



KENYATTA UNIVERSITY

**COMMUNITY DRIVEN DEVELOPMENT HOME CARE PROGRAMS FOR
THE PHYSICALLY CHALLENGED YOUTHS IN KIBERA INFORMAL
SETTLEMENT, NAIROBI COUNTY, KENYA**

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**A THESIS SUBMITTED TO THE SCHOOL OF
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UNIVERSITY**

MAY, 2017

DECLARATION

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

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DEDICATION

This thesis is dedicated to my beloved husband Mr. Eric Gathura Kariuki and our lovely children Jeremy Gathura and Jennah Gathura for their support towards my academic journey.

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I would like to thank my husband Eric, for his love, kindness and support that he has shown during the time it has taken me to finalize this project. Furthermore, I would also like to thank my mum Edith Kiarie for her prayers, endless love and support. Last but not least, I would like to thank my supervisors, Dr. Muia and Dr. Ombaka, for their assistance and guidance.

ABSTRACT

This study sought to find out Community Driven Development (CDD) home care programs for the physically challenged youths in Kibera informal settlement. Specifically, the study aimed at finding out the extent to which the CDD home care programs were accessible to the physically challenged youths, the benefits of CDD home care programs and the challenges the physically challenged youths faced in accessing CDD home care programs in Kibera informal settlement. Social action theory was used in the study. The study employed descriptive survey research design with both qualitative and quantitative approaches. Questionnaire, interview schedule and observation methods were used for data collection. Data was collected from 357 respondents from the total of 3312 physically challenged youths in Kibera. These respondents were picked from 13 villages in Kibera through stratified and snowball sampling techniques. Data was analyzed and presented in tables, pie charts and figures, using percentages and some of it qualitatively. The study established that even though home care programs were not adequately accessible, several home care programs were carried out in Kibera. They included provision of donations and grants, guidance and counseling, hygiene promotion, making of referrals, home visits and provision of education on various beneficial programs. The physically challenged youths had benefited from the home care programs in a number of ways. These included financial, nutritional, medical and material support. Generally, the findings indicated that even if not all the physically challenged youths knew or had access to the CDD home care programs, majority of them had benefited from these programs in one way or the other. The study further established that there were several challenges that hindered the youths from accessing the home care programs. They included lack of information or ignorance, physical body handicap, fear of stigma, illiteracy among others. The study concluded that there were a good number of home care programs offered in Kibera. However, a number of physically challenged youths could not access them due to distance, lack of proper information, financial constraints, fear of stigmatization, illiteracy and misrepresentation among others. The study recommended that the government, the NGOs and all the stakeholders champion education awareness in Kibera informal settlement especially on CDD home care programs. This was to enable the physically challenged youths to be informed of the available opportunities so that they could be able to utilize them.

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ABBREVIATIONS

AIDS:	Acquired Immune Deficiency Syndrome
BBC;	British Broadcasting Corporation
CBOs:	Community Based Organization
CDD:	Community Driven Development
DIESK:	Disabled Empowerment Society of Kenya
GOK:	Government of Kenya
ILO:	International Labour Organization
HIV:	Human Immunodeficiency Syndrome
AIDS:	Acquired Immune Deficiency Syndrome
KEDAN:	Kenya Disabled Action Network
MDGs:	Millennium Development Goals
NACOSTI:	National Commission of Science, Technology and Innovation
NGOs:	Non-Governmental Organizations
NCKK:	National Council for Churches in Kenya
UN:	United Nations
UNICEF:	United Nations Children's Emergency Fund
WB:	World Bank
WHO:	World Health Organization

CHAPTER ONE: INTRODUCTION

1.1. Background to the Study

Community Driven Development (CDD) is a worldwide development initiative that provides control of the development process, resources and decision making authority directly to community groups (Sommers, 2010). The underlying assumption of CDD projects are that communities are the best judges of how their lives and livelihoods can be improved and, if provided with adequate resources and information, they can organize themselves to provide for their immediate needs. Moreover, CDD programs advocate for people changing their own environment as a powerful force for development (Naidoo & Finn, 2001). This study thus sought to assess the contribution of CDD home care programs on the physically challenged youths in Kibera informal settlement, Kenya.

Home Care Programs refers to the services and care provided to people in their homes to ensure their wellbeing through training of care givers, proper nutrition, hygiene, sanitation, medical care and education awareness. The study was carried out in Kibera informal settlement. This is because most physically challenged youths in Kibera informal settlement have limited resources. The aim of this study is to assess the contribution of CDD home care programs on the physically challenged youths in Kibera informal settlement.

CDD has mainly been targeting the poor population both in rural and urban settings because since this group is always marginalized from development issues (ReliefWeb, 2010) By treating poor people as assets and partners in the development process, previous studies have shown that CDD has been responsive to local demands, inclusive, more cost-effective and reached target poor and vulnerable groups in the societies. These are children, women and the physically challenged.

CDD also supports, strengthens and finances poor community groups and facilitates community access to information and other important services like health and education (Dongier, 2002). A study by Labonne & Chase (2008) carried among rural population in Australia revealed that that CDD projects improve trust among group members, increase participation in village assemblies, and generally increase social investment among the target group members.

However, targeting the poor, the vulnerable and particularly the physically challenged, has been a major challenge of the CDD approach worldwide (Farrington & Slater, 2006). Empirical evidence of the contribution of CDD in achieving the desired objectives is mixed (Mansuri & Rao, 2004). Khwaja (2001) notes that one interesting question that has captured the attention of scholars of community development issues is the contribution of CDD in targeting the most vulnerable people in the communities. In fact, Labonne & Chase (2008) note that CDD projects have led to investment in many projects but have had little significant impact on the vulnerable members in development groups especially in poor and marginalized communities.

It also includes the day-to-day factors that enable or hinder people's access to services, including health education, adequate food, clean water, adequate shelter, sexuality and family life services. On the other hand, many vulnerable people including the physically challenged in Africa face challenges like harassment, discrimination, violence and harmful socio-cultural practices that hinder their participation in health development (Haider, 2012). These factors hinder people's access to services, funding and the ability of CDD to function effectively. Failure to address these issues has made interventions for CDD health projects unsustainable

and in some instances, failed, especially in informal settlements in Africa; where monitoring and evaluation is hard to carry out (Wrong, 2010).

In Kenya, CDD programs have been focusing on poor and vulnerable communities particularly the informal settlements; Kibera being the greatest beneficiary (People of Kibera, 2010). A review of CDD conceptual foundations and evidence on their effectiveness by Mansuri & Rao (2004) shows that CDD health programs have not been particularly successful at targeting the poor, vulnerable and the physically challenged in Kibera. There is some evidence that such programs have created effective community infrastructure, but there is little evidence of the causal relationship between the outcome and participatory elements of CDD health programs particularly among the physically challenged groups.

According to Population Council of Kenya (2006), youths in Kibera informal settlement account to about 36 percent. Among this group are the physically challenged who face difficult circumstances daily. The informal settlements are an unfavorable site for them. Harsh realities of life in the informal settlement are particularly more accentuated among physically challenged youths whose condition predisposes them to a host of challenges (ReliefWeb, 2010). Various stakeholders among them Community Based Organization (CBOS), Non-Governmental Organizations (NGOs), Churches and the Government have established CDD programs to help the youths in Kibera.

The International Labour Organization (ILO, 2010) report states that the government of Kenya has shown support for people with disabilities. It has adopted a number of laws and policies pertaining to people with disabilities, including their right to productive and decent work and basic services. The Persons with Disabilities Act (2003), is a comprehensive law covering rights, rehabilitation and equal

opportunities for people with disabilities. It creates the National Council of Persons with Disabilities as a statutory organ to oversee the welfare of persons with disabilities. The Law also requires that both public and private sector employers reserve 5 per cent of jobs for disabled persons.

National Development Plan (2002 - 2008), focuses on strengthening vocational rehabilitation centers for people with mental and physical disabilities and affirmative action in areas of employment, vocational training and education.

Vision (2030), provides a long-term development framework and initiatives aimed at sustaining rapid economic growth and tackling poverty. Under Vision 2030, Kenya hopes to become a globally competitive and prosperous nation with a high quality of life by 2030. Evidence shows that despite the support offered by the stakeholders, the physically challenged youths are still lavishing in poverty, poor health and illiteracy (People of Kibera, 2010).

According to Haider (2012), there are over 500 registered CBOs in Kibera yet many youths remain underemployed, underserved and cannot access adequate social services. Nevertheless, National Council for Churches in Kenya (NCCCK, 2010) report applauds these efforts arguing that youths in Kibera are now exposed to various organizations. However, the number of physically challenged youths involved with and benefitting from these organizations is still very low. Lenka (2007) observes that the total number of physically challenged youths active in CDD is less than one percent of the total population in Kibera.

In fact, physically challenged youths are not only still stigmatized in Kibera, but also in all regions in Kenya, particularly in informal settlements. A greater population of physically challenged youths in Kenya lives in informal settlements where life is unbearable for them. In these settlements people earn less than a dollar a

day. The houses are dominated by tin and mud shanties with very limited access to clean water, sanitation and electricity. Because of the limited access to these amenities, the physically fit and swift are able to get hold of them ahead of the physically challenged persons making their lives even more strenuous (DIESK, 2015).

Although physically challenged youths basically have the same needs as any other people, their handicap makes it much more difficult to fulfill those needs, more so in situations of poverty and stigma. Moreover, they are seldom included in overall developmental programs, even the most basic ones like education and health (People of Kibera, 2010). A report by Kenya Disabled Action Network (KEDAN, 2006) indicates that more often than not, physically challenged youths are lowly regarded in the society and have to go through numerous hardships to gain recognition. They face negative perceptions and derogative language. It is for this reason that this study was conducted to establish how CDD home care programs have benefited physically challenged youths in Kibera informal settlement.

1.2. Statement of the Problem

In Kibera, several CDD home care programs are provided by various stakeholders especially the government and NGOs. They include visitation, counseling, disease management, training of caregivers, community health education, hygiene promotion and sanitation, (DIESK, 2015). However, how the physically challenged youths benefit from these programs has not been adequately evaluated (ReliefWeb, 2010). It has been hypothesized that the physically challenged youths in Kibera are at risk of ill health due to limited or lack of access to health, education, unsafe environment, social discrimination and exclusion, health, employment or rehabilitation. Further, they experience hardships as a result of inbuilt social, cultural and economic prejudices, stigmatization, abuse and violence (People of Kibera,

2010). This situation prevails in the very center where numerous organizations are carrying out community based relief programs in an effort to improve the lives of informal settlement dwellers. It is on this premise that the researcher designed this study to assess the contribution of CDD home care programs on the physically challenged youths in Kibera informal settlement.

1.3. Purpose of the study

Physically challenged youths in Kibera informal settlement face numerous challenges especially in accessing health facilities and services although there are many CDD programs in place. That is why this study purposed to assess the contribution of CDD home care programs on the physically challenged youths in Kibera informal settlement, Kenya.

1.4. Objectives of the Study

1. To describe the extent to which the CDD home care programs are accessible to the physically challenged youths in Kibera informal settlement.
2. To identify the benefits of community driven development home care programs towards the physically challenged youths in Kibera informal settlement.
3. To investigate the challenges facing physically challenged youths in accessing community driven development home care programs in Kibera informal settlement.

1.5. Research Questions

1. To what extent are CDD home care programs accessible to the physically challenged youths in Kibera informal settlement?
2. What are the benefits of community driven development home care programs towards the physically challenged youths in Kibera informal settlement?

3. What are the challenges facing physically challenged youths in accessing community driven development home care programs in Kibera informal settlement?

1.6. Significance of the Study

The study evaluates the contribution of CDD home care programs and proposes appropriate recommendations which may help the CDD programs to achieve their objectives.

The recommendations of this study are intended to fill the gaps have been overlooked by various stakeholders of the CDD home care programs in their approaches and interventions.

The study adds knowledge to the existing body of theories on CDD programs, and on the contribution of the theories models used in implementing and assessing the CDD.

Information gained from this study may help policy makers in formulating favorable policies that promote or increase the contribution of community driven activities especially health initiatives. In Kenya, few studies have been undertaken to find out the casual relationship between the CDD programs and community participation especially in reaching the targeted groups. The study may add important knowledge by contributing towards filling this gap.

1.7. Scope of the Study

This study was conducted in the Kenyan Kibera informal settlement situated approximately five kilometers from the central business district, in Nairobi County. This study area was selected because it is an informal settlement and was deemed relevant to the main topic of this discussion. The study sought to establish the accessibility if CDD health care programs to the physically challenged youths, their

benefits and also the challenges these youths were facing in accessing these programs. The study was carried out between the 2016 and 2017.

1.8. Limitations of the Study

The study anticipated meeting some shortcomings that may affect the contribution of the research undertaking.

The study did not cover all the variables that could be investigated under CDD home care programs and the physically challenged youths in Kibera informal settlement. The study assessed some variables that were manageable owing to the limited time allocated for study. Information obtained thus helped the researcher make specific recommendations that could be used by other researchers for further studies in the same area.

This study used questionnaire, interview schedule and observation. All tools for data collection could not be used because this called for a lot of time and resources and the researcher could not manage this. This challenge could not be overcome fully but the researcher tried to formulate objective oriented questions that enhanced reliable and valid data collected as much as possible.

1.9. Operational Definition of Terms

Accessibility: This refers to the design of products, devices, services, or environments for physically challenged persons. Good accessibility should ensure both “direct access” that is, unassisted and "indirect access" meaning compatibility with a person's assistive technology and ability. It can also be viewed in study as the ability to access and benefit from some system or entity, that is, the CDD.

Capacity building: This is enhancing the assets and abilities of the community. In the study, it meant enhancing the abilities of the physically challenged youths so

that they could contribute towards the sustainability and growth of health activities in the community. The characteristics of capacity building included the presence of leadership, participation, skills and sense of community togetherness. Community capacity could be enhanced through skill-building workshops that allowed members of the community to become more effective leaders.

Community Driven Development: This is a process that increases choices of life by creating an environment where people can exercise their full potential to lead and be productive and creative within their locality.

Education: This refers to information regarding issues of health, training and skills provided to the local people.

Empowerment: This is a community social process that allows people to gain mastery over their lives and their community through education, training and support. In doing so, power relations are transformed between communities, institutions, and governmental agencies. For example, communities may feel more empowered when they work together to relieve their suffering and strengthen their community assets.

Health Activities: These include all the activities carried out in the community through community driven development aimed at improving the health of the local people. They include activities like setting up infrastructure. That is, health centers, medicine, health equipment, for example wheelchairs and clutches). They also comprise disease diagnosis, prevention, control, treatment, health interventions (counseling, treatment, follow up), home based care, community health education and provision of actions geared toward providing clean water and sanitation.

Home Care Programs: This refers to the services and care provided to people in their homes to ensure their wellbeing through training of care givers, proper nutrition, hygiene, sanitation, medical care and education awareness.

Participation: This refers to the ability of youths to make and implement decisions by taking part in the community's initiative and leadership so as to bring change.

Physically Challenged: These are people who have bodily limitations arising from birth, accidents or sickness that deter them from accomplishing certain important tasks or activities. They include, those suffering from polio, the deaf, blind, people with partial visual and hearing disability, paraplegics and quadriplegics. According to the study, physically challenged youths of between the ages of 20 to 30 years were considered.

Informal Settlement: This is an area which is highly populated and the inhabitants live in deplorable conditions. These conditions are characterized by inadequate access to safe water, inadequate access to sanitation, poor structural quality of housing, overcrowding and insecure residential status.

Social Capital: These are community resources that exist via relationships formed between community members. Social resources such as trust, reciprocity, and civic engagement can connect individuals in a fragmented community across social boundaries and power hierarchies, facilitating community building and organization. CDD needs to enhance social capital through networking support in order to build social capital.

1.10. Theoretical Framework

While the social sciences identify different concepts of theory, it was taken in the study to mean generalizations about, and classifications of, the social world. It is a

method of linking a set of ideas in order to help us understand a particular issue or set of issues. This network of ideas provides us with a theoretical framework (or conceptual framework). Thomson (2000) explains that a theory is a framework for understanding. The study was based on both theoretical and conceptual framework. The theory adopted was Social Action Theory.

1.11. Social Action Theory

This theory was founded by Max Weber. He articulated that 'social action' is an action carried out by an individual to which an individual attaches a meaning (Weber, 1930). The theory of social action accepts and assumes that humans vary their actions according to social contexts and how it will affect other people. When a potential reaction is not desirable, the action is modified accordingly (MacKinnon & Heise, 2010). Action can mean either a basic action (one that has a meaning) or an advanced social action, which not only has a meaning but is directed at other actors and causes action (or, perhaps, inaction). Weber used the word 'agency', with the conceptions of social action with direct allusion in which circular relationship of cause and effect between structure and agency must exist to bring a social change (Weber, 1930).

The strength of this theory is that it is a community-oriented and its views are used to increase the problem-solving ability of entire communities through achieving concrete changes towards social justice. That is, it views individuals in a wider societal perspective. Individuals within communities come together to redress the imbalance of powers or privileges between a disadvantaged group and society at large (MacKinnon & Heise, 2010). Although this theory is applicable to many social issues, it, in particular, it can be used to redress home care challenges and problems that are disproportionately affecting certain communities or vulnerable groups in

communities like the deaf, lame, dumb, HIV/AIDs victims among others (Minkler, Wallerstein & Wilson, 2008).

The Social Action Theory was important in the study since it applies key concepts that are used within many community-organizing and community-building models and which the study endeavored to explore in an attempt to assess the contribution of CDD home care programs in Kibera informal settlement. These key concepts include empowerment, critical awareness, community capacity building, social capital/security, issue of selection of activities to carry out, and participation of the physically challenged youths and relevance of these activities to them. These concepts are defined under the definition of terms.

This theory further states that in order to make society more equal, actors must engage in taking social (as opposed to individualized) action from the side of the less equal. These actions bring about positive social change linked to the idea of equality. This is relevant since this study studied the physically challenged youths in Kibera. The physically challenged people are always excluded and stigmatized but the objective of CDD is to target this group since majority are poor. CDD aims at empowering the poor by looking to them as a resource. The study assessed how effective this has been achieved especially in matters to do with home care programs.

This theory was also important for the study because interpretivists or social action theorists advocate for the use qualitative research methods to gather an in-depth understanding of human behavior and the reasons behind such behavior (MacKinnon & Heise, 2010). The qualitative method employed in the study investigated the why and how of the physically challenged youths' decisions making, and not just what, where and when. This included the use of observation (either overt or covert), questionnaires and unstructured interviews.

1.12. Conceptual Framework

Under the conceptual framework, there are various CDD home care programs that, according to reviewed literature, should be provided by any CDD for it to effectively benefit the physically challenged youths. The study assessed the accessibility of various home care programs including training caregivers, hygiene promotion and sanitation, counseling, donation of food and medicine and making referrals. The activities were the independent variables needed to be provided to benefit the physically challenged youths. It was assumed that, in relation to Weber (1930), these factors were to act as an agent in bringing about social change.

Running of home care programs needs a process that is effective in order to benefit the target group. With the process, there are factors that include government policies and social-cultural that act as intervening variables in the process of the implementation of CDD home care programs. The physically challenged youths are part of the whole process of implementation. They are provided with the education and training necessary so that they can be able to participate in the process. For this to be achieved the activities must be accessible to the youths or the youths should be facilitated to access so that they can share in implementation and in long run, benefit in one way or the other.

This means that effective CDD home care programs must facilitate education awareness, be accessible and participatory. Proper implementation enhances involvement and the desired objectives are realized. This will bring various benefits including but not limited to improved living conditions and health outcomes, for example, wellbeing. The Social Action Theory states that ‘social action’ is an action carried out by an individual to which an individual attached a meaning. CDD must provide a background where the physically challenged youths can discover

themselves, their plight and need for change and at the same time be given opportunities to engage in that change.

Independent Variables

- CDD Home Care Programs**
- Training caregivers
 - Hygiene promotion and sanitation
 - Counseling
 - Donation of food and medicine
 - Making referrals

Dependent Variables

- Benefits of CDD Home Care programs**
- Improved living conditions
 - Health outcomes e.g. well being
 - Financial assistance
 - Participation in decision making

Intervening Variables

- Challenges Facing CDD Home Care programs**
- Poverty
 - Lack of transport
 - Inadequate infrastructure
 - Financial constraints
 - Lack of education awareness

Figure 1.1 Conceptual framework
(Source: Researcher, 2016).

CHAPTER TWO: LITERATURE REVIEW

2.1. Introduction

The literature reviewed in this section specifically touches on physically challenged youths only and CDD driven home care alone. It also however captures a wide range of literature on the role of CDD in meeting its main objective of reaching the target group particularly the youths. The literature unveils the participation of poor youths in various CDD programs and activities and their contribution in general. It is also important to note that CDD home care programs are not independent processes but involve various interrelated activities as well. These are education, water and housing infrastructure. This justifies the scrutiny of a wide variety of literature to address such interrelated factors. This section therefore covers the following topics: the concept of community driven development and contribution of community driven health activities, the role of youths in CDD home care programs, reflection of Kibera informal settlement and knowledge gap.

2.2. Reflection of Kibera Informal settlement

Kibera's history goes back to 'colonial period' when the urban layout was based on government-sanctioned population. This was the era of racial segregation that separated people into the enclaves for Africans, Asians and Europeans. As an informal settlement, Kibera dates back to the 1920s' when the British colonial government decided to let a group of 'Nubian soldiers from Sudan to settle on a wooded hillside outside Nairobi. The British colonials then failed to repatriate the Nubians to their country or to compensate them with land title deeds to these acquired lands from the Kenyan people. Nubians built homes, and set up businesses while they were still squatters with no legal rights and they called the place Kibera, meaning 'forest' (BBC, 2009).

Kibera in Nairobi is the largest informal settlement in Kenya, and the second largest in Africa. Kibera covers an area of 256 ha and is home to approximately 800 000 people, a quarter of Nairobi's population (Kaiganaine, 2009). The overcrowded urban area has a population density roughly 30 times that of Manhattan (People of Kibera, 2010). The people of Kibera are mostly tenants, and young migrant workers who have been attracted to the city in search of work and form the majority.

Despite this, there is widespread unemployment, 80% among the youth (People of Kibera, 2010). Housing shelters are of low quality, temporary construction materials. Households commonly share a room of 3 by 3 meters. Water and sanitation infrastructure is extremely poor, with open sewers and contaminated water pipes being the norm. There is no formal system for waste management. There is virtually no engineered road, pavement and transport infrastructure. Electricity connection to houses is rare, and the power connections that do exist are often tapped into illegal connections. Volatile food prices due to drought, floods, famine and political unrest caused Kibera to be declared in a state of prolonged food crisis in June 2009 (ReliefWeb, 2010).

Kibera's land is officially government-owned and the residents are squatters. Insecure tenure means tenants and structure owners (like landlords but not land-owning) are in a vulnerable situation. Tribal tensions and poor policing contribute to insecurity and sometimes tense community cohesion. There are high rates of drug and alcohol abuse. Child abuse is also not uncommon. Standards of health are low due to high incidences of water-borne and vector-borne diseases, such as malaria and HIV/Aids. It is estimated that there are more than 50,000 Aids orphans living in Kibera. Access to health care, clean water and sanitation infrastructure, education, security and other public services is very poor in Kibera (ReliefWeb, 2010).

Kibera, the largest informal settlement in Nairobi, sits on the tributaries to the Ngong River and Nairobi Dam in the centre of this rapidly urbanizing city. The lack of water, sanitation and solid waste infrastructure makes the settlement a highly polluted environment that employs its main water courses as a form of conveyance for polluted rain water, human and domestic waste. There are overwhelming health, economic and social effects on the lives of the communities that co-exist with these watercourses which go on to transport severe pollution, waste and flooding downstream into the eastern reaches of the Nairobi River basin (People of Kibera, 2010).

Despite the lack of basic needs and services, Kibera is often regarded as a beacon of hope for youngsters of rural places to earn a living, enabling them to send remittances back home to their villages. Kibera offers affordable accommodation in a location that is well connected to the city centre. With that there is the opportunity of better access to education and more lucrative employment than back home in the village. There is a good sense of community and a thriving informal economy, but the majority of residents are living in poverty, with 60% of the population earning less than US\$1 per day (People of Kibera, 2010). However, there are also some relatively wealthy residents, owing to successful business and revenue from property rental. Although a significant proportion of Kibera's residents are content with what Kibera has to offer, they would of course welcome improved living conditions providing they remain affordable.

A casual look survey through Kibera informal settlement reveals that there is no easily visible government provision of basic services. However, there is a feeling among the population that it is the government's responsibility to provide such facilities to its people. A lack of confidence in the government due to lack of

transparency and widespread corruption in municipal systems has caused many informal settlement dwellers to resort to ‘making do’ with their situation or turning to CBOs for support to reprove their situation. Some people lack the motivation and empowerment to object, others fear the consequences of unaffordable fees if services are improved (Cronin & Guthrie, 2011). Even though there is a growing empowered youth movement across Kibera who are now campaigning for their rights, mobilizing the communities and resources as well as creating education awareness, many more are still lavishing in poverty and they cannot access basic necessities like health, education and better housing.

2.3. The Physically Challenged Youths

Worldwide, there are between 180 and 220 million youth with disabilities. Eighty percent of disabled youth live in developing countries, and therefore have even less access to education, health care, jobs and general rights (Sommers, 2010). Disabilities include physical, mental disabilities or mental illness. Many youth live normal and stable lives. However those with disabilities may experience more obstacles than those without due to potential limitations, those created by physical limitations and social limitations (World Bank, 2015).

Being a youth with a disability can create a financial burden on the individual, as well as to those who provide care and support. Their families also incur extra direct and indirect costs. Families with disabled youth spend money on health care, therapeutic, behavioral, or educational services; transportation; caregivers; and other special needs services (Haider, 2012). Indirect costs include reductions in parents' ability to work because of additional time that is required to care for a child with a disability combined with high costs or unavailability of adequate child care. These costs alone can decrease the financial stability of a family. Having a child with

disabilities increases the likelihood that the mother (or less often the father) will either curtail hours of work or stop working altogether (Un-Habitat, 2011).

Eighty percent of people with disabilities live in resource-poor societies. They are often considered to be a burden, and carry a very negative social stigma (Cronin & Guthrie, 2011). Many are unable to contribute to society, attend school, or find work. In the justice system, youth are disproportionately male, poor and have significant learning or behavioral disabilities to the extent that they require services listed under the idea. For example, There are 1,345,000 youth incarcerated in the U.S system, and 30% - 70% of these individuals are youth with disabilities (World Bank, 2015).

2.4. Community Driven Development

To alleviate problems of over reliance on central governments as the main service providers, CDD programs were launched by the World Bank to improve the accountability and services in key areas. These programs were designed and implemented in a way that promoted equity and inclusiveness, efficiency and good governance. By effectively targeting and including the vulnerable and excluded groups, especially the poor and physically challenged as well as allowing communities to manage and control resources directly, it was evident that CDD programs could allow poverty reduction projects to scale-up quickly, especially rural population (Mansuri & Rao, 2004).

CDD programs historically grew out of situations of crises (financial, disaster, conflict) or when governments usually newly installed administrations sought a different mode of service delivery (Asundi, 2008). Existing systems were considered ineffective in engaging citizens or delivering services in an effective manner (Wrong, 2012).

CDD aims at enhancing efficiency through responsive allocation of resources, reduced corruption and misuse of resources, lower costs and better cost recovery, better quality and maintenance, greater utilization of resources, while fostering community's willingness to pay for goods and services. CDD also enhances good governance by promoting greater transparency, accountability in allocation and use of resources because the community participates in project decision-making processes. Some of the principles of CDD such as participation, empowerment, accountability, and non-discrimination are also worthy ends in themselves (Asian Development Bank, 2011).

One argument in favor of CDD is that it can improve targeting, that is, identify the intended category of people and focus on them only. This is because CDD programs make better use of local knowledge to define and identify the targeted groups (Mansuri & Rao, 2004). A study in Senegal shows that a CDD program increased the access by physically challenged to clean water and health services and increased their consumption expenditures (Arcand & Bassole 2007). This study also noted that local leaders, like chiefs and local governments, played a major role in the placement of CDD programs. Several studies have also shown that CDD programs have been effective in targeting the physically challenged in communities with strong local institutions and fairly homogeneous socioeconomic characteristics (Bardhan & Mookherjee, 1999; Conning & Kevane, 2002; Platteau, 2004; Galasso & Ravallion, 2005).

CDD gives control of decisions and resources to physically challenged community groups. These groups often work in partnership with demand-responsive support organizations and service providers, including elected local governments, the private sector and NGOs. Their goal is to provide social and infrastructure services,

organize economic activity and resource management, empower physically challenged people, improve governance and enhance security of the poorest and the physically challenged in the community. Support to CDD usually includes strengthening and financing accountable and inclusive community groups or CBOs, facilitating community access to information through a variety of media, and increasingly through information technology; and forging functional links between CBOs and formal institutions. It also includes creating an enabling environment through appropriate policy and institutional reform, often including decentralization reform, promotion of a conducive legal and regulatory framework, development of sound sector policies, and fostering responsive sector institutions and private service providers (Dongier et al., 2002).

CDD is an effective mechanism for resource mobilization and capacity building. This is in terms of participation and settlement, complementing market- and state-run activities by achieving immediate and lasting results at the grassroots level. CDD also increases the efficiency and contribution of development efforts in areas of education, health and poverty reduction (Dongier et al., 2002). CDD programs work by providing poor communities with direct funding for development with the communities then deciding how to spend the money. Moreover, the community plans and builds the project and takes responsibility for monitoring its progress while benefiting from the services of the projects (Mansuri & Rao, 2004).

Wrong however notes that, what is equally important in looking at CDD programs design are the many assumptions/risks involved in this approach. There are risks that the technical assistance and capacity building may not be sufficient at the local level to facilitate involvement of the physically challenged and effective management of resources. Or that decision making can be done in a participatory

manner that allows for physically challenged representation and voice rather than elite capture or further reinforcement of existing patronage systems. All these design risks must be taken into account when designing and implementing a CDD program. The achievement of project objectives and real reform will not happen without numerous factors being in alignment, including many areas that are outside the control of communities and the project itself (Wrong, 2012).

Because CDD devolves responsibilities and resources to the local level, activities can occur simultaneously reaching a wide range of people even the physically challenged without being constrained by a central bureaucracy. When physically challenged communities are trusted to drive development and are given appropriate information, support, and clear rules, a system can be put in place not to provide for poor people, but to facilitate their active and ongoing role in rolling out poverty reduction efforts through active participation in the entire process.

Ravallion (1999) argues that CDD ensures that inclusion is enhanced and scarce public resources target the physically challenged groups that most need them. In the absence of reliable information to allow means testing (such as for household income), involving communities directly in the targeting process can improve efforts to target the poorest and most marginal individuals and groups.

On the same note, Sen (1999) opines that CDD empowers physically challenged people. The objective of development is not merely to increase incomes or to improve poverty indicators, but also to expand people's real freedoms. These are the choices people make between different valuable beings and doings, such as being nourished, being educated, participating in public debate, or being free to walk about without shame. Commenting on the same, Bardhan & Mookherjee (1999) observe that physically challenged people are often viewed as the target of poverty reduction

efforts. CDD, in contrast, treats poor and physically challenged people and their institutions as assets and partners in the development process. Experience has shown that, not only do physically challenged groups have greater capacity than generally recognized, they also have the most to gain from making good use of resources targeted at poverty reduction providers (Dongier et al., 2003).

Dongier et al. (2003) add that targeted community-driven approaches devolve control and decision-making to the physically challenged, which empowers them immediately and directly. While clear rules, transparency, and accountability are important safeguards to prevent corruption or the capture of community resources by elites, the speed and directness with which CDD empowers the physically challenged people is rarely matched by other institutional frameworks for poverty reduction.

Control over decisions and resources can also give the physically challenged the opportunity to build social capital (defined as the ability of individuals to secure benefits as a result of membership in social networks) by expanding the depth and range of their networks. This kind of network expansion, which is critical for long-term growth and development, also has positive short-term effects on welfare and risk exposure. Several studies conducted in Bolivia, Burkina Faso, Indonesia, and Tanzania found that social capital has a positive effect on household welfare, and that the effect was several times greater than that of human capital alone (Grootaert 1999a; Grootaert & Narayan 2000; Grootaert, Oh & Swamy, 1999).

Moreover, Asudi (2008) comments that, strengthening local associations that are inclusive can increase physically challenged youths' voice in local political processes and governance. In Kenya for example, physically challenged leaders of community groups formed and strengthened with the help of NGOs are increasingly being elected to leadership roles in local government bodies.

2.5. Contribution of Community Driven Home Care Programs

Community-driven development (CDD) gives control of decisions and resources to community groups. CDD treats poor people as assets and partners in the development process, building on their institutions and resources. Support to CDD usually includes strengthening and financing inclusive community groups, facilitating community access to information, and promoting an enabling environment through policy and institutional reform. Experience demonstrates that by directly relying on poor people to drive development activities, CDD has the potential to make health provision efforts more responsive to demands, more inclusive, more sustainable, and more cost-effective than traditional centrally led programs (UNICEF, 2012). CDD fills a critical gap in health promotion efforts, achieving immediate and lasting results at the grassroots level. With these powerful attributes, CDD can play an important role in strategies to enhance the provision and accessibility of home care health services to the vulnerable people (Grootaert & Narayan, 2000).

In many informal settlement settlements, accessing health care has been particularly problematic for children and young people. Clinics and hospitals are often located outside of informal settlements, making the financial and opportunity costs of visiting a clinic high, especially for people who are physically challenged. NGOs and CBOs often find themselves filling in the gaps in the health care system, providing a wide range of health delivery services, particularly for child and maternal health. Research in Kenya found that out of 503 health care facilities identified by informal settlement residents, 1% were public, 16% were private non-profit and the remaining 83% were private for-profit facilities (UNICEF 2012).

CDD are uniquely positioned to effectively monitor and document the experiences of key affected people and communities, the quality and reach of services

and the policies that are being implemented at community level. Monitoring and documentation will also contribute to engaging and empowering community members, who often feel they have little or no role in planning and design of programs in which they are expected to play a role, for example in disease prevention or community health care (Grootaert & Narayan, 2000).

However, evidence on the CDD health outcomes among informal settlement dwellers reveals that residents are often found to be faring poorly with regard to reproductive health outcomes in sub-Saharan Africa. Youths in particular are among those most vulnerable besides women and children to the environmental and physical conditions within informal settlements, often experiencing severe issues with regard to access to health care and immunizations, morbidity and mortality, nutrition, food security, sexual and reproductive health (Omran, 1971).

On the other hand, elite capture in which a few individuals in a local community have disproportionate political or economic power and dominate community based planning, governance, and benefits from community-based programs remains one of the major challenges of the CDD approach (Dasgupta & Beard 2007). Studies have identified cases of elite capture and failure to empower local communities to participate in development programs (Platteau, 2004).

Platteau (2004) observes that elite capture is a common problem for many donor-funded projects that support local communities with weak local institutions. Based on this observation, Dasgupta & Beard (2007) conclude that there is a difference between elite capture and elite control; in the second case, only decisions are controlled by elites, but resource allocation is targeted to the poor. Heterogeneity also leads to elite capture and ineffective focus on the poor. Conning and Kevane (2002) observed that the ability of CDD programs to target the poor in heterogeneous

communities with high social inequality was worse than that of externally managed programs. The opposite was true in egalitarian communities with open and transparent systems of decision making.

CDD also has limitations particularly when it comes to implementing large scale investments or in particularly complex urban environments which may, for example, require resettlement like Kibera and Mathare informal settlement. According to Baker, improving entire road networks, drainage networks, or the provision of utilities across the country cannot be effectively planned and implemented at the community level. Areas that are at particularly high risk to climate and natural hazards may require complex infrastructure planning or resettlement decisions which are beyond the scope of only the community. In addition, fundamental to the CDD approach is the participation process which can be substantially more time consuming than Government led upgrading programs (Baker, 2003).

A survey by Research International (2011) revealed that Kibera informal settlement is endowed with a range of facilities and amenities such as schools, health facilities, government offices, water points, shops, roads, telephones etc. This study confirmed that while such infrastructures are available, many of them are not adequate while others are not even accessible to the residents. Despite the high demand of these infrastructures, some are still underutilized due to the existence of social and economic costs. Most of them were also reported to be in poor conditions.

The literature by UNICEF (2012), Grootaert & Narayan (2000), Omran (1971), Platteau (2004), Dasgupta & Beard (2007) and Baker (2003) shows that CDD play a vital role in benefiting the youths. The authors conclude that effective CDD facilitates access to information of the local poor population, promote an

enabling environment, provide accessibility to health facilities and medical services, carry out research on the need of the people and provide the desired need to the same population. Moreover, effective CDD must carry out monitoring of its activities, set up accountable structures and improve on infrastructure like road network, drainage and provide utilities. This study aimed at finding out whether the CDD had provided these services to the physically challenged youths in Kibera informal settlement.

2.6. Role of the Physically Challenged Youths in CDD Health Care Programs

United Nations categorize the youths as those between the ranges of 15-24 years (World Bank, 2012). This is the time when important foundations are laid for learning and skills development. In this period, people establish their identities as individuals by moving from dependence to independence. In this stage of life, people are supposed to enhance the human capital they need to move themselves and their families out of poverty and lead to better and more fulfilling lives. While they begin to interact independently with the broader community, they start to be heard and recognized outside their families.

The chance to participate in the community development is one of the most important protective factors for the physically challenged youths (World Bank, 2005). The desire to create change in surrounding environments is natural to them and community driven development has great potential to them as it gives them this opportunity. The benefit is mutual; when the physically challenged youths (put their vast energy and talents into the support of their community, it thrives and on the other hand, the young gain self-esteem (World Bank, 2005).

The physically challenged youths have strong views and impressive community level accomplishments in improving governance, reaching inclusive societies and reducing tension (World Bank, 2015). The World Bank's CDD Unit sees

the community driven development approach as an important means to enhance the inclusion of the increasingly alienated the physically challenged youths in development programs. These programs present an instrument able to: improve the physically challenged youths access to economic/livelihood opportunities enhance their participation in decision making, provide spaces for sports and recreation, create conditions for social integration of youth and enhance social capital (World Bank, 2005).

The World Bank proposes a Youth Development Global Solutions. This suggests creating a new collaborative team that would work across global practices and country units on the challenges facing young people around the world. These would include issues such as the physically challenged youths engagement and participation, economic opportunities, youth services and jobs. Such a team would make young people a more visible development priority at the World Bank at a time when youth is shaping up to be a significant aspect of the post 2015 development agenda (World Bank, 2015).

In enhancing the contribution of CDD home care programs, the important roles that the physically challenged youths can and should play in achieving better health outcomes should be emphasized. Youths ability to deliver services within communities and with regard to their ability to affect the broader determinants of health that often outweigh any impacts intended through improving health service access and use should be highlighted (WHO, 1986). These determinants affect people's mental and physical health and wellbeing at many levels. The physically challenged youth players are in a unique position to work on these issues alongside health, social welfare and other actors and systems (Baker, 2007).

Development of the physically challenged youths' capacity is important for community leadership and progress towards community health goals. The physically challenged youths are a central resource for community organizations and groups, including employees and volunteers and members of community groups and networks (World Bank, 2005). When included in CDD programs, they provide advice and guidance; act as influencers, enable access to various sectors of the community; and contribute to activities such as fundraising, or supporting individuals and families and even themselves. Recruitment, retention and management of youths are key aspects of CDD strengthening and leadership for advocacy, but it is also essential to ensure that technical skills and experience are given high priority in order to assure program quality, achieve timely progress towards defined goals and build the evidence base for effective community contributions to health. The technical capacity of community the physically challenged youth actors is becoming increasingly important as combined strengthening of health and community systems and integrated service delivery is prioritized. This is in order to reach the Millennium Development Goals (MDGs), for example in disease integration, sexual & reproductive health and primary care in communities (World Bank, 2011).

However, the UN-Habitat (2003b) reports states that Kenya has 12 million youths (18-32 years) and statistics show that most of these youth face a lot of economic, social and political marginalization in society. For example, 67% of these youth are unemployed while 2.3% of these are physically challenged. Additionally, the report further illustrate that due to their economic inabilities, once in the cities, the youth tend to live in informal settlements since it provides low cost life as they try to position themselves in the city. Living in these locales, youth are not provided with

social amenities such as sanitation services and social institutions. This is despite informal settlements playing a great role in the running of the city.

Reviewed literature of World Bank (2006a), Baker (2007), UN-Habitat (2003b) and World Bank (2011), reveals that CDD is a fundamental plan that focus on empowering the physically challenged youths to make decisions about their investment needs and priorities. The benefits are intended to improve equity and inclusiveness of all youths particularly the poor and physically challenged. The authors propose that CDD provides an approach to both alleviate the physically challenged youths from issues of urban poverty such as unsafe housing, poor infrastructure, and utilities. CDD also promotes the intangible elements of collective community empowerment, strengthens social networks and promotes more open communication between communities and government institutions.

2.7. Knowledge Gap

With estimates of the population of young urban dwellers exceeding 1 billion (Haider, 2012), the future of physically challenged youths in Kibera is central to development. It is true that physically challenged youths in other urban areas of Nairobi, may benefit from a so-called urban advantage, with access to better service care including schooling, high-quality healthcare. However, such opportunities are not within the reach of physically challenged youths living in Kibera. Risks to health outcomes are often higher and more severe for physically challenged youths living in urban informal settlements or informal settlements. The physical conditions of informal settlements pose a significant threat to health and well-being, particularly to the physically challenged groups. The physically challenged are often vulnerable to negative health outcomes resulting from the stresses and hazards of the pathetic

conditions surrounding them in informal settlements. This challenge has not been adequately addressed.

Physically challenged youths living in Kibera are exposed to physical conditions and environmental contaminants that pose severe risks to their health and safety. Coupled with reduced access to preventative and curative healthcare, these physically challenged youths are often reported to have worse health outcomes and lowered rates of survival. Generally, young people in Kibera have particularly high rates of illness due to pneumonia, acute respiratory infections, and diarrhoea disease as compared to other urban and rural areas (People of Kibera, 2010). Factors influencing the likelihood of incidents of illness among Kibera youths and children include their age and employment status. It also includes maternal characteristics such as migrant status and educational attainment. Environmental factors that influence occurrences of illness are such as waste management procedures, drainage, water used and the type of toilet available to the household bearing in mind that most residents in Kibera use flying toilets (Kaiganaine, 2009).

Usually, youths dwelling in Kibera informal settlement often experience harsh deprivation and social exclusion. They live on the margins of urban life with little access to the advantages and benefits of city living. As they are home to a significant - and growing - number of children and youth, Kibera informal settlement is in need of youth-focused interventions to improve the lives of youths residing therein. This explains why several CBOs and NGOs have chipped in and employed youth-centered approach to Kibera informal settlement interventions, aimed at improving youths' rights, well-being, and participation in urban life, which is actually an appropriate method (ReliefWeb, 2010). However, how effective this had been especially in reaching the physically challenged youth was a concern of this study.

The literature reviewed exhibits various roles and objectives that any productive CDD should strive to achieve in order to effectively meet its mandate. It is then important for all informal settlement development initiatives to work towards providing health services and other necessities to the physically challenged. However this is not possible without a total participation of the target group within a well-defined framework that guides such a process. From the foregoing, adequate health services must be treated as a right for all to facilitate protection freedom of the informal settlement dwellers from diseases and other challenges associated with health. Health provision to the physically challenged youths should then be based on a rights approach to holistically address the expressed health needs of the physically challenged youths dwelling in informal settlements.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1. Introduction

This chapter discusses the research methods and instruments that were used by the researcher in data collection and analysis. The chapter has the following sections: research design, site of the study, study population, sample size and sampling techniques, research instruments, validity and reliability, data collection process, data analysis and logical, ethical and community considerations.

3.2. Research Design

The present study utilized descriptive survey research design to investigate the contribution of Community Driven Development home care programs in Kibera informal settlement. Survey research provided the researcher with a methodology for asking people to tell researchers about themselves, by the use of the questionnaire. The study employed both qualitative and quantitative methods of data collection.

The advantages of combining qualitative and quantitative techniques in research are given by Odera (2003), who points out that these methods triangulate and complement the results obtained from each of these approaches and minimizes the methodological problems that result from the weaknesses inherent in any of the research designs. Qualitative design serves to clear ambiguity and verify the results obtained from the dominant quantitative design.

This study focused on the daily life of physically challenged youths in Kibera informal settlement and how they coped with their daily life as they tried to access the health services. A qualitative approach was chosen because the focus involved an interpretive approach in which the aim was to understand the meaning the different health experiences had on the physically challenged youths in Kibera. The intention

of a qualitative approach was to develop a fuller understanding of the phenomenon under study.

Furthermore, a qualitative study gave access to people's own experiences and the meaning they place upon these. It offered a method to explore people's experiences, their views of the different aspects in their lives, and how a phenomenon arose. In addition, a qualitative study is useful where the phenomenon is sensitive and delicate and therefore difficult to investigate (Ryen, 2002). A qualitative approach in this study thus involved structured conversations, collecting data which was verbal or metaphorical. This implied an interactive approach as communication between interviewer and informant was fundamental. In that matter trust and respect were important factors in the relation between the interviewer and the informant, that is, the physically challenged youths in Kibera. Quantitative approach involved the collection of numerical data in order to explain, predict and analyze the phenomena under study, data analysis being mainly statistical.

3.3. Locale of the Study

Kibera is located 5 kilometers South East of Nairobi's central business district. It lies at an altitude of 1,670m above sea level, latitude 36 degrees, 50° east and longitude 1 degree, 17° south about 140 km south of the equator (Karanja et al, 2002). The growth of Kibera as an informal settlement is closely connected with Nairobi city's phenomenal growth. Kibera in Nairobi is the largest informal settlement in Kenya, and the second largest in Africa. Kibera covers an area of 256 ha and is home to approximately 800,000 people (Kaiganaine, 2009) a quarter of Nairobi's population. Life in Kibera is a daily struggle with poverty, crime, and diseases. Many Kibera residents work in Nairobi's industrial sector for wages near € 2 per day. The Kenya to Uganda railway passes through Kibera. Living structures are constructed

haphazardly on every available space leaving narrow alleys which serve as open sewers and footpaths (Karanja et al. 2002).

Kibera is divided into thirteen official villages, each with its own village elder. They include Olympic, Gatwekera, Kambimuru, Kianda, Kisumu Ndogo, Laini Saba, Lindi, Makina, Mashimoni, Raila, Silanga, Soweto East and Soweto West. The living conditions within Kibera are different depending on the area. There are very poor areas and there are estate areas with up to four storey houses, but the majority is simple mud houses with a tin roof. Except for the few roads around the estate areas all the tracks between the houses are mud. Improvements are made by people's or NGO's efforts (GOK, 2005).

Kibera was chosen to be the area of study because being an informal settlement; it is home to most poor and physically challenged youths. There is also presence of Community Driven Development programs.

3.4. Target Population

A population refers to an entire group of individuals, events or objects that have common observable characteristics (Orodho, 2003). A population describes the parameters whose characteristics the research will attempt to describe. This study targeted the physically challenged youths of Kibera informal settlement. By the time of the study, there were about 3,312 physically challenged youths in Kibera informal settlement (Population and Housing Census of Kenya, 2009; Kaiganaine, 2009).

3.5. Sample Size and Sampling

The study targeted physically challenged youths in Kibera informal settlement. According to the estimates of Population and Housing Census of Kenya (2009), there are about 3,312 physically challenged youths in Kibera out of which a sample was selected. According to Kothari (2004), the size of sample should neither be

excessively large, nor too small. It should be optimum. An optimum sample is one which fulfills the requirements of efficiency, representativeness, reliability and flexibility. While deciding the size of sample, researcher must determine the desired precision as also an acceptable confidence level for the estimate. The size of population variance needs to be considered. In case of a larger variance a bigger sample is needed. Costs too dictate the size of sample that we can draw. As such, budgetary constraint must invariably be taken into consideration when we decide the sample size. This study therefore selected a sample with 5% precision (Yamane, 1967).

$$n = \frac{N}{1+N(e)^2}$$

$$n = \frac{3312}{1+3312(0.05)^2}$$

$$n=357$$

Where; n = Sample size

N = Population size

e = Desired marginal error

1= Constant

The size of the population and amount of error determines the size of the selected sample. This formula helped the researcher determine (with 95 percent certainty) what the results could have been had the entire population been used. A sample of 357 respondents was taken for this study. This is because the target population was high and owing to the challenges faced in dealing with physically challenged people in terms of language barrier, accessibility, costs and congestion of the informal settlement. It was actually hard to access all the places since Kibera infrastructure is congested and one was always subject to attack by criminal gangs.

Since the population was high, sampling was important to help in getting representatives from Kibera informal settlement. To enhance representativeness, the

sampling frame covered the 13 official villages of Kibera. They included Olympic, Gatwekera, Kambimuru, Kianda, Kisumu Ndogo, Laini Saba, Lindi, Makina, Mashimoni, Raila, Silanga, Soweto East and Soweto West.

The sampling method that was used was stratified and snowball sampling. Since it was hard to determine the number of physically challenged persons in each village in Kibera, the 13 villages were treated as individual stratum with independent population so as to ensure equal probability of being studied. For the first 6 villages visited (Olympic, Gatwekera, Kambimuru, Kianda, Kisumu Ndogo) 28 respondents were picked from each of the villages. Then from the remaining 7 villages (Laini Saba, Lindi, Makina, Mashimoni, Raila, Silanga, Soweto East and Soweto West) 27 respondents were picked from each village. This enhanced equal representation of the geographically based villages to avoid biasness in a bid to arrive at the sample population of 357.

In every village, the researcher identified one physically challenged youth first. The key respondents (physically challenged youths) were selected on basis of their age (20-30 years) and those married or single with children but who were still within that age category. The youth was then requested to identify another physically challenged youth in the same village. The process continued until the desired sample (27 or 28) had been reached in one particular village before proceeding to another village. This was done in every village in Kibera until the whole area was covered. During questionnaire dissemination, the researcher interviewed two respondents from each village. The first and last respondent to fill a questionnaire in each village was interviewed bringing to a total of 26 respondents. Those interviewed also filled the questionnaire as well since interviews were conducted for argumentation purposes.

3.6. Data Collection Instruments

The study used both primary and secondary data. The main method of data collection was by the use of a structured questionnaire, interview schedule and observation. These methods helped collect both qualitative and quantitative data to enhance triangulation. Data collected from each method also helped to validate the other. These methods enabled the researcher get original views from the respondents. They bridged the hypothetical gaps in secondary sources to reach more informed conclusions. Primary data provided an opportunity to get firsthand information as well as experiences and related to bodily expressions, feelings and attitudes. Secondary sources were also used since they were important too. Despite the loopholes in secondary sources such as outdated data and lack of focus in the study's area of interest, they formed the basis of the research and actually influenced the researcher's interest to carry out a field study. In fact, through secondary information, the researcher was able to learn about the diversity and complexity of Kibera informal settlement and this enabled her prepare herself appropriately.

3.6.1. Questionnaire

A self-structured questionnaire was main method of data collection. This provided the researcher with an opportunity to observe both the subjects and the situations during data collection exercise. It also enhanced flexibility inherent in the questionnaire in that, questions were clarified where need arose and additional information was requested through the open ended questions. The questionnaire solicited for information first on bio data including age, marital status, number of people sharing a room, educational level and occupation. The researcher visited the respondents in their homes, places of work or at their place of relaxation so as to get

in-depth information and knowledge of the situation of physically challenged youths in Kibera and the CDD home care programs available.

3.6.2. Interview Schedule

Interviews were conducted with two respondents from each village in Kibera implying that 26 respondents participated. Those interviewed also filled in the questionnaire. The researcher used an interview guide which was designed to enable a deep insight into issues already raised in the questionnaire. The interviews were held in a language which the respondents understood better, that is, Kiswahili. The interviewing process was tape-recorded and subsequently transcribed whilst translating the results from Swahili to English. It was the responsibility of the field researcher to make sure that the statements and terms used by the interviewees were put into accurate English terminology. The analyzing process was done through an approach of qualitative content analysis so as to compare and complement the findings with the results of the questionnaire survey.

3.6.3. Observation

This consisted of detailed description of the nature of CDD health activities carried out in Kibera informal settlement and the environment in which the physically challenged youths were in. Therefore, as the researcher was moving around Kibera informal settlement distributing the questionnaire, she was exploring the health infrastructure and the activities carried out aimed at improving the health conditions of the informal settlement dwellers. The information which was acquired from observation was used to augment the study findings from the interview schedule.

3.6.4. Secondary Data

Secondary data was used to complement the data from primary sources. The researcher used extensive literature written about Kibera and other related

organizations to complement the data collected. Such literature was from sources such as, journals, articles from the website and books.

3.7. Validity and Reliability of the Instruments

Validity is the most critical criterion and indicates the degree to which the instrument used measures what it is supposed to measure. For example, the extent to which a measuring instrument provides adequate coverage of the topic under study, which will be determined by experts (content validity) and extent to which the instrument is relevant, free of bias, reliable and available (criterion validity) (MacGarty & Haslam, 2003).

To achieve validity of research instruments, the considerations of Kothari (2004) were considered. First, it was ensured that the research instruments were adequate in scope and coverage, by including all the issues to be investigated. The researcher made sure that questions posed in the research instruments covered all the aspects that were in the conceptual framework. These included factors to be assessed that measured the contribution of CDD home care programs. That is education awareness, participation, accessibility and benefits. The questions posed addressed all the objectives framed within the limits of the conceptual framework.

To attain reliability of the research instruments (MacGarty & Haslam, 2003) and reduce survey error (Dillman, 2000), it was ensured that the study population sample was broad enough. The respondents of the study included diverse categories of physically challenged youths in Kibera informal settlement. To make sure that the research instruments produced consistent results, the questions and instructions, including the layout, were made as clear as possible. This was achieved by pre-testing them (Birley & Moreland, 1998).

Pre-testing has always been highly touted as part of questionnaire design (Dillman, 2000). In pre-testing the research instrument, the researcher relied on 30n surrogate respondents from Mathare informal settlement for the purpose of refining the instrument. These respondents came from an area with similar characteristics as Kibera but they did not participate in the actual study. The suggestions provided by respondents were used to identify and change confusing, awkward or offensive questions. Pre-testing the questionnaire and interview schedule was intended to give the researcher an opportunity to identify items that tended to be misunderstood by participants, or that did not elicit the information needed. Pre-testing also helped in identifying poor instructions and unnecessary and missing questions. Adjustment to the questionnaire was done based on the general reactions of the surrogate respondents to the instrument during the pre-test. A sample of 30 respondents was sampled to participate in the pre-test exercise (Amin, 2005).

3.8. Data Collection Process

For protocol and ethical purposes, the researcher obtained an introduction letter from the Department of Sociology in Kenyatta University before the actual data collection process. The researcher then presented her proposal and introduction letter to the Ethics Committee at Kenyatta University. She presented her proposal, introduction letter, identification card, passport photo and curriculum vitae, to the National Commission of Science, Technology and Innovation (NACOSTI) for her to get her research authorization letter and permit. She then proceeded to Nairobi County Commissioner for approval. From there, the researcher made appointments with local leaders of Kibera informal settlement so that appointments could be made for the data collection exercise to begin. The study mainly gathered primary data in order to answer the research questions raised in the study. However, secondary data was also

solicited where necessary. The semi-structured questionnaire was administered directly to the physically challenged youths in Kibera informal settlement in form of questions. The data collection exercise lasted for one month.

3.9. Data Analysis

Both qualitative and quantitative data was sorted, coded, and entered into SPSS version 21.0. Summary of descriptive statistics was generated to give an indication of the contribution of the CDD home care programs in Kibera. In-depth analyses were carried out in line with the objectives of the research. Data was first edited before being analyzed. Editing as a data management task helped increase data quality, facilitated coherence, checked completeness of data, ascertained consistency and instituted accuracy. It helped determine the usability of the field information in realizing the research objectives. Editing also facilitated signaling areas that needed modifications or clarifications. Data editing was also meant to make data analysis easy. Data analysis was done with the help of a research statistician. Data was added into various categories of the codified themes of a special summary sheet according to similarities and differences in responses from questionnaire. Finally, all the data from similar themes in the summary sheet was put together to arrive at final conclusions which were the basis of the research findings.

Descriptive statistics such as frequencies and percentages were used to analyze the data. The processed data was presented in pie charts and tables and explanations were given. Qualitative data from the open ended questions was coded manually following a coding frame, and analyzed following principles and processes of the thematic approach. Some of the qualitative data was analyzed qualitatively through thematic discussion. Both the statistical and thematic analyses were synthesized to derive key interpretations and conclusions based on the study objectives.

3.10. Ethical Considerations

Awareness of ethical issues in research protects the integrity of the researcher and ensures honest research results. Some of the ethical issues relate to both the researcher and the research subjects. They include avoiding plagiarism, misusing privileges, for example, using collected data to stigmatize or entrap somebody, and maintaining the confidentiality and privacy of the human subjects (Mugenda & Mugenda, 1999).

Community considerations comprised ensuring anonymity of respondents, ensuring validity and informed consent of the human subjects, avoiding embarrassing questions that may have caused psychological harm to respondents and concealing research respondents after completion of the research. Confidentiality of the respondents was strictly assured through concealing identity of all respondents.

Interviews at times trigger emotional reactions that would have been difficult to cope with for the informant when the interview was finished and they were left alone. The planning of the field work thus comprised a plan for taking care of informants that needed follow up and support after the interview. Arrangements were made so that the community groups could take care of such situations. In this way, the community was taken care of, emotionally and psychologically.

The community was considered in terms of ensuring that the researcher investigated the needs of the physically challenged youths in Kibera. This was by respecting their local culture and tradition. She observed the highest standards of safety for the respondents. The researcher took care of the environment in which she was operating in and applied the highest standards of environmental management.

The researcher ensured access to information for the physically challenged youths, regardless of the type of disability. This meant that the researcher conducted

the interview in places which were accessible to the physically challenged youths.

Approval was sought from the local authorities for permission to undertake the research. Informed consent was achieved through adequate prior briefing of the respondents on the purpose of the study so that they could voluntarily and willingly participate in the study.

The study took into considerations the informants need for respect, integrity and dignity during the study. Under no circumstance were informants forced or persuaded to participate or to answer questions. In this matter the study was sensitive to different cultural standards, feelings and emotions of the respondents.

There was one very serious ethical issue connected in doing a study like this or any study of vulnerable people for that matter. This was the issue of raising expectations that may not be fulfilled. No matter how well the purpose of the study was explained, people who gave their consent to be interviewed hoped that the participation would gain something for them, and that hopefully the researcher represented someone who had finally come to help. The researcher did their best to explain that they were doing a study as an academic requirement, but the study would be made available to the Kenyan authorities. This was so that incase the government may want to help in future; it would have a reference in place. The researcher explained that the study would not be of benefit to the informants directly, but in the long run might influence policies and practices towards physically challenged youths and their families living in informal settlements.

CHAPTER FOUR: RESULTS, PRESENTATION AND DISCUSSIONS

4.1. Introduction

This chapter shows the results, presentations and discussions of data collected on the contribution of CDD home care programs. This is towards the health of the physically challenged youths in Kibera informal settlement, Kenya. Analysis of data has been presented as per the research objectives.

4.2. Socio-demographic Characteristics of the Respondents

The study assessed the socio-demographic characteristics of the respondents in terms of sex, marital status, age, level of education, number of people sharing the house and number of years one has stayed in Kibera Informal Settlement. The findings are presented in this sub-section of the report. Knowing the demographic of the respondents was essential in order to understand the nature of respondents and subsequently how this influenced the study findings.

4.2.1. Sex of the Respondents

The first demographic aspect investigated was sex of the respondents. Figure 4.1 shows the sex of the respondents.

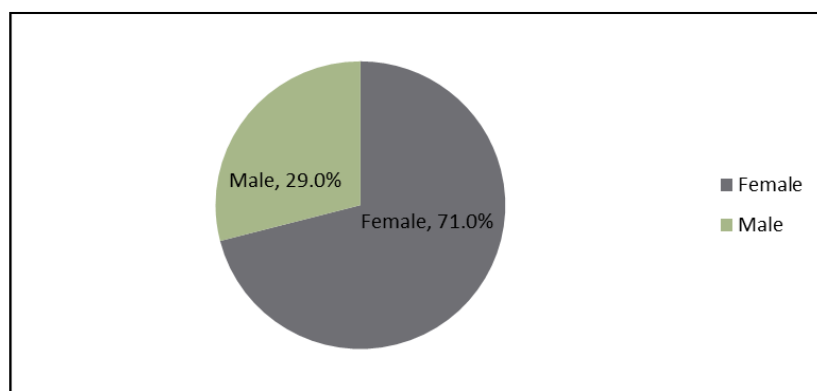


Figure 4.1. Sex of the Respondents
(Source; Researcher)

The study established that female respondents were more, at 71% compared to male respondents who were 29%. One factor that possibly contributed to this scenario

was that females are also likely to belong to village groups (women groups) which usually bring them together thus making them know each other. As a result, it was easier for them to identify their fellow physically challenged women within their village. Women who were able to walk also carried out small businesses in the settlement near their homes. Others did house chore jobs like washing clothes for other residents residing around Kibera, mopping houses and cooking among others hence finding them was easier.

4.2.2. Marital Status of the Respondents

The marital status of the respondents was assessed. Figure 4.2 shows the marital status of the respondents.

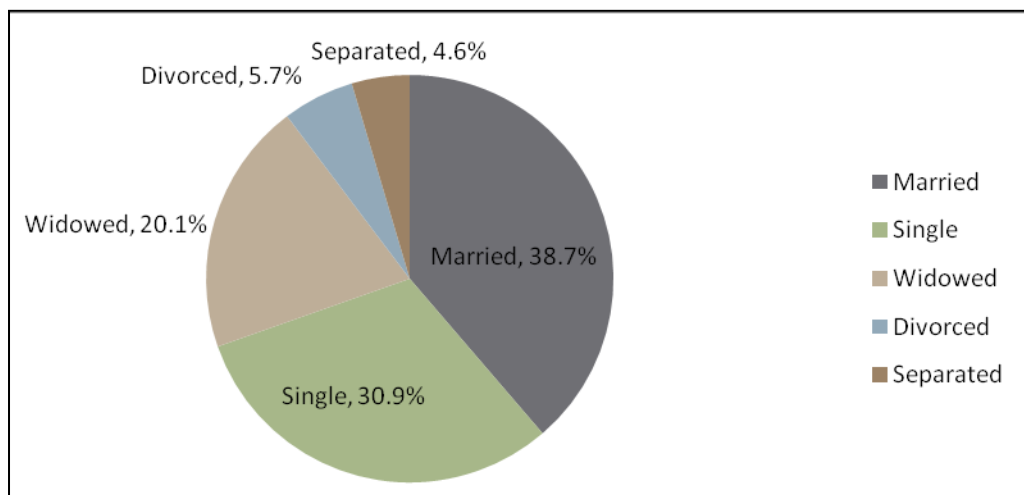


Figure 4.2. Marital Status of the Respondents
(Source; Researcher)

On the issue of the marital status of the respondents, married respondents were 38.7%, single 30.9%, widowed 20.1%, divorced 5.7% and separated 4.6%. This implies that married youths in Kibera were the majority. The fact that majority of the respondents were married, implied that this was an advantage to them since they had partners to take care of them. However, if the family was too poor or if the normal person got sick, the family was likely to be compounded with another problem. The physically challenged person had to work extra hard to meet the family needs. The

high number of widows found supported the previous literature, which notes that it was estimated that there were more than 50,000 Aids orphans living in Kibera and three quarters of this were women.

4.2.3. Age of the Respondents

The age of the respondents was also established to find out the age level of respondents who participated in the study based on the normal universal grouping of five years range. Figure 4.3 shows the age of the respondents who participated in the study.

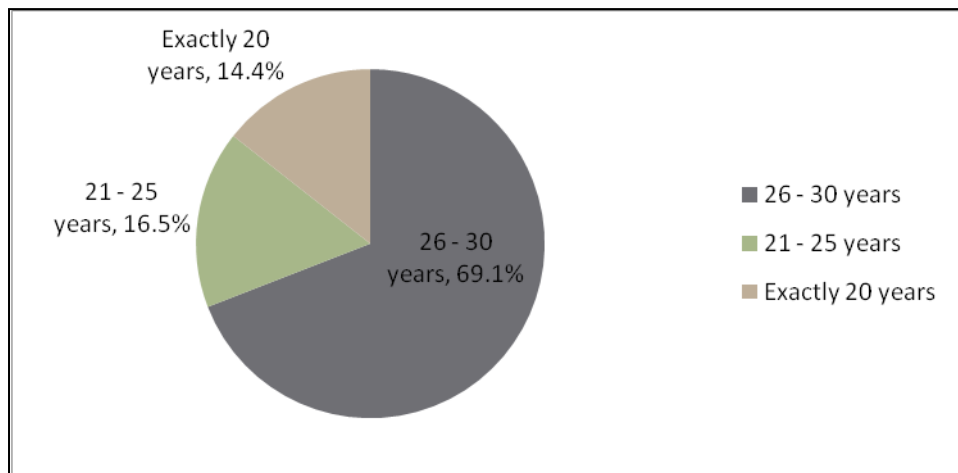


Figure 4.3. Age of the Respondents
(Source; Researcher)

Respondents between 26-30 years were the majority totaling to 69.1% of the total respondents. They were followed by respondents of between 21-25 years at 16.5%. Those who had exactly 20 years were the least at 14.4%. This indicated that respondents who were above 26 years were the majority. The study sampled physically challenged youths who were between the ages of 20-30 years. The fact that most respondents were above 26 years, explained why possibly most of them were also married. This also implied that they were mature enough to look for CDD facilities for help. This age bracket is also referred to as the productive age which is expected to drive community development (UNICEF, 2012).

4.2.4. Level of Education of the Respondents

The level of education was also established and it was found out that respondents had varying levels of education but majority had primary education.

Figure 4.4 shows the level of education of respondents.

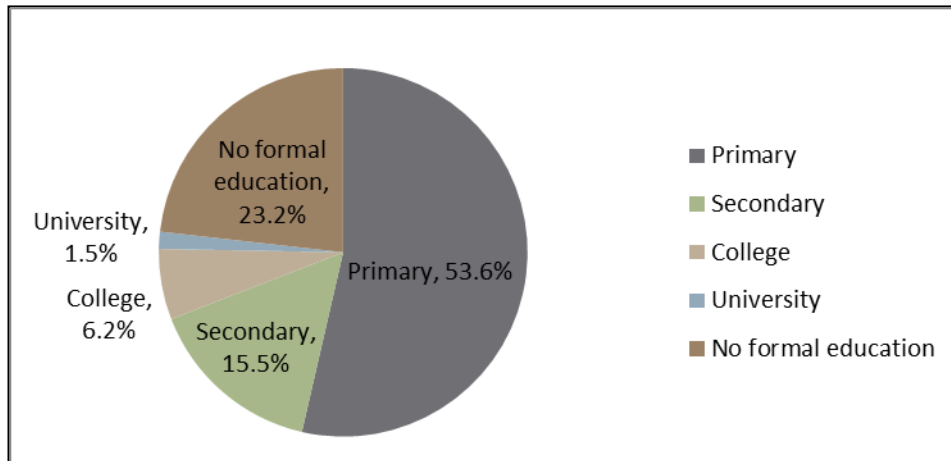


Figure 4.4. Education Level of the Respondents
(Source; Researcher)

Respondents with primary education were 53.6%, secondary 15.5%, College certificate 6.2% and university qualification 1.5%. Surprisingly, respondents without any formal education were 23.2%. The findings indicated that most respondents were not trained beyond secondary level. The employment sector in Kenya needs educated people no matter the health status. This is possibly why only 5.7% respondents were employed while 32.5% were still dependents.

The study findings agree with previous literature which states that access to education and other public services is very poor in Kibera. That is why there is lack of empowerment and skills among the residents to join the formal sector due to high level of illiteracy (Cronin & Guthrie, 2011). Even though there is a growing empowered youth movement across Kibera who are now campaigning for their rights, mobilizing the communities and resources as well as creating education awareness, many more are still lavishing in poverty and they cannot access basic necessities like

education. Subsequently, views obtained from the interviews revealed that many education centers were not equipped to receive the physically challenged persons. Some parents and guardians locked them in their houses so as to keep them safe from injury or getting lost in the informal settlements.

4.2.5. Number of People Sharing a Room

The study further established the number of people sharing a room. This is shown in figure 4.5 below.

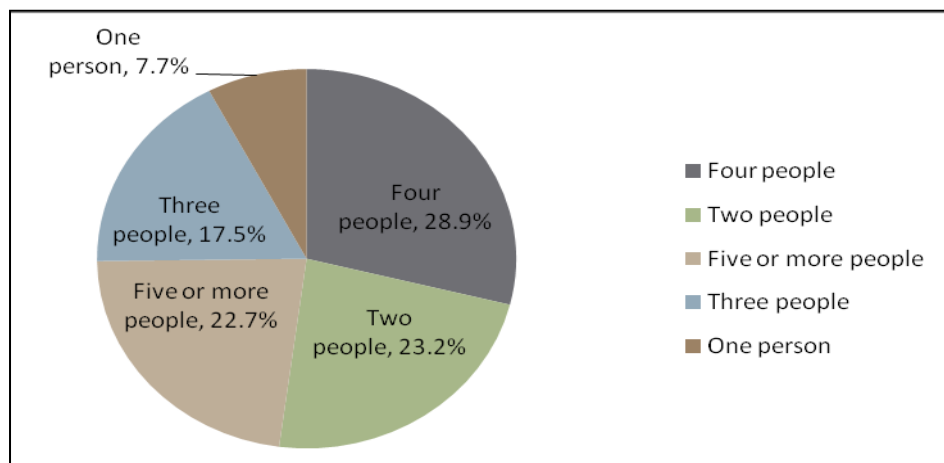


Figure 4.5. Number of People Sharing a Room
(Source; Researcher)

From the study findings, it was found out that respondents staying four in a room were the majority at 28.9%, followed by those who were staying two at 23.2%. Respondents who were staying five or more were third at 22.7%. Respondents who were staying three in a room were 17.5% and those who did not share the room with anybody were the least at 7.7% as indicated in Figure 4.5. This implied that majority of the physically challenged youths had people who could take care of them since some of them could not move far or carry out normal duties like cooking. For example, if their hands were handicapped. However, it should be noted that most houses in Kibera were congested and there was likelihood that there was competition for food and

space. This could have affected the physically challenged youths in terms of accessibility of the home care programs.

Commenting on this, Grootaert & Narayan (2000) observe that the creation of family and social networks helps to reduce exposure to risk among the physically challenged. Physically challenged and poor individuals can be helped to manage risks in many ways, including receiving reciprocal self-help to enable them participate in activities which they can manage.

4.2.6. Number of Years Respondents Had Lived in Kibera

It was also necessary to find out for how long respondents had stayed in Kibera. This was to help establish as to whether the respondents had enough life experience in the area that could enable them provide reliable information regarding CDD home care programs provision in the area. Figure 4.6 shows the number of years the respondents had resided in Kibera.

Table 4.1. Years respondents had lived in Kibera

Variable	Percentage
1 year and below	5.7%
2-4 years	24.4%
5-7 years	22.2%
8 years and above	47.9%

(Source; Researcher)

Respondents who had stayed for over eight years were the majority, at 47.9%. They were followed by those who had stayed there for 2 to 4 years at 24.4%. Respondents who had stayed for 5 to 7 years were 22.2% while those who had stayed there for one year or less were the least at 5.7%. This implied that most respondents, 70.1% had stayed in Kibera for over five years.

4.2.7. Source of Income of the Respondents

The study investigated the source of income of the respondents. This is because income plays a major role in determining one's ability to live a healthy life.

Respondents had various sources of income as established in the study. This is as shown in figure 4.7.

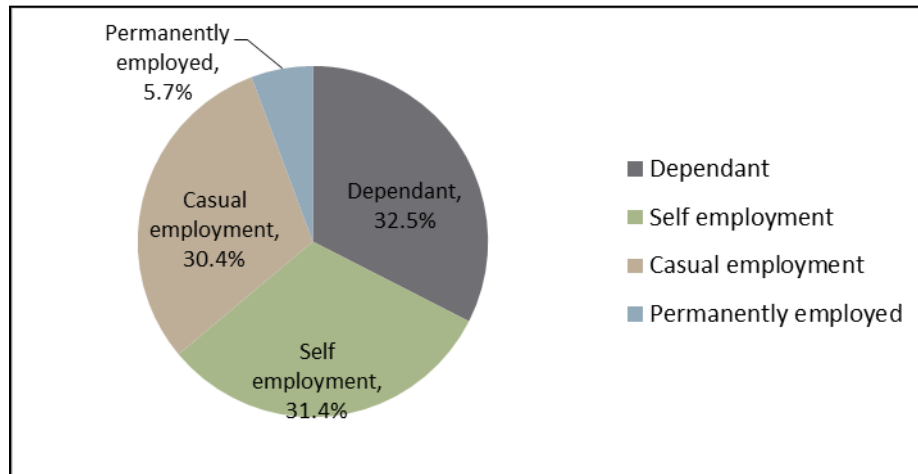


Figure 4.7. Source of Income of the Respondents
(Source; Researcher)

Respondents who were dependent on their parents, guardians or friends for food and other basic needs were the majority totaling to 32.5%. Those who were self-employed, of whom majority of them were in business were 31.4%. Those who were casual workers were 30.4%. The casual workers were majorly involved in manual labour near and around Kibera informal settlement. Only 5.7% of the respondents were employed permanently in formal employment sectors.

The findings showed that only a small portion of respondents were employed. This agrees with previous literature which states that there was widespread unemployment, at 80% among the youths in Kibera (People of Kibera, 2010). This is an indication that many physically challenged youths have no stable source of livelihood. This also explains why most the residents in Kibera are living below the poverty line (Kaiganaine, 2009).

4.2.8. Family Members Living With the Physically Challenged Youths

Family members play a vital role in taking care of the sick and the physically challenged youths. They also play a role in sharing responsibilities and information of what is taking place in the community. Most of the respondents were living with family members as shown in Figure 4.8.

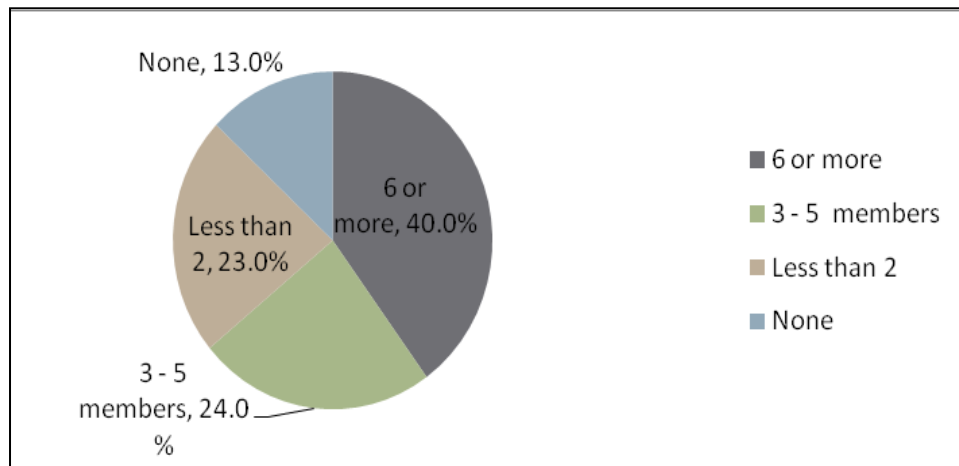


Figure 4.8. Number of Family Members of the Respondents Staying in Kibera (Source; Researcher)

This study moreover investigated the number of family members of the respondents who were staying in Kibera. As shown in Figure 4.8, 40% of the respondents had six or more family members staying in Kibera while those with 3 to 5 members were 24%. Respondents who had less than two family members were 23% and those without any were 13%. This indicated that 87% of the respondents had family members staying in Kibera informal settlement. The fact that most respondents had their family members living in Kibera implied that possibly these family members were taking care of some of them (32.5%) as established earlier in this study. The findings concur with previous literature which states that households commonly share a room of 3 by 3 meters (ReliefWeb, 2010). This implies that the physically challenged youths are staying with family members and these members can be used as

agents to transport them to CDD centers or introduce them to some of the health care programs.

4.2.9. Distance Traveled to the Community Driven Development Centers

The study established the distance travelled by the respondents to the CDD centers in order to establish how this hindered them from accessing the programs.

Figure 4.9 shows the distance travelled to Community Driven Development Health Center.

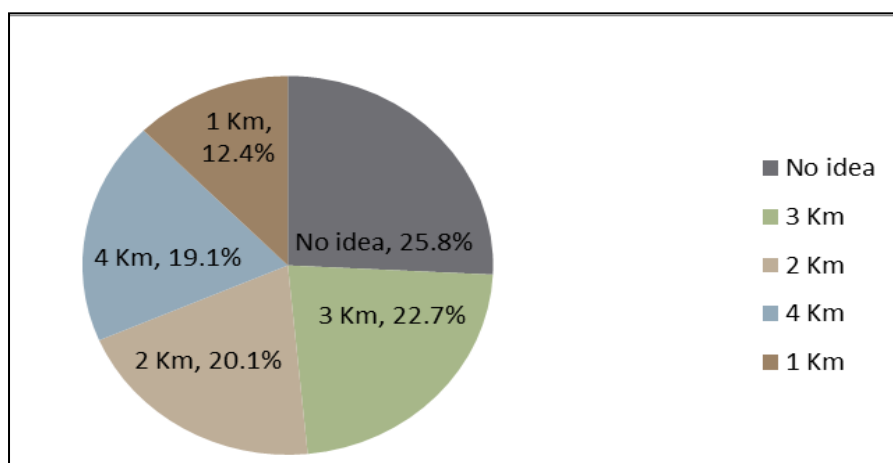


Figure 4.9. Distance traveled to CDD Health Centre
(Source; Researcher)

Finally on the issue of demography of respondents, the study established the distance traveled by the physically challenged to reach the CDD health centers or offices. As shown in Figure 4.9, 22.7% of the respondents traveled for 3km, 20.1% traveled for 2km, 19.1% traveled for 4km and 12.4% traveled for 1km. Interestingly, 25.8% of the respondents did not have an idea as to where the CDD health centers were found. Therefore they could not indicate the distance. The findings concur with previous reviewed literature which notes that access to health care, clean water and sanitation infrastructure, education, security and other public services is very poor in Kibera (ReliefWeb, 2010).

The assessed demographic data revealed that female respondents were almost two and half times more than male respondents even though the study employed simple random sampling to avoid biasness. This implied that views of the physically challenged female youths dominated this study. Most of the respondents were above 25 years and this explained why many of them were either married or widowed. The number of widowed respondents was high and the researcher noted this in conducting the study. On probing the reasons as to why this was the case, most of them said that their partners had died because of HIV/AIDS. This implied that HIV prevalence was still high in Kibera.

Moreover, most of the respondents had only primary education. They were followed by those who had no any formal education. This implied that illiteracy was very high among the physically challenged youths in Kibera; the worst affected group being the females because they were found to be the majority. This possibly explained as to why 25.8% did not even have an idea of where community driven development health centers were found. The fact the many respondents had family members staying in Kibera and some even stayed with the respondents, meant that they were possibly taken care of. This was because the physically challenged always needed support.

Most of the respondents, at 92.3%, were sharing rooms with other people and some were even more than six in a room. There was a likely hood that the respondents were staying with family members since as found from the study, 87% had family members staying in Kibera. The study established that some respondents depended on casual jobs to gain income while almost same number had businesses. Even those who were dependents were also substantive. However, those who were employed were very few.

Lack of formal education beyond secondary level at 92.3% as established earlier could have been the likely cause as to why most of the respondents, at 94.3% did not have formal employment. Most respondents, at 70.1% had stayed in Kibera for over five years. This implied that they were now conversant with the area and activities being carried out. Therefore they were in a good position to provide reliable information on matters related to CDD home care programs. It should be noted too that a good number respondents, 69.1% were above 26 years and possibly married. This implied that they were mature and responsible enough to respond to the questions raised during the interviews.

4.3. Accessibility of Home Care Programs

The first objective of the study aimed at establishing the extent to which the CDD home care programs were accessible to the physically challenged youths in Kibera informal settlement. The study first assessed the home care programs that were offered in Kibera.

4.3.1. Home Care Programs Offered

However, from the assessment of programs carried out, the study established that there were several CDD home care programs that were carried out in Kibera.

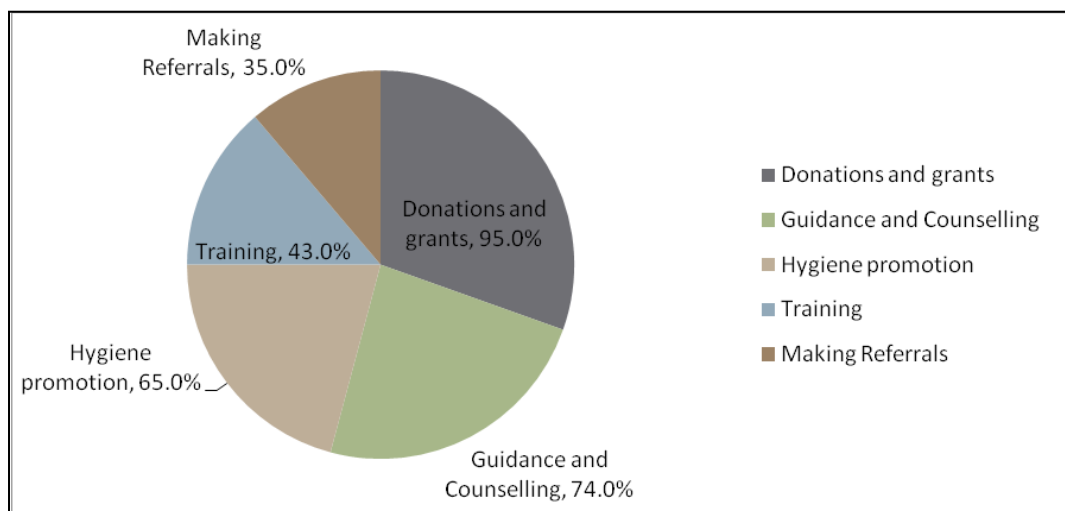


Figure 4.10 CDD Programs available in Kibera
(Source; Researcher)

From the study, it was evident that the CDD home care programs mostly provided donations and grants at 95%. This was followed by guidance and counseling at 74%. Hygiene promotion was third at 65%. It was followed by training at 43% and lastly making of referrals at 35%. As established earlier in the study, 31% respondents had established income generating projects.

The researcher investigated as to where they were getting capital from and most of them said that it was through the grants and donations from various stakeholders. This implied that there was correlation between the giving of donations and grants and establishment of income generating projects and businesses among the physically challenged youths.

Respondents were further asked as to whether there were other programs carried out in Kibera. From their responses, only 38% answered on the affirmative while 62% said there were no other programs. Among the programs they cited as being carried out included home visits to see how the locals were doing. Provision of sanitary facilities like toilet papers and sanitary towels, provision of clothes, school fees, books and provision of ARVs to the HIV positive physically challenged youths. Information on how to take the ARVs was also given. The caregivers were educated on how to give the ARVs to the physically challenged youths entrusted to them.

Other programs offered were provision of information on proper nutrition, life skills and business management skills. Reproductive health education and counselling was offered to all couples including the physically challenged, that is; the discordant couples, the HIV positive couples and the HIV negative couples, as well as counseling.

The study findings indicated that most physically challenged youths had access to various programs. As a matter of fact, CDD was meant to reach as many

people as possible within the target group. As Wrong (2012) notes, because CDD devolves responsibilities and resources to the local level, activities can occur simultaneously reaching a wide range of people even the vulnerable.

4.3.2. Awareness of CDD Home Care Programs

Through the data collected, respondents were asked to give their views regarding the accessibility of the CDD home care programs in terms of availability of the programs, distance, information, affordability and availability. They gave varying views. 56% of respondents said that they were not aware of CDD home care programs while 44% were aware. When the researcher probed for explanation for this, the respondents said that there were so many activities going on in Kibera to an extent that they could not differentiate between CDD programs and other programs. Some simply said they were not aware of them since they had not come across them.

4.3.3. Knowledge about CDD Home Care Programs

Information and knowledge played a central role in alerting the community of activities and opportunities that were available within the reach of the people. The study established whether information was provided by the CDD programs officials.

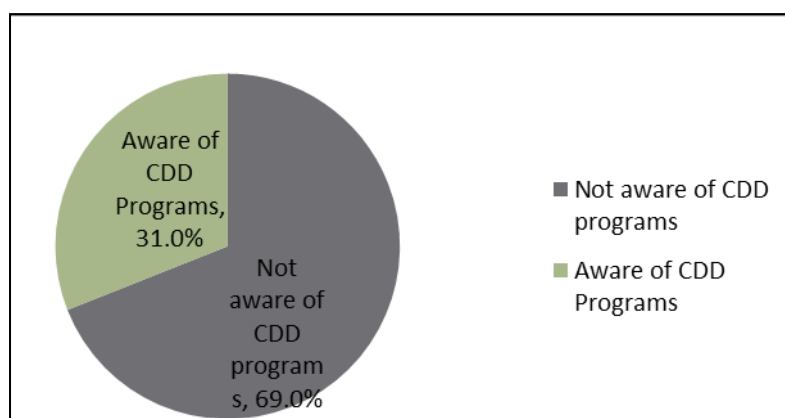


Figure 4.11 Provision of Information on CDD Programs
(Source; Researcher)

Regarding the provision of knowledge about the CDD home care programs, the study found out that majority 69% were not aware of CDD home care programs

and only 31% agreed that CDD officials provided knowledge on CDD home care programs. The rest said that they did not. The researcher probed the respondents further to know the kind of information they received. From their views, there was diverse knowledge being provided. This involved knowledge on business education so that they could manage their businesses well. The physically challenged youths were also educated on the need for proper nutrition. They learnt how to accept their condition of being physically challenged and not to be bitter. The physically challenged were taught how to practice the ABCs. This meant abstinence for those who were single and for the married couples, being faithful and using condoms to prevent the respondents from getting or spreading sexually transmitted diseases.

The study findings concur with the survey by Research International (2011). This survey reveals that Kibera informal settlement is endowed with a range of facilities and amenities such as schools, health facilities, government offices, water points, shops, roads and telephones. This study confirmed that while such infrastructures were available, many of them were not adequate while others were not even accessible to the residents. Despite the high demand of those infrastructures, some were still under-utilized due to the existence of social and economic costs.

The questionnaire revealed that there was several other CDD home care programs provided in Kibera informal settlement. They included training of the physically challenged youths on various issues like health (giving information on proper nutrition and proper administering and intake of medicine), hygiene promotion, donation and grants profusion, guidance & counseling, making of referrals. There was also training on acquisition of life skills and business skills and reproductive health education. However, a number of respondents were not aware that there were CDD home care programs. The major cause was due to lack of information

dissemination since 69% of the respondents actually said that they had not received any information. Coupled with the high illiteracy rate among the physically challenged youths and the long distance they had to travel to get to the CDD centers. The findings agree with Wrong (2012) who notes that CDD programs have always had a positive impact on access to and use of services, especially in health, education, and drinking water.

The fact that some youths had not received information and some were illiterate was a call to CDD program coordinators to champion education awareness. This was because CDD was meant to always educate the local population before the rendering of the services. As Dasgupta & Beard (2007) put it, an effective CDD facilitates access to information of the local poor population, promotes an enabling environment, provides accessibility to health facilities and medical services, carries out research on the need of the people and provides the desired needs.

4.3.4. Paying for CDD Home Care Programs

In terms of accessibility, respondents were asked to give their views as to whether the CDD home care programs were charged and whether they were able to afford them. This is as shown in figure 4.12.

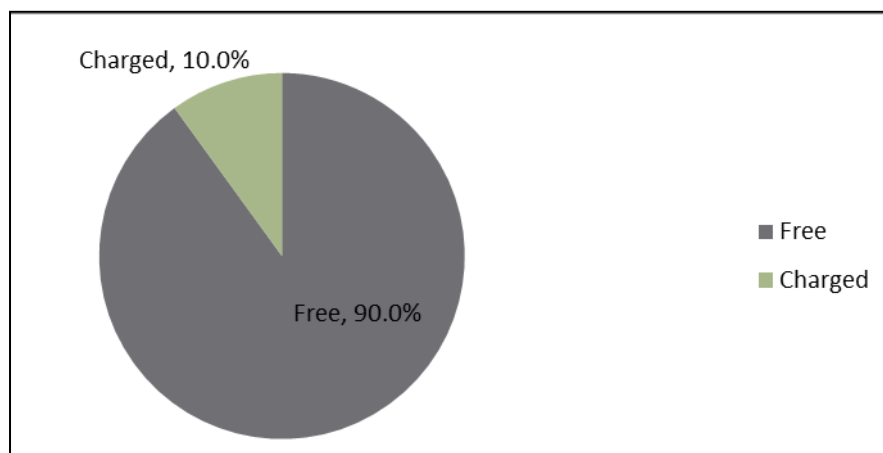


Figure 4.12 Paying for CDD Home Care Programs
(Source; Researcher)

From the study findings as shown in Figure 4.12, 90% of the respondents said that these programs were given for free and only 10% said that they were charged. Based on the previous findings, this implied that there were several CDD home care programs that were being provided and at no cost. Therefore, the physically challenged youths had the opportunity to access them. Failure to utilize these services could be attributed to other factors like lack of information and knowledge of their existence as revealed earlier on.

The findings suggested that most of the home care programs were given freely. This was actually the objective of CDD programs. They were always intended to be given freely to benefit the needy. The findings are in line with Ravallion (1999) who notes that CDD ensures that inclusion is enhanced and scarce public resources target groups that mostly need them. Absence of reliable information means testing and involving communities directly in the targeting process. This can improve efforts to target the poorest and marginalized individuals and groups.

Respondents were asked to give their views on the affordability of CDD projects. Figure 4.13 shows the affordability of CDD programs.

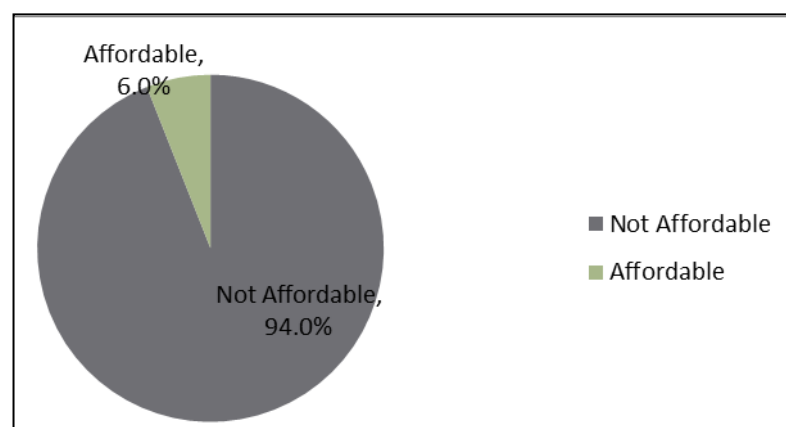


Figure 4.13 Affordability for CDD Programs
(Source; Researcher)

On the same note, respondents were asked as to whether they were able to afford for the services provided. As shown in Figure 4.12, an overwhelming majority

of 94% said that they were not able to afford for them. Only 6% of respondents said that they were able to pay for the programs. The number of respondents who could not afford for the home care services is slightly higher than that of the respondents who said that these home care activities were given free of charge. This implied that most respondents who were not able to pay for the activities primarily depended on free home care programs. This was in line with previous literature which states that the majority of residents are living in poverty, with 60% of the population earning less than US\$1 per day (People of Kibera, 2010).

The scenario in Kibera as established by the researcher gave the real picture of what the physically challenged youths were going through. Not all could access the CDD programs in terms of affordability, accessibility and availability. These findings are in line with the UN-Habitat (2003b) report that states that Kenya has 12 million youths (18-32 years). Statistics show that most of these youths face a lot of economic, social and political marginalization in society. For example, 67% of these youths are unemployed. Additionally, the report further illustrates that due to their economic inabilities, once in the cities, the youths opt to live in informal settlements since they provide low cost life, as they try to position themselves in the city. Living in these locales, youths are not provided with social amenities such as sanitation services and social institutions.

4.3.5. Involvement in the CDD Home Care Programs

The second objective of the study sought to find out to what extent CDD home care programs involved the physically challenged youths in Kibera informal settlement. Respondents were asked as to whether they were involved directly in the CDD home care programs. This is shown in figure 4.14.

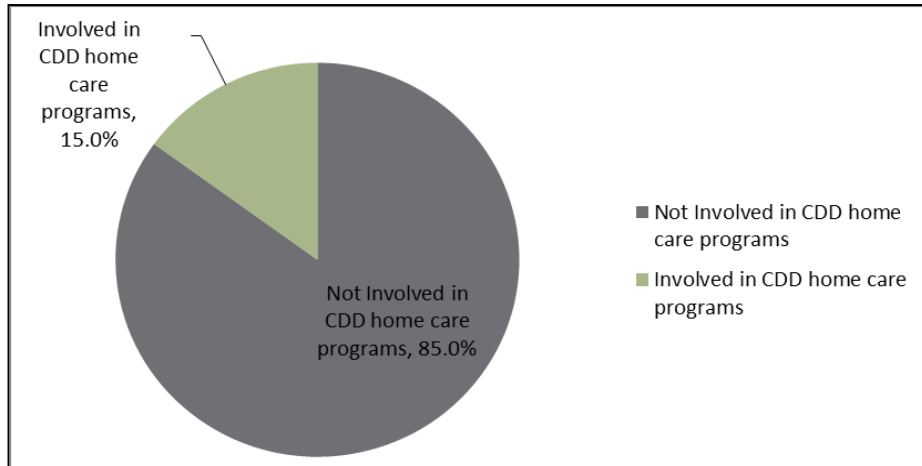


Figure 4.14 Involvement in CDD Home Care Programs
(Source; Researcher)

As pointed out in Figure 4.14 only 15% of the respondents admitted that they were directly involved in the CDD home care programs while 85% were not. This was an indication that despite the presence of these programs in Kibera and even respondents having knowledge of their existence, most of the respondents were not involved directly. This prompted the researcher to inquire as to whether those rolling out and running the CDD home care programs were involving the physically challenged youths. This is illustrated in figure 4.15.

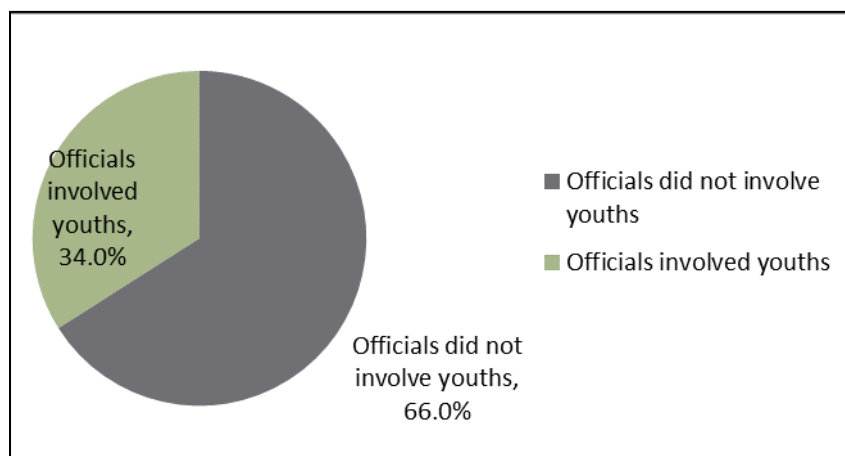


Figure 4.15 Officials Involving Youths in CDD Programs
(Source; Researcher)

From the findings as shown in Figure 4.15, 66% of the respondents felt that the physically challenged youths were not involved in the CDD home care programs. Only 34% said that they were involved. This implied that possibly, many youths were not involved in the CDD programs due to the fact that even those responsible for such programs were not involving them.

The findings show that the CDD programs in Kibera have not fully met one of the main objectives of any CDD. This is because, as Ravallion (1999) puts it, CDD ensures that inclusion is enhanced and scarce public resources target groups that mostly need them. Absence of reliable information means involving communities directly in the targeting process. This can improve efforts to target the poorest and marginalized individuals and groups.

It was noted however that, many respondents who participated in this study were illiterate, 92.3%. They had no education beyond secondary level. Over 23% did not have any kind of formal education. Coupled with the fact that information dissemination about the after care programs was inadequate, there was a likelihood that these factors among others were contributing towards the exclusion of the physically challenged youths from CDD home care programs.

However, it was revealed through the discussions that some respondents were able to access the CDD home care programs in a number of ways; they benefitted from home visits, were provided with sanitary facilities like toilet papers and sanitary towels, clothes, school fees and books. The physically challenged youths with HIV/AIDS, were given ARVs. They were taught on how to take the ARVs. Caregivers were educated on how to give the ARVs. The physically challenged youths were also given information on proper nutrition, trained on life skills and taught on business management. Reproductive health education was given to all

couples. These were the discordant couples, the HIV positive couples and the HIV negative couples. Guidance and counseling was also offered.

The study findings to some extent are in line with the views of UNICEF report (2012) which notes that CDD is meant to give control of decisions and resources to community groups. CDD treats poor people as assets and partners in the development process, building on their institutions and resources. Support to CDD usually includes strengthening and financing inclusive community groups, facilitating community access to information, and promoting an enabling environment through institutional reforms.

However, the reality on the ground revealed that not all the physically challenged youths were aware or could access the CDD programs. This is due to the fact that Kibera is a big informal settlement and traversing all of it is sometimes a challenge to the stakeholders. This agrees also with a report by UNICEF (2012) which states that in many informal settlements, accessing health care has been particularly problematic for children and young people. Clinics and hospitals are often located outside of informal settlements, making the financial and opportunity costs of visiting a clinic high, especially for people who are physically challenged.

4.4. Benefits of CDD Home Care Programs

The second objective of the study sought to find out the benefits of community driven development home care programs towards the physically challenged youths in Kibera informal settlement. Respondents were asked as to whether they had directly benefited from the home care programs. This is as shown in figure 4.16.

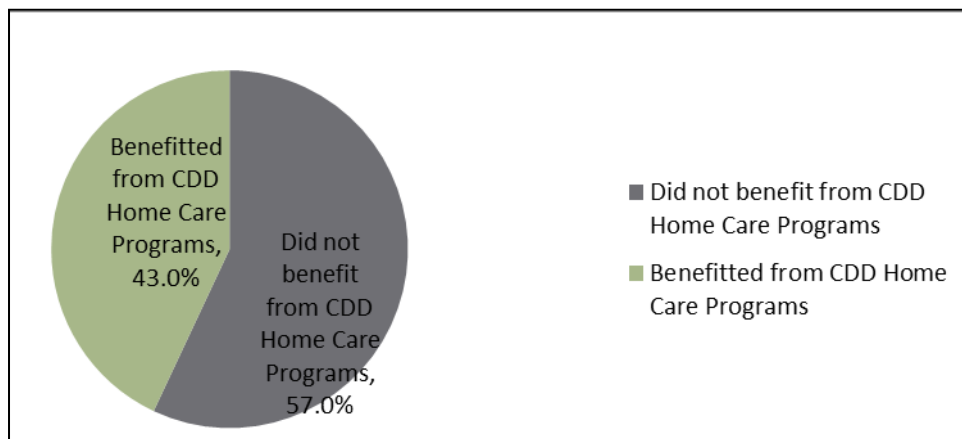


Fig. 4.16 Benefits from CDD Home Care Programs
(Source; Researcher)

From the study, 43% of the respondents said that they had benefited from the CDD home care programs. However 57% of the respondents said that they had not benefited at all. The researcher probed some questions further to unearth the reasons as to why they had not benefited from such programs. Among the reasons they gave were lack of information about such programs, illiteracy which sometimes hindered them from getting information from printed advertisement in the streets, bill boards and bulletins. Other factors included lack of finances to visit the CDD offices to inquire on the programs available and when they would be availed. Moreover, the researcher discovered that some respondents were content with their current lifestyle and others were hopeless. That is, some physically challenged youths did not think that anything good could come out of them. Some had fallen prey to fake CDDs and they had lost hope. In addition, some youths were just lazy. They had been used to having people take care of them that they did not want to learn and be empowered on how to be productive.

Respondents were further asked on how they had benefited from the CDD home care programs and they gave varying views. Table 4.1 shows the benefits of CDD home care programs.

Table 4.1 Benefits of CDD home care programs

Programs	Males	Females	Totals
Moral and spiritual support	21%	53%	74%
Material support like clothes, food and sanitary towels	18%	41%	59%
Nutritional support	8%	36%	44%
Medical support	9%	35%	44%
Financial support	11%	32%	43%
Information and knowledge acquisition	6%	27%	33%
Transport	5%	26%	31%
Employment	6%	21%	27%

(Source; Researcher)

From the study as shown in table 4.1, many respondents seem to have been empowered in several ways and particularly financially.

Moral and spiritual support

The physically challenged youths benefitted from moral and spiritual support given to them by the community health workers, missionary preachers and for some, their caregivers who had been taught how to do so (74%). This gave the physically challenged youths hope in life. It also showed them that there will be a better life in heaven, when their life on earth will be over. It also gave them the ability to accept their condition and have the strength to face the life ahead.

Material support

The physically challenged youths benefitted from material support (59%). They received donations of food, clothes, shoes, toiletries and sanitary towels. They got them from church organizations, schools, private organizations through corporate social responsibility (CSR), and the government. Food occupied a bigger percentage

of the donations, and therefore this ensured that the physically challenged youths did not suffer from hunger.

Nutritional support

Nutritional support was being given to the physically challenged persons (44%). They were taught on the need of eating a balanced diet. For the ones who were both physically challenged and HIV positive, they were advised on how to eat when taking the ARVs. For some, calcium and iron formed a bigger part of their diet. They were taught on what foods to eat and how to prepare the food so as to benefit from the nutrients. They were got this information from certified and experienced nutritionists.

Medical support

The physically challenged youths benefited medically by being given calcium tablets to strengthen their bones (44%). They also received information on how to take the prescribed drugs. For the instance whereby the physically challenged youths were quadriplegic, their caregivers were taught how to administer the drugs. Some received wheelchairs and hearing aids from non-governmental organizations (NGOs).

Financial support

Physically challenged youths benefitted from getting capital from CDDs (43%). They were given donations and grants. They received capital in form of money, machines or stock (goods to sell for profit). They received knowledge on how to conduct their business. For example, they were taught on data entry, how to record the balance sheet, maintain the profit and loss account, stock taking and how to be customer friendly so as to win and retain customers. For example, there were some women in Makina Market, in Kibera, who made a living from the embroidery machines that they had received from an NGO. They used the machines to sew table

cloths and put nice motifs and patterns on them. The beautiful table cloths were sold and the business proceeds were used to sustain them.

Information and Knowledge Acquisition

There were some CDD programs run by NGOs in Kibera that offered education to the physically challenged youths (33%). They offered education on computer packages at no fee. Some offered basic reading, writing and communication skills. This was a step in the right direction to empower youths.

Transport

This benefit was experienced in three ways. There were the physically challenged youths who were given funds for transport to seek medical services, from a better medical facility. This was the case when the community health centre could not manage to handle the case. Respondents were offered transport to trainings and even attend workshops and seminars. There was a bigger percentage of physically challenged youths, who benefitted from having the community health centre built near their residence. Therefore, they did not have to incur any transportation costs as indicated by 31% of respondents.

Employment

There were some physically challenged youths that benefitted from being employed in the CDD programs (27%). Some worked as inspirational/motivational speakers. They gave hope to others who were physically challenged like them. Some had been employed as front office receptionists in some CDD centres.

Generally, the findings indicated that even if not all the physically challenged youths knew or had access to the CDD home care programs, majority of them had benefitted from these programs in one way or the other. This implied that, if they were provided

with good education and information, there was likelihood that in future, most of them if not all would benefit from these programs.

The findings revealed that at least some physically challenged youths were benefiting from the CDD programs. The study findings concur with Dongier et al. (2003) who observed that CDD had also been shown to increase the efficiency and contribution of development efforts in areas of education, health and poverty reduction. CDD programs work by providing poor communities with direct funding for development with the communities. CDD programs decide on how to spend the money.

4.5. Challenges Hindering Accessibility of CDD Home Care Programs

The study investigated the challenges that hindered the physically challenged youths from accessing the community development programs. Figure 4.17 shows the challenges encountered in accessing the CDD home care programs.

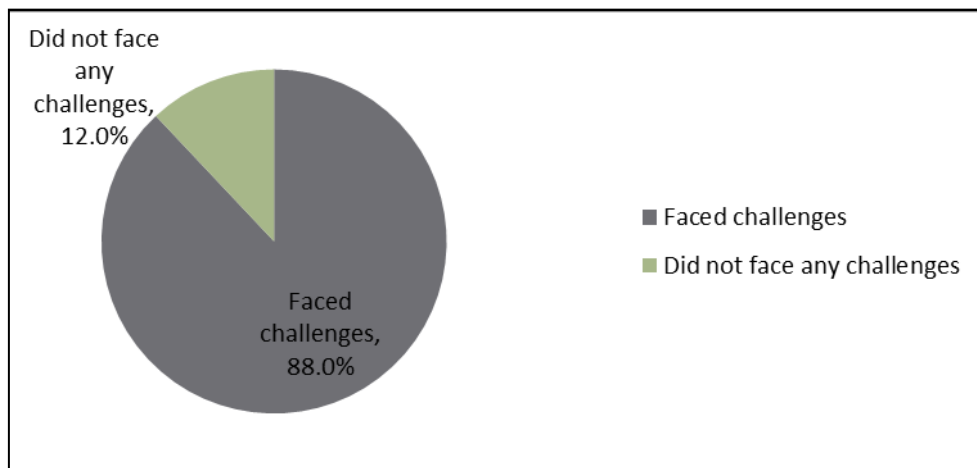


Fig. 4.17 Challenges in accessing CDD Home Care Programs
(Source; Researcher)

Respondents were finally asked to give views on the challenges they were facing in accessing and benefiting from the CDD home care programs. From the study as revealed 88% of the respondents admitted that they met various challenges in accessing the CDD home care programs. Only 12% said that they did not meet any

challenge. This showed that despite the many programs being rolled out in Kibera, there were still hindrances that kept the physically challenged youths from accessing them. Several challenges were cited as summarized in table 4.2.

Table 4.2. Challenges hindering accessibility of CDD home care programs

Challenges	Males	Females	Totals
Lack of information	25%	65%	90%
Physical body challenges	21%	49%	70%
Illiteracy	17%	46%	63%
Misrepresentation	13%	46%	59%
Financial constraints	18%	41%	59%
Loss of interest and hope	9%	34%	45%
Fear due to stigma	7%	29%	36%
Tailored facilities	7%	25%	32%
Language barrier	4%	17%	21%
Oppression by caregivers	4%	16%	20%
Few opportunities available	5%	14%	19%
Discrimination	2%	11%	13%

(Source; Researcher)

As shown in table 4.2 the main challenges cited as hindering the physically challenged youths from accessing the CDD home care programs in Kibera were lack of information or ignorance at 90%, physical body handicap (lame or blind) at 70%, illiteracy or lack of education at 63%, financial constraints at 59% and misrepresentation at 59%. This was observed in the decision making organs in Kibera where the youths were generally sidelined.

Lack of information

There were some CDD home care programs that did not engage in educating the public of their existence (90%). They did not promote awareness by advertising through bill boards, brochures, notice boards or door to door campaign.

Untailored Physical Facilities

Some facilities were not tailored to be accessed by the physically challenged youths (70%). For example, some toilets in Kibera could not be accessed by the physically challenged youths. This was because some were built on elevated ground and could only be accessed by climbing staircases. Others were so narrow that a physically challenged youth on a wheel chair could not be able access the toilets.

Illiteracy

There were some physically challenged youths who did not receive any formal schooling (63%). Therefore they were not able to read and write. This could have resulted in lack of acquiring information being communicated to them through notices or brochures. Most of the physically challenged youths had reached primary level of schooling. This could have also contributed to the lack of vigilance to gather information.

Financial constraints

For some physically challenged youths, the CDD home care program was situated far from their homes (59%). This meant that they could only access the facility by means of boarding a vehicle. This proved to be quite expensive for them. They had to choose on whether to provide a meal for their family or to visit the health facility. They therefore would decide to use the limited resources to provide for their basic needs at the expense of accessing the facility.

Fear due to stigma

Accessing the CDD home care program meant that the physically challenged person would be exposing their condition (36%). For example, in visiting a HIV/AIDS clinic to obtain ARVs, a physically challenged infected youth was likely to meet a neighbor or someone who might recognize them. Therefore to avoid

exposing their condition and be stigmatized by the community, they would not access the CDD home care program. For example, there were some respondents in Soweto village who said that they could go as far as Lani Saba to get ARVs due to the stigma associated with being HIV positive. They said that among the community health workers who were working at the nearby CDD centers, some were their neighbours, and getting ARVs from there would expose their status.

Other factors with substantive hindrance included discrimination and segregation (13%), oppression by the caregivers (20%), language barrier (21%) and availability of few opportunities (19%) that favor the physically challenged youths.

The study findings concur with Labonne & Chase (2008) who note that evidence on the CDD health outcomes among informal settlement dwellers reveals that residents are often found to be faring poorly with regard to reproductive health outcomes in sub-Saharan Africa. Youths in particular are among those most vulnerable besides women and children to the environmental and physical conditions within informal settlements. They often experience severe issues with regard to access to health care and immunizations, morbidity and mortality, nutrition, food security, sexual and reproductive health.

CHAPTER FIVE: SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1. Introduction

This section provides the summary, conclusion and recommendations based on the study findings.

5.2. Summary

The study was conducted to assess CDD home care programs towards the physically challenged youths in Kibera informal settlement. Specifically, the study aimed at finding out the extent to which the CDD home care programs were accessible to the physically challenged youths. To find out the benefits of community driven development home care programs towards the physically challenged youths. To establish the challenges facing physically challenged youths in accessing community driven development home care programs in Kibera informal settlement.

The study employed descriptive survey design with both qualitative and quantitative approaches. The study targeted physically challenged youths. Questionnaire, interview schedule and observation methods were used for data collection. 375 respondents were picked from 13 villages in Kibera through stratified and snowball sampling technique. Data was analyzed and presented in tables, pie charts and figures using frequencies and percentages and some of it qualitatively.

The study established that female respondents were more (71%) compared to male respondents (29%). Those who had been married were 63.4% even though some of them were divorced or separated by the time of the study. Only 6.2% had attained college education but most of the respondents (53.6%) had only attained primary education. Most of the respondents (92.3%) were sharing rooms with one or more other people and some were even more than six in a room. Some respondents depended on casual jobs or businesses to gain income but a good number were

dependents. In fact, those who were employed were very few (5.7%). Lack of formal education beyond secondary could be the likely cause as to why most of the respondents, 94.3% did not have formal employment. Most respondents, 70.1%, had stayed in Kibera for over five years. This implied that they were now conversant with the area and the activities were carried out. Therefore they were in a good position to provide reliable information on matters related to CDD home care programs.

The first objective sought to find out the accessibility of home care programs Kibera informal settlement. It was ascertained that accessibility was quite adequate. This is because there were several programs including provision of donations and grants, guidance and counseling hygiene promotion and making of referrals. Others included home visits to see how the locals were doing, provision of sanitary facilities like toilet papers and sanitary towels, provision of clothes, school fees, books and provision of ARVs to the HIV positive physically challenged youths. They also included information on how to take the ARVs, educating the caregivers on how to give the ARVs to the physically challenged youths entrusted to them and information on proper nutrition. The physically challenged youths were trained on life skills. They were empowered by being educated on how to manage their businesses. Reproductive health education was offered to all couples. That is, the discordant couples, the HIV positive couples and the HIV negative couples. Counseling was also provided.

The physically challenged youths were taught on how to accept their condition of being physically challenged and not to be bitter. On matters of sexuality, they were taught on how to practice the ABCs. This meant abstinence for those who were single. For the married couples, being faithful and using condoms was encouraged. This was to prevent them from getting or spreading sexually transmitted diseases. This was done to equip them with knowledge of survival amidst the challenges of Kibera. This

implied that even though the physically challenged youths could not afford for the services, most of them were able to access them simply because the programs were free. This suggested that accessibility to these programs was somehow adequate.

The second objective sought to find out the benefits of CDD home care programs towards the physically challenged youths. It was found out that the physically challenged youths had benefited from the home care programs in a number of ways. This included financial support, nutritional support, material support (clothes, food and sanitary towels), and medical support. It also included information and knowledge acquisition, moral and spiritual support, transport and employment. Generally, the findings indicated that even if not all the physically challenged youths knew or had access to the CDD home care programs, majority of them had benefited from these programs in one way or the other. This implied that, if they were provided with good education and information, there was likelihood that in future, most of them if not all would benefit from these programs.

The third objective sought to find out the challenges facing the physically challenged youths in accessing home care programs. The study established that there were several challenges. These challenges hindered them from accessing the home care programs. They included lack of information or ignorance, physical body handicap, fear of stigma, illiteracy or lack of education, financial constraints and misrepresentation among others.

5.3. Conclusion

The study concluded that there were CDD home care programs in Kibera. However, a good number of physically challenged youths were not aware of them. This was possibly because Kibera was congested and reaching everybody was a challenge. Coupled with the high illiteracy rate and poverty among the physically

challenged youths, and the long distance they had to travel to get into the CDD centers, there is likelihood that these barriers had hindered them from accessing these programs.

However, most of them had benefited in a number ways. They included moral, psychological, social and financial support. In fact, majority of the respondents to a large extent accessed the CDD home care programs but not adequately. Lack of involvement in the programs was actually a big barrier. This implied that the physically challenged youths were excluded from these programs to some extent. That is why they had not benefited fully from them. Lack of proper information was actually a barrier to accessibility to the home care programs. This suggested that had more effort been put towards education awareness, these youths could have benefited fully from the available home care programs.

It was saddening to note that some physically challenged youths had lost interest in life. They were not taking the initiative to gather information. They had lost hope in life, and lived each day as it came since they felt that the family members and the community at large had neglected them completely. This meant that they could not improve their way of life, by being proactive in looking for ways to earn a living and therefore have a decent life.

5.4. Recommendations

Based on the study findings, the study recommended the following:

- i. There was need for the government, the NGOs and all the stakeholders to champion education awareness in Kibera Informal Settlement especially on CDD home care programs. This was to enable the physically challenged youths to be informed of the available opportunities so that they could be able to utilize them.

- ii. There was also need for the general public to be educated too on how to live with the physically challenged people especially youths. Emphasis was to be communicated on the importance to accept the other person's condition and be tolerant with one another. By doing this, the physically challenged youths would be incorporated in the community programs and given a hope of facing the future.
- iii. Facilities were to be constructed in every village so that all the people in the community could be able to access them. Where there were staircases, a path was required. This would assist a physically challenged youth on a wheel chair or clutches to move without any difficulty. Toilets were to be constructed for the physically challenged youths. The physically challenged youths' toilets were meant to be spacious. This would allow them youths to access them, whether they were on a wheelchair or they were on clutches. The toilets were to be well labeled, and also have a disability sign, so that they could be easily noticed.
- iv. Emphasis was to be made on the need of ensuring that all children were educated regardless of their condition. Parents were to be encouraged to seek proper medical help on realization that their child was physically challenged. They were not to feel ashamed and hide the child at home, as this not only postponed the problem but also worsened the situation.
- v. Caregivers who mistreated the physically challenged youths were to have a course of action taken against them.

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APPENDICES

Appendix I: Questionnaire

Dear Respondent:

I am a student from Kenyatta University pursuing a Master of Arts degree in Community Development. I am currently carrying out research on Community Driven Development Home Care Programs and Health Outcomes of Physically Challenged Youths in Kibera Informal settlement. The research is part of the requirements for my program in the University. Kindly fill the questionnaire as honestly as possible to enable this research to be successful. The information you give is needed purely for academic research and will be treated as confidential.

Your assistance and cooperation is highly appreciated. Thank you.

SECTION A: BIO DATA OF THE RESPONDENT

1. Gender

Male Female

2. Marital status

Single Married Divorced Separated
Widowed

3. Age

Below 20years 21-25 years 26- 30yrs

4. Level of education

Primary Secondary College University
Other, please specify.....

5. Number of people you share the room with where you stay.

Below One Two Three Four
Five Six and above

6. Number of years you have lived in Kibera

Below One Year 2-4 years 5-7 years
8 years and above

7. What is your main source of income?.....

8. Occupation: Specify

9. Number of your family members living in Kibera: Specify.....

SECTION B

Are you aware of the CDD? Yes No

If yes, briefly explain.

.....
.....
.....

Are there CDD home care programs carried out in Kibera? Yes No

If yes, name them.

.....
.....
.....

Do the CDD officials provide any knowledge and information to you about their home care programs? Yes No

If yes, which type of information is provided?

.....
.....
.....

Have you as a person received any information and knowledge CDD home care programs?

Yes [] No [] If yes, which one?

.....
.....

Are you involved in the CDD home care activities? Yes [] No []

If yes, how?

.....
.....
.....

Does that CDD involve the physically challenged poor youths in the running of CDD health activities? Yes [] No [] If yes, how?

.....
.....

How best do you think the community driven home care programs can be implemented in order to reach all the youths?

.....
.....
.....

Have you benefited from community driven home care activities? Yes [] No []

If yes, how?

.....
.....

If no, why?

.....
.....
.....

Are there challenges you face as a physically challenged youth in accessing the health services? Yes [] No []

If yes, name them.

.....
.....

Which other programs do you feel should be brought on board to help the physically challenged youths in Kibera?

.....
.....

What do you think should be done so that the physically challenged youths benefit from these programs?

.....
.....
.....

Appendix II: Interview Schedule

1. Name the CDD home care programs available in Kibera.
2. What information, if any, is provided by the CDD officials provide about their home care programs?
3. Name the information you have received about the CDD home care programs.
4. How are you involved, if you do, in the CDD home care activities?
5. How are the physically challenged youths involved, if they are, in the running of CDD health activities?
6. How have you benefited from the CDD home care programs?
7. How best do you think the community driven development home care programs can be implemented in order to reach all the youths?
8. Are there challenges you face as a physically challenged youth in accessing the health services?
9. Which other programs do you feel should be brought on board to help the physically challenged youths in Kibera?
10. What do you think should be done so that the physically challenged youths benefit from these programs?

Appendix III: Observation Checklist

1. Community Driven Development Programs centers available, for example, health facilities.
2. Community Driven Development Programs offered.
3. Living conditions of the physically challenged youths especially sanitation and housing,
4. Distance travelled by the physically challenged youths to access the CDD centers.
5. The physical health condition of the physically challenged youths.
6. Physical barriers to accessing the Community Driven Development Programs.

Appendix IV: Proposal Approval Letter



KENYATTA UNIVERSITY
GRADUATE SCHOOL

E-mail: kubps@yahoo.com
dean-graduate@ku.ac.ke
Website: www.ku.ac.ke

P.O. Box 43844, 00100
NAIROBI, KENYA
Tel. 810901 Ext. 57530

Internal Memo

FROM: Dean, Graduate School

DATE: 15th April, 2016

TO: Ms. Gathura V. Muthoni
C/o Department of Sociology
KENYATTA UNIVERSITY

REF: C50/CTY/PT/21019/12

SUBJECT: APPROVAL OF RESEARCH PROPOSAL

This is to inform you that Graduate School Board at its meeting of 13th April, 2016 approved your Research Proposal for the M.A. Degree, Entitled "Contribution of Community Driven Development Home Care Programs on the Health of Physically Challenged Youths in Kibera Informal Settlement, Kenya".

You may now proceed with your Data collection, subject to clearance with the Director General, National Commission for Science, Technology & Innovation.

As you embark on your data collection, please note that you will be required to submit to Graduate School completed supervision Tracking Forms per semester. The form has been developed to replace the progress Report Forms. The Supervision Tracking Forms are available at the [University Website](http://www.ku.ac.ke) under Graduate School webpage downloads.



c.c. Chairman, Department of Sociology

Supervisors:

1. Dr. Dickson M. Ombaka
C/o Department of Sociology
KENYATTA UNIVERSITY
2. Dr. Daniel M. Muia
C/o Department of Sociology
KENYATTA UNIVERSITY

AM/coo

Appendix V: University Authorization Letter



KENYATTA UNIVERSITY
GRADUATE SCHOOL

E-mail: kubps@yahoo.com
dean-graduate@ku.ac.ke
Website: www.ku.ac.ke

P.O. Box 45844, 00100
NAIROBI, KENYA
Tel. 8710901 Ext. 57530

Our Ref: C50/CTY/PT/21019/12

Date: 15th April, 2016

Director General, National Commission for Science,
Technology & Innovation,
P.O. Box 30623-00100
NAIROBI


Dear Sir/Madam,

RE: RESEARCH AUTHORIZATION FOR MS.GATHURA V.MUTHONI REG.NO. C50/CTY/PT/21019/12

I write to introduce Ms. Muthoni who is a Postgraduate Student of this University. She is registered for M.A. degree programme in the Department of Sociology in the School of Humanities & Social Sciences.

Ms. Muthoni intends to conduct research for M.A Degree thesis entitled "Contribution of Community Driven Development Home Care Programs on the Health of Physically Challenged Youths in Kibera Informal Settlement, Kenya".

Any assistance given will be highly appreciated.

Yours faithfully,

MABEL PUTEH NJOROGE
FOR: DEAN, GRADUATE SCHOOL.

RM/cao

Appendix VI: Ethical Letter



KENYATTA UNIVERSITY
ETHICS REVIEW COMMITTEE

Email: chairman.kuerc@ku.ac.ke
secretary.kuerc@ku.ac.ke
Website: www.ku.ac.ke

P. O. Box 43844 - 00100 Nairobi
Tel: 8710901/12
Fax: 8711242/8711575

Our Ref: KU/R/COMM/51/758

Date: 26th August, 2016

Ms. Gathura Victoria Muthoni
Kenyatta University
P.O. Box 43844 – 00100
NAIROBI

Dear Gathura

APPLICATION NUMBER PKU/519/1611 – “CONTRIBUTION OF COMMUNITY DRIVEN DEVELOPMENT HOME CARE PROGRAMS ON THE HEALTH OF PHYSICALLY CHALLENGED YOUTHS IN KIBERA INFORMAL SETTLEMENT, KENYA” - VERSION 2

1. IDENTIFICATION OF PROTOCOL

The application before the committee is with a research topic, “Contribution of Community Driven Development Home Care Programs on the Health of Physically Challenged Youths in Kibera Informal Settlement, Kenya” – Version 2.

2. APPLICANT
Gathura Victoria Muthoni
3. SITE
Kibera, Nairobi County, Kenya
4. DECISION

The committee has considered the research protocol in accordance with the Kenyatta University Research Policy (section 7.2.1.3) and the Kenyatta University Ethics Review Committee Guidelines AND APPROVED that the research may proceed for a period of ONE year from 26th August, 2016.

5. ADVICE/CONDITIONS

- i. Progress reports are submitted to the KU-ERC every six months and a full report is submitted at the end of the study.
- ii. Serious and unexpected adverse events related to the conduct of the study are reported to this board immediately they occur.
- iii. Notify the Kenyatta University Ethics Committee of any amendments to the protocol.
- iv. Submit an electronic copy of the protocol to KUERC.

When replying, kindly quote the application number above.

If you accept the decision reached and advice and conditions given please sign in the space provided below and return to KU-ERC a copy of the letter.


DR. TITUS KAHIGA
CHAIRMAN ETHICS REVIEW COMMITTEE



I, VICTORIA M. GATHURA.....accept the advice given and will fulfill the conditions therein.

Signature..... Dated this day of 29TH AUGUST..... 2016.
cc. Vice-Chancellor
DVC-Research Innovation and Outreach

Appendix VII: NACOSTI Authorization Letter



NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

Telephone: +254-20-2213471,
2241349, 3310571, 2219420
Fax: +254-20-318245, 318249
Email: dg@nacosti.go.ke
Website: www.nacosti.go.ke
when replying please quote

9th Floor, Utalii House
Uhuru Highway
P.O. Box 30623-00100
NAIROBI-KENYA

Ref. No.

Date:

NACOSTI/P/16/47108/13143

11th August, 2016

Victoria Muthoni Gathura
Kenyatta University
P.O. Box 43844-00100
NAIROBI.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on "*Contribution of Community Driven Development Home Care Programs on the health of physically challenged youths in Kibera Informal Settlement Kenya,*" I am pleased to inform you that you have been authorized to undertake research in Nairobi County for the period ending 11th August, 2017.

You are advised to report to **the County Commissioner and the County Director of Education, Nairobi County** before embarking on the research project.

On completion of the research, you are expected to submit **two hard copies and one soft copy in pdf** of the research report/thesis to our office.


DR. STEPHEN K. KIBIRU, PhD.
FOR: DIRECTOR-GENERAL/CEO

Copy to:

The County Commissioner
Nairobi County.

COUNTY COMMISSIONER
NAIROBI COUNTY
P. O. Box 30124-00100, NBI
TEL: 341666

The County Director of Education
Nairobi County.



National Commission for Science, Technology and Innovation | ISO 9001:2008 Certified

Appendix VIII: Research Permit

<p>THIS IS TO CERTIFY THAT: MS. VICTORIA MUTHONI GATHURA of KENYATTA UNIVERSITY, 45339-100 NAIROBI, has been permitted to conduct research in Nairobi County</p> <p>on the topic: CONTRIBUTION OF COMMUNITY DRIVEN DEVELOPMENT HOME CARE PROGRAMS ON THE HEALTH OF PHYSICALLY CHALLENGED YOUTHS IN KIBERA INFORMAL SETTLEMENT KENYA</p> <p>for the period ending: 11th August, 2017</p> <p style="text-align: center;"> Applicant's Signature</p>	<p>Permit No : NACOSTI/P/16/47108/13143 Date Of Issue : 11th August, 2016 Fee Received :Ksh 1000</p> <div style="text-align: center;">  </div> <p style="text-align: center;"> Director General National Commission for Science, Technology & Innovation</p>
<p style="text-align: center;">CONDITIONS</p> <ol style="list-style-type: none"> 1. You must report to the County Commissioner and the County Education Officer of the area before embarking on your research. Failure to do that may lead to the cancellation of your permit. 2. Government Officer will not be interviewed without prior appointment. 3. No questionnaires will be used unless it has been approved. 4. Excavation, filming and collection of biological specimens are subject to further permission from the relevant Government Ministries. 5. You are required to submit at least two(2) hard copies and one (1) soft copy of your final report. 6. The Government of Kenya reserves the right to modify the conditions of this permit including its cancellation without notice 	<div style="text-align: center;">  REPUBLIC OF KENYA </div> <hr/> <div style="text-align: center;">  National Commission for Science, Technology and Innovation RESEARCH CLEARANCE PERMIT </div> <p style="text-align: right; color: red; font-weight: bold; font-size: 1.2em;">10585</p> <p style="text-align: center;">Serial No.A</p> <p style="text-align: center;">CONDITIONS: see back page</p>