ($r=0.16$, $p\leq 0.05$) and with number of HIV and AIDS orphans ($r=0.27$, $p\leq 0.05$). This is because households with more children and HIV and AIDS orphans are likely to have more needs to meet. These households are likely to experience problems in meeting orphan needs due to limited resources. These findings correspond with those of a study conducted by GOK/UNICEF (2001) in which it was found that caregivers face many problems in meeting the needs of the ever-increasing number of orphans. Many are overwhelmed by the myriad demands to provide food, health care and bedding for the orphans above their own personal needs. Also significant were relationships between problems of caregivers and number of needs of orphans ($r = 0.46$, $p\leq 0.05$), and unmet needs ($r=-0.52$, $p\leq 0.05$). These results imply that the more the number of needs, the more the problems experienced by the caregivers and hence high unmet needs.

Problems experienced by caregivers were also strongly related with caregivers' perception on number of problems experienced by the orphans ($r= 0.68$, $p\leq 0.05$). This is not surprising in that if caregivers experience problems in caring for orphans, then it is most likely that the orphans will experience problems, as their needs are not met. These results concur with those of GOK/UNICEF (2001), where it was noted that due to lack of adequate resources and

care systems, orphans experience problems that lead to some of them being forced to drop out of school since their caregivers cannot afford school fees, while some are made house helps.

Another positive significant relationship was between problems experienced by caregivers and the participation index ($r = 0.29$, $p \leq 0.05$). This implies that caregivers, with more problems in the care of orphans, participate more in community care programmes. This may be because the caregivers get assistance for the orphans through their participation in the community care programmes. Muia (1987) observed that participation of the beneficiaries enables them to identify their problems and seek ways of addressing these problems collectively.

A significant negative correlation between met needs and number of children ($r = -0.23$, $p \leq 0.05$) was noted, implying that the more the number of children, the less the met needs. This is because more children have more demands that may be difficult to meet due to limited resources. These results concur with those of Hunter & Williamson (1997) who noted that community resources have been depleted and are not able to meet the needs of orphans.

There was no significant relationship between age and needs of orphans, and age and problems of caregivers. This perhaps is because problems experienced by caregivers when caring for orphans are common irrespective of age. Also needs of orphans as perceived by caregivers do not differ depending on the age of the caregiver. In other words, caregivers perceived the needs of orphans similarly irrespective of age.

Participation in programme activities was correlated with the number of orphans ($r = 0.24$, $p \leq 0.05$), number of orphan needs ($r = 0.19$, $p \leq 0.05$), number of orphan problems ($r = 0.23$, $p \leq 0.05$), attendance at meetings ($r = 0.76$, $p \leq 0.05$) and problems of caregivers ($r = 0.35$, $p \leq 0.05$). This denotes that caregivers with more orphans and those with more problems participate more in the community care programmes. This is due to the fact that through their participation, they are

likely to get assistance for the orphans. For instance, they get food, clothes, beddings and education support, among others.

Participation in programmes activities was also correlated with caregivers' involvement in planning activities ($r=0.42$, $p\leq 0.05$) and attendance at meetings ($r=0.41$, $p\leq 0.05$). This implies that the more the participation in programme activities, the more the involvement in attendance at meetings and planning activities. The results further show a correlation between carrying out activities of the programme and planning ($r=0.49$, $p\leq 0.05$) and with making decisions ($r = 0.26$, $p\leq 0.05$). There is a tendency for community care programmes to work closely with caregivers actively involved in the community care programme. Those who participate more in carrying out activities of the programme are likely to be invited to meetings and consulted on certain issues unlike those caregivers who are not actively involved. Participation index was correlated with number of orphans ($r=0.19$, $p\leq 0.05$), number of caregivers' problems ($r=0.29$, $p\leq 0.05$) and participation in programme activities ($r=0.84$, $p\leq 0.05$). This implies that those who participate more are those with more orphans and those who experience more problems. Caregivers with more orphans may experience more problems in caring for the orphans. They are likely to participate more in the community care programmes since they get support for the orphans through their participation. It is also important to note that their participation has more to do with assisting in visitations of orphans and distributing any material assistance that is available for the care programme, like giving out clothes and food.

4.7.2.3 Relationships between socio-economic variables, care practices, community participation and success of the programmes.

The findings of this study indicate that success of community programmes and the number of met needs was positively correlated ($r = 0.41$, $p \leq 0.05$). This means that the more the met needs of orphans, the more successful the programmes. This is because a community care programme that meets the needs of orphans sufficiently may have its infrastructure in place. For example, it may have mobilized resources, both human and material for meeting those needs, and hence successful. Additionally, it may have community members' participation in the care programmes hence its ability to meet the orphan needs. The results further show a significant negative correlation between success of community care programme and number of HIV and AIDS orphans ($r = -0.21$, $p \leq 0.05$) and between success of community care programme and number of children ($r = -0.23$, $p \leq 0.05$). This implies that the more the number of HIV and AIDS orphans and children a caregiver has, the less the success of the community care programme. This is due to the fact that large numbers of orphans require assistance from the community care programme. However due to the limited resources, their needs may not be sufficiently met. In the orphan programming report by USAID/UNICEF (1999), it is pointed out that though local programmes and community initiatives have been set up to improve the lives of children affected by HIV and AIDS, the numbers of orphans are ever increasing and resources are scarce. This means that resources are overstretched and cannot be able to sufficiently meet the orphans needs.

The results further show a negative correlation between success of community care programmes and the number of orphan needs ($r = -0.31$, $p \leq 0.05$), success of community care programmes with number of orphan problems ($r = -0.49$, $p \leq 0.05$) and success of community care programmes with number of problems experienced by caregivers ($r = -0.58$, $p \leq 0.05$). This denotes

that high orphan needs, which are not met due to limited resources both at family and community levels, results to less success of the community programmes. As indicated from the study findings, most of the caregivers' participation in the community project is assisting in the orphan visitation and distribution of available materials, which they also receive for the orphans they care for. High orphan needs and more problems compel the caregivers to seek more assistance from the community care projects and due to limited resources, it becomes difficult for these needs to be met thus rendering the project less successful.

Furthermore, the caregivers may not be in a position to participate fully and make any contributions towards the community care projects to meet the orphan needs when they are experiencing many problems in caring for the orphans. They are constrained in terms of time and other resources that they can contribute to the project, as they are striving to provide for the orphan needs at household level. This is also why the results further reveal that care and support provided to orphans correlated negatively to success of programmes ($r = -0.25$, $p \leq 0.05$), meaning that community programmes are less successful when caregivers are providing more support to the orphans at household level. Less community participation and support to the project affects its capacity to provide assistance to the orphans, affecting its success. Muia (1987) and Mutiso (1991) had similar findings as they pointed out that community support is paramount to success of community programmes.

There were no significant relationships between success of programmes and the age of caregivers, and also with their level of education. Caregivers participate and are guided by programme staff on the activities, regardless of age and education level. This therefore has no implication on the success of programmes.

Further analysis showed a negative relationship between success of programmes and participation in organizations activities ($r = -0.26$, $p \leq 0.05$), attendance at meetings ($r = -0.34$, $p \leq 0.05$), involvement in planning activities ($r = -0.25$, $p \leq 0.05$), involvement in making decisions ($r = -0.20$, $p \leq 0.05$), carrying out activities of the organization ($r = -0.44$, $p \leq 0.05$) and participation ($r = -0.22$, $p \leq 0.05$).

These results indicate that success of programmes negatively correlates with participation of caregivers in the community care programmes. This implies that high participation of caregivers leads to less success of the programmes. These findings contradict those of Chitere & Mutiso (1991) and Muia (1987) whereby it is pointed out that high participation leads to success of community care programmes. Success in this case was measured in terms of the extent to which the project meets the needs of orphans. These caregivers, as already indicated in the results, have problems of meeting orphan needs and have no resources to contribute to the community care programmes. Their participation therefore, is at low levels, which, has more to do with receiving assistance for their orphans than making any financial or material contributions towards the programme that would enhance the programmes capacity in providing adequate assistance to the orphans. Participation of the caregivers is therefore seen as one of depleting the community care programmes' resources further, which leads to less success of the programmes.

4.8.0 Predictor variables for successful community care programmes

Logistic regression was used in this study. This is a statistical procedure that allows use of information about one variable to predict the value of the second variable in situations where the outcome variable is categorical (Mitchell, 1992). Logistic regression was used to determine whether the variables are related (i.e. predict) to the success or failure of the community care programmes.

The logistic model used is of the form $\text{Log} (p/\{p-1\}) = k+a_1x_1 + a_2x_2 + \dots\dots\dots a_n+x_n$, where k is the constant, p is probability of success and a_1 to a_n , are the predictor variables. This study used stepwise selection procedure, in which variables' usefulness is tested on entry to the model and they are removed if they are not found useful. Using this procedure, various variables including age, gender, education, marital status, occupation, number of children, number of HIV and AIDS orphans, needs of orphans, met needs of orphans, care provided to orphans, problems of orphans, problems experienced by caregivers, caregivers participation in planning, involvement in decision making process, caregivers attendance at meetings, caregivers involvement in carrying out activities and contribution made to community care programmes as major predictors of success of community care programmes were entered in the model. The procedure retained only two variables, number of HIV and AIDS orphans and number of problems experienced by caregivers which were found to be significant predictors of success of community care programmes. The results are as shown in Table 4.49.

Table 4.49

Table showing regression results for the prediction of success of community care programmes

Model	B	Std. Error	Wald Statistic	Exp (B)	Sig. T
Constant	4.253	1.009	17.785	-	0.00
Number of AIDS orphans	-.573	.315	3.313	.3056	0.05
Number of problems experienced by caregivers	-1.185	.286	17.164	.5635	0.00

Dependent variable: success of community programmes

4.8.1 The number of HIV and AIDS orphans as a predictor of successful community care programmes

Number of HIV and AIDS orphans was inversely predictive of success of community care programmes (Wald =3.31, df= 1, p=0.05). This means that success of a community care programme, is negatively influenced by number of HIV and AIDS orphans, implying that more HIV and AIDS orphans render a community care programme less successful. This is not surprising in that more HIV and AIDS orphans will require more assistance from the community care programmes, which may not be able to meet their needs sufficiently.

In support of these findings, a report by USAID/UNICEF (1999) on orphan programming points out that the increasing numbers of HIV and AIDS orphans needing care and support have depleted resources at both household and community levels thus rendering community care programmes incapable of supporting and meeting orphan needs.

4.8.2 The number of problems experienced by caregivers

The number of problems experienced by caregivers in supporting and caring for orphaned children was also inversely predictive of success of community care programmes (Wald =17.16, df= 1, p<0.001). This implies that the more problems caregivers experience in caring for orphans, the less successful community care programmes became.

This finding demonstrates that success of community care programmes is affected inversely by caregivers' problems. This is so in that when caregivers experience more problems in caring for orphans, they will seek assistance from the community care programmes, which may not be able to meet their needs sufficiently due to the limited resources, thus rendering the programme less successful. Moreover, increasing problems at the caregiver level in providing for the needs of orphans may make it difficult for the caregivers to find time for participation in the

care programmes and other form of resources to contribute towards the community care programmes, which largely depend on their participation.

4.8.3 Summary of predictors

The two variables (i.e. number of HIV and AIDS orphans and number of problems experienced by caregivers) emerged as important predictors of successful community care programmes in this study, have been included in the logistic equation $\text{Log} \left(\frac{p}{p-1} \right) = k + a_1x_1 + a_2x_2 + \dots + a_nx_n$ ($\text{Log} \left(\frac{p}{p-1} \right) = 4.25 - 1.19$ (number of HIV and AIDS orphans) - 0.57 (number of problems experienced by caregivers)). The two variables were found to be useful and have negative influence on success of community care programmes, implying that the chances of community care programmes succeeding decrease with high HIV and AIDS orphan numbers and increase in problems experienced by caregivers when caring for orphans.

From Table 4.50 showing logistic regression model summary of the predictors' performance, the results indicate that of the 18 observed unsuccessful community care programmes, the model was able to accurately predict 14 of them (77.8%). Also, of the 47 observed successful community care programmes, the model was able to accurately predict 46 of them (97.9%). Overall, the model performance is 92.3%.

Table 4. 50

Table showing logistic regression model summary of the predictors' performance

Observed success of community care programmes	Predicted success of community care programmes			%
	No	Yes		
No	14	4		77.8
Yes	1	46		97.9
Overall performance				92.3

Based on the hypothesized model, this study applied a community participation paradigm in the care of children orphaned by HIV and AIDS and also sought to determine the success of community care programmes in meeting orphan needs. The study looked at factors at the inputs and throughputs levels and how they function together to accomplish the output, which in this study was success of community care programmes. The results indicate that the two variables, number of problems experienced by caregivers and number of HIV and AIDS orphans were predictors of success of community care programmes, whereby number of problems experienced by caregivers was the most important predictor followed by number of HIV and AIDS orphans.

CHAPTER FIVE

5.0 SUMMARY OF FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

5.1 Summary of findings

The purpose of this study was to apply a community participation paradigm in the care and support of HIV and AIDS orphans and to also examine the success community care programmes in meeting the needs of these orphans. The Community Participation Paradigm, developed by Yeung & McGee (1986), was adopted in this study. The Community Participation Paradigm outlines the linkages between the input and throughput factors, which lead to the output that comprises the results achieved, including the achievement of the set goals. The fundamental principle of this conceptual framework is that involvement of the community in the throughput, that is, planning and implementing of projects leads to success of community participation process and thereby achievement of the set goals.

The findings of this study contribute to the understanding of the importance of the throughput factors, which include the community participatory planning, decision-making processes, attendance of meetings and participation in carrying out activities. These findings are also supported by the double ABCX model of McCubbin & Patterson (1983). They illuminate how orphan-hood, which is an increasingly overwhelming and stressful situation in many communities has been addressed. Stressful situations arising at family–community level require immediate attention; they disturb the status quo and therefore cause change in the family. The study findings demonstrate how families and community members have looked at the orphan-hood situation, made adjustments in their systems and applied resources in coping with the situations, especially through their participation in community care and support programmes.

This was largely a survey study. Interview guides for orphans, caregivers and programme leaders, and focus group discussion guides for community leaders were developed and used for collecting data. Kibera Location was purposively selected from Kibera Division in Nairobi for the survey. A sample population of 219 HIV and AIDS orphans and their caregivers (comprising 55 orphans from a community care project and 164 from those out of the community care project) were randomly selected for the survey. Through the orphans, their caregivers were identified and enlisted for the study.

The findings of this study show that the majority of the caregivers (68%) both in and out of the project were female. Most of the caregivers (60.6%) were also aged between 20-35 years old, while a few (8.4%) were above 55 years old. The findings further reveal that most caregivers (58.5%) were married and a few (12.3%) were single. With regard to education levels, it was found that most of the caregivers from in and out of project had primary and secondary school level of education. A few caregivers (13.8%) had no schooling at all, with the majority (86.6%) of them being from those out of project.

Most caregivers (28.2%) were engaged in small business, 17.6% were casual labourers while 21.3% were housewives. Most of those in casual labour and housewives were from out of the project, while the majority of those engaged in small business were from the project. This may be because through the community care programme, members were supported to start small businesses to raise income for the care of orphans. The family sizes averaged three children per family, with 54.8% of the caregivers having between one to three children. Additionally, more than half of the caregivers had between one to three children they were caring for, while 17.8% caregivers were caring for more than seven children. It was further found out that most of the caregivers (80.2%) were caring for one to two HIV and AIDS orphans. Most of them had lived

with the orphans for a period of less than three years. A few (18.7%) had lived with the orphans for more than six years.

The HIV and AIDS orphan respondents were 219 (104 girls and 117 boys). Most of them were aged between 11-15 years old, the majority of whom were from the project. The findings further show that the majority of the orphans from the project had primary school level of education, while most of those who had no schooling were from out of the project. This is because their support for education was limited.

Although the majority of caregivers (67%) felt they needed to make prior arrangements before taking in orphans for care, most of them (58.4%) had not made such arrangements. Such arrangements would include, preparation of accommodation and making provisions for other requirements such as clothing, school fees, and food.

Orphans responses, concurred with those of caregivers in that more than half of the orphans (52.8%) reported that they did not discuss their movement to their caregivers after their parents' death. The majority of them were from out of the project. Most of those who discussed their movement were from the project. This is because through the community care programme, those ailing with HIV and AIDS were encouraged to discuss the future with their children and make arrangements with those who will care for them after their death.

The needs of orphans as mentioned by most caregivers and orphans from in and out of project were food, clothing, shelter education and medical care. A few caregivers (42%) and orphans (34.2%) mentioned psychosocial needs, with the majority of them being from out of the project. Although psychosocial support has been reported as a major need for HIV and AIDS orphans due to the trauma and discrimination they undergo, this study found the contrary in that most caregivers did not mention it as a need. Medical care, education and clothing needs for

orphans were reportedly not adequately met, with most out of project orphans singling out medical care and shelter.

The study findings further showed that most caregivers from in and out of the project provided food (100%) clothing (90%), shelter (94.5%), education (74.0%) and medical care (71.2%) to the orphans. However, very few caregivers (37%) provided psychosocial support. This was attributed to caregivers not feeling it was a need, and secondly, due to lack of time and understanding about the importance of psychosocial support to the orphans by the caregivers. Additionally, findings show that though the above are provided to the orphans, they are not adequate. For instance, the food provided was not sufficient, clothes were old and worn out and housing lacked adequate space and had poor sanitation. Caregivers reportedly experienced problems in providing for the needs of orphans and this is why they were not adequately provided for. Most caregivers from both in and out of project mentioned that they experienced problems in food (26.9%) education (28.3%) and medical care (24.7%).

The orphans also indicated that they lacked adequate food, clothing, medical care, psychosocial support, school fees and other school requirements. They further observed that they experienced various problems while living with caregivers. Most of them indicated being overworked (34.2%), lacking adequate clothing (26.5%), experience school fees problems (26.0%) and some suffer from hunger (29.2%). Others mentioned being beaten, quarrelled, lack adequate shelter, clothing and medical care. Most of those who mentioned being beaten and quarrelled were from out of the project. Likewise, the majority of those who were overworked were from out of the project. Additionally, orphans reported that they were discriminated against compared to other family members in provisions made for them by caregivers. For example, they

did not get enough food, slept on the floor, lacked school fees and were overworked at home unlike the children of caregivers.

Faced with the above situation, various coping mechanisms were employed, these are the responses made by the family in management of the stressful situation. Those employed by caregivers included raising extra resources to provide for the needs of orphans, seeking assistance from other members of the society, and also seeking assistance from community orphan care programmes.

Orphans coping with the stressful situation resulted in their looking for casual jobs to earn some money for their livelihoods, some ended up begging in the streets or stealing, while some shared their problems with neighbours and teachers in schools or just accepted their situation and persevered as there was nothing they could do. Some orphans reportedly ran away from home when the problems became too much and sought refuge with neighbours while others moved to live in the streets.

Community participation results indicate that overall, very few caregivers were involved in community care projects. For example, only 5% of caregivers were involved in planning the activities of community care programmes, while only 2.7% said they are involved in decision making. They were, however, not involved in making any significant decisions. It was further found that very few caregivers (17.3%) were involved in carrying out activities of the community care programmes, which mostly involved reaching out to orphans and offering home based care and support. Additionally, very few caregivers (6.8%) made contributions to supporting the community care programmes.

In offering suggestions about care of orphans, most caregivers (37%) felt that orphans should be cared for within households. Caregivers, however further indicated that everyone in

the community should concern themselves with orphans and support caregivers living with orphans in provision of care and support to orphans. They noted that the problem of orphans should not be seen as a problem for the immediate relatives alone, but for the whole community. Caregivers perceived the orphan problem as a community problem that cannot be addressed single-handed. They argued that community care programmes should provide more assistance to orphans. This, they argued is because community programmes are better placed to mobilize resources for care of orphans from community members and other organizations than individual caregivers. The situation, therefore, should be addressed at the community level with participation of all community members. The number of orphans has become increasingly unmanageable. Some caregivers too felt overwhelmed that the number of demands of orphans requires institutions to care for orphans.

The study findings further show that most caregivers (45.7%) required financial assistance for meeting the various needs of orphans. Other caregivers required assistance in food (23.7%), sponsorship for education of orphans (34.7%) and clothing (21.5%). Orphans, however, reported that they required assistance in food (25.6%), clothing (27.9%) and school fees (26.9%).

From the foregoing, it is evident that needs of orphans have not been met sufficiently. Therefore, the majority of the families and community care programmes have not met orphan needs sufficiently. This study showed that more than half of the caregivers (56.2%) felt that the needs of orphans were not sufficiently met. It is evident that the majority of the families and community care programmes have not adapted to the orphan hood situation successfully.

This is because resources available at family and community levels are limited and thus not adequate to manage the situation arising at the family level. Equally, with low levels of

community participation, the emerging picture is one of families and communities not able to adequately adapt to the emerging stressful situation.

Generally, the study's findings show that there were no relationships between gender of orphans and types of problems experienced and needs of orphans. Only school fees support as a needed form of assistance showed a significant relationship between boys and girls. Most girls mentioned assistance in school fees support.

The findings further show that some types of problems experienced by orphans (e.g. inadequate clothing, hunger and being overworked), needs of orphans (i.e. food and shelter) and form of assistance required by orphans (i.e. getting higher education) showed significant relationships with orphans in and out of project. The majority of the orphans who mentioned food and shelter needs, and those who experienced problems of being overworked and inadequate clothing were from out of the project. This was attributed to their not being supported. However, most of those experiencing problems of hunger were from the project.

There were significant relationships between caregivers in and out of the project and shelter provided to orphans, as well as psychosocial support and problems experienced by caregivers while caring for orphans. In addition, there were significant relationships between caregivers in and out of project and invitation to attend meetings, involvement in decision making in community care programmes, participation in carrying out community care programme activities, and involvement in making other contributions to community care programmes. It is noted that most of those who participated in the community care programmes were from the project. No significant relationships were recorded between in and out of project caregivers and caregivers' involvement in planning programme activities.

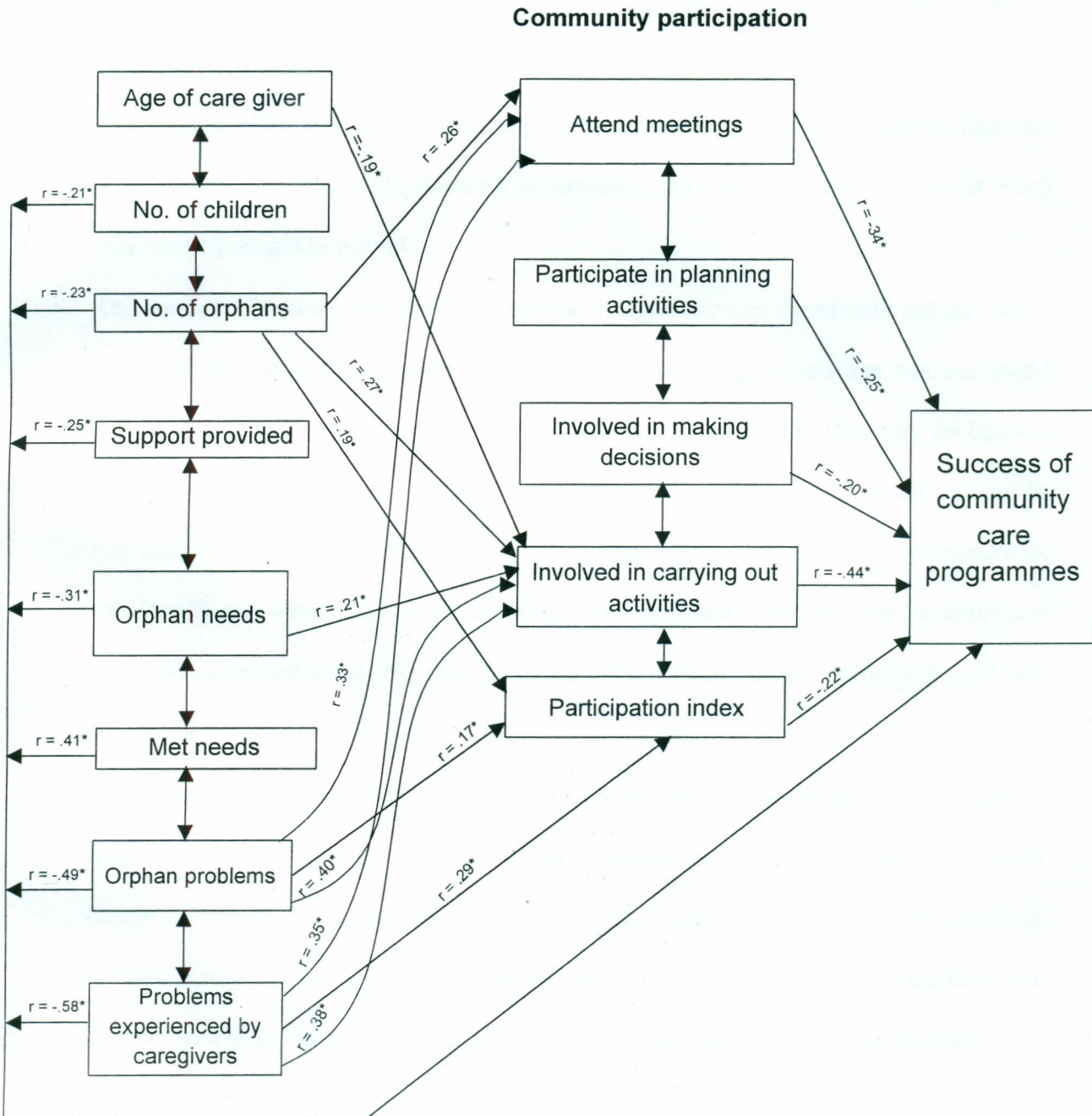
In establishing differences between caregivers and orphans in orphan care variables paired t-test was performed. The results show that there were significant differences in the number of orphan problems (with a high mean for caregivers, 2.35 as compared to that of orphans 2.11); number of orphan needs (with a high caregivers mean, 4.70 compared to that of orphans 2.60); and number of needs not adequately met (with a high orphan mean, 2.69 compared to that of caregivers 0.92). There were no significant differences in the length of stay of orphans with caregivers.

There were no significant differences between in and out of project orphans in the length of stay with caregivers, number of unmet needs and number of problems. There were however, significant differences in number of needs of orphans (out of project - 2.71, in project - 2.18).

Spearman rank correlation coefficient results indicate significant relationships between the success of community care programmes and, number of orphans, support provided, orphan needs, orphan problems and problems experienced by caregivers. Significant relationships between the variables categorized into inputs, throughputs and output are summarized in the reduced model shown in Figure 2.

Figure 2: A reduced model showing relationships between the input, throughput and output variables

Inputs → Throughputs → Outputs



* $p \leq .05$

The results, as indicated in the reduced model above, show that:

- The number of orphans is inversely related to success of programmes, implying that the more the HIV and AIDS orphans, the less the success of community care programmes. This may be attributed to high demands for support by orphans, which due to limited resources are not met adequately, and hence low success of the programmes as they do not meet the orphan needs sufficiently.
- The number of orphan problems is negatively correlated to success of community care programmes. The greater the demands by orphans, the more the support required which may not be possible to provide.
- The success of community care programmes is negatively correlated with the number of problems experienced by caregivers. Community care programmes are less successful when the number of problems experienced by caregivers is high. This may be because caregivers seek more assistance from the care programmes for orphans, which may not be met sufficiently. Secondly, caregiver's participation in the community care programmes may be affected when they are experiencing many problems. They may be constrained in time and other resources that they could contribute to the project, thus making it less successful.
- The number of care and support provided to orphans correlated negatively to success of programmes. This means that community programmes are less successful when caregivers are providing more support to the orphans at household level. This could be because caregivers are not available for participation. Less community participation and support to the project affects its capacity to provide assistance to the orphans, thus affecting its success.

- The met needs was positively correlated to success of community care programme implying that the more the met needs the more successful the programme.
- The attendance at meetings positively correlated with number of orphans, number of orphan problems and problems experienced by caregivers. Caregivers who attend meetings were those with more orphans and those experiencing problems while caring for the orphans. This may be because they need support, thus they attend meetings to seek assistance in caring for the orphans.
- The participation in carrying out activities at the community care programmes is positively correlated with number of orphans, orphan needs, orphans experiencing problems and caregivers experiencing problems while caring for orphans. This is not surprising considering that their participation is for material incentives and they would therefore be involved to get support in meeting the needs of orphans.
- The success of community care programmes negatively correlates with participation variables. This implies that high participation of caregivers leads to less success of the community care programmes. This may be attributed to the caregivers' form of participation. First, they participate in order to receive material incentives and often their participation stops when the incentives end. They were thus drawing on the resources of the care programmes without being actively involved in the programme or contributing resources towards the programme. Indeed the results show a statistically negative correlation between participation and the success of community care programmes. Secondly, results show that very few of the caregivers were involved in planning of the activities of the community care programmes, decision-making and implementing activities of the programme. Even so for the few who were involved, they were not

involved in making any significant decisions on planning or allocation of resources. Likewise, very few made contributions towards the community care programme. Their participation was at a low level, limited to receiving benefits from the programme, which does not appear to be supportive of the success of the programme.

The results also show that the number of HIV and AIDS orphans and number of problems experienced by caregivers in caring for orphans are predictors of success of community care programmes. These variables were inversely related to success of community care programmes implying that more HIV and AIDS orphans and more problems experienced by caregivers in caring for HIV and AIDS orphans lead to less success of community care programmes.

5.2 Conclusions

Orphan-hood has affected families and communities and created a stressful situation that has led to problems for both orphans and caregivers. Families faced with this situation use resources at their disposal to care for orphans, meeting their needs and also addressing their problems. They also seek other assistance from the community as well as from community care programmes. While it was evident that the caregivers played a significant role in supporting children orphaned by HIV and AIDS, the increasing numbers of orphans and their growing demand for care and support at the household and community levels has strained the existing resources. There were signs that they can no longer effectively take care of orphans. For instance, in provision of education to orphans, there was lack of learning materials, which is a major hindrance to the learning of the orphans. The shelter provided was also in poor condition while the food was inadequate. It can only be concluded that something has to be done to stem the problem.

It is important to note that community care programmes have been concerned with the welfare of children orphaned by HIV and AIDS and have taken positive initiatives to assist in caring and supporting them and their caregivers. Although the results of this study show that the majority of orphans whose needs were not adequately met are from out of the project, overall orphans' needs both in and out of the project were not sufficiently met. Thus, community care programmes seemed not to have sufficiently supported the orphans and their caregivers. There is a need for government and other organizations and agencies involved in matters of children to support community initiatives and families in caring for children orphaned by HIV and AIDS. This could be done by building their capacities through micro enterprises and also empowering them to participate in decision-making in care and support programmes.

Although generally there were no significant relationships between boys and girls in the needs of orphans and care and support provided, there was a significant relationship between boys and girls in education need. It was evident that among the orphans, girls' education was especially an unmet need, which was compounded by their overload in domestic work. There is a need to support girls' education by sensitising caregivers and other duty bearers to take the girls to school.

It was also evident that although caregivers were living with and caring for orphans, they had not made prior arrangements before taking in orphans, neither were the orphans involved in discussions before making movements to their caregivers. The results also show that some caregivers discriminated and mistreated the orphans. For instance, they overworked them while their own children were spared from working particularly those out of the project. Orphans were beaten, quarrelled and went hungry while other members of their families had food. It would generally be assumed that an orphan living with a caregiver would receive the same treatment as

other members of the family. This was, however, not the case as has been shown in the results of this study. This is a major concern as it affects the well-being of the child. It is important to put in place mechanisms at the community level to check against such mistreatments that occur within households. This could be done through schools, religious organizations and community care programmes where such cases can be reported and addressed, while at the same time those involved can be counselled. The orphans will thus grow up happy and live in a home environment conducive to healthy psychosocial development and have the same opportunities as other children.

This study documented that orphans as well as the caregivers underscored psychosocial support, which has been perceived in other studies, as a major need for orphans. This could be attributed to caregivers not having time for psychosocial support, while some caregivers may not really understand its importance. In view of the stressful life of caregivers and orphans, it can be concluded that psychosocial support would assist the children to adjust to and cope with their new families. This would be more useful for those who are being mistreated and discriminated against.

The study findings further show that the situation of orphan hood is perceived as challenging, the magnitude of the problem is increasingly overwhelming families and communities such that some families have almost despaired and felt that orphans should be institutionalised, while others felt that the community through community care programmes should support the caregivers caring for orphans in a much better way. The programmes should be participatory from their inception and involve community members in planning and decision-making and implementation of the programme. This way caregivers felt that the community members will own the process and the programme, and will have more active involvement. Such

participation by community members may enhance consolidated support by the community as well as, provide a process for community control and advocacy for support of such programmes.

The study findings also indicate that caregivers were rarely involved in the activities of community care programmes. Participation by caregivers in the care programmes is said to be resourceful. This is because participation offers psychosocial support and also provides a platform for mobilizing resources for support of the orphans and their caregivers. From the results, it is noted that very few caregivers participated in these programmes, and even for them there was a low level of participation (i.e. participation for material incentives which ends when the material incentives end). It was also evident that the few who participated in planning and decision-making were not involved in making significant contributions. It can be concluded that for effectiveness of community care and support programmes, viable arrangements should be made to tap participation of all actors and especially caregivers who are critical stakeholders in this case. Equally, efforts should be made to educate community members on the importance of their involvement in such programmes and encourage them to actively participate in them. This is vital in enhancing community care and support programmes.

Lastly, in view of the increasing incidence of orphan hood, it can only be concluded that the root cause of the problem is not being adequately addressed. Apparently, HIV and AIDS are still spreading fast. An ultimate solution is the invigoration of existing HIV and AIDS prevention and control measures. This can be done through the community identifying their role in the struggle, identifying their resources as well as what adjustments they can make in their lifestyles to reduce their vulnerability and that of orphans.

5.3 Recommendations

Based on this study's findings, the following recommendations, are made:

- i) Design integrated programmes and approach in assisting orphans, thereby striving to provide a greater part of their needs.
- ii) Design programmes to support caregivers and communities affected particularly those out of project and who have no form of assistance. This could be done through micro financing for small businesses to generate income to help care for orphans within their households and communities.
- iii) Educate infected parents. It is important that parents who are infected with HIV and AIDS are advised and encouraged through counselling programmes to engage and discuss with their children about their future. This will give children a chance to know their relatives and close family friends and possibly be prepared for the transition.
- iv) Capacity building of the caregivers. There is a need for caregivers to be informed and sensitised about children's rights. This would help to curb discrimination, neglect and any form of abuse towards children orphaned by HIV and AIDS.
- v) Police child abuse. The government, through the Children's Department and community should put in place mechanisms at the community level of identifying those who are abusing orphans and other children and take action against them.
- vi) Community participation and empowerment programmes. Based on the results of this study, there is need to involve communities and in particular, caregivers in the activities of the community care programmes. This can be done through

provision of education on group formation, goal setting, decision-making processes and resource mobilization.

- vii) Strengthen home-based care and support programmes. Supporting children while living with their caregivers is the preferred form of care of orphans over institutionalisation. The government and donor agencies should support the community care programmes at the community level through provision of infrastructure medical care, among others.
- viii) Establish orphan-support networks. There is need for all actors in orphan care programmes to network and collaborate in orphan care issues, as this would lead to efficient use of available resources.
- ix) Establish psychosocial support centres for orphans and caregivers. This is basically to deal with the trauma the orphans and caregivers go through. This will also facilitate the rehabilitation of abused orphans.
- x) Support orphan girls' education given their vulnerability to social vices including dropping out of school.
- xi) Intensify HIV and AIDS prevention and control programmes as a way of addressing the problem of orphans from its root causes.

5.4 Recommendations for further research

Further research is recommended to:

- i) Establish reasons for the low level of participation of caregivers in community care programmes;
- ii) Replicate this study in other low-income centres in the rural areas in Kenya; and
- iii) Establish best practices in care and support of orphans.

REFERENCES

- ACTION-AID, Kenya (1995). Needs assessment and support services for orphans and families affected by AIDS. Nairobi: Kariobangi Urban Development Project.
- Barnett, T., & Blaike, P. (1992). AIDS in Africa: its present and future impact. London: London Press.
- Barnett, T., & Whiteside, A. (2002). AIDS in the twenty first century: Disease and globalisation. New York: Palgrave Macmillan.
- Bogdan, C. R., & Biklen, S. K. (1982). Qualitative research for education: An introduction to theory and methods. Boston: Allyn and Bacon.
- Bwalya, M. C. (1985). The integrated development approach within the context of decentralization in Zambia. Trenton: Africa World Press.
- Chambers, R. (1983). Rural development: Putting the last first. Essex: Longman Group.
- Chitere, P. O. (1980). Decentralization of decision-making processes: Its implications for the implementation of the crops improvement programme in Kakamega District – Kenya. Unpublished Ph.D Thesis. Nairobi: University of Nairobi.
- Chitere, P. O. (1994). Community development: Its implications and practice with emphasis on Africa. Nairobi: Gideon S. Were Press.
- Chitere, P. O., & Mutiso, R. (1991). Background to the PAR project. In P. O. Chitere, and R. Mutiso (1991). Working with rural communities: A participatory Action Research in Kenya. Nairobi: Nairobi University Press.
- Crazian, A. M., & Raulin, M. L. (1993). Research Methods: A process of inquiry. New York: Harper Collins College Publishers.
- Deacon, R. E., & Firebaugh, F. M. (1988). Family Resource Management: Principles and Applications. Massachusetts: Allyn and Bacon. Boston.
- Dietrich, F. H., & Kearns, T. H. (1989). Basic Statistics: An inferential approach. (3rd ed.) California: Dellan Publishing Company.
- FAO (2002). Improving nutrition programmes: An assessment tool for action. Rome: Food for Agriculture Organization of the United Nations.

- Fergusson, A., & Johnston, T. (1997). *AIDS, gender and school drop out*. Nairobi: Population Communication Africa.
- Food for the Hungry International, Kenya (2001). *Life Initiative Project: Feasibility study on orphans and vulnerable children in Isiolo, Meru, and Embu Districts and Nairobi area*. Nairobi: Food for the Hungry International.
- Gall, M. D., Borg, W. R., & Gall, J. P. (1999). *Educational research: An introduction*. New York: Longman Publishers.
- Godfrey, A. I. (1977). *Quantitative methods*. London: Edward Arnold Publishers Ltd.
- Government of Kenya (2001). *1999 Population and Housing Census: Volume II: Socio-economic profile of the population*. Nairobi: Central Bureau of Statistics and Ministry of Finance and Planning.
- Government of Kenya - Ministry of Health (1997). *AIDS in Kenya*. Sessional Paper Number 4. Nairobi: Government Printers.
- Government of Kenya - Ministry of Health (1999). *Lessons learned. Report of the second national conference on HIV and AIDS*. Nairobi: Ministry of Health.
- Government of Kenya / United Nations Children Emergency Fund (2001). *Situation of AIDS orphans and vulnerable children in Kenya*. Nairobi: United Nations Children Emergency Fund.
- Government of Kenya / United Nations Children Emergency Fund (2002). *Gender, sexuality and HIV and AIDS in Kenya*. Nairobi: United Nations Children Emergency Fund.
- Government of Kenya / United Nations Children Emergency Fund (2000). *The impact of HIV and AIDS on education and the potential for using education in the widest sense for the prevention and control of HIV and AIDS*. Nairobi: United Nations Children Emergency Fund.
- Government of Kenya / United Nations Children Emergency Fund (1999). *Comprehensive education sector analysis report of 1994*. Nairobi: Government Printers.
- Grimm, L. G. (1993). *Statistical applications for the behavioural sciences*. New York: John Wiley & Sons, Inc.

- Hope for African Children Initiative (2002). Situation analysis of the current and future state of orphans and vulnerable children affected by HIV and AIDS in Kenya. Nairobi: Hope for African Children Initiative.
- Hall R. (1972). Organizations, structure and process. New Jersey: Prentice Hall, Inc.
- Harnett, D., & Murphy, J. L. (1985). Statistical analysis of business and economics. Massachusetts: Addison Wesley.
- Hunter, S., & Williamson J. (1997). Children on the brink: Strategies to support children isolated by HIV and AIDS. USAID.
- Jorgenson, N. O. (1977). Economic constraints for housing the lower income groups. Housing Research Development Unit. Nairobi: University of Nairobi.
- Joint United Nations Programme on HIV and AIDS (1998). Report on the Global HIV and AIDS Epidemic. Nairobi: Joint United Nations Programme on HIV and AIDS.
- Leonard, K. D. (1977). Reaching the peasant farmer: Organisation, theory and practice in Kenya. Chicago: The University of Chicago Press.
- Mbithi, P. M. (1974). Rural sociology and rural development: Its application in Kenya. Nairobi: East Africa Literature Bureau.
- McCubbin & Patterson (1983). In P. Boss (1988). Family stress management. California: Sage Publications.
- Mitchell, D. (1992). Measurement, statistics and evaluation. Baltimore MD: University of Maryland.
- Miles, B. M., & Huberman, A. M. (1994). Qualitative data analysis. (2nd ed.). Thousand Oaks, California: Sage Publications.
- Mugenda, O. M., & Mugenda, A.G. (1999). Research methods: Quantitative & Qualitative approaches. Nairobi: Acts press.
- Muia, D. M. (1987). The nature and participation of community leaders in development. Unpublished M.A. Thesis. Nairobi: University of Nairobi.
- Muia, D.M. (1991). A conceptual examination of the phenomenon of participation in rural development. In P. O. Chitere, and R. Mutiso (1991). Working with rural communities: A participatory Action Research in Kenya. Nairobi: Nairobi University Press.
- Mutiso, R. (1991). Working with rural communities: A participatory action research in Kenya. Nairobi: Nairobi University Press.

- National AIDS Control Council (2000). Strategic Plan. Nairobi: National Aids Control Council.
- National AIDS Control Council /Ministry of Home Affairs (2003). National programme guidelines on orphans and other children made vulnerable by HIV and AIDS. Nairobi: Ramco printing works limited.
- National AIDS/STIS Control Programme (1999). AIDS in Kenya: Background, projections, impact, interventions and policy. Fifth Edition. Nairobi: National AIDS/STIS Control Programme.
- National AIDS/STIS Control Programme (2003) AIDS in Kenya: background, projections, impact, interventions and policy. Nairobi: National AIDS/STIS Control Programme.
- Nation Newspapers (2004, January 6). Children sue state. Nairobi: Nation printers.
- Nation Newspapers (1999, September 22). Virgin raped in AIDS cleansing rite. Nairobi: Nation printers.
- Ngige, L. W. (1993). Intrahousehold resource allocation, decision-making and child nutritional status in rural Thika, Kenya. Ph.D Thesis. Michigan State University. U.S.A.
- Nyambedha, E. O. (1999). Preliminary report on a study of support systems for orphaned children in Nyang'oma Sub-location, Bondo District. Nairobi: Nairobi: Kenyan Danish Health Research Project (KEDADR) document.
- Ondigi, A. (2003). Factors influencing prenatal health status among women attending prenatal clinics in selected low-income areas of Nairobi, Kenya. Nairobi: Unpublished Ph.D Thesis. Kenyatta University.
- Oppenheim, A. N. (1979). Questionnaire design and attitude measurement. London: Morrison and Gibb Ltd.
- Oyugi, W. O. (1985). Centre- Periphery linkages in the development process: An assessment of the Kenya experience. Trenton: African World Press.
- Prewitt, K. (1974). Introductory research methodology: East African applications. Sessional paper No. 10. IDS. Nairobi: University of Nairobi.
- Russell, J. F. A. (1983). "Farmer participation and the village extension worker": A comment in : Cernea M. M. (eds.). Agricultural Extension by training and visit. The Asian experience. Washington, D.C: World Bank.
- Saoke, P., & Mutemi, R. (1994). Needs assessment of children orphaned by AIDS. Nairobi: United Nations Children Emergency Fund.

- Timberlake, L. (1985). *Africa in crisis: The causes, the cares of environmental bankruptcy*. London: Earth Scan Publications.
- Topouzis, D., & Hemrich. (1995). *The Socio-Economic impact of HIV and AIDS on rural families in Uganda*: New York: An emphasis on youth.
- United Nations (1989). *Convention on the rights of the child*. Geneva: United Nations.
- United Nations Children Emergency Fund. (1998). *Children and Women in Kenya: A Situation analysis*. Nairobi: United Nations Children Emergency Fund /Government of Kenya.
- United Nations Children Emergency Fund (2002). *Estimated number of children orphaned by HIV and AIDS in Kenya*. Nairobi: United Nations Children Emergency Fund.
- United Nations Children-Emergency Fund/United States Agency for International Development (1999). *Orphan Programming in Kenya: Building community capacity to manage comprehensive programmes for prevention, care and support*. Nairobi: United States Agency for International Development / United Nations Children Emergency Fund.
- United Nations Task Force on Rural Development (1977). In P. O. Chitere, and R. Mutiso (1991). *Working with rural communities: A participatory Action Research in Kenya*. Nairobi: Nairobi University Press.
- United States Agency for International Development/ United Nations Children Emergency Fund (2000). *Orphans and vulnerable children in Africa. Proceedings of the Eastern and Southern Africa regional workshop on orphans and vulnerable children*. Zambia: United Nations Children Emergency Fund.
- World Conference for Religions and peace-Kenya / United Nations Children Emergency Fund (2002). *Responses by religious organizations to orphans and vulnerable children*. Nairobi: World Conference for Religions and Peace-kenya.
- World Health organization/ United Nations Children Emergency Fund (1994). *Action for children affected by AIDS: Program profiles and lessons learned*. Nairobi: United Nations Children Emergency Fund
- World Bank (2000). *The impact of HIV and AIDS on education sector*. Nairobi: World Bank.
- World Vision, Kenya (2003). *Situation analysis to shape the world vision OVC initiative*. Nairobi: World Vision.
- Yeung, Y. M., and McGee, T. G. (1986) *Community participation in delivering Urban Services in Asia*. International Development Research Centre.

APPENDICES

APPENDIX A: COVERING LETTER

Mrs. Alice Bonareri Akunga
Kenyatta University
Textile, Family and Consumer Sciences Department
P.O Box 43844
NAIROBI

Date:

Dear Sir/Madam

RE: POSTGRADUATE RESEARCH INTERVIEWS

I am a postgraduate student at the Kenyatta University currently carrying out a research to establish community participation in the care of HIV and AIDS orphans in Nairobi. In this regard, I would be grateful if you could be available for the research interviews.

I thank you in advance for your cooperation in this respect and assure you that the research is an academic one and any information you give will be useful and treated as strictly private and confidential.

Yours faithfully


AKUNGA, ALICE BONARERI

APPENDIX B: DATA COLLECTION INSTRUMENTS**1. INTERVIEW GUIDE FOR CAREGIVERS****Introduction**

This interview schedule for caregivers seeks to obtain information on the socio-economic profiles of the caregivers, the needs of orphans, the problems experienced by the orphans and the caregivers, and the existing care structures and services provided to the HIV and AIDS orphans. The interviews will be held with the caregivers and the information given will be treated as highly confidential.

Date: _____

Name of interviewer _____ Household No. _____ Division _____

Location _____ Sub location _____ Village _____

PART A: SOCIO-ECONOMIC FACTORS

1) What is your gender? (Tick the most appropriate)

1. Male
2. Female
- 3.

2) How old are you?

3) What is your marital status? (Circle your answer)

1. Married
2. Divorced
3. Separated
4. Widowed
5. Single
6. Other

4) What is the highest level of education you have achieved?

1. No schooling
2. Primary school level

3. Secondary school level
4. College level
5. University level

5) What is your occupation?

1. Housewife
2. Professional (e.g. lawyer, teacher, doctor)
3. Small business (Jua kali)
4. Large business (house rentals, shop owner)
5. Casual labourer
6. Employed salaried (specify)
7. Other (specify)

6) How many children do you have?

7) How many other children do you live with and take care of that are not your own?

PART B: ORPHAN CARE INFORMATION

8) How many of these children are HIV and AIDS orphans?

9) For how long have you lived with the HIV and AIDS orphans?

10) Were there any prior preparations made by you or any other body before taking in the orphans?

1. No
2. Yes

If yes, explain

11) Are there any preparations you feel need to be made before taking in an orphan?

1. No
2. Yes

If yes, explain which ones

12) What type of care do you give the orphans? (Tick all that apply) and indicate the type of care given.

<u>Care</u>	<u>Specific type of care</u>
1. Food []	-----
2. Clothing []	-----

3. Shelter [] -----
4. Education [] -----
5. Medical [] -----
6. Psychosocial support [] -----
7. Others (specify) [] -----

13) What are the needs of the orphans? (Tick all that apply) and explain the nature of the need.

<u>Need</u>	<u>Nature of need</u>
-------------	-----------------------

- | | |
|-----------------------------|-------|
| 1. Food [] | ----- |
| 2. Clothing [] | ----- |
| 3. Shelter [] | ----- |
| 4. Education [] | ----- |
| 5. Medical [] | ----- |
| 6. Psychosocial support [] | ----- |
| 7. Others (specify) [] | ----- |

14) Which of these needs are you able to meet adequately?

15) Which of these needs are you not able to meet adequately?

16) Do the orphan(s) in your household experience any problems?

1. No
2. Yes

17) If so, what problems do they experience and how do you solve these problems?

<u>Problem</u>	<u>How you handle problem</u>
----------------	-------------------------------

- 1.
- 2.
- 3.
- 4.
- 5.

18) Do you experience any problems in taking care of the orphans?

1. No
2. Yes

19) What type of problems do you experience and how do you solve these problems?

<u>Problem</u>	<u>How you solve problem</u>
----------------	------------------------------

1.

2.

3.

4.

5.

Existing Care Structures

20) Are there any individuals or organizations that assist orphans within your community?

1. No
2. Yes

21) If so, name them and indicate the assistance they give.

<u>Organization</u>	<u>Assistance given</u>
---------------------	-------------------------

1.

2.

3.

4.

5.

22) Do you receive any assistance from any individuals or organizations to take care of the orphans you have?

1. No
2. Yes

23) If so, name them and indicate the assistance they give.

<u>Individuals/Organizations</u>	<u>Assistance given</u>
----------------------------------	-------------------------

1.

2.

3.

4.

PART C: PARTICIPATION IN COMMUNITY ORPHAN CARE PROGRAMMES

24) Are there any organizations within the community that provide care and support to the orphans?

1. No

2. Yes

25) If yes, name them and indicate the type of support do they provide?

<u>Organizations</u>	<u>Type of support given</u>
1.	
2.	
3.	
4.	
5.	

26) To what extent do they meet the needs of the orphans?

1. Not sufficiently

2. Fairly sufficiently

3. Quite Sufficiently

27) If not sufficiently, which needs are not met?

28) Do you participate in the activities of that organization?

1. No

2. Yes

Explain your answer.

29) Are you invited by the organization to attend meetings?

1. No

2. Yes

Explain your answer.

30) If yes, How often?

1. Once a week

2. At least monthly

- 3. At least quarterly
- 4. At least half yearly

31) Do you contribute in planning of activities within those organizations?

- 1. No
- 2. Yes

Explain your answer.

32) Have you ever been involved in making decisions within those organizations?

- 1. No
- 2. Yes

Explain your answer.

33) Do you participate in carrying out the activities of the organization?

- 1. No
- 2. Yes

Explain your answer.

34) Are there any other contributions you make to the organization?

- 1. No
- 2. Yes

Explain your answer.

PART D: SUGGESTIONS ON ORPHAN CARE

35). Where do you feel that orphans can best be cared for and why?

- 1. Household [], Explain
- 2. Community [], Explain
- 3. Institution [], Explain
- 4. Other Specify) [] Explain

36) Who should be responsible for care of orphans in the community?

Explain

37) How do you think communities should organize themselves to take care of orphans?

Explain

38) What support would you require to care for orphans?

(Specify and indicate why)

2. INTERVIEW SCHEDULE FOR ORPHANS

Introduction:

This interview schedule seeks information about the socio economic profiles of the HIV and AIDS orphans under study, their needs and problems, and the extent to which their needs are met. The interview will be carried out with the HIV and AIDS orphans and the information given will be treated as being highly confidential.

- 1) What is your gender? (Tick the appropriate) ✓
 1. Male
 2. Female
- 2) How old are you?
- 3) What is your educational level? ✓
 1. No schooling
 2. Primary level
 3. Secondary level
 4. College level
- 4) Whom do you live with? (caregiver) ✓
 1. Auntie/uncle
 2. Cousin
 3. Grandmother/father
 4. Elder sister/brother
 5. Neighbour
 6. Institution
 7. Others (specify)
- 5) For how long have you lived with your guardian?
- 6) Did you discuss your movement to your caregivers place?
 1. No
 2. Yes
- 7) Do you experience any problems while living with your guardian?
 1. No
 2. Yes

8) If so, which problems do you experience and how do you solve these problems

<u>Problem</u>	<u>How you solve problem</u>
----------------	------------------------------

- 1.
- 2.
- 3.
- 4.
- 5.

9) What are your needs and indicate the nature of the need?

<u>Need</u>	<u>Nature of Need</u>
-------------	-----------------------

1. Food [] -----
2. Clothing [] -----
3. Shelter [] -----
4. Education [] -----
5. Medical [] -----
6. Psychosocial support [] -----
7. Others (specify) [] -----

10) Which of these needs are met adequately?

1. Food
2. Clothing
3. Shelter
4. Education
5. Medical
6. Psychosocial support
7. Others (specify)

11) Which are not met adequately and how do you cope with the unmet needs?

<u>Unmet Need</u>	<u>How you cope</u>
-------------------	---------------------

1. Food -----
2. Clothing -----
3. Shelter-----
4. Education-----

5. Medical -----

6. Psychosocial support -----

7.) Others (specify) -----

12) Do you get any assistance from any other individuals/organizations other than your guardian?

1.No

2.Yes

13) If yes, name them and indicate the type of assistance they provide.

Individuals/Organizations

Form of assistance

1.

2.

3.

4.

5.

14) What other form of assistance do you require?

3. FOCUS GROUP DISCUSSION GUIDE (Community Leaders)

Introduction

This guide will be used to obtain information on orphan problems; existing care structures for orphans, and community members' participation in orphan care programmes. The discussion will be held with community leaders. They will be required to respond as accurately as possible and the information given will be treated as private and confidential.

1. What are the problems associated with HIV and AIDS in this community? How is the community coping with the problem?
2. Who are the most vulnerable/affected population segments of the community? (Probe on HIV and AIDS orphans)
3. When parents die who takes care of the orphans? -
4. What problems do orphans face in this community? -
5. What form of assistance is the community giving to orphans?
6. What organizations assist in the care orphans in this community? What type of assistance do they give?
7. Are community members involved in planning, and implementation of activities within these programmes? If so, how?
8. Do community members participate in decision making in this programmes? If so, at what stages and to what extent?
9. What contributions does the community make to these orphan care programmes?
10. How have you organized yourselves to meet the needs of orphans within your community? What problems have you faced, and how do you intend to address these problems?
11. How best do you feel communities should organize themselves take care of their orphans at community and household level? What help does the community need?
12. Any other additional information you want to give.

4. INTERVIEW GUIDE FOR COMMUNITY CARE PROGRAMME LEADERS.

Introduction:

The guide will be used to obtain information from those organizations offering care and support to the HIV and AIDS orphans. It will seek information on the organization profiles, the services they provide, the existing care structures, community involvement in the organizations activities, and how the services offered can be further improved to meet the needs of the orphans fully.

The interview will be held with the leader of the organization and the information given will be treated as being highly confidential.

Date of interview _____

Name of institution _____

Position of interviewee _____

Village _____

1. How many staff does your organization have?
2. How long have you worked in this area and what is your coverage, i.e. districts, divisions, locations covered? (Name them)
3. What is your target group?
4. How do you raise resources for your programmes?
5. What resources do you get from this community?
6. Do you offer care and support to HIV and AIDS orphans in this community? How do you identify them?
7. Are you meeting their needs adequately? (What are some of the things you have not done better?)
8. What problems does your organization face in provision of care and support to the orphans?
9. What suggestions would you make on improving delivery of services to the orphans?
10. How has the organization utilized community participation in its planning, management, decision-making and implementation of its activities?

11. How do you get community members to contribute in your programmes? What do they contribute?
12. How could the community be strengthened to participate more in community initiatives?
13. What other assistance does your organization require in the provision of care and support to the orphans?
14. What other organizations offer care and support to the orphans? (Name them and indicate the type of support provided).
15. How can the capacity of this community be improved in order to cope with the care and support of HIV and AIDS orphans?

APPENDIX C: HIV PREVALENCE RATES IN KENYA

Appendix: HIV Prevalence Rates by Sentinel Site and Province

Province	District	Year	
		2001 (%)	2002 (%)
Central	Nyeri	11.0	7.9
	Thika	10.8	7.0
	Maragua	8.0	7.9
	Njambini	5.8	6.3
Coast	Mombasa	14.3	14.2
	Tiwi	10.0	6.5
	Kilifi	9.8	5.1
	Bamba	9.4	4.0
	Wesu-Wund	7.4	5.4
Eastern/North Eastern	Kitui	17.4	6.1
	Karurumo	6.4	4.0
	Kangundo	13.5	6.7
	Mutomo	2.4	5.3
	Meru	9.8	5.1
	Garissa	9.0	4.3
Nyanza	Kisumu	28.5	25.8
	Chulaimbo	24.6	21.7
	Kisii	17.4	13.9
	Tabaka	11.2	4.3
	Suba	30.9	34.0
Rift Valley	Lodwar	16.5	18.0
	Kitale	12.8	16.3
	Baringo	9.6	5.5
	Maralal	15.0	5.3
	Mosoriot	4.0	5.1
	Sir-Turbo	5.4	4.5
	Nakuru	12.2	12.1
	Kajiado	7.6	5.2
	Fatima	22.0	7.5
	Kaplong	8.5	6.1
Western	Kakamega	11.3	14.3
	Busia	15.3	15.5
	Mbale	11.1	10.8
	Mt. Elgon	21.1	5.5
	Teso	6.3	-

Source: Republic of Kenya, Ministry of Health, NASCOP (2003). HIV and AIDS surveillance in Kenya. Nairobi. Kenya.

**APPENDIX D: ESTIMATED NUMBER OF CHILDREN ORPHANED BY HIV and AIDS
IN ALL DISTRICTS IN KENYA**

1. Eastern Province			
District	Year		
	2001	2005	2010
Embu	18,256	32,853	39,848
Mbeere	11,219	20,188	24,487
Isiolo	1,158	2,084	2,528
Kitui	12,872	23,164	28,096
Machakos	27,765	49,965	60,604
Makueni	23,628	42,520	51,574
Marsabit	1,395	2,511	3,045
Meru North	39,640	71,334	86,523
Meru Central	32,738	58,914	71,459
Meru South (Nithi)	13,482	24,262	29,428
Mwingi	7,588	13,654	16,562
Moyale	1,336	2,403	2,915
Tharaka	6,627	11,926	14,466
Total Eastern	199,706	357,786	433,545
Kenya	968,287	1,780,557	2,204,115
2. Nyanza Province			
Gucha (S/Kisii)	13,324	24,122	29,416
Homa Bay	15,731	28,480	34,730
Kisii Central	14,215	25,736	31,385
Kisumu	27,497	49,782	60,707
Kuria	8,281	14,992	18,282
Migori	28,071	50,822	61,976
Nyamira (N/Kisii)	14,398	26,067	31,788
Nyando	16,352	29,604	36,101
Rachuonyo	16,744	30,314	36,967
Siaya	26,179	47,396	57,798
Suba	8,487	15,365	18,737
Bonda	13,018	23,568	28,741
Total Nyanza	202,297	366,248	446,629
Kenya	968,287	1,780,557	2,204,115

3. Central Province			
District	Year		
	2001	2005	2010
Kiambu	30,755	54,845	65,987
Thika	26,691	47,599	57,269
Maragwa	9,847	17,561	21,129
Nyandarua	12,181	21,722	26,135
Nyeri	16,781	29,926	36,006
Muranga	8,841	15,766	18,968
Kirinyaga	11,602	20,690	24,894
Total Central	116,699	208,109	250,388
Kenya	968,287	1,780,557	2,204,115
4. Coast Province			
Kilifi	14,446	26,791	33,380
Kwale	21,640	40,131	50,001
Lamu	1,929	3,578	4,458
Malindi	7,473	13,858	17,267
Mombasa	17,650	32,733	40,783
Taita	6,272	11,632	14,493
Tana River	2,115	3,923	4,888
Total Coast	71,526	132,645	165,268
Kenya	968,287	1,780,557	2,204,115
5. Nairobi Province			
Nairobi	68,882	134,377	175,189
Kenya	968,287	1,780,557	2,204,115
6. Rift Valley Province			
Baringo	8,223	15,433	19,435
Bomet	11,879	22,294	28,076
Buret	6,871	12,897	16,241
Kajiado	6,983	13,107	16,506
Keiyo	2,474	4,644	5,848
Kericho	14,538	27,286	34,362
Koibatek	4,287	8,047	10,134
Laikipia	8,432	15,826	19,930
Marakwet	2,419	4,539	5,717
Nakuru	59,469	111,615	140,562
Nandi	17,959	33,707	42,449
Narok	6,290	11,806	14,868

Samburu	2,469	4,633	5,835
Trans Mara	2,934	5,506	6,934
Trans Nzoia	17,864	33,527	42,222
Turkana	7,754	14,553	18,327
Uasin Gishu	19,323	36,267	45,673
West Pokot	5,298	9,944	12,524
Total Rift Valley	205,467	385,631	485,643
Kenya	968,287	1,780,557	2,204,115
7. North Eastern Province			
Garissa/Ijara	5,132	11,477	16,925
Mandera	3,273	7,321	10,796
Wajir	4,174	9,335	13,766
Total North Eastern	12,579	28,134	41,487
Kenya	968,287	1,780,557	2,204,115
8. Western Province			
Bungoma	19,795	36,054	44,204
Busia	19,393	35,323	43,308
Butere/Mumias	10,771	19,618	24,053
Kakamega	13,628	24,821	30,432
Malava/Lugari	4,876	8,882	10,889
Mt Elgon	4,116	7,496	9,191
Teso	5,532	10,075	12,353
Vihiga	15,022	27,362	33,547
Total Western	93,133	169,632	207,976
Kenya	968,287	1,780,557	2,204,115

Source: UNICEF. (2002). *Estimated number of children orphaned by HIV and AIDS in Kenya.*
UNICEF. Kenya.

APPENDIX E: MAP OF NAIROBI

