

30004

**FACTORS INFLUENCING CARE-GIVING APPROACHES IN  
REHABILITATION CENTRES FOR STREET CHILDREN  
DURING IN-FORMAL LEARNING ACTIVITIES  
IN NAIROBI  
KENYA**

**BY:**

**GICHUBA CATHERINE WAMBUI**

**E55/6018/2003**

**A THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE  
REQUIREMENTS FOR THE DEGREE OF MASTER OF EDUCATION  
IN EARLY CHILD HOOD STUDIES OF  
KENYATTA UNIVERSITY,**

**NOVEMBER, 2009**

**KENYATTA UNIVERSITY LIBRARY  
MAIN CAMPUS**


Gichuba, Catherine  
*Factors influencing  
care-giving*



2011/351062

**DECLARATION**

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

  
.....  
Signature

23/12/09  
.....  
Date

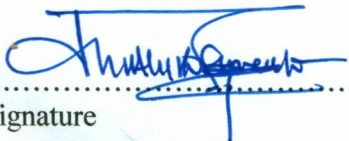
GICHUBA CATHERINE WAMBUI  
E55/6018/2003

We confirm that the work reported in this thesis was carried out by the candidate under our supervision as university supervisors.

  
.....  
Signature

23/12/09  
.....  
Date

PROFESSOR DANIEL M. KIMINYO  
Professor of Educational Psychology Early Childhood Studies

  
.....  
Signature

23-12-09  
.....  
Date

DR. JOHN A. ORODHO  
Senior Research Fellow, Department of Educational  
Management, Policy and Curriculum Development

## DEDICATION

To my husband James and our children, Maxwell and Winnie. To you I say,  
 "May God bless you with long life".

First, I acknowledge the assistance given to me by my supervisors, Professor Daniel M. Kinsley, and Dr. J. A. Gribble, who patiently studied and encouraged me through the research project. Their criticism and prompt reading of my work were most helpful and motivated me to work harder and strive for perfection.

The manager, clinical workers, and the support staff of the Gynecological Clinic, especially Kayoko Hight and Joseph King, also which participated in the study are also thanked for the assistance they offered to me in any way possible. It was significant towards the completion of this work.

Special thanks go to Dr. Gribble, for his invaluable contribution in analyzing the data. My love and thanks go to my friend Zipporah Wanjiku for moral support and invaluable assistance throughout the duration of the study. Mr. A. D. Hujana deserves special thanks for his efficient coordination.

Special thanks go to my children Maxwell and Winnie who offered moral support and encouragement throughout the duration of this work.

Special mention goes to my fellow students and staff of Barty Clinical Department, Kenyatta University for their support.

## ACKNOWLEDGEMENTS

The completion of this thesis would not have been possible without the cooperation, guidance, help, and encouragement received from a number of people and institutions. Special thanks are directed to several people and institutions.

First, I acknowledge the assistance given to me by my supervisors, Professor Daniel M. Kiminyo, and Dr. John A. Orodho, who patiently guided and encouraged me through this research providing invaluable expertise and guidance. Their critical and prompt reading of my work at various stages enlightened and motivated me to work harder and strive for perfection.

The managers, social workers and the support staff of the three rehabilitation centres namely; Kayole, Bahati and Joseph Kang'ethe which participated in the study are also thanked for the assistance they offered to me in one way or another. It was significant towards the completion of this work.

Special thanks also go to Dr. Ochoo, for his invaluable contribution in analyzing the data. My heartiest thanks go to my friend Zipporah Wanjiku for moral support and invaluable assistance she gave me throughout the duration of the study. Mr. A. D Bojana deserves special gratitude for his editorial contribution.

I thank my husband James Muhia and my two children Maxwell and Winnie who offered material and moral support that led to the completion of this work.

Special mention goes to my fellow students and staff at Early Childhood Department, Kenyatta University for their support.

## TABLE OF CONTENTS

Title Page.....	i
Declaration.....	ii
Dedication.....	iii
Acknowledgement.....	iv
List of Tables.....	viii
List of Figures.....	xi
Abbreviation and Acronyms .....	x
Abstract.....	ix

### CHAPTER ONE: INTRODUCTION

1.1 Background to the Study.....	1
1.2 Statement of the Problem.....	6
1.3 Purpose of the Study.....	8
1.4 Objectives of the Study.....	8
1.5 Hypotheses.....	9
1.6 Significance of the Study.....	9
1.7 Assumptions.....	10
1.8 Scope and Limitations.....	10
1.9 Theoretical Frame Work.....	10
1.10 Conceptual Framework.....	14
1.11 Operation definitions of terms.....	16

	<b>Page</b>
<b>CHAPTER TWO: LITERATURE REVIEW</b>	
2.1 Introduction.....	17
2.2 Rehabilitation Centres.....	17
2.3 Caregivers in Rehabilitation Centres.....	23
2.4 Social Development of Pre-Schoolers.....	30
2.5 Education for Street Children.....	32
2.6 Management Styles.....	36
2.7 Care-giving Approaches.....	40
2.8 Summary of Literature Review.....	44
<b>CHAPTER THREE: RESEARCH METHODOLOGY</b>	
3.1 Introduction .....	47
3.2 Research Design.....	47
3.3 locale of the Study.....	47
3.4 variables.....	48
3.5 Target Population.....	50
3.6 Research Instruments .....	51
3.6.1 Questionnaire.....	52
3.6.2 Observation Schedules.....	52
3.7 Pilot Study.....	53
3.7.1 Reliability.....	53
3.7.2 Validity.....	54
3.8 Data Collection .....	54

	<b>Page</b>
3.9 Data Analysis.....	55
3.10 Data Presentations.....	57
 <b>CHAPTER FOUR: RESULTS AND DISCUSSIONS</b>	
4.1 Introduction.....	59
4.2 Descriptive and Inferential Analysis.....	59
4.3 Comparison of Care-Giving Approaches.....	63
4.4 Comparison of Management Styles.....	77
 <b>CHAPTER FIVE: SUMMARY, CONCLUSIONS AND RECOMEDATIONS</b>	
5.1 Introduction.....	87
5.2 Summary.....	87
5.3 Conclusion.....	88
5.4 Implications.....	89
5.5 Recommendations.....	91
<b>REFERENCES.....</b>	<b>96</b>
<b>APPENDICES.....</b>	<b>102</b>
Appendix I Questionnaire .....	102
Appendix II Observation schedule I.....	105
Appendix III Observation schedule II.....	106

## LIST OF TABLES

	<b>Page</b>
Table 3.1 Observation pattern.....	53
Table 3.2 Mean scores for management styles.....	56
Table 3.3 Mean scores for approaches.....	57
Table 4.1 Distribution of care-givers by gender.....	60
Table 4.2 Distribution of care-givers by Education level.....	61
Table 4.3 Population distribution in the centres.....	62
Table 4.4 Ranked scores in approaches.....	63
Table 4.5 Mean scores of care-giving approaches.....	64
Table 4.6 Analysis of variance of approaches .....	67
Table 4.7 Distribution of care-givers' age in the rehabilitation centres.....	69
Table 4.8 Correlation coefficient of the age of care-givers.....	71
Table 4.9 Distribution of care-givers' experience in years.....	72
Table 4.10 Correlation coefficient of the experience of care-givers.....	73
Table 4.11 Distribution of care-givers training levels.....	75
Table 4.12 Correlation coefficient of the training of the care-givers.....	76
Table 4.13 Ranked scores in management styles.....	78
Table 4.14 Comparison of the use of management styles by care-givers.....	79
Table 4.15 Analysis of variance of management styles.....	81
Table 4.16 Correlation coefficient of management styles & care-giving approaches.....	82
Table 4.17 Correlation coefficient of specific management styles & specific Care-giving approaches.....	83

## LIST OF FIGURES

	Page
Figure 1.1 Conceptual frame work.....	15
Figure 4.1 Comparison of the use of approaches by care-givers in the centres.....	66
Figure 4.2 Comparison of the use of management styles in the centres .....	80

### **Abbreviations and Acronyms**

AIDS	- Acquired Immune Deficiency Syndrome
AHRQ	- Agency for Healthy Care Research and Quality
CBO	- Community Based Organizations
CNSP	- Children in Need of Special Protection
ECD	-- Early Childhood Development
FPE	- Free Primary Education.
HIV	- Human Immune Virus
NACECE	- National Centre for Early Childhood Education
NARC	- National Alliance Rainbow Coalition
NASC	- National Alliance for Street Children
NCBDA	- Nairobi Central; Business District Association
NFCA	- National Family Caregivers Association
NGO	- Non Governmental Organization.
NICHD	- National Institute of Child Health and Human Development
SFRT	- Street Families Rehabilitation Trust
UNICEF	- United Nations International Children's Education Fund.
ANOVA	- Analysis of Variance
SPSS	- Statistical Package of Social Sciences
MDG's	- Millennium Development Goals
EFA	- Education For All

## ABSTRACT

The Government of Kenya led an emergency response to provide and improve the situation of the street children, youth and families, which was initiated in 2003 and commenced in 2004. This led to establishment of rehabilitation centres to cater for children from the streets. Care-givers were employed to perform responsibilities of reforming and promoting the developmental aspects of these children through rehabilitation, according to set standards in the country. However, this is not the case and the problem of the street children seems to persist. There is a possibility that care-giving services offered in the centres are not of quality that can transform and help reduce the psychosocial imbalance in street children. The purpose of the study was to investigate factors that influence care-giving approaches among care-givers, in rehabilitation centres during non-formal education sessions for street children. The objectives were to identify care-giving approaches, investigate management styles used, and establish if there was any significant relationship between these approaches and the age, experience, training and management styles of the care-givers. The study was guided by Bandura's Social Learning Theory. It emphasized on the role of the adult and social environment of the child. From existing literature, it showed that early interpersonal experiences with the family plays a decisive role in the psychosocial development of a child. The study adopted an exploratory ex-post-facto research design. Fifteen care-givers were involved from three Government rehabilitation centres in Nairobi Province. The sample was selected using purposeful sampling procedure. A questionnaire was used to establish demographic data from care-givers; observation schedule was utilized to probe for the frequency of the use of the care giving approaches and management styles. The data collected were coded, quantified, and then analyzed. Data presentation was done using means, percentages, tables and graphs. Hypotheses were tested using ANOVA and Pearson Product Moment Correlation ( $r$ ). The probability level of testing hypotheses was at 0.05 and 0.5 respectively. This was done in line with Statistical Package for Social Science (SPSS) program. The study was of great significance to policy makers, social workers, managers, educationists, practioneers, care giving institutions, and curriculum developers. The study reports findings on use of care-giving approaches and management styles among the care-givers. It was noted that determination approach was more frequently used in all centres. The management style that was more frequently used by care-givers was authoritarian in all the centres. However, the findings showed that, there was no significant difference between care-giving approaches used in all centres, and there was no significant relationship between the management styles and care-giving approaches in the centres. Recommendations were made to managers, social workers, educationists who deal with street children, policy-makers, curriculum developers and others who are interested with rehabilitation of street children. Further studies were also recommended on other factors thought likely to affect the use of the overall care-giving approaches.

## CHAPTER ONE

### INTRODUCTION

This chapter consists of the background information, statement of the problem, purpose, objectives, questions of the study, hypotheses, theoretical /conceptual frame work, and operational definitions.

#### 1.1 Background Information

Children in need of special protection (CNSP) are children whose rights to survival, development, protection, and participation have been violated (UNICEF, 1996). This results in situations where the children may live in extremely difficult circumstances. The situations of CNSP have not been well captured, and documents with available data are often incomplete and sometimes overlap (Katambo, 2001). Some of the children under difficult circumstances include orphans, neglected, and street children. Street children are vulnerable to various forms of exploitation and abuse. They are deprived, not only of their rights as children, but also of their childhood. They live without guidance, concern, love, education and security. These children face an obscure future (UNICEF, 1996).

The problem of street children is universal (UNICEF, 2004). It is estimated that there are 100 million street children in the world (Volp, 2002). The number has plummeted in recent decades because of wide spread recession, political turmoil, civil unrest, increasing family disintegration, urban and rural poverty, natural disaster and rapid industrialization (Mohamed, 2002). The United Nations International Children's Education Funds (UNICEF), estimates that, out of 100 million children who call

streets their homes, only 20 million children live in streets, without their families. In South America alone, there are at least 40 million children, in Asia, 25 million children and Europe approximately 25 million. Estimates in most countries have fluctuated widely (UNICEF, 2004).

In Brazil, the exact number of street children is not known. According to unofficial estimates, the numbers range between 200,000 and 1 million. But this number does not necessarily correspond to the number of children who live on the streets. These children fall between ten and eighteen years of age. Most of them work in Brazil streets. These children do what they can to survive ranging from selling candy on street corners, shoe shining and watching parked cars; to drug peddling, petty theft and prostitution (Mitchell, 2003).

In Pakistan, there is a population of 135.6 million, where more than 22.5 million are adolescents. In a survey conducted by the National Council of Pakistan, about 1.2 million children are reported to be in the streets of Pakistan's large cities, working as beggars, vendors, or shoeshine boys. Children become homeless because of abuse and poverty and once on the streets, they are exposed to countless hazards, including child labour and sexual exploitation. Cities like Mumbai, Calcutta, Manila, Zenario, Mexico, Bangkok, are some of the examples where street children are found in large numbers (Mohamed, 2002).

Due to poverty, abuse and HIV/AIDS, there are thousands of children in the streets in the African region. It is estimated that 450,000 children live on the streets of Ethiopia

and 35,000 in Khartoum, Sudan (Save Children Sweden, 2003/2004). Once children are forced on the streets, it is very difficult to resettle them in the society.

In Kenya, the exact number of street children and families is unknown. However, a survey conducted in 13 districts under Government of Kenya (UNICEF, 1996) programme of cooperation, estimated that, there were 109, 763 such children. The estimates were as high as 250,000 with 60,000 street children reported in Nairobi but the estimates were not based on a practical survey. It was estimated that over 600,000 children in Kenya were in need of special protection (UNICEF, 2004). A practical headcount of street children in Nairobi identified some 10,000 street urchins (UNICEF, 2004) suggesting the total number may be under 20,000 street children. This could have been as a result of children going back to the streets from rehabilitation centres. There is, at the same time a moral concern for the society to do something to help the street children. With the increasing number of street children, youth and families, also the number of Community-Based Organizations and Non-Governmental Organizations (CBOs and NGOs), and private interventions addressing the plight of street children they have increased to about 250,000 in greater Nairobi alone (Kevin, 2004). While existing efforts to address the plight are commendable, they have proved insufficient (Office of the President, 2001).

The Government of Kenya led an emergency response, which was initiated in early 2003 to provide and improve the situation of street children, youth and families and offer services such as Free Primary Education (FPE), shelter and food, among many. This was implemented in January 6<sup>th</sup> 2003, (David, 2003). Further developments in

the readiness of programme of destitute children so far include the efforts made by Ministry of Gender and Children Affairs and Ministry of Local Government in rehabilitation of street children and families through Street Families Rehabilitation Trust Fund. This initiative commenced on 24<sup>th</sup> January 2004. The projects coupled with the Free Primary Education programme (FPE) have been interpreted as positive developments in the readiness of the street children reality (Mugo, 2004). This led to the establishment of rehabilitation centres to cater for children from the streets.

The government employed care-givers to perform the responsibilities of reforming and promoting the development aspects of these children, according to the set standards in the country. Through socialization, children learn social skills, attitude and values, which enable them to interact, relate with other members of the community and preparation for schooling. The psychosocial development follows similar pattern all over the world, although social customs vary in different societies (Munyakho, 1992).

More research focusing on children living and working on the streets has been carried out, and is documented in the work of Munyakho (1992), Suda (1997). On the legal dimension with street children, Kattambo, (2001); Slade (1979) wrote on the "law of adaptation in Kenya", and was closely followed by Ikiara's (1980) dissertation on 'child abuse'. The other works include Miring, (1988) on the status of children in Kenya; Kabeberi, (1990) on the child custody, care and maintenance; Mugo, (2004) on rehabilitation of street children in Kenya (2004). As indicated by these research works, there has been a general bias towards sociological and legal

questions. Care-giving approaches and the challenges facing rehabilitation centres have only been a by-the-way, if they are there at all (Mugo, 2004).

The introduction of the Children's Act Cap 586, gave the government the mandate and responsibility to protect all children especially those in difficult circumstances and provide for their rights. There is recognition of the need to have clear policies to implement actions which will address the phenomenon of street children. Most importantly, they need to be steered back to the main stream of social life, through proper education opportunities, reformation, care and rehabilitation (Mohamed, 2002).

Education is a basic human right, which should be provided to all children even those in difficult circumstances without discrimination. This is in line with the Millennium Development Goals (MDGs) that the Universal Primary Education should be achieved by 2015. This is also supported by the Education For All (EFA) goals whereby a comprehensive Early Childhood Care and Education (ECCE) for the most vulnerable and disadvantaged children should be expanded and improved by 2015.

One important way of empowering children in especially difficult circumstances, is ensuring that they access quality education, and making sure that they are able to function in the global arena. In this connection, the use of care-giving approaches and management styles in the rehabilitation centres is significant. Care-giving approaches and management styles are used by the care-givers to inculcate values, in acquisition of knowledge and social skills in children. Care-givers who use these approaches and

styles help children to participate in their daily activities more actively, confidently, acquires new skills, knowledge and develop personally and socially. It also helps to sustain children in centres long enough to equip them with skills for self-reliance.

The main aim was to transform and help reduce the psychosocial imbalance in the street children, to be able to steer them back to the main stream and sustain them in the centres which are the only places these children can be provided with basic education and vocational training. They need to be sustained long enough to equip them with appropriate education and vocational training skills necessary for self-reliance. This was to be done through the use of the care-giving approaches and management styles. At the same time, there is a growing awareness of the gaps in care service provision at both reception and rehabilitation levels, available for street children (GoK, 2003). Some children have gone back to the streets resulting to increased number of children again in the streets of Nairobi. This has not been explored and documented.

It is against this background that the study investigated why this is the case, and this called for the need to establish and document the care-giving approaches and management styles used in the rehabilitation centres, and the relationship between these approaches, and management styles.

## **1.2 Statement of the Problem**

Globally, a lot of studies have been done on care-giving approaches. These studies have reported that some care-giving approaches such as loving, determination and

courtesy are most effective and are more likely to lead to positive outcome for children. Management styles such as authoritarian, democratic styles are effective if employed appropriately by the care-givers in the rehabilitation centres (Kings & Hayslip, 2005). There is a lot of emphasis on the role of adults and social environment and they show that an early interpersonal experience with the care-givers plays a decisive role in psychosocial development of a child. They have further shown that, care-giving approaches and management styles are important for holistic growth and development of young children. This helps in sustaining children in the rehabilitation centres long enough to be equipped with skills for self-reliance (Jennifer, 2006). This implies that it is important to study care-giving approaches and management styles employed in rehabilitation centres for street children. Such studies are largely lacking in Kenya. Children are going back to the streets from the rehabilitation centres resulting to increased number of children in the streets. There is a possibility that the low sustainability of street children in rehabilitation centres for street children could be due to use of inappropriate care-giving approaches and management styles. The need to establish care-giving approaches and management styles used in the rehabilitation centres and the relationship between these approaches and management styles is imperative. Without proper understanding of these approaches, management styles and their relationships could deter the objective of sustaining street children in rehabilitation centres long enough to equip them with skills for self-reliance.

### **1.3 Purpose of the Study**

The purpose of the study was to find out how care-givers' age, experience, training and management styles influence the use of care-giving approaches, in the rehabilitation centres for street children during in-formal learning activities in Nairobi.

### **1.4 Objectives of the Study**

The study focused on the following objectives:

- i. To identify different care giving approaches used in the rehabilitation centres for street children during informal learning activities.
- ii. To establish any significant relationship between overall care-giving approaches used during informal learning activities and care-giver's age.
- iii. To establish any significant relationship between overall care-giving approaches used during in formal learning activities and care-giver's experience.
- iv. To establish any significant relationship between overall care-giving approaches used during in formal learning activities and care-giver's training.
- v. To establish any significant relationship between management styles and care-giving approaches used in the rehabilitation centres during informal learning activities.

## 1.5 Hypotheses

- H<sub>01</sub>: There is no significant difference between the frequencies of care-giving approaches used in the rehabilitation centres during informal learning activities.
- H<sub>02</sub>: There is no significant relationship between care-givers' age in years and overall use of care giving approaches during informal learning activities.
- H<sub>03</sub>: There is no significant relationship between care-givers' years of experience and overall use of care giving approaches during informal learning activities.
- H<sub>04</sub>: There is no significant relationship between care-givers' level of training and overall use of care-giving approaches during informal learning activities.
- H<sub>05</sub>: There is no significant relationship between the frequency of the management styles and overall use of care-giving approaches used in the rehabilitation centres during informal learning activities.

## 1.6 Significance of the Study

The findings of this study may be useful to policy makers, who may see the need of coming up with appropriate and clear policies to guide rehabilitation centres on rehabilitation process, training, and recruitment of the care-givers. The managers who may see the need of using appropriate management styles, and appropriate care-giving approaches during informal learning activities for enhancing holistic development of young children. The social workers, care giving institutions and other practitioners should be aware of factors that may influence the approaches. The curriculum developers who may see the need to come up with a curriculum on care-giving approaches as well as its supervision. The report could also serve as a source

of information and reference to the public and other bodies concerned with the rehabilitation centres.

### **1.7 Assumptions**

It was assumed that the rehabilitation centres employ a variety of care-giving approaches and provided children with basic needs.

### **1.8 Scope and Limitations of the Study**

The study was conducted in Nairobi Province the capital city of Kenya. There are a lot of industries which attract the rural- urban migration resulting to high population. This leads to poor housing, unemployment, inadequate social amenities and most of the families live under less than a dollar a day, this leads children going to the street due to lack of basic needs. The study confined itself to the care-givers in the rehabilitation centres for the street children in Nairobi which were managed by the government.

### **1.9 Theoretical Framework**

This study was based on Social Learning Theory by A. Bandura (1962). It is also referred to as an Observational Learning Theory or Modelling, which emphasizes on the interaction and modelling which helps the child to develop psychosocial aspect (Bandura 1962). This theorist found that, for an individual to learn from observing models, four components have to take place (Bandura 1971 as quoted by Thomas (1990).

These components are attention process, which depends on attending to, and perceiving accurately, significant features of the modelled behaviour. Attention is regulated by the observer's characteristics, features, of the modeled activities and the structural arrangements of human interactions. Retention process is dependent on memory or retention of modelled activities. However, observation learning is dependent on two representational systems- imaginable and verbal. More so, visual imagery is vital in early ages while verbal skills are minimal or lacking. An important element of symbolic coding for retention is rehearsal, which can be mental or physical.

Motor Reproduction process, modeled patterns result in reproduction of behaviour as an achievement after organization of responses. The end product depends on availability of component skills and ability to assimilate. Deficits in performance can be reduced by modelling and more practice. For purposes of accuracy, it is important to correct and adjust as practice goes on. Trial and error fumbling can be refined to perfect performance after thorough practice.

Motivation process, acquisition and performance will depend on observed consequences. Negative consequences will result in rejection as opposed to what is self-satisfying (Bandura 1971:24, 28). Provision of models will not necessarily produce similar behaviour due to many factors controlling observational learning. Demonstration of desired responses instructs and prompts those who fail while rewarding those who succeed. This provides a framework through which the

acquisition of behaviour, by means of a series of complex reciprocal interactions between the organisms and environment can be understood (Bandura, 1971).

Bandura emphasizes on the social environment of the child. The theory is very important in the study because it can be used by the care-giver to modify behaviour (Thomas, 2002). It also describes specifically the motor skills, concepts, moral values that the learners are to acquire and be shown in observable actions. The theory was important to the study because it emphasizes on the role of society, culture and adults who are the care-givers who act as models to the child. The Social Learning Theory can be used in modification of behaviour by the care-giver since it is a behaviourist theory of imitation. It is based on the assumption that learning involves models of various kinds (Alexander 2005). This is the act of social influence on the child.

According to Alexander (2005), the term model refers to an actual person whose behaviour serves as a guide, a blue print, and an inspiration for somebody. It also refers to a symbolic model, which includes such things like books, verbal, cartoons or even film character and TV programme. According to Social Learning Theory, children learn from observation and imitating people who are powerful and significant in their lives. This initiated behaviour can be learnt without reinforcement or with only vicarious reinforcement (Bandura, 1971). He describes these effects of imitation on learning in children.

Modelling effect is a way children imitate or model behaviour and receive reinforcement for that action. The individual has an active role in determining what classes of behaviour are imitated, with what frequency and intensity. Care-givers are probably the most powerful models in a child's life and, therefore, potentially the best teachers, and this helps the child to do something new, that is, they behave in a normal way to show that modelling effect has taken place. The next level is where very often the model will serve to elicit or precipitate a behaviour that already exists in the repertoire of the learner but what has not been called actively stimulated. Much behaviour is not facilitated unless they become necessary. The social care of eliciting effects by observing a model, however, can also act to disinhibit or inhibit a behaviour, which can be done through interaction with other models. Bandura (1962) emphasizes on the social environment of the child. The theory is very important in the study because it can be used by the care-giver to modify behaviour (Thomas, 2002). It also describes specifically the motor skills, concepts, moral values that the learners are to acquire and be shown in observable actions.

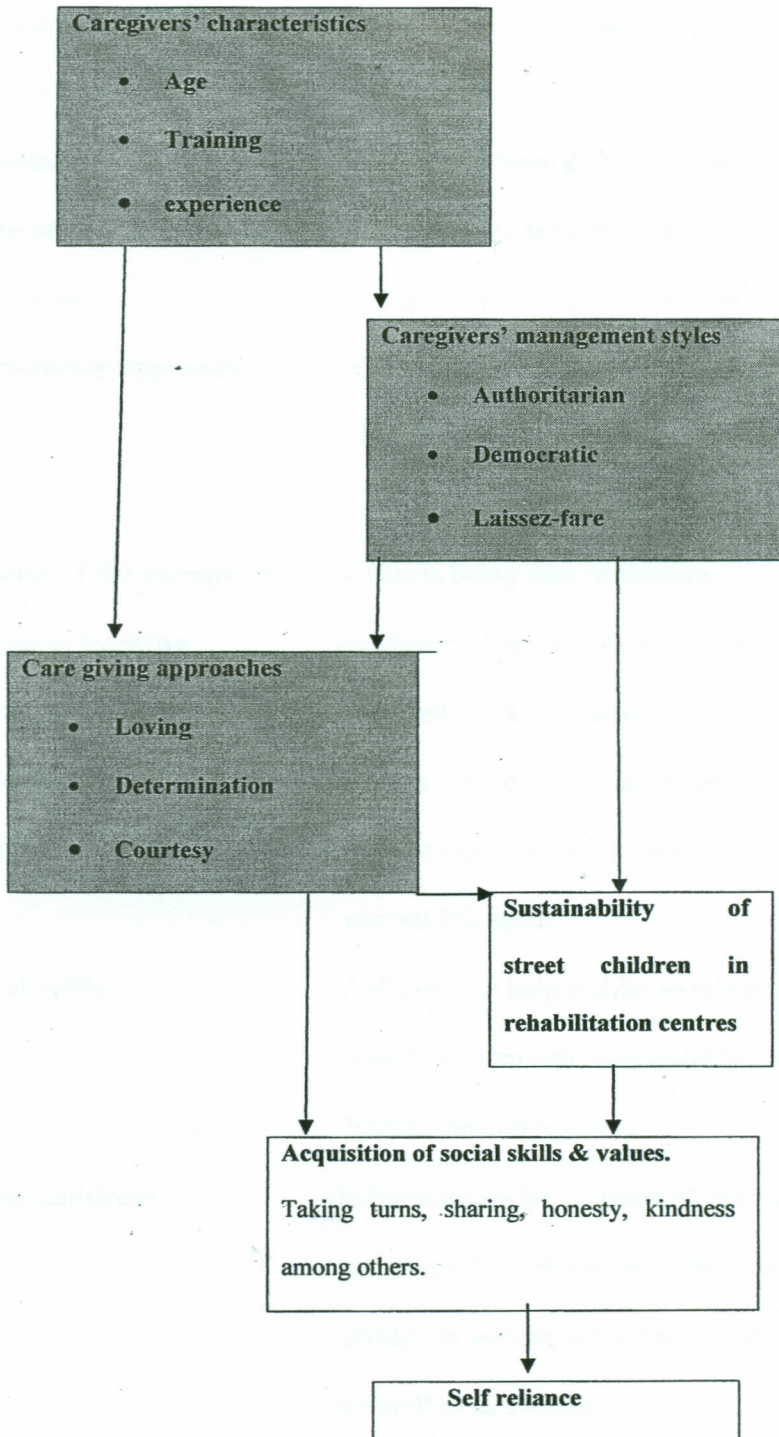
### 1.10 Conceptual Framework

The conceptual framework(Fig. 1:1) below explains the effects of the care-giver's characteristics which are the care-givers' age, experience, and training, to management styles which are the authoritarian, democratic and *laissez-faire* to the care-giving approaches which are loving, determination and courtesy, and their effects on sustainability of street children in the centres.

The care-givers' characteristics influence the care-giving approaches, which affect the sustainability of street children in the centres and as a result influence the acquisition of social skills of children in the rehabilitation centres for self-reliance. The care-givers' characteristics may influence the management styles which affect the sustainability of the street children in the rehabilitation centres.

For children to be self-reliant, they need to acquire social skills and values, only if they are sustained in the rehabilitation centres long enough to be empowered. This is determined by the care-giving approaches and management styles used by the care-givers which are influenced by the care-givers' characteristics.

**Figure 1:1 Effects of care-givers characterizes**



**Source: Researcher**

### 1.11 Operational Definitions of Terms

- Academic level of caregiver:** - The highest level the care-giver has attained in education.
- Attention:** - Ability to learn through observations.
- Burn out:** - Stress that has built up to an intolerable level.
- Care-giver:** - Person who handles and takes care of children.
- Care-giving approach:** -This constitutes the total frequencies of use of certain behaviours by care-givers to instill values in children in rehabilitation centres for street children.
- Gender of the caregivers:** - This is being man or woman.
- Informal learning** -Activities that are not structured. They are carried out the centres that disseminate skills and knowledge.
- Pre-school child:** -This is a child who is aged between 4 and 6 years.
- Rehabilitation centres:** - A place where street children are helped to have a normal life again.
- Social skills:** - Abilities that help a child to relate to physical and social environment such as taking turns, sharing interaction and courtesy.
- Street children:** -Individuals under 18 years of age who have completely or partially ruptured ties with their families and engage in various activities on the street. They are also referred to as urchins.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1 Introduction**

This chapter reviews literature related to this study under the following sub-sections: rehabilitation centres, care-givers' role, characteristics of the care-givers, training, ratio, and age, social development of the pre-schoolers, management styles, and care-giving approaches and education programmes for street children.

#### **2.2 Rehabilitation Centres**

Rehabilitation treatment centres refer to any of several kinds, or levels, of counselling available for individuals that have problems with drugs, alcohol abuse or behaviours. Some rehabilitation centres are residential, offering long term or short-term services, which depend on the result of competent substance abuse (glue) screening, and evaluation done by rehabilitation centres. There are also places where children are housed, fed and given care, which can be qualitative and quantitative, that is, fulfilling the needs of the children (Andy, 2007).

Individual participation brings satisfaction, better understanding and liking, desire to learn more. The children should be provided with nutritious food, which will satisfy their salient needs, and the environment should be conducive to enable children to have appropriate growth and development of all aspects. Street children are involved in many undesirable activities before they join rehabilitation centres. Some of these include stealing, mugging and drug trafficking (Philip, 2002). The mission of

rehabilitation centres is to improve family capacity, to be self-sustaining while creating a safe and permanent living environment for children (Panter, 2002).

Alchlom (1969) developed therapeutic methods to work with young offenders. Through the years up to the 1970s, treatment with offenders was dominated by methods following psychodynamic principles, with counseling and group therapy in particular, widely-applied. In addition, educational programmes proved popular during that period are still evident today (Schweinhert, Barners & Barners & Welkart, 1993). Treatment with a psychodynamic tradition continues today (e.g Conders & Cox, 1996), the decades 1970s 1980s and 1990s has been an upsurge in offender treatment programmes based on behavioural and cognitive- behavioural principles ( Hollin: 2004, Mcquire: 1995: Nitzel: 1979: Ross & Fasino, 1985). This is certainly why by the late 1950s and into 1960s, a position had been reached in which psychological theories had been applied to criminal behaviours and associated treatments were relatively widely used for a range of offender groups.

If the 1980s saw a fall of rehabilitative ideal, then the early 1990s witnessed a spectacular resurrection mainly in Canada, Britain and parts of the United States. Studies done on effects of offenders treatment show that, treatment can have a small but significant effect in terms of reducing, reoffending further when certain treatment factors are combined, the meta analysis suggests that this small effect can be considerably enhanced. It has, therefore, proved possible to describe the characteristics of high impact programmes for offenders. Briefly, high impact programmes would have the following characteristics. Practically, they would be delivered using a

structural programme with defined aim and objectives. The treatment would be delivered by highly trained practitioners. Organizations would support, manage and evaluate the programmes to ensure high treatment integrity (Hollin, 2004).

In Pakistan, the Edhi Foundation runs centres called Ana Guar (our home) for street children and the mentally ill orphans and runaways. There are ten such homes in the country, out of which seven are located in Karachi. About 6000 people live in Edhi home. A destitute or homeless person becomes a member of Edhi family once he/she enters its premises (Mohamed, 2002).

Marie Adelaide rehabilitation programmes has centres, which is among those actively pursuing the cause of street children based on Burns Road Karachi. It is one of the few centres providing meaningful services to these children where they can take bath, have access to medical checkup services, and consultations with street counsellor. They are also provided with clothes. There are around 60 children from different parts of Karachi who regularly visit the centres and use the facilities. Though the children were initially reluctant to visit the centres, they were eventually convinced and started to bring their friends involved in glue sniffing and were being rehabilitated as well (Phases 1, 2005).

In Latin America, Casa Alianza is a branch of the New York based covenant house. It serves some 4,000 street children a year. It is dedicated to helping children from the

streets and back to meaningful and productive lives through a four-termed programme that fosters stability and restores hope. (Casa, 2000).

Casa Alianza's four tiered programme helps to reach the street children and encourage them to leave the streets. The programme is designed to meet their needs. The very first step is to reach out to children on the streets, in parks, in darkened hall alleys around garbage dumps, and bus terminals. They provide emergency medical care, counselling, non-formal education and other basic needs (Casa, 2000).

### **2.2.1 Crisis Centres**

Children are provided with a structured and supportive environment. In these centres, children are fed, clothed, given clean beds, diagnostic and medical treatment, education and vocational training, security and most importantly hope and love. Children also participate in non-formal educational activities which prepare them for public school system. As soon as they regain some self-respect and hope for better tomorrow, the children are transferred to transition homes. The staff in the homes are specifically trained to help the children develop long-range goals and to inspire a desire for an independent and productive life. Young children are enrolled into public schools and have productive life. Average residency in a transition home is four months, and then children will move to a group home. The last step in the arduous journey from despair to self-sufficiency involves residency in a group home, where children are nursed by a carefully chosen team of counsellors, who try to replicate a positive family environment.

It is in such a setting that children learn to bond with a surrogate family while pursuing further education or professional opportunities. Each home or house has an average of 14 boys and girls. The children remain at the home until their eighteenth birthday or until they complete their education. When they leave the home as young adults, they have vocational and life skills indispensable for independent living.

In Guatemala and Mexico in response to the growing number of street girls who became pregnant, and to prevent the death of babies who were dying from lack of care, this programme was started. It offers rehabilitation services for such individuals and groups therapy and childcare training vocational training (Manuel 2001). In most of the centres, staff are rehabilitated addicts so they work with more enthusiasm and commitment (Mohamed, 2002).

In Kenya, the National Alliance of Rainbow Coalition (NARC) government demonstrated a clear political commitment to improve the wellbeing of children, youth and families in the streets (GoK, 2003). The current government has assumed responsibility for preventing and stopping violations of human rights and this has clearly been demonstrated through powerful emergency response to the situation of street children.

The NARC manifesto also motivated society in general to participate in translation of political goodwill into positive outcomes for street children, youth and families. However, for NACR government, resolving the problem associated with street homelessness is an integral part of alleviating poverty throughout Kenya (GoK, 2003).

In spite of the efforts that had been put in place in the institutions, National Institute of Children Health and Human Development (NICHHD) researchers discovered that many street children remanded juvenile courts in Nairobi for protection and discipline, had been released back to the street because there was no room in the institutions and often the institution itself may be inappropriate to the needs of the street children (Munyakho, 1992).

Although the Kenya government is obligated to provide education for all, many actors play vital roles in delivery, from international agencies to all local communities, non-governmental organizations (NGOs) and religious groups. All over the world, NGOs have initiated education programme for street children (Ouma, 2004).

In Kenya, there are about 250 NGOs offering formal and non-formal education such as *Undugu* Society of Kenya. (USK), Tunza Dada, Kwetu Home, Good Samaritan Home and *Imani* among others (Ouma, 2004). Besides feeding, sheltering and educating disadvantaged children, in rehabilitation homes, they look into employment creation, and small enterprise development in the pursuit of affordable shelter, nutrition and health. Their objectives are to rehabilitate, educate and train these children within the framework of a wide range of community development to improve the conduct and prospect of all local children whose future appears uncertain (Ouma, 2004).

The implementation of Free Primary Education (FPE) for all, and land resettlement programmes are important contributions towards removing and eliminating the conditions that cause children, youth and families to take to the streets. For this to

benefit current population however, reintegration process must be put in place, that enables children youth and families to build the emotional, cognitive and social competencies required before they can take full advantage of either educational, or income-generating activities. It is worth noting that providing opportunities alone without adequate reintegration process, few street children will be able to sustain income-generating activities. This led to establishment of rehabilitation centres to provide re-integration, and cognitively to be able to fit well in society and in the classroom experiences (GoK, 2003).

### **2.3 Care-givers in Rehabilitation Centres**

In rehabilitation centres, there are employees whose duty is to provide care to the children. It is estimated that more than fifty million people have been care-givers. The role of care-givers is expected to increase as population ages. However, the number of individuals for care-giving is likely to diminish. In addition, men increasingly fill care-giving roles and family care-givers can be found across the spectrum of household income. From the available body of literature and reports, it has been reported that most care-givers are females. There are differences in ways that men and women fill care-giving roles. Female care-givers tend to report greater levels of stress or strain than do males (Neil, Ingersoll- Dayton, & Starels, 1997. Montgomery & Kosloki, 1991; NAC/ AA RP, 1997, Stone *et al.*, 1987; Wagner, 1997). However, the number of male care-givers appear to be rising and survey conducted by the National Family Care-giver Association (NFCA) found that 44% of the care-givers interviewed were males (Gail, 2000). Moreover, among spousal care-givers, men are more likely to be the primary care-givers as compared to women (Gail, 2000).

The effective care-givers serve as advocates and nurses. More so, they organize and understand the childrens needs, socialize while performing and promoting the development aspects. Close attachment and bonds between children and care-givers, are important part of children's development and learning (Niagara, 2004; Gail 2000).

### **2.3.1 Role of Care-givers**

Through the comforts and responsiveness of an adult, pre-schoolers will learn to handle their emotions, and to seek help when needed. Adults need to praise their efforts and provide feedback about what the child has done well. This leads to children being encouraged to take more activities independently, gain confidence and feel motivated to be independent (Shauna, 2004). Adults can also be available for them and be prepared to talk, and give special responsibilities, which lead children knowing that the care-giver takes interest in their activities. They feel valued by the care-givers' availability, and feel secure. They also have a special role. They feel independent, gain confidence and have a stronger sense of self. Parents can provide opportunities for the pre-schoolers to create their own stories, either by drawing pictures or just telling them to others, and praising their efforts. This results into the children using their imaginations, experimenting, feeling proud of their accomplishment and having a strong sense of their abilities (Bandura; 1975, Junn, 1997).

Through opportunities for play, children will experience joyful, free spontaneous moment of fun, while also learning about themselves and others. There is need to provide opportunities to play with others, adults to spend time playing simple games.

This leads them to practise some of the skills and refine them for school. They will also be involved in problem solving and conversation. They feel a sense of belonging and learn to play co-operative games (Neil, 1981, Shauna, 2004).

Through routines, children being emotionally and physically, safe, and having secure environments, they learn how to think, solve problems, and communicate. The care-givers need to ask specific open-ended questions, explain reasons behind requests, and encourage them to stay involved in play activities. This will lead children in the centre having a better understanding of routines, rules and limits. They will learn to persist on task, feel a sense of leadership and feel valued and important (Junn, 1997). Children develop skills at an even rate. Any child may be “above average” in one skill, and ‘below average” in another, for an individual child’s abilities and interest at any point in the development of young children (Shauna, 2004). Why do children grow in an even rate? Does it have a relationship with care-giving approaches used by the caregivers?

### **2.3.2 Training and Experience of the Care-givers**

Care-givers with strong knowledge of child development recognize how important it is for children to have a sense of belonging, being loved and trusted in their environment. Warm and caring relationships with adults provide children with the basis for all types of learning. For instance, studies show that presence of alternative care-givers encourages children to explore their worlds (Shauna, 2004; Junn, 1997). Responsive adults’ help children extend their learning and reach out to other children.

Specific training in Early Childhood Education is critical because even most supportive care-givers may not fully understand children's needs at different stages of their development. Also, working with groups of young children is very different from relating to one's own child or neighbours' child. Care-givers who attend workshops, courses, and staff development programmes are better able to create strong bonds with children and are responsive to all children in their care (Shauna, 2004; Gichuru, 1987).

The National Institute of Child Health and Human Development (NICHD, 2006) stated that the higher the care-giver's education level, the prediction is higher quality of observed care and better developmental outcomes for children. Research presumed that quality childcare promotes the developmental wellbeing of children, (NICHD 2004). Because very young children have limited ability to communicate their wants and needs, it takes a skilled and experienced adult who knows the child well to recognize different signals and respond appropriately. Care-givers should be sensitive to each child's learning needs, a unique combination to individual, developmental and cultural characteristics. Such attention helps children develop self-confidence and self-worth. (Suda, 1994; Jill, 1997). Good care-givers know that children's learning occurs best in informal activities and as much as in formal instructions. Children's language development, for example, begins with their earliest interactions. Attentive care-givers, help children to learn the words with which to communicate their needs effectively. They see everyday caring routines as opportunities for expanding children's language skills (Niagara, 2004; Gail, 2000). The care-givers are trained in Early Childhood Education (ECE). With particular regard to: use of appropriate

activities, preparing children for bed, behaviour management using positive methods of child guidance and emergency procedures (Niagara, 2004; Gail, 2000).

According to a study by Alexander (2005), statistically significant but smaller correlation was observed between care-giving and care-givers' experience indicating that positive care-giving was more frequent among caregivers with fewer years in the field. He also observed that care-giving was not significantly correlated with specialized training related to children's experience *per se* did not affect positive care-giving. Care-givers formal education and specialized training did not appear to contribute substantively to the frequency or rating of positive care giving although research by McCarty (1988; Vandell & Powers, 1993, White book *et al.*, 1990) indicates their importance.

According to professional standards for childcare recommended by the American Academy of Pediatric and the American Public Health Association on training and education of the staff, those providing childcare should have formal high school training including certificate, or college, degree in child development, Early Childhood Education related field (NICHD, 2006). The research revealed that when education of care-givers is limited, the care provided tends to be of lower quality and children's development is less advanced (NICHD, 2004).

From the literature reviewed, there is a clear indication that it is important to have knowledgeable and experienced care-givers on child development issues. This is because they are also able to: address the children's needs at various stages, create

strong bonds with children and are responsive to all children in their care. They also provide appropriate activities, which help learning to occur. And they encourage children to explore their world.

### **2.3.3 Adult Child- Ratio**

To be able to provide adequate care and stimulation, the aspects of age and the number of children the adult should handle is very important. It is, therefore, recommended that for children below one year, the care-giver to child ratio should be 3-4 children per adult while the care-giver: child ratio for 3 year old children, should be, 10-15 per adult (GoK/MoE, 1999). For group size 6 months-1 ½ years to have 6 children, in the group1, 1½ years-2 years have 8 children and 2-3 years to have 14 children in a group as recommended by the American Academy of Pediatrics (NICHD, 2006).

The following features help to strengthen the ties between children and the care-givers: having small groups of children not more than six to eight babies, six to ten toddlers and sixteen to twenty pre-schoolers and always with at least two adults; also the childcare campaign and advocacy organization in U.S.A. recommends not four infants in a group, not more than eight to ten toddlers in a group and at least with one adult. There is need to have a primary care-giver assigned to infants and toddlers to promote consistency and responsiveness. Also, scheduling that keeps groups of children with the same care-givers, for extended periods of time, rather than changing with traditional school years or even more frequently. There should be a low staff turnover to reduce any anxiety caused by changing faces and styles of handling the children (Niagara, 2004). Ratio of adult to child is very important due to the individual

attention that the care-givers provide to the child, which enables them to learn better to perform to their potentials. If the ratio is high, the care-givers will not be able to perform to the expectation as a result of the workload, which can impact negatively on the development of the children, and, the quality of care giving services in the rehabilitation centres (Andy, 2007).

According to NICHD 2006, the lower the number of children, the better the observed quality of care and the better the developmental outcomes. Also, with regard to the number of children in a group, the smaller the group, the more they are associated with better observed quality of care (NICHD, 2006). From the study by Alexander (2005), group size and ratio were strongly and positively related. Providers that cared for more children had worked longer in childcare and had more specialized training pertaining to children. Positive care-giving assessed in terms of frequency counts and qualitative rating was higher when the group size and children ratio was smaller. Importance of group size and ratio was consistent with research on children by Alhwasen (1992), Clarkstewart, Gruber & Fitzgerald (1994), Folburg (1981), Furburg *et al.*, in fact, it appears that childcare is particularly susceptible to structural dimensions. The closer the ratio of 1:1, the higher was the probability of sensitivity in care-giving (Alexander, 2005).

#### **2.3.4 Care-givers' Age and Characteristics**

The people who handle children especially under three's should have some basic knowledge and love for the children. The care-givers should be: patient, friendly, reliable/trustworthy, well-behaved, kind, understanding, confident, have will power,

humble, disciplined, just, loving, courteous, creative, cooperative, devoted, a good example to children, polite, morally sound and knowledgeable (GoK/MoE, 1999). For children aged fifteen and below, the care-giver must be at least eighteen years old. In case where oldest child is above fifteen years, a care-giver must be at least twenty-one years older. A baby sitter providing care in a foster home during the short absence of a foster parent must at least be fourteen years old, and mature enough to handle common emergencies (Junn, 1997). While the characteristics of care-givers vary tremendously, survey research findings have been used to create a profile of the “typical” American care-giver. This caregiver has been described as a married person aged 46 years, working full-time while caring for a 77 year old mother, mother in-law or grandmother. One should be a high school graduate who provides care for an average of 18 hours per week (Junn, 1997).

From the literature reviewed it is clear that it is important for a care-giver to be above eighteen years old in order to take care of the children in any care-giving situations. Too young care-givers would have difficulties in handling the children and might not be able to meet the expectations that the children need. This can negatively affect the development of the children depending on the quality of care-giving services offered.

#### **2.4 Social Development for Pre-Schoolers**

According to Shauna (2004), social development means, being able to make friends and get along with others; to work as part of a team, and be a good leader. After gaining trust in their care-givers, infants start to discover that they have a will of their own and they assert their sense of autonomy. If the infants are restrained too much,

they are likely to develop a sense of shame and doubt (Boeree 2003). Most of the pre-schoolers generally begin to share, take turns, and learn concepts of fair play. By five years, play is cooperative, practical and conforming. They are interested in group and pretend to play. They are not ready for competitive play, because they hate to lose. They enjoy simple board games, based on chance, not strategy (Andy 2007). They have sex differentiation in play roles, interest, and they enjoy looking at books and listening to stories from books (Junn 1997; Neil 1981). There are emerging skills at this stage, where children begin to grasp the concept of sharing, enjoying games with rules, enjoying dramatic play with others, taking turns, complying with requests from parents they look and seek for adult approval (Neil, 1981, Shauna, 2004).

As pre-school children encounter a widening social world, they are challenged more and need to develop more purposeful behaviour to cope with these challenges. Children are now asked to assume responsibilities. Uncomfortable guilt feelings may arise though if the children are irresponsible, they are made to feel too anxious (Boeree, 2003).

## **2.5 Education Programmes for Street Children**

Every child has a right to education which is a basic human right. Education is the way of personal and social development. It provides the individual knowledge, skills adequacy to maintain a successful and happy life (UNICEF, 1996).

The main target is providing formal basic education in consistence with their needs and completing stages, vocational and life skills development. Education will help the

children to be adequate, productive, responsible, conscientious, fully functional and healthy adults beyond having reading and writing skills (Nalan, 2006).

In Turkey, vocational education support project has benefited quite large number of citizens. They have gone through the programme and have started to participate in their daily life more actively, easily, confidently and satisfied with their new knowledge and skills. They have developed personally and socially with the education, which is one of the basic human rights and with the results, the education support project can be seen as a considerably important life-long model that assists the street children (Nalan, 2006).

In Egypt, in the reception centres, they contain literacy classes and simple training workshops to explore their skills and technical tendencies. In short-term, the programme besides reuniting children to their families includes medical services, and literacy classes and vocational skills. This type of educational programme is not structured and children can be involved at any time (Abla, 2002).

Children are provided with food, clothes, a sleeping place, recreation, gymnastics and psychological care. They are trained in some internal handicrafts such as carpets, weaving, and carpentry among others. They also join external workshops to be trained on other kinds of handicrafts considering this is a means to help in developing the relation between the child and the surrounding community (Abla, 2002). There are programmes like child-child that aim at transferring sound and proper knowledge and

behaviour to children on the streets by means of their mates. In addition to educational subjects, the schools provide vocational trainings.

In Bangladesh, over two million children live in the slums and streets; they have little or no access to basic education, although primary education has been declared free and compulsory. Many parents cannot afford to send their children to school due to financial and social factors (Arise, 1999). Being members of very poor families, these children are often involved in different odd jobs to supplement their family income. The government wants to reach a small segment of these children by providing them with basic education through its education extension programme. The main activities in the basic education based on national curriculum, are providing awareness on health and sanitation, discovery and juvenile features films and screened in the classroom as part of education and recreation, and vocational training. The main objective was to enhance the accessibility to educational facilities for street children, to integrating child literacy with environment and vocational training so that education becomes meaningful in their lives (Arise, 1999).

Achievement of universal primary education in the world's nations can be a great step in helping curb the problem of street children and the poor nations should be helped by donor agencies to realize this significant milestone as stipulated in the Millennium Development Goals (MDG's) and Education For All (EFA). Although the government of Kenya instituted free primary education in 2003, parents are still expected to provide uniform, stationery and other basic needs that the children require. Unfortunately, children in especially difficult circumstances may have no-one

to provide for them these basic necessities. Such children are not able to access quality education then, unless some interventions are put in place to address their plight (Njoroge, 2009).

Undugu Society in Kenya does operate an informal basic education programme to help to address basic literacy and numeracy needs of the street children (Dallape, 1987). The programme runs over a period of three years, after which learners are exposed to a variety of vocational skills during the fourth year. For example, they get introduced to carpentry, tailoring and sheet metal cutting and modelling. Upon completion, learners are encouraged to join informal sector where they select a vocation to engage in.

Dallape (1987) observes Undugu Education Programme gives street children the opportunity to raise their social responsibility, by participating in various extra-curricular activities such as Youth Week, Day of the African Child, Universal Children's Day, among others. In addition, the children who join the programme gain the opportunity to participate in team sports, and other activities which instill a sense of belonging and achievement.

In the rehabilitation centres, there are different programmes in place which children are involved in such as vocational training, sporting, guidance and counselling, medical services among others. In these programmes the aim is to help children participate in their daily activities more actively, confidently, acquire new skills, knowledge and develop personally and socially (Ouma, 2004).

Education is a cornerstone to successful life and for survival of children in the real world. Indeed, education is the principal instrument in awakening the child to cultural values preparing him/her for later professional training and helping him/her to adjust normally to his/her environment. These days, it is doubtful that any child may reasonably be expected to succeed in life if he or she is denied the opportunity of an education. Yet, education is something that is often lost to the street children and other children in extremely difficult circumstances in Kenya and elsewhere (Njoroge, 2009).

Investment in education should target children in difficult circumstances in order to prevent them from dropping out of school and also to have the ones, who have not been enrolled, join the school system. With this in mind, it is important for the community groups, government, and non-governmental organizations to work together to address the educational needs of the street children (Njoroge, 2009).

The care-givers have a big role to play in provision of care-giving services to the children in rehabilitation centres. This is through the use of care-giving approaches to provide basic education during informal learning activities, and help them to participate in co-curricular activities and vocational skills. They should be appropriate so that children can be sustained long enough to equip them with basic knowledge and skills for self-reliance. Through care-giving approaches, children will form a strong foundation to be able to empower them through education offered for national development.

## **2.6 Management Styles**

The social environment of the child is very critical. It should be conducive and have models who are care-givers, who should prepare the child. In the social environment, there are different management styles and leadership behaviours that are used. These are the ways in which the functions of leadership are carried out in which the leader typically behaves towards members of the group. Goleman (2000) summarizes his article by saying that business environment is continuously changing and a leader must respond in kind, hour-to-hour, day-to-day, week-to-week. The leadership styles can be classified into four groups that are commonly used namely; authoritarian, democratic, and *laissez-faire*.

### **2.6.1 Authoritarian Style**

Authoritarian managers go by variety of names. They are sometimes called top-down managers, control freaks or dictators. They do this without much expression of warmth and affection. They attempt to set strict standards of conduct for children. The managers expect the staff to do what they are told and generally don't allow for disputes or negotiations (Mark, 2005). The managers don't explain why they want the staff to do things; they are not expected to question a rule or command. They focus on bad behaviour rather than the positive ones and the staff are scolded (Vincet, 2004).

This is where the focus of power is with the leader and all interactions within the group move towards the leader and he or she mobilizes people towards a vision (Goleman, 2000). The leader is the sole decision maker who tends to be dictatorial. It

is strict, rigid, thinking not allowed, there is no compromise, and rules are there to be followed. Its one way traffic, no recognition or praises.

According to Alexander's (2005) study, he stated that care-givers with formal education, more training, and experience in child care had less authoritarian style and were in settings that were rated as more safe, clean and stimulating. Care-givers with non-authoritarian style tend to have more positive interaction with the children than do care-givers with more authoritarian styles (Annet, 1989; McCartley, 1984.) Authoritarian care-givers have high demands but they are not responsive to their children instead they are obedient and status-oriented; they expect their orders to be obeyed without explanations (Baumrid, 1991).

### **2.6.2 Democratic Style**

Democratic managers are much egalitarian; they believe that seeking consensus with staff is the best way to draw on broadest range of resources and get the best results. They also believe that providing staff with responsibilities and showing confidence in them, helps them to develop as employees and as individuals (Mark, 2005).

This is where the focus of power is more with the group as a whole and there is great interaction within the group. The leader forges consensus through participation and collaboration, team leadership and communication (Goleman, 2000).

The leadership functions are shared with members of the group, and the leader is more of a member of the group. Group members have a greater say in the decision-

making. The leader asks for and uses suggestions from subordinates but still makes decisions. It is relaxed thinking which is allowed; it is two-way-traffic, and there is recognition and praises.

According to Alexander (2005), care-givers who often use the democratic management style are accommodative; they assign responsibilities to the children, they encourage active participation, team work and give clear instructions in any assignment given to the children. Care-givers who use democratic style in their daily routine tend to have more consultations and deliberations before they make any final decision on any problem (Mark, 2005).

### **2.6.3 *Laissez-Faire* Style**

This is a let's wait and see approach. Mostly, the leader is a non-committal. There is no authority, there is extreme freedom, no control, and there is no job description. In this case, the leader is the care-giver in the rehabilitation centres who takes care of these children. They are the role models and all what they do to the children are the ones to be experienced. They are uninvolved care-givers characterized with demands, low responsiveness, and little communication. A care-giver only provides basic needs and they are generally detached from their children's life that they take care of. In most cases these care-givers who use this management style may even reject or neglect the needs of their children (Baumrind, 1991).

All the management styles used have an impact on psychosocial development of the children. Conventional wisdom has it that purely authoritarian managers are never

good managers. This view makes sense because people don't react well to being constantly given orders. Nonetheless with business being what it is, often, there isn't time to think through and discuss in details, every problem that comes up: Sometimes things have to be done with no questions (Mark, 2005). This affects the way care-givers carry their mission of modelling since they are not given a chance to express their views they only follow orders.

Democratic managers seek input about a problem. They will still have to make a decision and it will have a better chance of being correct if some inputs have come from competent employees. Management styles in their extreme forms are problematic in practice (Mark, 2005).

#### **2.6.4 Authoritative Style**

An authoritative manager helps the staff to be responsible for them and to think about consequences of their behaviours. They do this by providing clear reasonable expectations for their staff. They establish rules and guidelines to be expected. Managers who use this style are responsive to their staff and willing to listen to them. They are more nurturing, assertive but not intrusive and restrictive. Their disciplinary methods are supportive rather than punitive. They like their staff to be assertive and self regulated as well as co-operative (Vincent, 2004). Baumrind's (1991) study findings stated that care-givers who use this type of style are responsive to their children and willing to listen to questions. They also help children to be responsible.

## 2.7 Care-Giving Approaches

Care-giving is a broad term encompassing a variety of situations and circumstances from caring for a child or a person. A search for literature readily illustrates the amount of work researchers have done to better understand these relationships. However, given the complexity of care giving relationships, research often results in mixed findings and more questions to be explored (Kings & Haslip, 2005). The studies on care-giving have explored the positive and negative results of caring for others, attempting to provide a logical rationale for the range of consequences.

Kings and Hayslip (2005) observed that, what has remained unclear is why some persons manage these responsibilities with little noticeable struggle, while others under similar circumstances find the demands unmanageable (Annshantel *et al.*, Montgomery & Williams, 2001). To better understand the unique combination of variables that appear to create distinctive patterns of behaviour and feelings for each individual, care-givers (Kings & Haslip, 2005) suggested management styles may influence later approaches to care giving.

Kings and Hayslip's (2005) study illustrated a parallel relationship between management styles and care-giving approaches exists. Some care-giving approaches are more adaptive than others. There are many ideas about how to care for children. Some care-givers adopt the ideas and advice from the other care givers or reading from books. No one has all the answers (Jennifer, 2006). However, psychologists and other social scientists now know which care-giving approaches are most effective and are more likely to lead to positive out comes for children. Ideas about care-giving can be

grouped into three approaches as Jennifer (2006) observes: Loving, determination and courtesy.

In loving approaches, the care-giver gives warmth to the children in the way he or she handles them. There is a lot of involvement where the care-givers show love to children or others that they take care of through hugging, smiles, patting at the back when one does something good for encouragement, gives direction and is welcoming. Before the care-giver takes any action, there is participation and involvement between the child and the care-giver in all the activities. They are good in nurturing and they are easy going. The care-giver helps the children to be responsible and to think about the consequences of their behaviour. They do this by providing clear, reasonable expectations for the children and explanation for why they expect the children behave in a particular manner. They also monitor their children' behaviour to make sure that they follow through rules and expectations (Kings & Hayslip, 2005). Care-givers guide children's behaviour by teaching not punishing. They are responsive to their children and willing to listen to their questions.

Bamaurid suggests that these care-givers “monitor and impart clear standards for their children's conduct. They are assertive, but not intrusive and restrictive. Their disciplinary methods are supportive, rather than punitive. They want their children to be assertive as well as socially responsible, self-regulated and co-operative” (1991). Those care-givers who use courteous approach tend to use words like sorry, please, thank you, excuse me, and they are always polite while working with children. In most cases, they tend to tie with the loving approach.

The care-givers who use determination approach have courage; they are confident in what they do, they have will power and strong belief as they undertake their daily routines. There is corporal punishment and they guide their children by demands and not by reason, they use physical punishment as a way of discipline. These care-givers reasons and have different punitive strategies. They use threats as punishments. They are verbally hostile and they explode with anger towards the children. In this approach, care-givers may the child to do something while care-givers who use loving approaches tend to reason with the child and explain the importance of what they are to do (Partrick, 2005).

Kings and Hayslip (2005) in their study revealed that age, and education level of the care givers were of little influence on the care-giving approaches. Their findings suggested that rather than being situational determined, care giving approaches might be long standing mindset that develops through early experiences and as a result of age, education, and the degree of care-giving responsibility might have insignificant impacts on care-giving approaches (Kings & Hayslip, 2005).

From the study by Jenniffer (2006). There is revelation that a significant negative relationship was found among care giving approaches and management styles that were not parallel or characterized by dissimilar beliefs and behaviours. Several studies have been done in other parts of the world on care-giving approaches and parenting styles as in the works of (Anneshentel, Pearl, Mulan, Zarit & Whilatch, (1995) Cicirelli,(1993) Rozaria, Morrow-Howell & Hinterlog, (2004) Shechan & Nuttal, (1988) Tarlow *et al.*, (2004), Townsed & Frank; (1995) Vitalion, Zhang, Scanlan,

(2003). What has remained unclear is why some persons have managed these responsibilities with little noticeable struggle while others under similar circumstances find the demands unmanageable.

To better understand the unique combination of variables that appears to create distinctive patterns of behaviours and feelings of each individual care-giver, Kings and Hayslip (2005) suggested that management styles may influence later approaches to care giving. They developed a care-giving style scale to investigate the relationship between management and care-giving approaches.

The study by Kings and Hayslip (2005) illustrated a parallel relationship between management styles and care-giving approaches exists and some care-giving styles are more adaptive than others. Indeed, research has demonstrated that bidirectional interaction occurs in care giving relationships between the care-giver and the recipient (Aneshencel *et al.*, (1995) Haslip & Hicks Partrick, (2003); Hirsion, (1998) Lyons *et al.*, (2002) Mui, (1995). The interaction is important and therefore the care-giving approaches may impact as well as be derived from interaction with the care recipient. In this light it would be interesting to examine whether care giving approaches are stable over time as has been examined in the parenting literature (Holden & Buck, 2002). At the same time greater attention to the impact of particular care-giving approaches upon the care-recipient would be beneficial to ascertain the positive and negative consequences to approaching care-giving from one style to another (Jennifer, 2006).

Globally, a lot has been done in the area of care giving, but in Kenya there is no documented study done to cover this area. From the recommendations of the study by Holden & Buck (2002) to examine the stability of the care-giving approaches, it is important first to identify and examine if these approaches are offered or not in the rehabilitation centres and establish if there is any significant relationship between care giving approaches, age, experience, and training of the care-givers. It is also important to look at the relationship between management styles and care-giving approaches used in the rehabilitation centres.

## **2.8 Summary**

The literature reviewed, has shown the contribution made by the studies done on the care-givers' role, characteristics approaches used, age, training level, ratio of children, in relation to care-giving approaches, social development for pre-schoolers, and rehabilitation centre. This revealed that in most countries such as Latin America, Pakistan, Guatemala Brazil among others the issue of street children have been addressed by providing the basic needs which they lacked from their homes hence causing them to run away to the streets. When they are taken to the centres, they are provided with food, clothing, medical care, shelter, counseling and other services. This helps them to reform, and therefore, be able to fit well in the society.

In the rehabilitation centres, the care-giver's role is very crucial in enhancing the psychosocial development of the young children, where productivity and efficiency of care givers matter. The care-givers need to be trained and have enough knowledge, so that they can handle children and therefore assist them. There must be the right adult to

child ratio and the right care-giving approaches to inculcate in these children to help them to grow and develop in the right way and in an even rate of growth (Andy, 2007).

According to Alexander (2005), care-giver's formal education, years of experience, and training did not have significant effect to the prediction of observed positive care giving. For positive care-giving ratio of adults to children and non authoritarian styles tend to have more positive interactions than the caregivers with authoritarian styles in the centres.

These results were consistent with research by Ernest (1989) and McCartry (1984) which linked observed interactions findings of significant associations between positive care-giving behaviour and physical environment. Other research by Dunn (1993), Howes (1983) Scar, Elsenberg & Dewater (1994) supports the lay views of parents and care-givers. This aspect of childcare has generally been given less emphasis in the scientific community than other factors such as ratio, and care-givers training results suggested that the importance of the physical environment should not be underestimated.

According to Kings and Hayslip (2005), care-giving approaches and management styles that are more parallel and characterized by dissimilar beliefs and behaviours were found generally to have a significant negative relationship such as loving, care-giving approach and authoritarian management style. However, a significant positive relationship was found between the care-giving approaches and management styles that were having similar beliefs and behaviours. It is important to examine if care-

giving approaches are offered or not and establish the relationship between the management styles and the care-giving approaches in the rehabilitation centres.

### 1.1.1. Introduction

The study was conducted in the rehabilitation centres in the city of ... The study was conducted in the rehabilitation centres in the city of ... The study was conducted in the rehabilitation centres in the city of ...

### 1.1.2. Research Objectives

The study aims to investigate the relationship between management styles and care-giving approaches in the rehabilitation centres. The study aims to investigate the relationship between management styles and care-giving approaches in the rehabilitation centres. The study aims to investigate the relationship between management styles and care-giving approaches in the rehabilitation centres. The study aims to investigate the relationship between management styles and care-giving approaches in the rehabilitation centres. The study aims to investigate the relationship between management styles and care-giving approaches in the rehabilitation centres.

### 1.1.3. Scope of the Study

The scope of the study was limited to the rehabilitation centres in the city of ... The study was conducted in the rehabilitation centres in the city of ... The study was conducted in the rehabilitation centres in the city of ... The study was conducted in the rehabilitation centres in the city of ... The study was conducted in the rehabilitation centres in the city of ...

## **CHAPTER THREE**

### **RESEARCH METHODOLOGY**

#### **3.1 Introduction**

This chapter deals with the research design, location of the study, sampling procedure, research instruments, procedures followed in data collection, coding for data analysis and presentations.

#### **3.2 Research Design**

The study adopted an exploratory approach using an ex-post -facto research design, to investigate the care-giving approaches among caregivers and factors that influence these approaches in the rehabilitation centres. Kerlinger (1973:379) defines ex-post-facto research design as a systematic, empirical inquiry in which the researcher does not have direct control in the independent variables because their manifestations have already occurred. The variables occur in a natural setting and the researcher attempts to determine the relationship occurring between the variables.

#### **3.3 Locale of the Study**

The area of the study was Nairobi Province. Nairobi is the capital city of Kenya consisting of 3 million people from different cultures, ethnic groups, races, social economic class and faiths (Bojang, 2006). Some of the children have gone back to the streets resulting in increased number of children in the streets again (Stephen, 2004). This led the CBOs, and NGOs having more focused attention on these rehabilitation centres especially in Nairobi. The researcher selected Nairobi as an area of study because of the fact that it has a considerable number of rehabilitation centres. It is also

within the urban setup where children return to, when they leave the rehabilitation centres immaturely.

### **3.4 Variables**

To conduct a research it is essential to identify the research variables, clearly distinguished between the independent and dependent variables, while dependent variable is one that varies as a function of the independent variable (Mugenda & Mugenda, 1999).

#### **3.4.1 Independent Variables**

An independent variable is one that a researcher manipulates in order to determine its effect on another variable. There were four independent variables that were studied. According to Straffon and Hayes (1998), an independent variable is one that an experimenter sets up to cause an effect in an experiment. They are the existing features of a subject. In this study the following are the independent variables:

- (i) Age of the care-giver** – This is the number of years the care giver has lived.
- (ii) Experience of the care-giver**-This is the number of years the care-giver has worked with the children.
- (iii) Training level of the care-giver** – This is the level of training of the care-giver. The specific levels are certificate, diploma, degree and any other which was to be specified.

**(iv) Management Styles-** They are three different styles. They were operationalised as follows:

- **Authoritarian Style:** This constitutes the total frequencies of authoritarian styles behaviours by care-givers. They include being strict, having rules, one way communication, and no praises.
- **Democratic Style:** This constitutes the total frequencies of democratic styles behaviours by the care-givers. They having a relaxed atmosphere, two-way communications, have praises, and have consultations.
- **Laissez-fare style:** This constitutes the total frequencies of *laissez-fare* styles behaviours by the care-givers. They include having no control, have no authority, extreme freedom, and no job description.

They were measured through observations during the data collection period.

### 3.4.2 Dependent Variables

Dependent variable is one that varies as a function of the independent variable (Mugenda & Mugenda, 1999). This is a variable which is measured as an indicator of the outcome of an experiment (Straffon & Hyes, 1988). The dependent variable in this study was the;

**(i) Care-givers' use of care-giving approaches.** They were three approaches used.

They were operationalised as follow;

- **Loving approach:** This constitutes the total frequencies of loving approaches behaviours by the care-givers. They include smiles, patting the child, hug, give direction, and welcoming.

- **Determination approach:** This constitutes the total frequencies of determination approach behaviours by the care-givers. They include having courage, being confident, having will power, initiating, and having strong belief.
- **Courtesy approach:** This constitutes the total frequencies of courtesy approaches behaviours by the care-givers. They include using words like sorry, please, thank you, excuse, and being polite. They were measured through observations made during the data collection period.

### 3.5 Target Population

The study targeted all the care-givers in rehabilitation centres for street children in Nairobi. This was because the care-giver takes care of children where they provide care giving approaches to enhance children's psychosocial development. Children rely on the care-givers for their provisions within the rehabilitation centres. The care-givers are the role models for the children.

#### 3.5.1 Sample Size

The study involved 15 care-givers. This number of care-givers was selected from the government institutions. Some children had gone back to the streets resulting in an increased number of children in the streets again. Care-givers in three rehabilitation centres for street children were selected on purpose since they took care of children aged 4-6 years. This small number of care-givers was selected because the study used in-depth repeated observations.

### 3.5.2 Sample Selection

The sampling unit was Nairobi Province. In Nairobi, most of the rehabilitation centres are privately managed and they cater for children aged one day old and above. The government rehabilitation centres mainly cater for children aged four years and above. A purposive sampling technique was used to identify the centres. This was based on the fact that government rehabilitation centres for street children mainly cater for children aged four years and above. Out of thirty nine rehabilitation centres in Nairobi, only three were managed by the government. There were five care-givers in each centre making a total of fifteen. There were eight males and seven females. These formed the sample.

### 3.6 Research Instruments

The study used two instruments, a questionnaire and observation schedules. The questionnaire was used to elicit data on care-givers demographic data, the age, education level, experience, gender, number of children in the centre among others as stated in Appendix 1. It was important to use it in order to get detailed information about the caregivers. It helped to save time, and confidentiality.

Observation schedules were used by the researcher in the centres during non-formal education sessions, to observe whenever the care giver used any of the care giving approaches, such as loving, determination, and courtesy and also if they used any of the management style which were authoritarian, democratic, and *laissez-faire* as in Appendix II and III respectively. It was important to use the observation schedules

since the actions for different approaches and management styles were observed and recorded.

### **3.6.1 Questionnaire**

The questionnaire contained a series of questions for care-givers to respond and to enable the researcher to obtain important demographic information about their personal characteristics. The questionnaire was given to the care-givers in the rehabilitation centres during the first visit and they were requested to indicate their age, experience in years, academic level and their training levels. The researcher went through it with the respondents then left it to be completed and be collected later during the last visit. The questionnaire was easier to administer and also economical in terms of time.

### **3.6.2 Observation Schedules**

The researcher was observing the care-givers using the fifteen elements under the approaches and twelve elements under management styles. Observations were made during non-formal education sessions. This was formatted in five columns of five minutes each and a break of one minute. Thirty minutes were used for each observation made. Four different pages were used for recording, four different times that observations were made. Visits were made by the researcher and it took sixty (60) days as stipulated in table 3.1. Each care-giver was visited four times.

**Table 3.1 Observation Pattern**

D	D1	D2	D3	D4	D5	D6	D7	D8	D9	D10	D11	D12	D13	D14	D15
C	C1	C2	C3	C4	C5	C6	C7	C8	C9	C10	C11	C12	C13	C14	C15

**Key-** D represents day

C represents Care-givers

**Note:** The above observation pattern only represented the first visit. Second, third and fourth visit followed the same trend.

### 3.7 Pilot Study

The pilot study was conducted in Nairobi Province Embakasi division prior to collection of data for the final study among the care-givers. The pilot study was carried out in a private rehabilitation centre and with care givers that were not to be used in the final study. The researcher purposefully sampled 4 care-givers. The care-givers were observed during in formal learning activities and filled in the questionnaire where the researcher was an active participant during the observations. The results were used to test the validity and reliability of the instrument for the final data collection for example; correction of language, timing during observation and filling of the questionnaire was done.

#### 3.7.1 Reliability of the Instrument

This focused on the degree to which the instruments gave similar results over a number of repeated trials. A test-retest reliability measure was used to ascertain

reliability. The care-givers were observed twice and the results compared. All the items in the two tests were scored separately. The Spearman Rank Order Correlation was used to help establish relationships between the responses made at .05 level of significance. The Spearman Rank Order Correlation was used to compute the scores and a correlation coefficient of “r” =0.73 was obtained. The research instrument was thus considered to be reliable enough to be utilized for the study.

### **3.7.2 Validity of the Instrument**

This was done through item analysis of the instrument based on the following considerations; vague questions were refined and questions rephrased to convey the same message to all subjects which enhanced the validity. This was also concerned with establishing whether the questionnaire was measuring what it was supposed to measure. Three specialists in the area of study focused on assessing the relevance of the content used in the instruments. Corrections were made to ambiguous phrases in the questionnaires and some questions which appeared repetitive were omitted to ensure validity of the contents. This helped in the improvement and refinement of the instrument and enabled the researcher to have first hand experience in administration of the instruments.

### **3.8 Data Collection**

The researcher used two instruments to collect the data. These were the questionnaire and observation schedules. The researcher first created a good rapport and ensured confidentiality of the report with the care-givers. This was to get rid of any anxiety that the care-giver could have towards the researcher, then they were given the

questionnaire. The researcher was an active participant in the centre and observed different types of approaches and management styles used by care-givers during the informal learning activities.

During the first visit to the centre, the respondents were given the questionnaire to fill in. Observations were made for thirty minutes in blocks of five minutes and recorded using tally method, which was done within a stipulated time which later was coded, and then quantified. The filled in questionnaires were collected during the last visit. Due to time, funds and other logistics, the visits were four for each care-giver.

### **3.9 Data Analysis**

#### **3.9.1 Test of Variations between the Samples was done using F-test**

The objective of the F-test is to find out whether two independent samples of a population differ significantly. Thus, it is a test of variance between samples.

F-test is a ratio of the means between samples; the calculated ratio with the table value for the relevant degrees of freedom (df) at the required level of significance. If the calculated value is greater than the table value, it is concluded that the difference in sample means is significant and the null hypotheses is rejected on the other hand. If the calculated value is less than the table value, the null hypotheses is accepted, and it is inferred that the samples have come from the population having some variance at 0.05, the ratio will be expressed as:

$F_{0.05} = \frac{\text{between samples}}{\text{Within samples}}$

Within samples

The F-test is based on the following assumptions:

- (i) Normality-i.e. the values in each group are normally distributed.
- (ii) Homogeneity-the variance within each group is equal for all groups.

### 3.9.1 Test of the Distribution

Kolmogorof-Smirnov test of distribution (K-S test) was used. For assumed normal distribution of the sample, the  $p > 0.05$ . If there is no difference, between the mean of the sample, and that of a normal distribution with the same mean, and standard deviation. Then, the sample is probably normal.

#### 3.9.1.1 Overall Management Style

From the management styles mean scores for all the centres were used to test the distribution of the sample.

**Table 3.2** Mean Scores for the Management Styles

Total mean score	std Dev	K-S value	2-tailed p-value
60.2	3.7834	0.9698	0.3038

Because the p-value is greater than 0.05, it can be concluded that the distribution of the scores of the sample in management style, is a normal distribution. It can, therefore, be concluded that the sample used represents a normal.

#### 3.9.1.2 Overall Care-Giving Approaches

From the care-giving approaches mean scores for all the centres were used to test the distribution of the sample.

**Table 3.3** Mean Scores for the Care -Giving Approaches.

mean score	std Dev	K-S value	2-tailedp-value
49.13	10.65	0.5435	0.9292

P-value is greater than 0.05, therefore, it can be concluded that the distribution of the scores of the sample, in the care giving approaches, is a normal distribution. It can therefore, be concluded that the sample used represent a normal distribution. With the above discussions, the fifteen care-givers used were a representation of the target population distribution.

### 3.10 Data Analysis and Presentation

Data and other materials from the field were systematically arranged, coded, quantified, and then analyzed. Before the testing of the hypothesis, tests of variations between the samples were carried out using F-test. Test of the distribution was also carried out using Kolmogorof-Smirnov test of distribution (K-S test).

In this study, the following five hypotheses were tested.

H<sub>01</sub>: There is no significant difference between the frequencies of care-giving approaches used in the rehabilitation centres during informal learning activities.

H<sub>02</sub> There is no significant relationship between care-givers' age in years and overall use of care-giving approaches during informal learning activities.

H<sub>03</sub>: There is no significant relationship between caregivers' years of experience and overall use of care-giving approaches during informal learning activities.

H<sub>04</sub> There is no significant relationship between care-givers' level of training and overall use of care-giving approaches during informal learning activities.

H<sub>05</sub>: There is no significant relationship between the frequency of management styles and overall use of care-giving approaches used in the rehabilitation centres during informal learning activities.

H<sub>01</sub> and H<sub>02</sub> were analyzed using ANOVA since significant difference was to be established at a .05 significant level. H<sub>03</sub>, H<sub>04</sub>, H<sub>05</sub> were tested using Pearson's Correlation coefficient at a 0.5 significance level. In these hypotheses, the relationships between the independent and dependent variables were tested. The specific analysis is presented in details in chapter four.

## CHAPTER FOUR

### RESULTS AND DISCUSSIONS

#### 4.1 Introduction

In this chapter the detailed data analysis, study findings and discussions of these are presented. Specifically the following are presented:

- (i) Descriptive analysis
- (ii) Inferential analysis.

The inferential analysis is presented by hypothesis.

#### 4.2 Descriptive and Inferential Analysis

##### Distribution of Care-Givers' by Gender

To make a comparison of the care-givers in the three centres by gender, the number and proportion of male and female care-givers were calculated. These proportions are presented in table 4.1.

**Table 4.1** Proportion of care-givers in the rehabilitation centres by gender.

Caregivers gender	Centres						Total	
	A		B		C		N	%
	N	%	N	%	N	%	N	%
<b>Female</b>	2	28.6	3	42.8	2	28.6	7	47
<b>Male</b>	3	37.5	2	25	3	37.5	8	53
<b>Total</b>	5	33.3	5	33.3	5	33.3	15	99.9

The total number of care-givers observed was fifteen from three rehabilitation centres and each centre had five care givers, which was equivalent to 33.3%. The study revealed that all centres had equal number of care givers and they were 8 (53%) males and 7(47 %) females as indicated by the Table 4.1 above. This indicated that men were more than women with a 53% against 47%. This may be as a result of the nature of the street children who are harsh, difficulty to control, and therefore, discouraging women from being involved in the caring and rehabilitation process. This attracts more men, since men are more aggressive than women.

#### **Distribution of Care-Givers' by Education Level**

To make comparisons of the care givers in the centres by education levels, the number and of the care givers who had attained the different levels of education was calculated. These numbers were presented in table 4.2.

**Table 4.2** Number of care-givers in the rehabilitation centres by education level.

Caregivers Education level	Centres			Total
	A	B	C	
KCPE	-	1	1	2
O" Level	4	3	3	10
Certificate	1	-	1	2
Diploma	-	1	-	1
Degree	-	-	-	0
<b>Total</b>	<b>5</b>	<b>5</b>	<b>5</b>	<b>15</b>

From the Table 4.2 above it shows that majority of the care givers had attained "O" level of education where the caregivers were ten (10) in number. This was followed by KCPE level with two (2) care-givers and the certificate level in social work had the same number of caregivers. The diploma level had only one (1) care-giver and there was none for the degree level. This implied that care-givers who attains higher levels of education tends to move to more attractive jobs leaving those with lower education levels to handle children in the rehabilitation centres.

### **Population Distribution in the Centres**

To make a comparison of the population of the children, the adult –child ratio and the age range in each centre, the number and proportion of the number of children, the ratio were calculated. These proportions are presented in table 4.3

**Table 4.3** Number and proportion of children in the centres, by the care giver-child ratio and the age range.

Centre	Number of children		Caregiver- Child- ratio	Age range
	N	%		
A	65	29.1	1:13	5-8 years
B	78	35.0	1:15	4-8 years
C	80	35.9	1:16	4-8 years
Total	223	100		

The total number of children who were in the centres during the time of study was 223 from all centres. The highest number of children was 80 in centre C which was equivalent to 35.9% compared to the other centres, while the lowest was 65 in centre A, which was equivalent to 29.1% as indicated by Table 4.3 above. The study revealed that the number of care-givers was equal but the ratio was different where in centre C the ratio was too low (1:16) followed by centre B (1:15) and then center C (1; 13). This may be, because during recruitment of the care givers adult –child ratio is not the determining factor. This could have affected the use of the overall care-giving approaches by the care-givers during non-formal education sessions. The age range of the children in the centres was also different with only centre ‘B’ and ‘C’ where the care-givers had the same age range of 4-8 years unlike in centre ‘A’, which had an age range of 5-8 years which also could have an effect on the use of the approaches. This may be because, during the entry of the children to the rehabilitation centre, the age of the children is not considered.



The scores were ranked in different groups as follows: 10-14, 15-19, 20-24, 25-29, and 30-34. These were ranked so that a clear picture of the scores was reflected as per each centre in terms of the frequency of each care giving approaches.

Analysis of variance (One-Way ANOVA) was utilized to test the hypothesis with the results shown as in Table 4.5, and Figure 4.1.

### Mean scores of care giving approaches

To make comparison of specific care giving approaches from the three centres, the mean scores of specific care giving approaches were calculated. These mean scores are presented in table 4.5.

**Table 4.5** Mean scores of specific care-giving approaches by the centres

Approaches	Centers			Total
	A M	B M	C M	
Loving	16.2	18.2	17.8	52.2
Determination	17.2	19.0	22.4	58.6
Courtesy	12.2	12.4	14.0	38.6
<b>Total</b>	43.6	49.6	54.2	

From Table 4.5 it was revealed that the use of loving approaches was at a mean score of 52.2 and was highly used in two centres. The use of courtesy approaches was at a mean score of 38.6 and was highly used in one centre. The use of determination

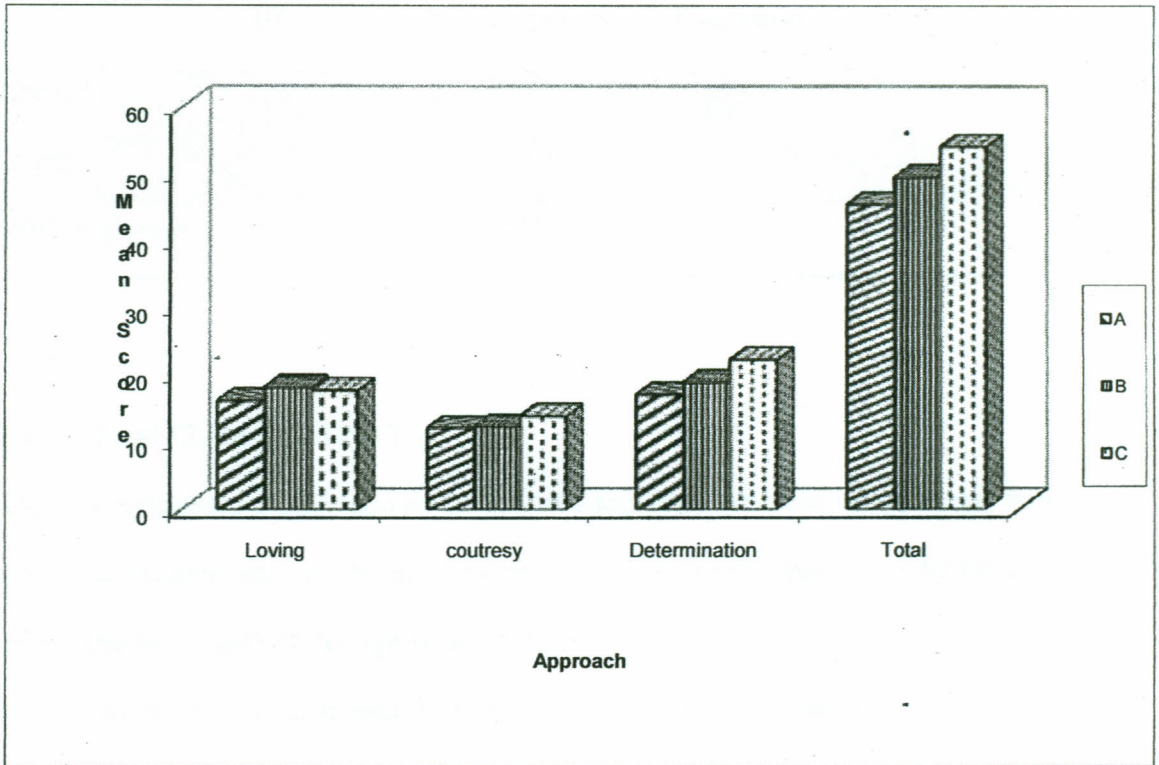
approach had the highest mean of 58.6 and it was highly used in all centres as compared with other approaches.

Determination approaches were more frequently used in all centres which may be as a result of high expectations from the institution to the care-givers to have quick and a perfect process in rehabilitating and reintegration of the children. This could have been as a result of physical environment, care-givers' attitude, motivation, and also job satisfaction. These are some of the factors that could have made the care givers use the kind of approach more frequently than others.

#### **Trends of specific care giving approaches**

To show the trends of specific care giving approaches from the centres clearly the mean scores from table 4.5 were translated into a graph. The trends are presented in figure 4.1.

**Figure 4.1** A graph to show the trends for specific care giving approaches



From Figure 4.1 it shows that determination approach was higher than any other approach in all the centres. This was followed by loving and then courtesy approach.

#### **Analysis of variance of care-giving approaches**

To establish significant difference between the total frequencies of all the approaches in the three centres, ANOVAs values for the approaches were calculated. These ANOVAs values are presented in table 4.6

**Table 4.6 ANOVA values for the approaches**

	<b>Df</b>	<b>Mean squares</b>	<b>F<sub>0.05</sub> ratio</b>	<b>P-value</b>
<b>Between groups</b>	2	141.2667	1.2968	0.3091
<b>Within groups</b>	12	108.9333		

For  $df=2$  and  $12$ , the table ratio  $F_{.05}=3.88$

Thus the calculated  $F_{.05}$  ratio of  $1.2968$  was less than the table value, hence, there was no difference between the different groups in the overall approaches by the care-giver. The  $H_{01}$  (null) of no significant difference between the approaches used in the three centres, during in-formal learning activities was therefore accepted and the alternative hypotheses rejected. This implied that even if the approaches differed among the care-givers, the difference was not significant.

### **Care-Giving Approaches**

From the study findings, it emerged that there was no significant difference between the approaches used in all the rehabilitation centres during informal learning activities. This implied that even if the approaches differed among the care-givers, the difference was not significant. This contradicted the previous study by Shauna, (2004) and Neil, 1981; Gail, (2000) and Junn (1997), which indicated that adults need to give individualized attention to the children depending on their needs and avoid routine way of carrying out their responsibilities. It contradicted the study by Gichuru, (1987), and

Alexander (2005), which stated that care-givers need to be responsive to all children needs in their care.

When positive care giving was assessed in terms of frequencies counts and qualitative, the rating was higher when the group size and adult-child ratio was smaller. It appeared that childcare is particularly susceptible to structural dimension and the closer the ratio of 1:1, the higher the probability of sensitivity in care-giving. This is contrary to the reality in the centres under study where the ratio was too low ranging from 1:13 to 1:16. This was consistent with the study by Alexander (2005) that stated that group size and ratio were strongly related. The closer the ratio of 1:1, the higher the probability of sensitivity in care-giving. This contributed highly on lack of sensitivity to the needs of the children since the number of children to be taken care of was so high and the number of the care-givers was only five in each of the centres and as a result the care-givers used determination approach more frequently than any other in all the centres. A study by Ernest (1989) and McCarty (1984), linked interaction findings of significant association between positive care-giving behaviour and physical environment.

It can be concluded that there were other factors hindering care-givers from using their knowledge on approaches, such as care-givers motivation, attitude towards children and job satisfaction. This resulted in lack of proper utilization of their skills and knowledge on the use of the approaches which impacted negatively to the development of the children in the rehabilitation centres. Care-givers were not giving individualized attention and they had a routine way of caring out their daily responsibilities. This

resulted as a result of lack of a proper system and clear guidelines in the centres to carry out the rehabilitation process and also high expectations from the management of the centres. Most of the care-givers had a minimum education level which could have affected the use of care-giving approaches.

## Hypothesis 2

**Ho<sub>2</sub>** There is no significant relationship between care-givers' age and overall use of care-giving approaches during informal learning activities.

### Distribution of care-givers in rehabilitation centres by age

To make comparisons of the care-givers in the three centres by age, the numbers and proportion of care-givers' age were calculated. These numbers and proportions are presented in table 4.7.

**Table 4.7** Proportion of caregiver's in rehabilitation centres by age

Age category(yrs)	Centre A		Centre B		Centre C		Total	
	N	%	N	%	N	%	N	%
31-35	3	42.8	2	28.6	2	28.6	7	46.7
36-40	2	50	1	50	1	25	4	26.6
41-45	-	-	-	-	-	-	-	-
46-50	-	-	2	50	2	50	4	26.6

From Table 4.7, it was revealed that majority of the care-giver's age ranged from 31-35(46.7%) while 36-40 years and 46-50 years had the same number of caregivers

(26.6%). From the table it also indicates that there were no care-givers aged between 41-45 years in all the centres. This may be as a result of the individual care-giver's low self-motivation and lack of job satisfaction. This could have been contributed by care-givers leaving the centres for other attractive jobs.

According to Junn (1997) from the care-giver's profile where the care-giver would be knowledgeable, experienced, mature enough to handle emergencies, a high school graduate, and provides care for average of eighteen hours per week and preferred to be 46 years of age. Majority care-givers age ranged between 31-35 yrs. This was below the recommended care-giver's age, which could have an effect on the overall use of the approaches. Kings and Hayslip (2005) study revealed that, age and education level of the care-givers is of little influence to the care-giving approaches. This may be as a result of individual care-givers' negative attitude towards work and care givers' self-motivation where they are not intrinsically motivated to handle the children from the streets. Also, working for long hours in the centres without a break due to shortage of care-givers in the centres.

### **Correlation coefficient of the age of the care-givers and the approaches**

To establish correlation coefficient for the relationship between care-giver's age and the total frequencies of the care-giving approaches P values were calculated. These P values are presented in table 4.8.

**Table 4.8** Correlation coefficient for relationship between the care-givers age and total frequencies for care giving the approaches.

	<b>Loving</b>	<b>courtesy</b>	<b>determination</b>	<b>overall</b>
<b>Age</b>	0.5459	0.6020	0.5302	0.6330
	p=0.0035	p=0.018	P=0.042	p=0.011

The correlation coefficient obtained was significant. Therefore, the  $H_0$  (null) of no significance relationship between care-givers' age categories and the overall use of approaches during informal learning activities was rejected and the alternative hypotheses accepted. This implies that the care-giver's age has a significant relationship with the overall approaches since the p-value is >than .5.

### **Age of the Care-Givers'**

The results of the study revealed that there was a significant positive relationship between the age of the care-givers and the overall use of the approaches during informal learning activities. This concurred with the study by Junn,(1997) and also was in consistence with the study by NICHD (2006) which stated that the more standards a child care setting meets the more positive the care-giving, the higher the quality of care and the better the child development outcome. For children in care in smaller groups of children cared for by the trained care-giver aged above 45 years of age with higher level of education in a setting with low adult-child ratio the care provided tend to be warm attractive and intellectual stimulating. Children who receive such care are better off developmentally (NICHD, 2006). The findings of this study was in line with the study by Kings and Hayslip (2005) which revealed that age of the care-givers were of

little influence on the care-giving approaches. These findings suggested that rather than being situational determined, care-giving approaches might be long standing mind set that develops through early experiences and as a result of age and the degree of care-giving responsibilities might have insignificant impacts on care-giving approaches (Kings & Hayslip, 2005).

### Hypothesis 3

**H0<sub>3</sub>:** There is no significant relationship between caregivers' years of experience and overall use of care giving approaches during informal learning activities.

### Distribution of care-givers by experience in years

To make comparisons of the care-givers in three centres by their experience in years, the numbers and proportion of experience in years of the care givers were calculated.

These proportions are presented in table 4.9.

**Table 4.9** Proportion of care-giver's by experience in years

Experience in years	Centre A		Centre B		Centre C		Total	
	N	%	N	%	N	%	N	%
5-10	4	80	4	80	4	80	12	80
11-15	1	20	1	20	1	20	3	20
<b>Total</b>	5	100	5	100	5	100	15	100

From Table 4.9, it was revealed that majority of care-givers had served for 5-10 years. They were 12 care-givers equivalent to 80% who had worked for five to ten years. This was compared to 3 care-givers equivalent to 20% who had worked for eleven to fifteen years. This may be as a result of during the inception of the centres, there were few number of children which called for few number of care-givers. As the number of children increased more care-givers were recruited with minimal experience. According to Suda (1994), and Junn (1997), it takes an experienced and skilled adult to recognize different signals and respond appropriately to the children's needs. This was adequate time for the care-givers to acquire skills to be able to attend to the children using the required approaches hence rehabilitate efficiently and effectively. However, the caregivers could come up with their own patterns of achieving their goals and not necessarily following the right procedures.

#### **Correlation coefficient of the experience of the care-givers**

To establish correlation coefficient for the relationship between the care-giver's experience in years and the total frequencies of the specific care-giving approaches, P-values were calculated. These P-values are presented in table 4.10. Pearson's Correlation Coefficient was utilized to test the hypothesis at .05 significant level.

**Table 4.10** Correlation coefficient for the relationship between experience of the care-givers and the total frequencies of specific care-giving approaches.

	<b>Loving</b>	<b>courtesy</b>	<b>determination</b>	<b>overall</b>
<b>Experience</b>	0.0589	0.2113	0.1925	0.1716
	p=0.835	p=0.018	p=0.042	p=0.541

The correlation coefficient obtained was not significant. Therefore, H<sub>03</sub> (null) of no significant relationship between the care givers years' of experience and overall care-giving approaches used by the care-givers during informal learning activities was therefore accepted and the alternative hypotheses rejected.

### Care-Givers' Experience

The results of the study revealed that there was no significant relationship between the care-giver's years of experience and the overall use of care-giving approaches during informal learning activities. This contradicted the study by Suda, (1994) Jill, (1997) which reported that a skilled and experienced care-giver knows the child well and can recognize different signals and responds appropriately. It was consistent with the study by Alexander (2005), which stated that positive care-giving was frequent to those with few years in the field. This indicated that experience *per se* did not affect positive care-giving. Therefore, this indicates that as experience increases the overall use of approaches does not increase significantly, which can be inferred that there were other factors that might have been hindering the care-givers from using the approaches significantly in the environment.

### Hypothesis 4

H<sub>04</sub> There is no significant relationship between care-givers' training and overall use of care-giving approaches during informal learning activities.

### Distribution of care-givers by level training

In order to make comparisons of care-givers in three centres by level of training the numbers and proportions of care-giver's level of training were calculated. These proportions are presented in table 4.11.

**Table 4.11** Proportion of care-givers in rehabilitation centres by level of training

Training levels	Centre A		Centre B		Centre C		Total	
	N	%	N	%	N	%	N	%
Diploma(2 yrs)	1	6.67	-	-	1	6.67	2	13.3
Certificate(2 yrs)	-	-	1	6.7	-	-	1	6.7
Shortcourse(2wks)	4	33.33	4	33.33	4	33.33	12	80

From Table 4.11, it was revealed that majority of the caregivers had gone through the short course. They were twelve care-givers equivalent to 80% followed by diploma with two care-givers equivalent to 13.3%. The lowest number was the certificate level with one care giver equivalent to 6.7%. Majority of care-givers had gone through a short course and the two weeks duration of training is not adequate enough to have grasped the content on care-giving services as required. This may be as a result of most of the care givers in the rehabilitation centres after the intervention programme by the government lacked basic knowledge and skills since the intervention measure was an emergence response. This resulted in incorporating all the workers in the rehabilitation centres and they were taken through a two weeks induction course.

### Correlation coefficient of care-givers' levels of training

To establish the correlation coefficient for the relationship between care-giver's level of training and the total frequencies of specific care-giving approaches, P values were calculated. These P values are presented in table 4.12.

**Table 4.12** Correlation coefficient for the relationship between Training levels of the Care givers and the total frequencies of the specific care giving approaches.

	loving	courtesy	determination	overall
<b>Training</b>	0.0776	0.1556	0.1180	0.1408
	p=0.784	p=0.580	p=0.675	p=0.617

The correlation coefficient obtained was not significant. Therefore, the  $H_0$  (null) of no significant relationship between the training levels of the care-givers was therefore accepted and the alternative hypotheses rejected. This implies that even if the caregivers had undergone induction training there was no significant increase in the overall use of the approaches.

### Care-Givers' Levels of Training

The results of the study revealed that there was no significant relationship between the care givers training levels and the overall use of care giving approaches during informal learning activities. This study was in line with study by Alexander (2005), which stated that care givers formal education and training did not have significant effect to the prediction of the observed positive care-giving. On the other hand, it contradicted with Shauna, (2004) and Gichuru, (1987) which stated that care-givers

who attend specific training courses are better able to create a strong bond with children and are responsive to all children in their care. Despite the obvious difference in the length of training among the various training program in care-giving, the assumption was that the two weeks short course duration was not adequate enough for the care givers to have grasped the content of the course to be able to handle issues of children in the centres. The findings of this study concurred with the findings of the study by American Academy of Pediatrics and Public Health Association on training and education of the care-givers if they are limited the care provided tends to be of lower quality hence impacting negatively on development of children (NHCHD 2004).

As a result of the above, it was concluded that there were other factors that might be hindering the care-givers from using the acquired skills, knowledge, and attitudes on approaches that would have improved. The education level could also have had an impact where the majority of care-givers had 'O' level of education with little or no basic skills on care-giving training which would have affected the use of care-giving approaches significantly.

#### **4.4 Comparison of Management Styles**

To compare management styles in the rehabilitation centres, the following hypothesis was tested:

### Hypothesis 5

**Ho<sub>5</sub>:** There is no significant relationship between the frequencies of management styles and the total frequencies of care-giving approaches used in the rehabilitation centres during informal learning activities.

### Ranked Scores of specific management styles

To compare the total frequencies of specific management styles in the three centres, the scores of the specific management styles were calculated. These scores are presented in table 4.13.

**Table 4.13** Total frequencies of specific Management Styles scores by the three centres

Scores	Authoritarian			Democratic			Laiszzer-fare		
	A	B	C	A	B	C	A	B	C
10-14	0	0	0	1	2	0	1	1	0
15-19	1	2	1	3	1	4	4	4	2
20-24	0	1	0	1	1	0	0	0	2
25-29	2	1	4	0	1	1	0	0	0
30-34	2	1	0	0	0	0	0	0	0

The scores were ranked in different groups as follows: 10-14, 15-19, 20-24, 25-29, and 30-34. These were ranked so that a clear picture of the scores was reflected as per each centre in terms of the frequency of each management style.

### Mean scores of management styles

To compare specific management styles from the three centres the mean scores of specific management styles were calculated. These mean scores are presented in table 4.14.

**Table 4.14** Mean scores of specific management styles by centres.

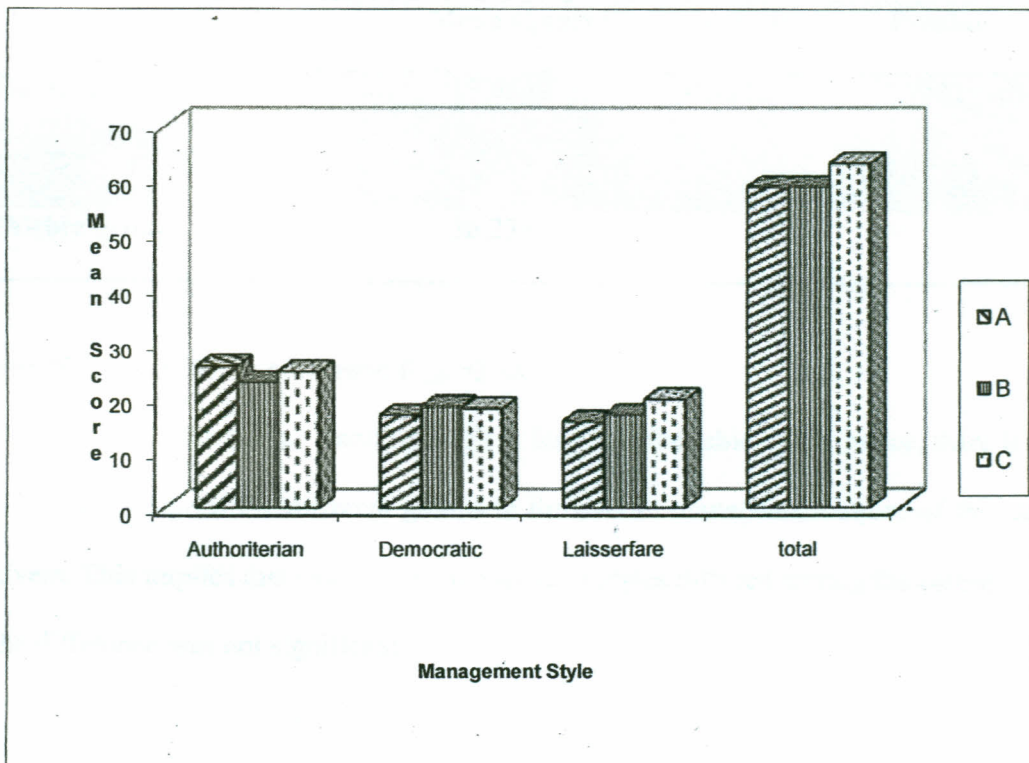
Mean scores	Centre A	Centre B	Centre C	Total
<b>Authoritarian</b>	26.0	23.0	25.0	74.0
<b>Democratic</b>	17.0	18.6	18.2	53.8
<b>Laisser-faire</b>	15.8	17.0	19.8	52.6
<b>Total</b>	58.8	58.8	63.2	
<b>Std Deviation</b>	4.025	3.975	1.095	
<b>Std Error on mean</b>	1.800	1.780	0.490	

From Table 4.14, it was revealed that authoritarian management style was used more frequently than any other management styles. It had a mean score of 74.0 democratic and *laisser-faire* styles scored a mean of 53.8 and 52.6 respectively. As a result of the use of authoritarian, this might have contributed to the hindrance in the use of most of the approaches by the care-givers in the rehabilitation centres. This may have been resulted due to the nature of the children from the streets they needed care givers who were firm for behaviour modification.

### Trends of specific Management Styles

To show the trends of specific management styles from the three centres clearly, the mean scores from table 4.14 were translated into a graph. The trends are presented in figure 4.2.

**Figure 4.2** A graph showing specific management style in three centres



From figure 4.2, the trend shown is that authoritarian style was highly used in all the centres. It was followed by the determination and then *laissez-faire*.

### Analysis of variance of management styles

To establish the significant difference between the total frequencies of management styles from the three centres, P values were calculated. These P values are presented in Table 4.15.

**Table 4.15** ANOVA values for the total frequencies of the management styles

	Df	Mean squares	F <sub>0.05</sub> ratio	P-value
Between groups	2	12.0667	0.3330	0.7232
Within groups	12	36.233		

For  $df=2$  and 12, the table ratio  $F_{.05}=3.88$

Thus, the calculated  $F_{.05}$  ratio of 0.333 is less than the table value, hence, there is no difference between the different groups in the overall management styles of the care-givers. This implies that even if the management styles differed among the care-givers, the difference was not significant.

### The correlation coefficient for total frequencies of management styles and the total frequencies of care giving approaches for the three centres

To establish the correlation coefficient for the relationship between the total frequencies of the management styles and the total frequencies of the care-giving approaches, the P values were calculated. These P values are presented in table 4.16.

**Table 4.16** Correlation coefficient for the relationship between the total frequencies of the management styles and the total frequencies of care-giving approaches by centres

Centres	Centre A	Centre B	Centre C
Overall styles	-0.7496	-0.7574	0.2062
& approaches	P=0.145	P=0.138	P=0.739

The correlation coefficient obtained was not significant. In Table 4.16, it revealed that in centre 'A' and 'B', the relationship was in the same direction which was negative. This implies that the two cannot reinforce each other, but in centre 'C' the relationship was positive. This showed that the two (management styles and approaches) went in the same direction and reinforced each other, although it is a weak reinforcement, the relationship was not significant.

#### **Correlation coefficient of specific management styles and specific care-giving approaches**

To establish the correlation coefficient for the relationship between the total frequencies of the specific management styles and the total frequencies of the specific care-giving approaches, the P values were calculated. These P values are presented in table 4.17.

**Table 4.17** Correlation coefficient of total frequencies of specific management styles and total frequencies of specific care-giving approaches

	loving	courtesy	determination	Total Overall (Approaches)
<b>Authoritarian</b>	-0.9753	-0.5383	-0.5469	-
	p=0	p=0.038	p=0.035	-
<b>Democratic</b>	-0.6251	0.2374	0.3079	-
	P=0.013	P=0.394	P=0.264	-
<b>Laissez-faire</b>	0.3758	0.5461	0.8047	-
	P=0.167	P=0.035	P=0	-
<b>Total Overall (Management )</b>	-	-	-	-0.3019 P=0.274

Table 4.17 on correlation coefficient of the management styles and care-giving approaches showed that the authoritarian style had a negative relationship with all the care-giving approaches, but for the democratic and *laissez-faire* styles there was a positive relationship with the care-giving approaches.

The correlation coefficient obtained was not significant. Therefore, the  $H_{05}$  (null) of no significance relationship between the management styles and the care-giving approaches used during informal learning activities was accepted and the alternative rejected. This implies that when care-giving approaches are improved, the overall management styles are weakened and the more the care-giver improves on the management styles, the more the approaches are weakened. However, the correlation

between the management styles and care-giving approaches is weak implying that it is difficult to conclude that management styles will definitely have influence on the care-giving approaches.

### **Management Styles**

From the study, it emerged that there was no significant relationship between the management styles used in the rehabilitation centres and care-giving approaches during in-formal learning activities. This implied that even if the management styles and the care-giving approaches had a relationship, it was not significant which was negative. The findings also showed that there was no significant difference between the management styles used in all the rehabilitation centres during informal learning activities. This implied that even if the management styles differed among the care-givers, the difference was not significant. This is in line with what would be expected since they are all government run institutions and they are expected to follow the same procedure in the management. However, the use of one style was dominant in all the centres which was authoritarian style.

The overall management styles were positively correlated in centre 'C,' while negatively correlated in centres 'A' and 'B'. This showed that in two centres, the type of management styles used were in the same direction, which was negative correlation. This implies that the management styles and care-giving approaches could not reinforce each other. If one is stronger the other becomes weaker. This implies that if the approaches are improved then, the management styles are weakened, that is, if a care-giver improves on loving approaches, then, the authoritarian style weakens.

The total management styles against the total care-giving approaches showed a negative correlation and the link between them is however, weak implying that it is difficult to conclude that the management styles will definitely have influence on the approaches. The findings contradicted Kings and Hayslip's (2005) study that suggested that management styles may influence care-giving approaches. It was consistent with the study by Jennifer (2006) which stated that there was a significant negative relationship that was found between the management styles and care-giving approaches that were not parallel. This was discovered between the loving approaches and the authoritarian style.

The findings of this study showed more frequent use of authoritarian style, which was in line with the study by Alexander (2005), which suggested that care-givers with formal education, and more training and experience in childcare had less authoritarian style. Care-givers with non-authoritarian styles had more positive interaction with children than do care givers with more authoritarian styles. This may have been as a result of the majority of the care-givers who had training which was inadequate since majority had undergone short courses and also their education level where the majority had attained 'O' level of education. As a result, majority of the care-givers lacked basic knowledge, and skills due to lack of adequate training and the level of education. The high expectations from the institution to the care-givers to have quickly and perfect process in rehabilitation and reintegration of the children to their families could also have had an influence.

The authoritarian style had a negative correlation with all the approaches. This implied that if the care-givers improve on the care giving approaches the authoritarian style will diminish while the other management styles, the correlation was positive hence they reinforced each other with the care-giving approaches. This implies that if the care-givers improve the approaches, it may improve the management style. It also implies that one cannot predict if the care-giver improves any approach that the management style will change. With the findings of this study, it is important for the care-givers to use and improve on the care-giving approaches used in the rehabilitation centres to be able to sustain the children long enough in order to empower them and lay a firm and strong foundation for acquisition of knowledge skills which will equip children to be actively involved in their daily activities, confidently and to be adequate, productive, responsible, conscious, fully functional and develop personally, socially for future healthy adult beyond having reading and writing skills.

## CHAPTER FIVE

### SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

#### 5.1 Introduction

This chapter starts with a summary of the findings, followed by conclusions, then implications and recommendations that were made. The chapter ends with recommendations for further research.

#### 5.2 Summary

The study had set out mainly to investigate the extent of use of the care-giving approaches by the care givers in rehabilitation centres.

#### **The following were the major findings:**

1. There is no significant difference between the frequencies of care-giving approaches used in the three rehabilitation centres during informal learning activities.
2. There is a significant relationship between care-givers' age and overall use of care giving approaches during informal learning activities.
3. There is no significant relationship between care-givers' experience and overall use of care giving approaches during informal learning activities.
4. There is no significant relationship between care-givers' training and overall use of care giving approaches during informal learning activities.
5. There is no significant relationship between the frequency of management styles and the care-giving approaches used in the three rehabilitation centres during informal learning activities.

### **5.3 Conclusion on Care Giving Approaches and Management Styles**

The main purpose of the study was to investigate the extent to which the care-giving approaches were being used by the care-givers in the rehabilitation centres during informal learning activities. It was also anticipated that the four independent variables selected would have an influence on the use of the approaches. However, the study generally showed that the four independent variables under investigation did not have a significant effect on use of the care giving approaches, indicating that there were other factors that were at play other than the ones used in this study. The main probable ones that came out were inadequate training on care giving, individual motivation, the level of education, attitude, long working hours, job satisfaction and high expectations from the centre on the process of rehabilitation which caused pressure to the care-givers. There was inadequate staff where the ratio of adult to the children was too low resulting to over worked staff for long hours which may cause burn out among the care givers and hence poor practice of the approaches in rehabilitation centres during informal learning activities. The attitude of the care-givers to deal with the former street children was also a hindrance in the overall use of the approaches.

Other observations made showed that there were challenges during, reintegration to their families, and children were bored due to delays during placements to other levels after rehabilitation process and even provision of basic needs such as food, clothing and shelter was a big challenge.

Management styles used by the care-givers in the centres during informal learning activities had no significant relationship with the care-giving approaches. The findings revealed that the relationship was negative in two centres and in one centre, it was positive. This implied that when the care giving approaches were improved the overall management styles weakens, especially for the authoritarian style, it showed a negative correlation to all the approaches used. This implies that, if the care-giving approaches are improved and used appropriately then, the authoritarian style will diminish. This will have an implication during the informal learning activities since children will be actively involved in all the activities they will be confident, acquire skills, knowledge and develop personally and socially, they will also be prepared adequately for schooling in the formal learning.

#### **5.4 Implications for the Findings**

This section outlines the implication of this study for the various stakeholders, the policy makers that is the Ministry of Gender and Children Affairs, managers, social workers, educationists, curriculum developers and other interested people with the rehabilitation centres of street children. An implication for further research is also outlined.

For the policy makers, that is, Ministry of Gender and Children Affairs, and other interested policy makers, there is need to come up with appropriate and clear policies to guide rehabilitation centres on training, recruitment of the care-givers, rehabilitation process and have systems specifically for street children, strengthening and enforcing the supervision of all the rehabilitation centres. The study results also

implied the need for continually having refresher courses for staff development to enable the care-givers to handle the former street children and use the appropriate approaches during informal learning activities. The results also implied the need of protecting the care-givers from the management to rehabilitate the former street children in a quick and fast process. All this would help the care-givers to work without pressure from the management. The policy makers should therefore come up with clear guidelines stipulating the duration that the rehabilitation process should take.

Observations made during data collection revealed that there were conditions that the care-givers were working under implying difficulties in using the approaches during in-formal learning activities. This may imply that if the conditions or the environment are made better the conditions might make it easier and more attractive for the care-givers to use the overall approaches during informal learning activities for enhancement of holistic development and carry out the proper procedures during the rehabilitation processes. For social workers it is important to be aware of these factors that may influence the use of the overall approaches, and try to avoid them. These factors could be the education level, and training of the care-giver. This also implies that the importance of physical environment should not be underestimated.

For the curriculum developers there is need to come up with a curriculum on care-giving approaches as well as its supervision procedures. This also applies to the trainers who need to have a harmonized curriculum on the same. There is also need

to review the duration and content of the training courses to be adequate and of help to the care-givers who go through it especially the short course.

To better generalize the results, to the population and increase on knowledge of use of the approaches left out by the study, it is implied that further research be conducted on other variables and in other geographical areas. This research could also extend to cover other stakeholders in the field of the care-givers in rehabilitation centres. All this would lead to acquisition of more wholesome knowledge on the approaches that would contribute to its more effective use during informal learning activities. This research could further be extended to cover other factors which may affect use of care-giving approaches in other aspects.

### **5.5 Recommendations**

After due consideration of the foregoing findings of the study, recommendations were made in four areas as follows:

1. Suggestions to managers and social workers of the rehabilitation centres that would aid their rehabilitation centres to be better in rehabilitation process and informal learning activities.
2. Recommendations to the relevant authorities on the formulation or enforcement of policy guidelines that would enable better management of the rehabilitation centres and create a better working environment for care-givers.
3. Recommendations to the curriculum developers on review of the content and duration of the training courses for the care-givers especially those dealing with

rehabilitation of the former street children. To be able to handle the challenges that they go through while carrying out the rehabilitation process.

4. Recommendations on additional areas of research that would increase the better use of care-giving approaches during informal learning activities in the rehabilitation centres.

### **5.5.1 Recommendations for Managers and Social Workers**

To improve their centres in rehabilitation process, the following recommendations were made to the managers and the social workers:

1. Field observation had revealed high usage of determination approach. To improve the use of overall approaches in the centres, it is recommended that the managers set realistic goals to reduce the pressure among the care-givers. This will provide more opportunities for the care-givers to practise and apply all the relevant care-giving approaches during informal learning activities.
2. Following field observation of implying difficult conditions, it is recommended to managers and social workers to improve the working environment to make it more conducive for optimum use of effective overall care-giving approaches. In this regard, it is recommended that they speed up the reintegration and placement to process take place on time to reduce frustration of the care-givers and the boredom of the children who have gone through the process. It is important to improve on the approaches to be able to eliminate some of the management styles that affect children negatively not allowing active child participation.

### 5.5.2 Recommendations for Policy Makers

In the area of the policy, it was found from the field observation that there was a major lapse in implementation of the rehabilitation processes in the centres resulting in the observed implying conditions. Consequently, the following recommendations were made:

1. Ministry of Gender and Children Affairs to formulate and enforce the policies to guide on training, and recruitment of the care-givers in the rehabilitation centres and come up with a clear guideline stipulating the duration that rehabilitation process should take.
2. Ministry of Gender and Children Affairs intensifies and increases supervision of the rehabilitation centres. That would enable better management of the rehabilitation centres and create a better working environment for care-givers.
3. Ministry of Gender and Children Affairs to organize refresher training course for the care-givers to ensure that they keep abreast with new approaches that continue to promote the rehabilitation processes in the centres. Further to this the use of the overall use of the approaches.
4. Ministry of Gender and Children Affairs to ensure that the centres have adequate staff to avoid overworking that may lead to burn out of the care-givers resulting to poor practices in rehabilitation process in the centres.
5. Ministry of Gender and Children Affairs to come up with clear guidelines stipulating the duration that the rehabilitation process should take.
6. Ministry of Gender and Children Affairs to allocate adequate funds to cater for the needs of the centres to be able to met the basic needs of the children

in each centre and provide adequate materials for use during informal learning activities.

### **5.5.3 Recommendations for Curriculum Developers**

To improve on the curriculum of the care-givers in rehabilitation process the following recommendations were made to the curriculum developers:

1. The curriculum developers to come up with a harmonized curriculum for the trainers on care-giving approaches for them to be able to impart relevant knowledge, skills and attitude to the care givers during their training.
2. The curriculum developers to review the content and duration of the training courses for the care-givers especially those dealing with rehabilitation of the former street children. To be able to handle the challenges that they go through while carrying out the rehabilitation process.
3. The curriculum developers to come up with regular short courses for the practising care-givers to refresh themselves with new knowledge and be trained on how to cope with stress and burn out which most of them experience in their day-to-day experiences.

### **5.5.4 Research Recommendations**

Since the non-significant results of the three independent variables pointed to other factors as being the ones influencing frequency of the overall use of care-giving approaches during informal learning activities, the study makes several

recommendations on future research that would unearth such factors and thus enhance knowledge on use of the overall care-giving approaches. The recommendations are as follows:

1. Other factors that thought to affect the use of the approaches by care-givers during informal learning activities should be considered. The study recommends such variables as, care-giver's attitude, motivation, working hours, -and burn out, delay during reintegration and placements after rehabilitation process.
2. To verify and validate the findings of the study, it is recommended that the research be carried out on frequency of use of care-giving approaches during informal learning in other geographical areas including other provinces.
3. A research on job satisfaction among the care-givers should be done.

## REFERENCES

- Abla E. (2002). *An Approach to Confront Street Children. A Problem in Egypt.* London: London University Press.
- Alexander, (2005). *Child Care and Development. Results from the NICHD Study of Early Childhood and Youth.* The Guilford Press: London,
- Andy C. (2007). *Journal of child and Adolescence psychphesichology*, Aprial, 17(2) 271-272 -
- Arise. (1999): *A Review of Existing Services Relating to Street Children.* Dhaka: Department of social services.
- Baumrind, D (1991). Child Care Practices Antecending Three Patterns of behaviour. *Genetic Psychology, Monography, 75, 43-88.*
- Bandura A. (1962). *Social Learning Theory through Imitation.* University-of Nebraska Press, Lincoln NE.
- Bandura A. (1971). *Social Learning theory and Personality Development:* Rinehart & Winston: Inc NE.
- Boeree G. (2003). *Personality Theories*; Copyright, Adapted from Erick Erickson.
- Bojang, B. (2006). *Children in Nairobi slums.* World Food Programme. United Nations.
- Bureau of Education Research, K.U (2<sup>nd</sup> edition 1997). *Causal Analysis of Children in Need of Special Protection.* The Kenya Situation. UNICEF: Nairobi.
- Casa, A. (2000). *Agency for Health Care Research and Quality.* The characteristics of Long Term Care Users and Quality. Covenant House: Mexico
- Dallape, F. (1987). *An Experience with Street Children in Nairobi.* Nairobi: Undugu Society Publication.

- David, O. (2003). *Free Education for all at last*. Daily Nation, January 9<sup>th</sup> pg 13.
- Evans, (2001). *Right and Welfare*. Children on the Streets are no longer boys, they are men and women. East Africa standards, March, 21st.pg 9
- Gail .R. (2000). *Empowering Care-givers Expectations*. London university press
- Gibbs, J. (2004). Educating the Homeless. *Techniques* 25.
- Gichuru. (1987). *Basic Education for Street Children in Kenya*. Nairobi.
- Gichuru, F.X. (1993). *Street Children in Nairobi*. The Undugu Experience. Nairobi: UNICEF.
- Goaleman, (2000). *Management styles, Leadership and communication*, Oxford University Press: London
- GoK/MoE (1999). *Guidelines for Early Childhood Education Developemnt in Kenya*. NACECE/KIE: Nairobi.
- GoK, (2003). *Poverty Strategy for Wealth Employment Creation*. Nairobi: Kenya
- GoK, (2003). *Progress Report, Internal Working Document*. Nairobi: Kenya.
- Gupta, S. (1999). *Statistical Methods*, pg A-5; Published by Sultan Chand & Sons.
- Habitant, (2000). *Urban Management Programmes Street Children and Gangs in Africa's Cities: Guidelines for local authorities* N.C.H.S. Nairobi.
- Hollin R. (2004). *The Essential Handbook of Offender Assessments and Treatment*. John Wiley & Sons Ltd.
- Ikiara, (1980). *Child Abuse A.B.A* .Unpublished dissertation Presented in the Department of Sociology, Nairobi University.
- Jennifer, K. (2006). *Care Giving Approaches in Diverse Samples of Care-givers*. Unpublished PhD Dissertation University of North Texas.
- Jill G. (1997). *Caregivers Characteristics and Needs*. London: Oxford University Press.

- Junn, E. (1997). *Child Growth and Development*. 3<sup>rd</sup> Edition Dushkin Publishing Group.
- Kattambo, (2001). *Urban Child in Especially Difficult Circumstances*. Nairobi: *Legal Issues*. Kenya.
- Kabeberi J. (1990): *The Child Custody: Care and Maintenance*. Nairobi: Oxford University Press.
- Kevin, J. (2004). 'Dust Bin Kids': No Solution Insight. *Kenya Times*, July 6<sup>th</sup> pg 15.
- Kings & Hayslip. (2005). *Parenting and Care-Giving Approaches*. New York Publishing Press: USA.
- Manuel, (2001). *New Alternatives of Care for Children in and on the Street*. (3<sup>rd</sup> Edition) Guadalupe: Mexico.
- Mark, (2005) *Art of Leader Ship*. London: Oxford University Press.
- Minnnet, P. (1992). *Childcare and Development*. London: Publishing Press.
- Mitchelle, G. (2003). *Discussion Paper on Street Children and the Inter American*. Development Bank Lessons From Brazil.
- Mohammed, A. (2002): *Street Freedom*. New York Publishing Press: USA.
- Munyakho, D. (1992): *Child New Corners in the Urban Jungle*. UNICEF International Child Development Center. Nairobi: Kenya.
- Mugo, J. (2004). *Rehabilitation of Street Children in Kenya*. Frankfurt: London.
- Murungi. K. (1998). *The Status of Children in Kenya: The Legal Dimension in Application of Rights of Children*. A Kenyan perspective: Nairobi, pp. 13-25.
- Mugenda, O. M. and Mugenda, A. G. (1999). *Research Methods: Qualitative and Quantitative Approaches*. Nairobi: Acts Press.

- Nalan, Y. (2006). *A Model for Social Inclusion for all: The National Education Support*. Turkey.
- Neil, J. (1981). *Theories of Human Development*. New York: John Willey & Sons.
- Niagara, (2004). *Family Caregivers in California*. New York: Publishing Press: U.S.A
- NICHHD, (2006). Early childcare Research Network .*Child Development*, New York: Hudson Street pp. 75, 280-295.
- NICHHD, (2004): *Journal of child and Adolescence Pyschphesichology*, Aprial, New York: Winston pg 17(2) 271- 272
- Njoroge, M. (2009). *Aspiration and Educational Challenges of Kenya Street Children*. Published Saarbrucken, Germany: VDM Velgar Publishers: 2009 ISBN 978-3639-16427-5.
- Office of the Vice President (2001): *Ministry of Home Affairs, Kenya Programme of Action for Children Framework Based on the National Conference on Children. Theme. Our Children's Future*.
- Orodho, J. (2004). *Techniques of Writing Research Proposals and Reports in Education and Social Sciences First Edition*. Nairobi: Masolā Publishers, Kenya.
- Orodho, J. (2004). *Elements of Education and Social Science Techniques of Writing Research Methods*. First Edition. Nairobi: Masola Publishers, Kenya.
- Ouma (2004). *Education for Streets Children in Kenya. The Role of Undugu Society*. Paris ITEP: UNESCO.
- Panter-Brick.C. (2002). Street Children; Human Rights and Public Health. A critique and Future Directions. *Annual Review 33, Anthropology, 2002, PPI, 147-71*.

Partrick *et al.*, (2005). *Benefits of Authoritative Feeding Style: Care Giver Feeding Styles and Consumption Pattern*. Bates Street. Tx 77030 USA.

Phase 1. (2005). *Department of Human Services: Ways and Means of Presentation*. London.

Philip Kibride, et al (2002). *Street Children in Kenya Voices: Children in Search of a Childhood*. London.

Save the children-Sweden (2003-2004). *Support and Safety for Children on the Streets*. Programme Profile, Eastern and Central Africa Region.

Shauna, S. (2004). *Invest in Kids Social Development*. Retrieved on July, 2007 from [www.Child-development-guide.com](http://www.Child-development-guide.com).

Slade, I. H. (1979). *The Law of Adoption in Kenya*: in S.O.S. Children and Law. Nairobi University: IDS. Occasional Paper No. 35, 1979.Pp54-62.

Strathmore University, (2007). *The Art of Leadership. Teacher Enhancement Programmes*. Nairobi: Kenya.

Stratton, P. (1998). *A student Dictionary of Psychology*. New Delhi: Universal Book Seller. India.

Stephen, O. (2004). Street Families' Menace, Posing Great Insecurity to Those Dwelling in the Urban Centres. *Kenya Times*, April 7<sup>th</sup> pg 8.

Suda, C. (1994). *Report of a Baseline Survey on Street Children in Nairobi Kenya*. Child Welfare Society of Kenya: Nairobi.

Suda, C. (1997). *Street Children in Nairobi and the African cultural ideology of Kinbased Support System in: the Abuse*. Revenue Vol. 6.197 pp199-217. London: John Wiley and Sons.

- Thomas, B. (2002). *Green Light for Street Children's Right European Network for Street Children Worldwide*. ENCSCW: Brussels.
- Thomas, B. (2000). *What Works in Street Children Programming*. Batlimore: The JUJONI Model in Sensational Youth Foundation.
- UNICEF, (2004). Proceedings: "*The Other Side of the Street*". Exhibition Child Trust. Nairobi: Kenya.
- UNICEF, (1996). *Children of the Run Away Cities*: UNICEF International Child Development Center. Nairobi: Kenya.
- Vincent, I (2004). Socialization in the context of the family: Parent child interaction in P.H. Mussen & E. M. Hetherington. *Handbook of Child Psychology*: Vol. 4.
- Volp, E. (2002). *Street Children; Promising Practices and Approaches* A paper for World Bank Institute September. London: HMSO. Company Publisher.

**APPENDICES****APPENDIX 1:****Questionnaire for the Care-givers.**

Tick appropriately

1. Name of the institution \_\_\_\_\_ zone \_\_\_\_\_ Gender \_\_\_\_\_
2. Which category is your institution?
  - Public
  - Private
3. How many children are enrolled in the institution?
  - Below 100
  - 100-200
  - 200-300
  - Above 300
4. What is your gender?
  - Male
  - Female
5. How old are you?
  - 20-25 yrs
  - 26-30 yrs
  - 31-35 yrs
  - 36-40 yrs
  - 41-45yrs
  - 46-50yrs

6. What is your highest education level?

- KCPE
- Certificate
- Diploma
- Degree

7. Are you trained in childcare?

- Yes
- No

8. Which level of training have you attained?

- Certificate
- Diploma
- Degree
- Any other (specify.....)

9. For how long have you been working with young children in this and in other centres?

- 5-10 yrs
- 11-15 yrs
- 16-20 yrs
- 21-25 yrs
- 26-30 yrs
- Above 31 yrs



## APPENDIX II

## Observation Schedule on Care-Giving Approaches

Institution: \_\_\_\_\_ zone \_\_\_\_\_ Gender: \_\_\_\_\_

The care-giving approaches were grouped into three sections, and the actions to be observed as follows.

Approaches	Action Observed	Time				
		5 m	5 m	5 m	5 m	5 m
1. Loving	Smile					
	Pats the child					
	Hugs					
	Gives directions					
	Welcoming					
	Total					
2. Courtesy	Using words like:					
	Sorry					
	Please					
	Thank you					
	Excuse me					
	Being polite					
	Total					
3. Determination	Courage					
	Confidence					
	Will power					
	Initiates					
	Strong belief					
	Total					

Tally method will be used to record the observations.

KEY: (/) No. of times action is made.

(5 m) No. of minutes observed.

## APPENDIX III

## Observation Schedule on Management Styles.

Institution: \_\_\_\_\_ zone \_\_\_\_\_ Gender: \_\_\_\_\_

The Management styles were grouped into three sections, and the actions to be observed as follows.

Styles	Action Observed	Time				
		5 m	5 m	5 m	5 m	5 m
1. Authoritarian	Strict					
	Have rules					
	One way					
	No praise					
	Total					
2. Democratic	Relaxed atmosphere					
	Consultations					
	Two way					
	Praises					
	Total					
3. laissez-faire	No control					
	No authority					
	Extreme freedom					
	No job description					
	Total					

Tally method will be used to record the observations.

KEY: (/) No. of times action is made.

(5 m) No. of minutes observed.

**KENYATTA UNIVERSITY LIBRARY**  
**MAIN CAMPUS**

PAGE 2

THIS IS TO CERTIFY THAT:

Prof./Dr./Mr./Mrs./Miss.....  
GICHUBA  
CATHERINE WAMBUI

of (Address).....  
KENYATTA UNIVERSITY  
P.O. BOX 43844 NAIROBI

has been permitted to conduct research in.....

.....Location,  
NAIROBI District,  
NAIROBI Province,

on the topic.....  
FACTORS INFLUENCING CARE  
GIVING APPROACHES IN REHABILITATION  
CENTRES FOR STREE CHILDREN IN  
IN NAIROBI KENYA

for a period ending 30TH APRIL 20.08

PAGE 3

Research Permit No. MOST 13/001/38C 31

Date of issue..... 22.2.1008

Fee received..... SHS. 500.00



*M.O. Ondieki*  
M.O. ONDIEKI

Applicant's Signature FOR Permanent Secretary  
Ministry of Science and Technology

MINISTRY OF SCIENCE AND TECHNOLOGY



REPUBLIC OF KENYA  
**MINISTRY OF SCIENCE & TECHNOLOGY**

Telegrams: "SCIENCE TEC", Nairobi  
Telephone: 02-318581  
E-Mail: [ps@scienceandtechnology.go.ke](mailto:ps@scienceandtechnology.go.ke)

JOGOO HOUSE "B"  
HARAMBEE AVENUE,  
P.O. Box 9583-00200  
NAIROBI

When Replying please quote

Ref. MOST 13/001/ 38C 31/2

22<sup>nd</sup> February 2008

Gichuba Catherine Wambui  
Kenyatta University  
P.O. Box 43844  
NAIROBI

**RE: RESEARCH AUTHORIZATION**

Following your application for authority to carry out research on, '*Factors Influencing Care Giving Approaches in Rehabilitation Centres for Street Children in Nairobi*'

I am pleased to inform you that you have been authorized to carry out research in Nairobi for a period ending 30<sup>th</sup> April 2008.

You are advised to report to the Directors of the centres you will visit before embarking on your research project.

On completion of your research, you are expected to submit two copies of your research report to this office.



M. O. ONDIEKI

**FOR: PERMANENT SECRETARY**

Copy to:

The Directors  
Rehabilitation Centres  
NAIROBI