INFLUENCE OF SOCIAL PROTECTION SYSTEMS ON ORPHANED AND VULNERABLE CHILDREN WELL BEING IN NYANG'OMA DIVISION, BONDO DISTRICT-KENYA

BY

JOY ADHIAMBO OTIENO

A RESEARCH PROJECT REPORT SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DEGREE OF MASTER OF ARTS IN PROJECT PLANNING AND MANAGEMENT OF THE UNIVERSITY OF NAIROBI

2013

DECLARATION

This research project report is my original work and has not been presented for an award in any university.

_____ _____

Joy Adhiambo Otieno **DATE**

L50/70614/2011

This research project report has been submitted for examination with our approval as university supervisors:

_____ _____

Dr. John Ouru Nyaegah **DATE**

Lecturer: Department of Extra Mural Studies

University of Nairobi

_____ _____

Dr. Maria Onyango **DATE**

Part time Lecturer, Department of Extra Mural Studies

University of Nairobi

DEDICATION

This research project is dedicated to my late Mother Jenipher Akoth Otieno, who inculcated and inspired in me the value of education during my tender years.

ACKNOWLEDGEMENT

I wish to acknowledge the invaluable guidance, encouragement and contributions of my supervisors; Dr. Ouru Nyaegah and, Dr. Maria Onyango for ensuring that this Research Project is well written, completed and presented within reasonable time for defense. Their insights, suggestions, advice, contributions and suggestion guidance helped in ensuring that the proposal met the threshold for academic discourse. I would also like to thank all the lecturers who guided me through the course work and research process. I sincerely appreciate the contributions of my course lecturers in shaping my thoughts and discourse: Prof. Omollo Ongati, Dr. Raphael Nyonje, Dr.Raphael Nyonje, Dr. Charles Rambo, Dr. Paul Odundo, Mr. Wilson Nyaoro and Mr. Michael Ochieng'.Your inspiration, encouragements and motivation enabled me to conceptualize this research project. I also wish to acknowledge the contribution of the University of Nairobi support staff especially the administration assistant and the librarian for their contribution to the entire undertaking.

Many thanks to the University of Nairobi Masters of Arts in Project Planning and anagement class of 2011 who in various ways contributed to the project idea in general and development of this research project in particular. I wish to recognize Mr. George Agengo and Miss. Zipporah Wanaswa for their diverse knowledge, the constructive criticisms and comradeship shared during the entire period. I would not forget to thank my research assistants, data entry clerks , the respodents and my family ,.Mr Peter Ouma, My children Vina and Venessa for their love, encouragement, support and patience during this process. It is through their support that enabled me to have a very conducive atmosphere to complete this work

TABLE OF CONTENTS

LIST OF TABLES

List **Page**

LIST OF FIGURES

Page

LIST OF ABBREVIATIONS AND ACRONYMS

AU	-	African Union
BMI	-	Body Mass Index
BRIGHT	-	Burkinabe Response to Improve Girl's Chances to Succeed'
CCT	-	Conditional Cash Transfers
CEE	-	Central Eastern European
DCO	-	District Children Officer
DFID	-	Department for International Development
FFE	-	Food for Education
GDP	-	Gross Domestic Product
GTZ	-	German Technical Cooperation
HIV/AIDS	-	Acute Immune Deficiency Syndrome
HSPN	-	Hunger Safety Net Programme
IADB	-	American Development Bank
ICDS	-	Integrated Child Development Services
ILO	-	International Labour Organization
MDGs	-	Millennium Development Goals
NGO	-	Non-governmental Organization
OECD	-	Organization for Economic Cooperation and Development
OVC	-	Orphaned and Vulnerable Children
PSNP	-	Productive Safety Net Programme
SOPs	-	Standard Operating Procedures
UK	-	United Kingdom
UN	-	United Nations
UNAIDS	-	United Nations Programme on HIV and AIDS
UNDP	-	United Nations Development Programme
UNICEF	-	United Nations Children's Fund

US - United States

WFP - World Food Programme

ABSTRACT

Social protection for poor and orphaned children and widows date from the 16th and early 17th century English Elizabethan Poor Laws. As early as 1948, social protection was specified in the Universal Declaration of Human Rights, with the statement that everyone has the right to social security. There are a number of interventions targeting people infected and affected by HIV and AIDS to improve their household welfare as well as that of Orphan and Vulnerable children (OVC) in Nyang'oma Division of Bondo District, but little is known about the influence of these interventions in children wellbeing. The study sought to examine the influence of social protection systems on education, health, food security and family care of OVC well-being. The study adopted the descriptive survey research design. The target populations for the study included 4590 OVC'S households from the 7 sub-locations of Nyang'oma Division .There was proportionate allocation of the sample of 357 based on the population per the existing 7 sub location. Simple random sampling was then used to pick sample per household to identify the OVC and caregiver to interview. Data was collected using the questionnaire that was reviewed by peers and later the supervisor to ascertain its face and construct validity. The questionnaire was pilot-tested using a sample of 20 households who were not part of the actual sample. Six key informants from government departments that support social protection systems/programme in the study area were also purposively selected and interviewed. The data obtained was analyzed with the aid of Statistical Package for Social Scientists (SPSS) computer programme. Descriptive data was analyzed using percentages and frequencies while inferential analysis was done using Pearson Product Moment Correlation (PPMC).The study established that there was a significantly positive relationship between social protection systems and education of the OVC ($r=0.44$; $n=171$; $p<0.01$). The relationship was of moderate strength, indicating that completion of education of the OVC was associated with social stronger protection systems, hence the stronger the social protection systems the more likely that the OVC would complete school and enroll at the next education levels. A moderate and significant positive relationship existed between the caregivers' satisfaction with the OVC health and social protection systems($r=0.39$; $n=171$; $p<0.01$).Further food adequacy and nutritional diversity was found to have a positive correlation of ($r=0.26$; $n=171$; $p<0.01$).while there was an absence of any significant relationship between social protection systems and number of meals per day. A statistical significant and moderate, positive relationship between social protection systems and family care ($r=0.36$, $n=171$, $p<0.01$) was found to exist which implied that strong family care was associated with more social protection systems. Taking care of the well-being of children is a fundamental human right that the policy makers including caregivers should be involved in .Organized social protection systems should therefore be encouraged and adequately funded for the realization of Orphans and Vulnerable Children well-being

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Social protection (social security) for poor and orphaned children and widows date from the 16th and early 17th century English Elizabethan Poor Laws. As early as 1948, social protection was specified in the Universal Declaration of Human Rights, with the statement that everyone has the right to social security. And the right of children to various aspects of social protection is included in the 1989 Convention on the Rights of the Child (CRC) (Gatenio and Kamerman, 2006). With the trend toward globalization beginning in the 1980s, there has been a growing recognition of the importance of social protection systems.

Latin America provides an excellent source of country illustrations of social protection for the middle-income countries. Thirteen countries in the region have implemented conditional cash transfer programs, in most cases with support from the Inter-American Development Bank (IADB) (IADB, 2006). In a report of the study of the effectiveness of conditional cash transfers in reducing poverty, inequality and human capital development in developing and developed countries, Heinrich (2006) describes coverage of these programs as extensive in some of the larger countries, for example, Plan Familias in Argentina Bolsa Familia in Brazil, and Oportunidades in Mexico, helping a total of almost 17 million families living in extreme poverty. Evaluations report positive effects on poverty as well as on school enrollment rates, grade retention, consumption levels, immunization rates, nutrition and reductions in child labor.

In Asia, targeted cash benefits are the social protection policy instrument used most often, established largely by central governments. Unfortunately, there is little that is targeted on or affects children directly. Cash benefit programs are often supplemented by commodity programs, typically food programs, and are targeted on young and school-aged children and on lactating or pregnant women. These supplementary food programs often distribute food through schools or public health

centers. Another common supplement to the cash programs are the "food-for-work" programs, using surplus food as a wage supplement, These programs were found to be successful in alleviating poverty but participation was limited by the lack of child care services (Babu, 2003).

In Thailand, among families that have taken in OVC, 78.6 percent of these families received no support at all. Children whose families receive any support (medical, emotional and psychological, material, social or educational) account for 21.4 percent. The percentage of OVC whose households have received all the five types of support is only 0.1 percent (UNICEF, 2006).

Broader social insurance is almost non-existent in West and Central Africa, the most notable exception being Ghana, where the government enacted legislation in 2003 to set up the Ghana National Health Insurance Scheme (NHIS). This was intended to provide universal access to health insurance and by 2008 had enrolled 42% of the population (Sultan and Schrofer, 2008).

Senegal's second Poverty Reduction Strategy Paper (PRSP II - 2006–2010) recognises the need to give specific attention to improving the lives of poor and vulnerable groups, including children, by extending social protection mechanisms that can help ensure that these groups benefit from wealth creation, are protected from risks and have better access to social services (République du Sénégal, 2006a). The PRSP shows there is awareness by policymakers about the need to reduce social and economic vulnerabilities and mitigate risks, which is a positive entry point for policy engagement to promote child-sensitive social protection, particularly given the government's commitment to achieving the MDGs by 2015 and the potential contribution of social protection to doing so.

The Malawi social cash transfer pilot programme has provided an important learning opportunity for policy makers and practitioners alike, in an unprecedented manner. This is a regular, predictable, non-contributory transfer to ultra-poor and labour-constrained households which enables them meet their basic needs and allows the households to build assets in to escape from shocks and make them economically less vulnerable. This is arguably the only available programme in Malawi that would

reach the ultra-poor. (Save the Children, Help Age International, and Institute for Development Studies, 2005).

The Government of Ethiopia's Productive Safety Net Programme (PSNP) started in 2005 has been heralded across Africa as an example of how social protection is both affordable and practical. The intention of the PSNP initiative was to support vulnerable, food-insecure households. The PSNP aims to be a social protection measure with a focus on food security that helps individuals, households and communities. It has been credited with providing millions of Ethiopians with the support needed to directly and indirectly build household and community assets to move out of the cycle of poverty. The PSNP reached 5 million people in 2005, 7 million in 2006 and in 2007/8 reaches some 8.3 million. (Devereux, Sabates-Wheeler, Tefera, and Taye, 2006).

South Africa is one of the few countries that offer benefits specifically for the support of all poor children. The old age pension is the largest program and has marginally reduced the number of people living below the poverty line; but it has demonstrated more significant positive impacts on children's health and nutrition (Barrientos et al, 2003). There is evidence that this unconditional child benefit boosts the nutrition of poor families' children (Aguero, Carter, and Woolard, 2006).

Informal support from the community continues to dominate social protection in Kenya, along with NGOs; and the latter may provide cash benefits as well as services. Kenya also houses a government-led and donor supported poor orphan and vulnerable child support program. Kenya has over one million orphans as a result of the HIV/AIDS endemic, and the principle objective of the child cash benefit program is that children be cared for by families and communities rather than be institutionalized. Three-fourths of the child benefits are for the care of children orphaned by parents with HIV/AIDS and the rest is for other economically vulnerable children (Save the Children UK, 2005). The program began distributing cash benefits in December 2004. There are other small-scale cash transfer initiatives among local and international NGOs many of which seek to assist children who are orphaned or have been affected by AIDS/HIV. These programs offer health and preventive

services, cash and commodity transfers, and counseling and home-based services to both children and families.

1.2 Statement of the Problem

It is estimated that more than 15 million children under 18 years world over have been orphaned as a result of AIDS. Around 11.6 million of these children live in Sub-Saharan Africa (UNAIDS, 2008). Recent surveys suggest that overall, about 15% of orphans world over, are between 0 to 4 years old, 35% are between 5 to 9 years old, and 50% are between 10 to 14 years old (Monasch, et al, 2004). AIDS is responsible for leaving vast number of children across Africa without one or both parents and the trend varies across countries. The Statistics South Africa (2009) study indicates that there are 1.9 million orphans due to AIDS in South Africa. The HIV and AIDS prevalence of Bondo District is 23% against the national prevalence of 15% (NASCOP, 2008).

The impact of orphan hood has devastating effects on children in a number of ways. The loss of a parent either through death, abandonment or other social factors, not only has an immense emotional impact on a child but for most children, it is the beginning of a cycle of economic hardship. Collins and Leibbrandt (2007) state that; "80% of families would lose more than half their per capita income with the death of the highest income earner, suggesting a lingering and debilitating shock of death. The loss of a parent or adult caregiver can have serious consequences for a child's access to basic necessities such as shelter, food, clothing, education and health care. Children whose parents have terminal illness may suffer neglect, including emotional neglect, long before they are orphaned. The orphans and other vulnerable children could drop out of school to work, look after siblings or due to lack of a parent to provide emotional support and encouragement desired by the child.

Response to the orphans' crisis has been driven by communities which provide a safety net for care and support of orphans and vulnerable children, caregivers and their families through the networks. However, this has been faced by challenges, which lead to incapacity of traditional family patterns due to the force of contemporary realities. Family groups are becoming internally

deinstitutionalized, carrying out fewer traditional functions, and becoming smaller and more unstable. With the growing number of orphans and vulnerable children, many approaches and social protection models have been employed in trying to enhance the well-being of these children to improve their household wellbeing, but little is known about the effects of these interventions that are coined around education, food security, health and family care of the Orphans and Vulnerable children. It is against this background that this study sought to examine the effects of social support interventions on the Orphans and Vulnerable children's well-being.

1.3 Purpose of the Study

The purpose of this study was to examine the influence of social protection systems on Orphans and Vulnerable children well-being in Nyang'oma Division, Bondo District of Kenya.

1.4 Objectives of the Study

The study was guided by the following objectives:

1. To assess how social protection systems influence the education of Orphaned and Vulnerable Children in Nyang'oma division, Bondo District.
2. To determine the extent to which social protection systems influence the health of Orphaned and Vulnerable Children in Nyang'oma division, Bondo District.
3. To examine the influence of social protection systems on food security of Orphaned and Vulnerable Children in Nyang'oma division, Bondo District.
4. To determine the influence of social protection systems on family care of Orphaned and Vulnerable Children in Nyang'oma division, Bondo District
5. To assess how social protection systems influence the education of Orphaned and Vulnerable Children in Nyang'oma division, Bondo District.

1.5 Research Questions

The study sought to answer the following research questions:

1. To what extent do social protection systems influence education of Orphaned and vulnerable children in Nyang'oma division, Bondo District?
2. How do social protection systems influence the health of Orphaned and Vulnerable children in Nyang'oma Division .Bondo district?
3. What influence does social protection systems have on food security of orphaned and vulnerable children in Nyang'oma Division, Bondo district?
4. Do social protection systems influence family care of Orphaned and Vulnerable children in Nyang'oma division, Bondo District?

1.6 Hypothesis of the Study

To achieve the objectives of the study, the following null hypothesis were generated and tested:

1. Social protection systems has no significant relationship on the education of orphaned and vulnerable children in Nyang'oma division, Bondo District
2. Social protection systems has no significant relationship on the health of orphaned and vulnerable children in Nyang'oma division, Bondo District
3. Social protection systems has no significant relationship on food security of orphaned and vulnerable children in Nyang'oma division, Bondo District
4. Social protection systems has no significant relationship on the family care of orphaned and vulnerable children in Nyang'oma division, Bondo District

1.7 Significance of the Study

The results of this study provide documented evidence on the milestones made by the existing social protection systems on OVC wellbeing on orphaned and vulnerable children well-being in Nyang'oma Division. The study therefore provides opportunity for development practitioners and government to design policies and programmes that will positively uplift the well-being of Orphaned and Vulnerable children.

The study's findings would also be useful to the caregivers and the orphaned and Vulnerable Children whom these systems have been designed to benefit in informing them of their role in ensuring their success due to their importance. Finally, the study findings will contribute to the body of knowledge that would provide basis for future studies on social protection systems and orphan and vulnerable children well-being.

1.8 Basic Assumptions of the Study

In conducting the study, it was assumed that social protection systems covered a wide range of outcome areas that the study intended to investigate across all the sampled households. It was also assumed that the targeted respondents from the sampled households would be willing to provide all the information sought by providing honest opinion on the social protection programs and related benefits. Moreover, it was assumed that the orphans and vulnerable children would be available at their homes at the time of data collection. Lastly, the study also assumed that the sample size selected for the study would be credible enough and an appropriate representation of all the households in Nyang'oma Division to allow generalization of the findings to the entire division.

1.9 Limitations of the Study

All the findings of this study are based on the information provided by the respondents, and are subject to the potential bias and prejudice of the people involved. A large sample size that was assumed to give results at a confidence level of 95% and 0.5% margin of error was, therefore, utilized to increase the reliability of the findings. The study was restricted to the study of households in Nyang'oma Division of Bondo District. As such, the findings may change if the study were to be applied to a different area and demographic landscape or socio-economic variables. Additionally, the distance covered and the terrain of the area in reaching out to the respondents who were spread throughout Nyang'oma division posed great challenges in traversing the study locations; this was, however, overcome by use of local trained research assistants who were conversant with the terrain and area of study. Some respondents were of low literacy levels thus seemed to deviate from the issues

under study during interview. Caution was exercised in dealing with such respondents by avoiding irrelevant information while upholding respect and exercising due patience with them.

1.10 Delimitations of the Study

The study examined the influence of social protection systems on OVC's wellbeing with respect to education, health, food security and family care. The study was conducted in Nyang'oma Division, Bondo District of Siaya County and was limited to 2,295 OVC households as per the District Children Officer's (DCO) records in the Bondo District. Nyang'oma Division being one of the areas in Bondo district with the highest prevalence rate in HIV/ AIDS at 23% against the national prevalence of 15% (NASCOP, 2008) hosts the largest number of OVC benefiting from social protection programmes, particularly the government initiated cash transfer programme.

1.11Definitions of Terms Used in the Study

The following terms assumed the stated meanings in the context of the study.

Social Protection: Social protection systems referred to interventions from public, private voluntary organizations and informal networks to support communities, households and individuals in their efforts to prevent, manage and overcome a defined set of risks and vulnerabilities.

Vulnerable children: referred to children who belong to high-risk groups such as not having parents therefore lacking access to basic social requirement and deprived of enjoying his right.

Health of Orphaned and vulnerable children: Was used to refer to the medical support accorded to the OVC and their accessibility to the health facilities.

Education of Orphaned and Vulnerable children; meant the accessibility, enrollment and the retention of children to school.

Food security of orphaned and vulnerable children: Referred to availability of nutritious food all year round.

Family care of Orphans and Vulnerable children: was used to mean home based care rendered to an OVC in a family set up.

Child wellbeing: The state at which a child is able to freely and fully enjoy their rights to participation, protection, development and survival. This would lead to contented state of being happy and healthy prosperous .Within the context of this study, it is related to receiving education, being healthy, being food secure and enjoying family care.

1.12 Organization of the study

This research project report contains five chapters. Chapter one provides an introduction that includes; the background of the study; statement of the problem; purpose of the study; the research objectives; research questions that guided the study; significance of the study; delimitations and limitations of the study; the basic assumptions of the study and finally definitions of significant terms used in the study.

Chapter two is the literature review of relevant works done related to social protection and security systems in various regions. This section describes the impact of social protection on the various dimensions of OVC wellbeing. The chapter sought to identify the gaps in research in social protection and the wellbeing of OVC. This section also provided the theoretical and conceptual frameworks of the study.

Chapter three is a description of the Research Methodology used to conduct the study. The research design and target population is explained. The chapter also contains a description of the sample size and sample selection procedures. A description of the research instruments used, their validity and reliability is also included. There is also an elaboration of data collection procedures, data analysis techniques and ethical considerations.

Chapter four is data analysis, presentation, interpretation and discussions of the findings of the research study. The findings of the study are presented in the form of tables and interpretation, explanations and discussions of the same provided below each table.

Chapter five summarizes the findings of the study, concludes and gives recommendations based on the study's findings. Finally, suggestions of areas for further research are provided at the end of this chapter.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter reviewed the general and empirical literature related to the study. The literature review is discussed under sub-headings of the concept of; Social protection system, orphaned and vulnerable children; social protection systems and education; social protection systems and health; social protection systems and food security and social protection systems and family care of OVC. The later sections of the chapter provide the theoretical and conceptual frameworks and summary of the literature review.

2.2 The Concept of Social Protection Systems.

In the immediate pre-independence period, social protection networking was prevalent in families and communities. (Marumbasi, 2009). In its strategic paper on Social protection quoted in, the Kenya government notes that 'About 46% of the population of Kenya live below the national poverty line while 19% live in extreme poverty. The high poverty levels are as a result of several factors including, but not limited to; natural disasters, environmental degradation, the HIV/AIDS pandemic, unemployment, a lack of income in old age and a breakdown of traditional safety net mechanisms.Christiaensen (2004) quoted in Omiti and Nyanamba (2007), observes that With a 50% chance of falling below the poverty line, Nyanza was the most vulnerable region in Kenya and Central at 14% was the least vulnerable. Specifically Siaya county in the former Nyanza province where Nyang'oma division falls has a poverty rate of 35.6% (KIHBS,2005/2006).

The Kenya Strategic Paper on Social Protection states that social protection measures include:"Policies and actions for the poor and vulnerable which enhances their capacity to cope with poverty, and equips them with skills to better manage risks and shocks."The four key areas in the provision of services are Education,Health,Water and sanitation(Kidd, 2007). It can also be looked at from the human rights perspective as entitlement to benefits that society provides to individuals and

households to protect against low or declining living standards resulting from a number of basic risks and needs.

Cash transfers a major component of social protection are regular and predictable transfers,often in the form of cash, provided by the state as part of a social contract with its citizens. They include child support grants, orphan care grants, disability grants, social pensions, and transfers to poor households, among others. There objective is to alleviate poverty, provide social protection, or reduce economic vulnerability. Some cash transfers may be unconditional; others are conditional, aimed to promote particular behaviors, such as school attendance or regular health checkups (Bryant ,2009).

Since the 1990s, large-scale cash transfer schemes have been launched in a growing number of developing countries, including Brazil, Colombia, Honduras, Mexico, Nicaragua, and South Africa. Increasingly, these schemes are being seen as a right of citizenship, and evidence is growing that they can help tackle hunger, increase living standards, and improve the education and health of the poorest families.In their extensive review of the evidence for the potential impact of cash transfer programs to strengthen families, Adato and Bassett (2008) argued that "cash transfers have demonstrated a strong potential to reduce poverty and strengthen children's education, health, and nutrition, and thus can form a central part of a social protection strategy for families affected by HIV and AIDS.

According to Omiti and Nyanamba (2007), the Cash Transfer for Orphans and Vulnerable Children Programme is a government initiative supporting very poor households that take care of orphans and vulnerable children to enable them take care of those children and help to grow up in a family setting. The programme is financed by the Government of Kenya with support from development partners that include World Bank, UNICEF and DFID. The main goal of the CT-OVC programme is to strengthen the capacity of poor households to protect and care for orphans and vulnerable children to ensure these OVC receive basic care within families and communities.

The selection of Programme districts is based on the magnitude of the problem of OVC they present as manifested by their OVC population and their subsequent needs. Thus, to qualify, a district

should manifest a heavy burden of orphanage and or vulnerability as demonstrated by the following indicators: level of HIV/AIDS prevalence and number of OVC , level of visible poverty and presence and quality of other interventions for OVC. Programme beneficiary households are identified and selected through an elaborate community-based selection process. To qualify for selection and enrolment, a household has to meet a selection criteria that includes being very poor, taking care of an orphan or vulnerable children under the age of 18 years and not receiving cash assistance from any other Programme. (Ministry of Gender,community and social development, 2008)

Ministry of Gender, Culture and Social Development, (2008) in its operational manual further indicate that the programme is currently implemented in 60 districts supporting 102,000 households and benefiting 375,000 orphans and vulnerable children.The process is managed through a series of committees at the national, district and community levels.At the national level there is a national steering committee that provides policy guidelines while the District Area Advisory Committee, (AAC) manages the community level implementation with the assistance of a location orphans and vulnerable committee, LOC at the community level.

The care givers and guardians are required to fulfill their roles and responsibilities to ensure effective programme delivery at the household level.These roles include ensuring: OVC aged 0-5 years are taken for immunization and growth monitoring; OVC aged 6-17 regularly attend basic education; OVC acquire birth certificates; Care givers attend awareness sessions. Enrolled caregivers receive a cash payment of KSH. 1,500/= per month paid every two months through the Post Office and district treasury.

2.3 Orphaned and Vulnerable Children (OVC)

The emerging trends in children's vulnerability are one of the current development concerns many developing countries are fraught with (UNAIDS, 2008). Several aspects of vulnerability have been identified. However, orphan hood and poverty have been noted to be among the major challenges of children. The impact of HIV/AIDS is producing orphans on an unrivalled scale in recent times. In the

past, large-scale orphaning was a short-term problem associated with war, famine, or large scale poverty and other social disasters. In recent times, orphaning caused by AIDS is increasingly becoming a challenge affecting many countries and this is increasing the number of orphans exponentially (UNICEF, 2008). It is estimated that more than 15 million children under 18 years world over have been orphaned as a result of AIDS. Around 11.6 million of these children live in sub-Saharan Africa (UNAIDS, 2008). AIDS is responsible for leaving vast number of children across Africa without one or both parents and the trend varies across countries.

The children face a variety of disadvantages and impediments which increases their state of vulnerability and helplessness. The OVCs have poor health and nutrition and have less access to healthcare (Levin, 2001); do badly in school or drop out of school; have poor educational, vocational training and employment opportunities (Tania and Kate, 2006).

The stark is that orphans and other vulnerable children in rural and poor environments are less likely to optimize the full benefits of the support systems that are available to cushion the effects of their social circumstances. The United Nations Secretary General argued that OVCs are less likely to receive adequate nutrition, leading to irreparable damage at a critical stage of physical and mental development; have smaller chances of completing primary education and acquiring the knowledge and skills that could help them escape from poverty and thus perpetuating an intergenerational cycle of impoverishment (UNICEF, 2007).

Orphans and other vulnerable children could drop out of school to work or look after siblings. The child could also drop out of school due to lack of a parent to provide emotional support and encouragement desired by the child. The child may miss out on school enrolment, have interrupted schooling or perform poorly in school as a result of their situation. School expenses such as school levies and school materials could present major barriers to the child's schooling especially if the caregivers cannot afford these costs. The extended families of a vulnerable child could decline

taking additional child to support due to factors which may include lack of resources to support school related activities (Matshalaga, 2002).

2.4 Social Protection System and Education of Orphaned and Vulnerable Children

Social protection can have an impact on education by addressing the underlying economic and social causes that prevent access to school, and by improving the quality of the services provided to young students and their families (Sanfilippo, de Neubourg and Martorano, 2012). School feeding in particular is one of the most frequently adopted interventions since such programmes are able to address multiple objectives at the same time (Buttenheim *et al.,* 2011). However, its overall effectiveness is related to a range of factors, including the modality of provision, the targeting and the costs (Bundy *et al.,* 2009).

Sanfilippo *et. al*., (2012) contend that receipt of a cash transfer can improve enrolment by helping poor households to overcome the cost barriers to schooling (fees, uniforms, books etc.). This effect can be seen both for transfers specifically focused on children and those which are not (e.g. when pension recipients distribute a portion of income to the household). In Bangladesh, Ahmed (2004) reports a 15.2 per cent difference between the gross enrolment rates of schools in rural feeding programme areas and those in control areas while in Burkina Faso, Kazianga *et al.* (2009) report that Girls' enrolment in rural areas increased by 5 and 6 per cent on site and take home ration, respectively following successful implementation of the WFP school feeding programme.

Evidence from Colombia indicates that on-site feeding supports school enrolment of the youngest children, while take home rations have a stronger impact on attendance. School feeding has contributed to the recent increase in net enrolment in the country. It has been estimated that in schools promoting on-site feeding enrolment has increased by 2-2.5 per cent between 2002 and 2009, with a slightly greater impact recorded for girls (2.4-3 per cent). (Sanfilippo *et. al.,* 2012).

Evidence on cash transfers is also growing. One-third of Productive Safety Nets (PSNP) beneficiary households in Ethiopia enrolled their children in school and over 80 per cent of these

beneficial impacts was said to be due to the programme (Devereux, Sabates-Wheeler, Tefera, and Taye, 2006). In Zambia, the Kalomo Social Cash Transfer contributed to achieve interesting results in terms of school enrolment, with rates increasing by 3 per cent (GTZ, 2007). With respect to Conditional Cash Transfers (CCTs), in their review of the evidence Fizbein and Schady (2009) report quite significantly that virtually every programme that has had a credible evaluation has found a positive effect on school enrolment.

From Colombia, Attanasio et al. (2005) report that Young children (10-13) in urban areas increased their time at school by 4.5 hours per day. Urban children (14-17) and rural children (10-13) increased their time at school by 3.8 and 2.5 hours, respectively. In Brazil, Veras Soares et al. (2008) posit that for treated children (7-14 years) participation in the programme reduces the probability of absence (3.6 per cent), dropping out (1.6 per cent) and failing to advance in school (4 per cent). In Namibia, participation of 14 out of 16 students was solely due to their grandparents receiving a pension (Devereux, 2001). A large number of recipients of the basic income grant used the money to pay school fees. As a consequence, a decrease of 42 per cent in non-attendance due to financial reasons has been recorded and drop-out rates have fallen from 40 per cent before to almost 0 a year after the launch of the pilot programme (UNICEF 2012).

Cash transfers play an important role in access to education, not only by providing households with the means to pay school fees, but also to purchase peripheral requirements associated with attending school, such as uniforms, books and stationery. Provision of cash increases enrollment rates: Zambia's Social Cash Transfer increased school enrollment rates by 3% to 79.2%, and 50% of youth who were not in school at the time of the baseline study were enrolled by the time of the evaluation (MCDSS/GTZ, 2007).

In summary, review of the literature above indicates that evaluations of the influence of the social protection systems/programs focused generally on the influence of these programs on children, with no special reference on their impacts on education of the OVC, given that they experience higher

vulnerability compared to other children. This study, therefore, assessed the influence of social protection systems on education of OVC as a component of child well-being in Nyang'oma Division, Bondo District.

2.5 Social Protection Systems and Health of Orphaned and Vulnerable children

As in the case of education, existing evidence shows a more conclusive nexus between social protection and outputs including access to and utilization of health services, this being especially true for preventive services for children (Department for International Development (DFID), 2011). Social protection programmes can facilitate access to and utilization of health services for the poor thus enhances prevention and health outcomes for the poor children (Sanfilippo *et. al.*, 2012).

In some African countries unconditional cash transfers have contributed to an increase in utilization of health services, such as in the case of the Mchinji transfer in Malawi (Yablonski and O'Donnell, 2009). Evidence on access and utilization of healthcare is however richer in the case of Conditional Cash Transfer (Lagarde et al., 2007). Conditions attached to CCTs force poor people to use health services with regularity, such as in the case of Bolsa Familia in Brazil or Familia in Acción in Colombia. While conditions imposed on the receipt of a transfer will have an effect, making people aware of the need to regularly use health services is also of outstanding importance. However, a study by Fiszbein and Schady (2009) shows that only some preventive services, including regular check-ups for children, are more likely to be affected by CCTs compared to others (e.g. immunization).

More specific interventions designed to protect children have proven successful in increasing access to healthcare. The voluntary component of the health insurance system in Viet Nam is specifically focused on school children, individuals eligible for humanitarian assistance and other adults. Most of the beneficiaries (about 95 per cent), however, are children, given that schools are encouraged to put pressure on pupils' parents to obtain health insurance for them. The impact analysis found that members of the health insurance system were more likely to seek treatment in health facilities rather than to self-treat (Jowett, 2001).

In addition, programmes not directly focused on children have an important role in fostering poor households to increase their pupils' access to health services. The Health Card system in Indonesia was designed to provide poor households with access to healthcare during the economic crisis experienced by the country at the end of the 1990s. The utilization rate of children from households possessing health cards was larger than that of children who did not have one; as pre-treatment levels were quite similar among the two groups, the difference probably resulted from possession of a health card (Johar, 2007). In Malawi, a study evaluation of the Mchinji unconditional social transfer programme has shown that over the period 2007/08 a large share, around 80 per cent of children in beneficiary households have improved their health and referred to health care when sick against respectively 15 and 8 per cent of non-treated (Miller *et al.*, 2008).

Evaluation results of studies conducted on CCTs in various Latin American countries show that for children up to 36 months old benefitting from Progresa in Mexico, illness rates were over 20 percentage points lower than non-participants (25.3 for children aged 0-24 months and 22.3 for 0-36) (Gertler, 2004). A decrease in the risk of illness has been reported by Huerta (2006) for children aged between 24 and 59 months participating in the same programme. Whilst improved nutritional status directly promotes improved health status of household members, cash transferred to households allows recipients to afford treatment. In Zambia, for example, incidence of illnesses reduced from 42.8% to 35%; and incidence of partial sightedness reduced from 7.2% to 3.3%, potentially due to the fact that beneficiary households could afford minor eye surgery (MCDSS/GTZ, 2007).

The studies highlighted above do not point to any evidence of the influence of the social protection systems on the health of orphaned and vulnerable children, which this study investigated and to bridge the gap and focused on OVC in Nyang'oma Division, Bondo District Kenya.

2.6 Social Protection Systems and Food Security of Orphaned and Vulnerable children

Reducing hunger, with its consequences on children's health and cognitive capacities, and promoting food security has long been an objective of social protection policies in the developing

world. An instrument typically adopted for this aim is school feeding, the original purpose of which was to protect children against food insecurity (Devereux et al., 2010), though its impacts are largely affected by the main features of design. Results from the evaluation of a school feeding programme in Kenya show quite clearly that the contribution of school feeding accounted for about 30 to 90 per cent of the recommended daily allowances in terms of energy and protein for the majority of the students (about 80 per cent), while it accounted for almost the whole intake of vitamin A in more than 20 per cent of cases (World Food Programme, 2010).

Based on principles similar to those of school feeding, but providing households with a monthly ration of food, the 'Food for Education' programme in Bangladesh has contributed to improving weight-for-age for the pre-school children (6 to 60 months) of beneficiary households compared to primary school-age children not attending school (Ahmed and Del Ninno, 2002).

Programmes in the form of cash transfers in general also have a positive impact, given that recipient households tend to spend much of the transfer on food (Adato and Basset, 2009; ILO, 2010; DFID, 2011). The extent to which this can have an impact on child nutrition has been found to depend on key design features including the duration of the transfer, the age of recipient (0-24 months being the most critical), and the size of transfer (Yablonski and O'Donnell, 2009).

Analyzing anthropometric survey data, Aguëro *et al.* (2007) have shown that provision of the child support grant in South Africa during early childhood translates into an increase in height for age resulting in an average gain of 3.5 cm in adulthood. The *Samurdhi* programme in Sri Lanka, consisting of various measures including a cash transfer to poor households, has been found to impact on children's nutritional status, both in the short term (through weight-for-height) and long-term (through height-for-age) measures (Himaz, 2008).

The Cash-for-Work programme Chars Livelihood in Bangladesh shows an impact in terms of children's height, weight, BMI and mid-upper arm circumference. The treated children gained on average 0.7 mm in height, 210g in weight and 1.39 mm in mid-upper arm circumference more than

those children from the control group (Mascie-Taylor *et al.*, 2010). At the level of the household, there is plentiful evidence to show that cash transfers improve food security and nutrition. An evaluation of Malawi's Food And Cash Transfers (FACT) showed that 75.5% of the transfer was typically spent on groceries (Devereux et al, 2006). In Lesotho the number of old age pensioners reporting that they never went hungry increased from 19% before the pension to 48% after it was introduced (Croome and Nyanguru, 2007).

As well as increasing the volume of food available, cash transfers lead to an increase in the variety of foods consumed within the household: in Zambia 12% more households consumed proteins every day and 35% consumed oil every day if they received a transfer, compared with those households that didn't (MCDSS/GTZ, 2007).

2.7 Social Protection Systems and Family Care of Orphaned and Vulnerable children.

Most children exist within a family structure. This structure may have variations, but usually there is one person, the Primary Care Giver, who assumes responsibility for the care of the child. Ideally, the primary carer would be an adult. Even where children live on the streets or in child-headed households, with no adult carers, they nevertheless have some group structure, and assume adult roles for the care of younger siblings and children. The child cannot be separated from its 'family' context, and thus the well-being of the child is dependent on the well-being of the family (Teresa, 2002). Consequently, social security benefits cannot target children in isolation, but must use their family, usually the primary care giver, as the channel for reaching the child. While it is hoped that the grant would be spent directly on the child's needs, this cannot be tracked nor ensured, and therefore it is assumed that by increasing the household income, the well-being of the child will be automatically enhanced.

A comprehensive social security system seeks to provide a package of benefits that together meet the range of needs of vulnerable persons. Thus it is not a case of either cash transfers or feeding schemes. It must be recognized that while the child's need for good nutrition is paramount to their survival and development, it is not their only basic need. Children have the right to a minimum

standard of living, housing, clothing, health and education. Thus housing schemes are essential, as are cash transfers to empower care giver to provide for the child's range of needs (Teresa, 2002).

Family support programs are grounded in a family development model that is drawn from family systems theory, as well as an ecological view of child development that assumes that children develop within families and that families function within the community (Walker, 2005). Family and community culture is regarded as a significant factor in the family support approach (Emarita, 2006; Walker, 2005). Home-based caregivers may be members of a child's family and certainly part of the community in which the family functions. Home-based caregivers are often from the same culture as the children in their care.

Family support programs typically aim to improve child outcomes by enhancing parenting capacity. They use a wide variety of strategies, including home visitation, parent-child activities in a group setting, peer support groups, and parent training. While many programs espouse family support principles - such as participant-driven services, mutually respectful relationships, and a strengths-based approach to working with families - some research has examined a set of programs that explicitly identify themselves as family support programs (Toni, Diane, Del Grosso, Sarah, Rachel, and Lee, 2010).

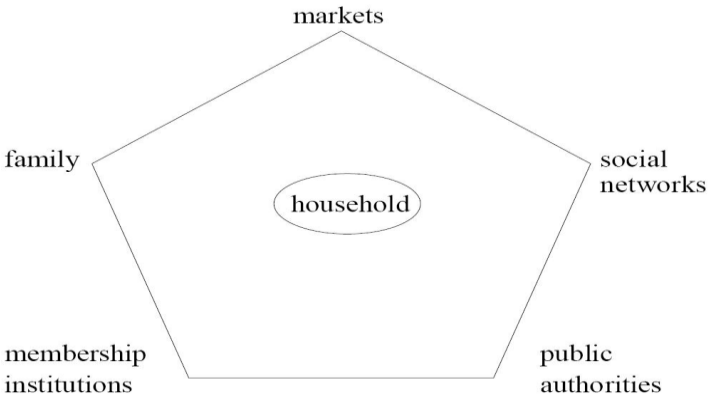
The meta-analysis of family support programs in the United States, Great Britain, and Canada sought to determine their effects on families and children, as well as to identify the effectiveness of different kinds of programs and services (Layzer et al., 2006). It included 665 studies associated with 260 programs and analyzed data for five parent outcomes (parenting knowledge, behavior, family functioning, adult mental health/health risks, and family economic self-sufficiency) and four child outcomes (cognitive development and school performance, physical development and health, child safety, and social-emotional development). The study found that nearly all the programs had a two-generation focus: they aimed to support parents and promote the healthy development of their children (Layzer et al., 2006). Approximately half aimed to serve low-income families, like many of the families

who use home-based child care and the caregivers who provide it. Research indicates that home-based caregivers may serve a relatively high proportion of children with special needs (Paulsell et al., 2006; Brandon et al., 2002).

If caregivers respond to the family support-type services as parents as these studies did, initiatives based on a family support approach could have modest effects on such outcomes as care-givers knowledge, behavior, and well-being and on such child outcomes as improved social competence, self-regulation, and social skills. The findings also suggest that intensive services may produce larger effects, and that family support services may be more beneficial for especially vulnerable children, such as those with special health care needs (Toni et. al., 2010). This study examined the influence of social protection programmes on family care for OVC in Nyang'oma Division.

2.8 Theoretical Framework of the Study

The key role of theories is to tell us why something occurred. They help us organize the data from research into a meaningful whole. This study employed the Livelihood Portfolio Theory Based on the Welfare Pentagon (Neubourg, 2009). The Neubourg welfare pentagon depicts five core institutions namely family, markets, social networks, membership institutions and public authorities, as shown in Figure 1



:

Figure 1: The Welfare Pentagon

Source: Neubourg (2009)

The theory makes a number of assumptions. First, that individuals and households maximize income under constraints. Second, all households face the risk of becoming poor at a certain point in future. To prevent this risk, households' consumptions should be smoothened and resources need to be set apart to finance future consumption. The ability to smoothen consumption is an important factor for well-being. It is individual's capacity to satisfy basic needs tomorrow, despite the existence of risk and occurrence of shocks. Hence social protection then becomes a consumption smoothing strategy. Households use these to satisfy their current and future needs at any given society, though their relevance may differ by society and over time. Each institution has a function and they are used as a livelihood strategy in order to generate income and smoothen consumption.

Also individuals within the society need access to relevant institutions of the welfare pentagon. For instance, to obtain social security benefit, individuals need access to public authorities that control social benefit, just as getting support from family implies having access to a family. For instance, households can be insured against certain risk by public authorities through paying social insurance contributions or simply a citizen can rely on social networks or family to generate money to compensate him or her after-shocks (Neubourg 2009).

Individuals within the society can access the welfare pentagon institutions much better if they have a certain amount of capital available. Individuals and households differ in their possibilities to invest in financial, social and political capital. This makes it important for the state to assist in promoting social protection through various social policy instruments and providing goods and services for free or at low cost. In spite of their functions, the institutions of the welfare pentagon channels are substitute for one another. This means public authorities can step in to provide social protection, just as local self-initiatives or the family can do so. It also means that if the public authorities withdraw or lower their inputs in providing social protection other channels of the welfare pentagon will have to make a greater effort to assist the household in meeting their needs. If the state does not assist in providing social

protection, the burden is shifted towards individuals with higher risks and the burden is even more difficult for individuals and households with fewer resources (Neuboug 2009).

The strength of Neubougs theory is that the theory highlights the important role of the various institutions of the welfare pentagon. Institutions in society need to collaborate with one another to promote individuals well-being and enhance economic growth to achieve equity. It is important that each society makes effective use of existing institutions. The weakness of Neubornгs theory is that it overlooks the new discourse of social protection which recognizes that in the absence of effective collective managements to manage risks, individuals and households, particularly those who are most vulnerable must be engaged in micro level informal risk management strategies which impose very high cost of their own (Conway and Norton 2002).

2.9 Conceptual Framework of the Study

The study was based on the conceptual framework shown in Figure 1.

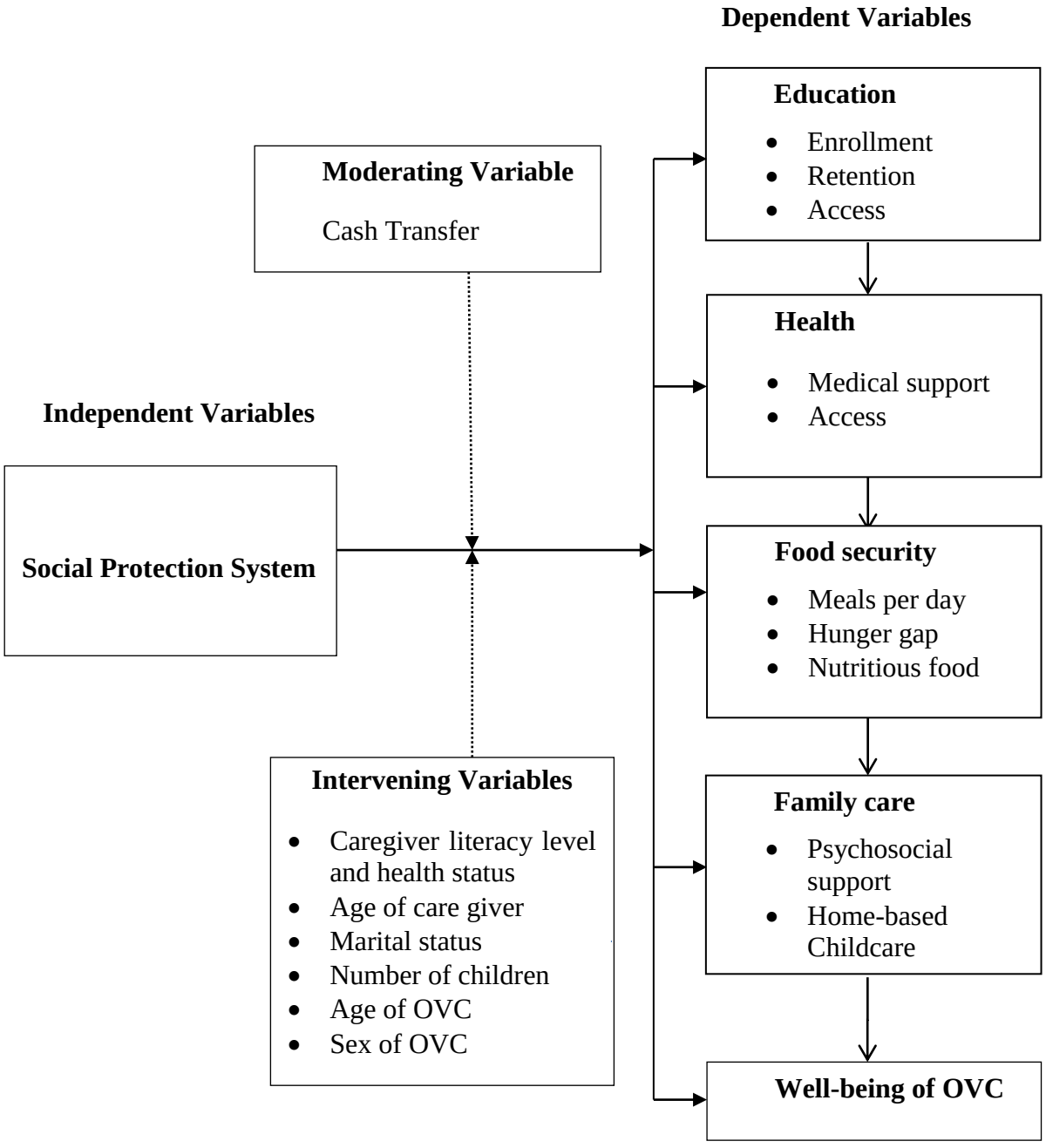


Figure 2: Conceptual Framework of the Study

SOURCE; Self conceptualization

The conceptual framework in Figure 2 shows the linkage between the independent variable (social protection systems) and the dependent variables (education, health, food security and family care). It was conceptualized that the social protection system impacted on the dependent variables which then lead to the wellbeing of the OVC. Education of the OVC was examined in terms of enrolment, retention and access. It was conceptualized that when OVC are covered by the social protection systems, they would have access to education, indicated by enrolment and retention in the formal education system.

Health was evaluated in terms of the OVC accessing and utilizing health/medical services when the OVC are supported by the social protection systems. Access to health services would also be achieved through OVC's attendance of school where health programmes exist within the framework of child-friendly schools. On the other hand, food security for the OVC was evaluated on the basis of the number of meals the OVC obtained within a period of one day and nutritional security (access to foodstuffs of diverse nutritional content). The study conceptualized that social protection systems that impacted on food security would lead to improved nutritional status and hence positive health outcomes.

Family care was conceptualized to constitute psychosocial support and home-based childcare. Under a comprehensive social protection system that impacted on education, health and food security of the households of the OVC, the caregiver's burden was considered to have lessened, thus providing them with more time to concentrate on the children, providing them with parental care that comprised psychosocial support and improved child care. A constellation of these dependent variables in a synergy was visualized as leading to the wellbeing of the OVC.

Cash transfer was seen as a moderating variable in the sense that it would enable the actualization of the social protection system to impact on the dependent variables. The intervening variables included: caregiver's literacy level, age, marital status, number of children under the care of the care giver, age and sex of the OVC.

Literacy level of the caregiver is likely to have an effect in the provision of basic needs of the OVC as the caregiver may not be in a position to prioritize the most basic needs that OVC require. The caregiver may be sickly and this may mean that much of the money received would be used in treatment of the caregiver. This would leave very little or nothing for the OVC's upkeep. More importantly, the OVC may take much time nursing the sick caregiver and therefore fail to regularly attend school. The age of the caregiver equally poses a challenge; the age gap between some caregivers and OVC if large may at times create misunderstanding between the caregiver and the OVC. Some caregivers may also be too young for the responsibility of caring for their sibling.

The number of children in a household may also put pressure on the amount of money given for support of the OVC household as the figure given does not take in consideration how many people are in a household. Sex preference of certain household for boys rather than girls or uniform preferential treatment may also mean that specific needs of a particular sex are not taken care of. In addition, slightly older OVC may be in a position to stand strong and confident by openly expressing their needs as opposed to a younger OVC.

The conceptual framework, therefore, conceptualized that if there existed social protection system that was moderated by cash transfer and the intervening variables addressed, then this would lead to the well-being of OVC.

2.10 Summary of Literature Review

So as to understand the concept of social protection and its impacts on orphans and vulnerable children, this chapter reviewed literature related to experiences from different countries /organizations in their implementation of social protection systems. The literature was based on global, regional and local perspectives.

Social protection measures highlighted includeed Policies and actions for the poor and vulnerable which enhanced their capacity to cope with poverty, and equipped them with skills to better manage risks and shocks.The four key areas in the provision of services are Education, Health, Water and

sanitation. It is seen as important component of poverty reduction strategies and efforts to reduce vulnerability to economic, social, natural and other shocks and stresses

As the literature revealed that the number of OVC was growing exponentially and they are faced with a myriad of challenges. Further, OVC in rural and poor environment are less likely to optimize the full benefits of the support systems that are available to cushion the effects of their social circumstances. Education, health, food security and family care are important needs that the OVC grapple with and there are institutions that have been able to offer protection system to cushion them with remarkable achievements recorded globally.

Social protection programs that target Education of children have over the years addressed issues on access, enrollments and or attendance and consequently retention of the children. The cash transfers programs have been instrumental; in providing cost on school fees and feeding. However there is limited evidence in terms of whether the transfer results in improvements in final outcomes.

Accessibility to health service nevertheless was shown to be improved by the social protection system. Literature reviewed revealed that programmes not directly focused on children have an important role in fostering poor households to increase their children's access to health services. The social protection systems therefore work together with the household in improving their accessibility through health cards and supplementary feeding.

Promoting food security has long been an objective of social protection policies in the developing world. An instrument typically adopted for this aim is school feeding, the original purpose of which was to protect children against food insecurity. Families tend to spend more on food and measures that can be used to sustain the supply of the food. Child Nutrition on the other hand has been found to depend on key design features including the duration of the transfer, the age of recipient (0-24 months being the most critical) and the size of transfer.

From the literature, there existed a gap in terms of the impact of social protection systems on orphaned and vulnerable children with most of studies and findings based on general conditions of the

children. Thus, this study specifically investigated the impact of the social protection systems on OVC's in a rural set up.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter presents and describes the research methodology that was followed in conducting the study. The chapter is discussed under sub-headings of research design; study location; population of study; sample size and sampling procedures; instrumentation and their validity and reliability; data collection; data organization and analysis.

3.2 Research Design

The study utilized the descriptive survey research design. A survey involves studying a situation as it is in an attempt to explain why the situation is the way it is (Wiersma, 1999). Kothari (2004) asserts that the purpose of descriptive research is to describe facts and characteristics concerning an individual, group or situation. According to Lokesh (1984) descriptive studies are designed to obtain pertinent and precise information concerning the status of phenomena and whenever possible to draw valid general conclusions from the facts discovered. In this study, therefore, descriptive survey design was appropriate because it was used to determine, describe and report on the influence of the social protection systems on the various dimensions of OVCs wellbeing in Nyang'oma Division.

3.3 Target Population

Mugenda and Mugenda (1999) define target population as that population to which a researcher wants to generalize the results of the study. The ideal setting for research study is one that directly satisfies the researcher's interest and should be accessible to the researcher (Singleton, 1993). The study was carried out in Nyang'oma division of Bondo District, which was reported to have a high HIV /AIDS prevalence that had resulted in many households with OVC hence various social protection systems had been implemented in the area to cushion the OVC. According to the Kenya National Bureau of Statistics (2009), the division covers 187.91 sq. km with an approximate population of 34,483 people and 10,360 households which constituted the study population. The division has two

locations, South and Central Sakwa and seven sub-locations. According to the records in the department of children services in Bondo District, the division had a total of 2,295 OVC households. Therefore the target population for the study comprised 4,590 households arrived at by multiplying the number of households by two. This was due to the fact that those targeted were two members of each OVC household: the care giver and a child aged between 5-18 years. This was used as the sampling frame from which a sample of households was selected to participate in the study.

3.4 Sample Size and Sampling Procedures

The sample size and the sampling procedures used in obtaining the study's sample of the population are described below.

3.4.1 Sample size

Fraenkel & Norman (1990); Kathuri & Pals (1993) recommend that for descriptive surveys, a minimum of 100 subjects are acceptable provided that none of the sub-samples will be less than 20. However, based on the table of Krejcie & Morgan as cited by Kasomo (2007), a target population of 4590 households gave a sample size of 357, since the total target population tends towards N=5000 (Appendix I). The study therefore, utilized a sample size of 357 households. These households were divided into two: 178 households from which the caregivers were interviewed and the other 179 for interviews with the OVC, one child between the ages of 5-18 years. In addition, 6 key informants from government departments that is; Area education officer, Divisional health officer, Divisional Agricultural officer, Divisional Social service officer that support social protection systems/programmes in the study area were also interviewed.

3.4.2 Sampling Procedures

Sampling is the procedure of selecting members of a research sample from accessible population which ensures that conclusion from the study can be generalized to study population (Frankel and Wallen, 2000).The sample was drawn from the target population of 4590. Since the target population may not have been homogenous, stratified random sampling was used to obtain representative

households with OVC from each of the 7 sub-locations; Uyawi, West Migwena, Nyang'oma, Ndenda, East Migwena, Got Abiero and Nyaguda of Nyang'oma Division. Stratified random sampling ensured that all the households with OVC benefiting from social protection systems had a chance of being included in the sample (Kathuri & Pals, 1993). The lowest unit of sampling used was the sub-location which is administratively headed by an assistant chief. The choice of the assistant chief as the focal point was due to the fact that the assistant chief is the chairperson of the sub location Development monitoring committee and therefore would be able to assist the research team to identify the OVC household locations.

Proportionate allocation of the sample size based on the population of each of the sub locations was used to select the households from each of the 7 sub locations as shown in Table 3.1. All the households were numbered and a list for every sub-location generated. Systematic sampling was then adopted where, from every household in an even position, the caregiver was interviewed while an OVC from every household in every odd number position was interviewed.

Table 3.1: Target population and proportionate sub- sample sizes.

Administrative sub location	Number of HH with OVC Multiplied by 2	% of OVC HH of target population	Sample size per sub-location
Uyawi	780	17	61
West Migwena	596	13	46
Nyang'oma	918	20	71
Ndenda Yamo	368	8	29
East Migwena	368	8	29
Got Abiero	550	12	43
Nyagunda	1010	22	78
Total	**4590**	**100**	**357**

The Area Education Officer, Division Agricultural office, Divisional Health officer and Social service officer as key informants were selected purposively to participate in the study. Purposive selection was premised on the fact that these key informants deal directly with the cases of orphaned and vulnerable children and therefore had the required information to assist the study in arriving at valid conclusions

3.5 Research Instruments

The study utilized the household questionnaire, observation schedule and interview schedule for primary data collection. The care giver and OVC household questionnaires were used to collect information from the sampled households. The questionnaire is a systematic and structured tool that aims at obtaining information from a large population of respondents concurrently, in a direct, open and confidential manner (Kothari, 2004). The questionnaire was considered appropriate since it would

cover a large sample of respondents, thereby allowing a reasonable degree of generalization of the findings. Both open and closed-ended questions were included in the questionnaires.

The caregiver household questionnaire had three main parts. The first part sought to gather information on the respondent's profile such as gender, age level of education and marital status. The second part included the household characteristics. The section gathered information respondents' relationship to caregiver, age, and school and parent survivorship. The third section carried items that addressed issues related to the study objectives, specifically the impact of social security systems on the health, education, food security and family care dimensions of OVC well-being in Nyang'oma Division. The OVC household questionnaire on the other hand had questions on OVC well-being, related to issues on education, health, food security and family care.

A key informant interview schedule was also developed for conducting in-depth interviews with the identified key informants. The guide contained questions related to the objectives of the study that sought to gain deeper insight into themes or issues pertaining to the impact of the social security systems on the indicated dimensions of OVC well-being.

3.5.1 Pilot testing

To ensure that the instruments used to collect data actually measured what they were intended to measure, the questionnaires was pilot-tested. Pilot-testing involved testing questionnaire items in the field. The instruments were pilot-tested using a sample of 20 OVC households from two of the sub-locations of the neighboring in Nyang'oma Division, where 20 caregivers and 20 OVC responded to the pilot-test. The selected Sub locations were notified through the assistant chiefs and the research team prepared for the exercise after training on the data collection instruments.

The subjects were encouraged to make comments and suggestions concerning the instructions, clarity of questions asked and their relevance (Mugenda and Mugenda, 1999). The procedures used were similar to those used during the actual data collection.

3.5.2 Validity of the Instruments

Validity refers to the degree to which the empirical measures or several measures of the concept, accurately measure the concept (Orodho, 2005). It is also the extent to which a research performs what it was designed to do and how accurate the data obtained in the study represents the variables of the study (Mugenda, and Mugenda, 1999). In constructing the instrument items, effort was made to construct clear and precise items thus avoiding ambiguity. After constructing the instruments, the researcher discussed the items in the instrument with the supervisor and colleagues in the Department of Extra-Mural Studies of the University of Nairobi as recommended by Mutai (2000), to ascertain their construct and face validity. Content validity of an instrument is improved through expert judgment (Gall, 1989). In addition, the responses in the pilot study were used to restructure and clarify questions that were not clear.

3.5.3 Reliability of the Instruments

Reliability of a research instrument is a measure of its internal consistency or stability over time (Borg and Gall, 1989). A measuring instrument is reliable if it provides consistent results. Reliability is a measure of the degree to which a research instrument yields consistent results or data after repeated trials. It is influenced by random error. As random error increases, reliability decreases. Random error is defined as the deviation from a true measurement due to factors that have not been addressed by the researcher. Errors may arise from coding, fatigue and bias (Mugenda and Mugenda, 1999).

The split-half technique was used to test reliability of the questionnaire. Kaplan & Saccuzzo, (2001) point out that the split-half technique involves splitting the statements of a test into two levels, odds and even items then calculating the Pearson's correlation coefficient (r) between the score using the formula:

$$r = \frac{\sum XY - \frac{\sum X \sum Y}{N}}{\sqrt{\left(\sum X^2 - \frac{(\sum X)^2}{N}\right)}\sqrt{\left(\sum Y^2 - \frac{(\sum Y)^2}{N}\right)}}$$

Where:

N=Number of pairs of scores

$\sum xy$=Sum of the products of paired scores

$\sum x$=sum of x scores

$\sum y$=sum of Y scores

Σy^2 =sum of squared y scores

Σx^2 =sum of squared x scores

To increase the estimate reliability even more, Spearman-Brown formula was applied as follows to calculate the estimate correlation between the two halves**.** A reliabilty coefficient of 0.70 and above was considered credible enough for the study. Kaplan & Saccuzzo, (2001)

Spearman Brown formula: $r = \frac{2r}{1+r}$

3.6 Data Collection procedures

Permission to carry on with the research and collect date was sought from the Graduate School of the University of Nairobi and a research permit from the National Council of Science and Technology. Permission to collect data was then secured from the Provincial Administration in Bondo District and the District Children Officer. This was followed by an exploratory visit to the area of study to meet with local leader's specifically assistant chief who assisted in mobilizing the households that participated in the study.

Seven research assistants were engaged and trained to assist in data collection. Key areas of training for the research assistants included basic principles of research approach such as interviewing skills, data quality management and standard operating procedures (SOPs) during field work. The trained research assistants then administered the questionnaire. The questionnaires were administered to sampled household respondents and observation scheduled completed at the same time. The researcher sought prior appointments with the key informants for the in-depth interviews.

3.7 Data Analysis Techniques

The objectives of the study were analyzed quantitatively using simple descriptive statistics and the findings summarized and presented using percentages and frequency distribution tables. After data collection, all the returned questionnaires were numbered and the data coded. Preliminary editing was done where the data was checked for accuracy and errors committed. Clarity and legibility of all questions was established and questionnaires with ambiguous responses eliminated. The coded data was then entered into the computer and analyzed with the aid of the Statistical Package for Social Scientists (SPSS).

Quantitative data was analyzed by cross-tabulating the independent variable against each of the dependent variables and the emerging trends in the interaction between the social protection systems and the components of OVC well-being discussed as per the objectives of the study. The findings were summarized and presented using percentages and frequency distribution tables. Correlation analysis was also done using the Pearson's Product Moment Correlation (PPMC) to determine the relationships between social protection systems and each dimension of the OVC wellbeing and the findings presented in correlation matrices. For the unstructured type of questions in the questionnaire and the interview guides, all responses given for each question were extracted and discussed qualitatively along the main objective areas of the study.

3.8 Ethical Considerations

The requisite approvals for conducting the research were sought before data collection (McMillan & Schumacher 1993). Initial approval was obtained from the University of Nairobi, and then a research permit sought from the national Council of Science and Technology (NCST).

Research respondents were asked to give their prior consent by reading and signing the consent form attached to this report as an appendix. Once consent was given, the purpose of the research was meticulously explained to respondents in simple and concise language. Respondents were also informed that they had a right to choose not to answer a question or if they wished, they could withdraw from the interview at any time without any form of penalty. The wish of a respondent to decline an interview was respected. In addition, the identities of all interviewees were kept anonymous and where name was requested, it was used purposely for making reference to the data collection process.

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION AND INTERPRETATION

4.1 Introduction

This chapter presents and discusses the research findings under thematic sub sections in line with the study objectives. The chapter is divided into: response rate; background of the respondents; social protection systems and education; social protection systems and health; social protection systems and food security and social protection systems and family care of OVC. The data was analyzed both quantitatively and qualitatively. The data has been presented in forms of tables, pie chart, percentages, graphs which make the results easy and possible to read.

4.2 Response Rate

The study had designated sample sizes of 178 OVC care givers and 179 OVC. The questionnaires were administered to the respondents with the help of trained research assistants. For the caregivers who showed considerable literacy levels the questionnaire was self-administered while for those who exhibited lower levels of education as well as the children respondents, the questions were read out to them and interpreted in the local (*Dholuo*) language without changing the meanings of the questions. Face to face interviews were held with the key informants. Table 4.1 shows the response rates.

Table 4.1: Response Rates

Group	Designated Sample size	Number Achieved	Response Rate
Care givers	178	171	96.1%
OVC	179	175	98.8%
Key Informants	4	3	83%
Total	**363**	**351**	**96.7%**

One hundred and seventy one (171) household caregiver and 175 OVC questionnaires out of the designated sample sizes of 178 household caregiver and 179 OVC questionnaires respectively were

returned. In addition, 3 key informant interviews were successfully conducted out of the envisaged 4. These figures represented response rates of 96%, 99% and 83% respectively for the caregivers, OVC and key informants respectively. Overall, there was an average response rate of 97%. This response rate was considered representative enough to give results at the set confidence level as according to Nachmias and Nachmias (2005), a response return rate of more than 75% is enough for the study to continue.

4.3 Background of the Respondents

This section discusses the respondents' sex, marital status, level of education, occupation and the average household income. Other than confirming that the respondents were representative of the target population, these personal and socio-demographic variables had a bearing on the respondent's ability to provide valid information that enabled the study to reach its conclusions.

4.3.1 Distribution of the Respondents by Sex

Both the caregivers and the OVC were asked to indicate their sex. Table 4.2 shows the distribution of the respondents by sex.

Table 4.2: Distribution of the Respondents by Sex

Sex	Caregivers		OVC	
	Frequency	**Percentage**	**Frequency**	**Percentages**
Male	44	25.7	85	48.6
Female	127	74.3	90	51.4
Total	**171**	**100.0**	**175**	**100**

A total of 127 (74%) female and 44 (26%) male caregivers responded to the household questionnaire for caregivers. On the other hand, 51% of OVC were female while 49% were male.

4.3.2 Age of the Respondents

The respondents, both the household caregivers and the OVC were asked to indicate their ages. The findings were as shown in Table 4.3.

Table 4.3: Distribution of the Respondents by Age

Age Bracket (Years)	Caregivers		OVC	
	Frequency	Percentage	Frequency	Percentage
3-6	-	-	37	21.1
7-10	-	-	33	18.9
11-14	-	-	88	50.3
15 -18	-	-	17	9.7
25 to 29	36	21.1	-	-
30 to 34	25	14.6	-	-
35 to 39	43	25.1	-	-
40 to 44	32	18.7	-	-
above 45	35	20.5	-	-
Total	**171**	**100.0**	**175**	**100.0**

The findings indicate that half of the OVC interviewed were aged 11-14 years, 21% were 3-6 years of age, 19% ranged from 7-10 years of age while 10% were 15-18 years of age. Therefore, children at various developmental stages were reached by the study, making the information obtained from the children largely representative.

As regards the caregivers, 25% were 35-39 years old, 21% in each case were aged 25-29 and above 45 years, 19% were 40-44 years old and 15% were aged 30-34 years. Cumulatively, majority of the caregivers were of youthful age.

4.3.3 Marital Status of the Caregivers

The caregivers were asked to indicate their marital status. Married caregivers provide the children with a conducive home atmosphere where they get the attention and care of both male and female parents/guardians. The caregivers were further required to indicate their relationships with the household heads. The distribution of the caregivers by their marital status was as shown in Table 4.4.

Table 4.4: Distribution of the Caregivers by their Marital Status

Marital	Frequency	Percentage
Married	81	47.4
Divorced	14	8.2
Widowed	76	44.4
Total	**171**	**100.0**

The findings revealed that 47.4% of the caregivers were married, 44.4% were widowed while 8.2% were divorced. With respect to the relationship of the caregiver respondents with the household heads, 90% of the caregivers were household heads themselves, 8% were spouses to the household heads while 2% were relatives of the household heads. Of those who were household heads, 18% were male while 82% were females. The percentage of caregivers who reported being widowed is significantly high and, together with those who were divorced indicates that the vulnerability level of children in the study area is significantly high. In addition, the 82% female household heads implies that majority of the households are female headed. Given differential socio-economic vulnerability between men and women in the society, with women being potentially highly susceptible to such vulnerability and give their gender-ascribed roles of child rearing, these percentages indicate the need for social intervention programmes to specifically target women if they are to successfully address the lives of OVC.

4.3.4 Distribution of the Respondents by their Level of Education

The caregivers were required to indicate their highest level of education as at the time of the study. The findings were as shown in Table 4.5.

Table 4.5: Distribution of the Caregivers by their Level of Education

Level of Education	Frequency	Percentage
Primary level incomplete	63	36.8
Primary level complete	50	29.2
Secondary level incomplete	19	11.1
Secondary level complete	39	22.8
Total	**171**	**100.0**

The findings revealed that the highest percentage (37%) of the caregivers who participated in the study had incomplete primary level education, 29% had completed primary education, 23% completed secondary education and 11% had incomplete secondary level education. This reflected the low literacy levels within the community, implying a higher need for capacity building efforts. Higher level of education for the caregiver is associated with the quality of childcare they give and high-quality care supports positive development in young children (Vandell and Wolfe, 2002).

4.3.5 Distribution of the Caregivers by their Occupation

The caregivers were asked to indicate the nature of their respective occupations. Their responses were analyzed and the findings were as presented in Table 4.6.

Table 4.6: Distribution of the Caregivers by their Occupation

Occupation	Frequency	Percentage
Business person	54	31.6
Artisan	2	1.2
Farmer	61	35.7
Government	7	4.1
Fish trade	47	27.5
Total	**171**	**100.0**

Thirty six percent (36%) of the caregivers indicated that they were farmers, 32% business persons, 28% were involved in fish trade and 4% were government employees. The goal of the cash transfer for OVC programme is to strengthen the capacity of poor households to protect and care for orphans and vulnerable children to ensure these OVC receive basic care within families and communities.

4.4 Social protection systems and education of Orphan and Vulnerable Children.

The first objective of the study was to assess how social protection systems influence the education of orphaned and vulnerable children in Nyang'oma division. In order to examine the relationship between social protection systems and education of the OVC, the study first sought to identify the social protection systems, other than the cash transfers, that the OVC households had further benefited from over a five-year period before the study was conducted. On other hand, education of the OVC was examined in terms of enrolment, retention and access. This section, therefore, presents and discusses the findings the social protection systems and their influence of education of the OVC.

4.4.1 Social Protection Systems for the Households

The caregivers were asked to indicate the social protection systems that their households had at least benefitted from between 2008 and 2012, that were provided either by the Government or NGOs/CBOs. The findings were as presented in Table 4.7.

Table 4.7: Social Protection Systems Benefiting OVC Households

Social Protection System	Frequency	Percentage
Free Primary Education	87	50.9
Farm inputs	61	35.7
School fee bursary	54	31.6
Grant for Income Generating Activity	53	31.0
Home based care training	44	25.7
Hospital fee waiver	35	20.5
Older person cash transfer	-	-

Half of the caregivers reported that they had benefited from free primary education. In addition, 36%, 32%, 31%, 26% and 21% of the caregivers' households had benefited from farm inputs, school fee bursaries, and grants for income generating activities, home-based care training and hospital fee waivers respectively, though in different years between 2008 and 2012. None of the caregivers' households had ever benefited from older person's cash transfers, probably due to the fact that majority of the households had caregivers who were either youthful or middle aged hence did not qualify for such transfers.

4.4.2 School Attendance by Orphan and Vulnerable Children.

The caregivers were asked to indicate whether the children they were taking care of attended school or not. From their responses, majority of them (98%) indicated that the children attended school while 2% indicated that the children did not attend school. Table 4.8 shows the caregivers' responses.

Table 4.8: Attendance of School by OVC

OVC Attending School	Frequency	Percentage
Yes	167	97.7
No	4	2.3
Total	**171**	**100.0**

The main reason given by the caregivers who reported that the children did not attend school was that they lacked school fees and school uniforms. This could be attributed to large family sizes that the cash transfers may not have been adequate to provide all the OVC needs. Each OVC household receives Ksh. 1,500 per month, without regard to the number of OVC that a household may have. Cash transfers play an important role in access to education, not only by providing households with the means to pay school fees, but also to purchase peripheral requirements associated with attending school, such as uniforms, books and stationery, thus increasing enrollment rates. MCDSS/GTZ (2007) earlier reported that in Zambia's, Social Cash Transfer increased school enrollment rates by 3% to 79.2%, and 50% of youth who were not in school at the time of the baseline study, but were enrolled by the time of the evaluation.

When asked to indicate whether there were instances when the children failed to go to school, 82% of the caregivers responded on the affirmative, 15% indicated that there were no such cases while 4% did not respond to the question. Sixty one percent (61%) of the caregivers indicated that instances when the children failed to go to school were rare, 23% sometimes,1% always while 15% indicated did not respond to the question, the percentage which did not experience such cases.

The OVC responses as to questions related to school attendance were as shown in Table 4.9

Table 4.9:OVC Responses on School Attendance

School attendance	Response				Total
	None of the time	Some of the time	Most of the time	All the time	
I attend school	2.3%	36.6%	25.1%	36.0%	100.0%
I like school	2.3%	24.0%	11.4%	62.3%	100.0%
My teachers treat me like the other children	2.3%	14.9%	26.9%	56.0%	100.0%
My caregiver pay my school levies	4.0%	53.7%	23.4%	18.9%	100.0%

Thirty seven percent (37%) of the OVC interviewed reported that they attended school "some of the time", 36% "all the time", 25% "most of the time" while 2% indicted that they did not attend school. Reasons for children not attending school regularly included absenteeism to take care of the younger siblings and sickness/illnesses. Majority of the OVC liked their school as indicated by the 62% and an additional 11% who liked school all the time and most of the time respectively. On the other hand, the 56% and 27% of the OVC who reported that their teachers treated them like the other children all the time and most of the time respectively reflect a positive and conducive learning environment for the OVC, free of discrimination that may discourage school attendance and thus denying the OVC access to education. The low percentages of OVC indicating that their caregivers paid school levies all the time (19%) and most of the time (23%) while more than half reported that the levies were paid only some of the time is due to the Free Primary Education (FPE) policy that benefits children, with very minimal additional levies that caregivers have to take care of.

4.4.3 Social Protection Systems and Certainty of OVC Completing School

The study sought to establish the extent to which social protection systems affected the caregivers' certainty that the OVC would complete school. The extent to which the OVC households had benefited

from social protection systems was evaluated by adopting a score of 1 for every social protection system that a household benefited from in addition to the cash transfers, which all the surveyed households were recipients. The total score for social protection systems that each household had benefitted from was then cross-tabulated with the caregivers' responses on how often they had had to worry whether the children would complete school. The findings were as shown in Table 4.10.

Table 4.10: Social Protection Systems and Certainty of OVC Completing School

Certainty	Number of Social Protection Systems						Total
	1	**2**	**3**	**4**	**5**	**6**	
No response	-	(3) 30%	(3) 30%	(4) 40%	-	-	**(10) 100.0%**
Never	-	(2) (4%)	(1) (2%)	(30) (60%)	(16) 32%	(1) 2%	**(50) 100.0%**
Sometimes	(5) 8.5%	(28) 47.5%	(26) 44.1%	-	-	-	**(59) 100.0%**
Always	(8) 15.4%	(18) 34.6%	(26) 50%	-	-	-	**(52) 100.0%**
Total	**(13) 7.6%**	**(51) 29.8%**	**(56) 32.7%**	**(34) 19.9%**	**(16) 9.4%**	**(1) 0.6%**	**(171) 100.0%**

The figures in parentheses () are frequencies

The findings in the table indicate that the highest percentage of 33% households had benefited from at least 3 different social protection systems , 30% had benefited room 2, 20% from 4, 9% from 5, 8% from 1 only (cash transfers for OVC) and less than 1% had benefited from 6 social protection systems. Among those who were never worried about the children completing school, 60% had benefitted from at least 4 social protection systems, 32% from 5 systems, 4% from 2 and 2% in each

case from 6 and 3 social protection systems. On the other hand, all those who indicated that they were always worried about their children completing school had benefited from at most 3 social protection systems. These findings implied that caregivers from households that had benefited from more social protection systems were more optimistic of the OVC's education completion than were those from households that had benefitted from fewer social protection systems, thus the stronger the social protection systems the more likely are OVC to access education.

4.5 Social Protection Systems and Health of OVC

The second objective of the study sought to determine the extent to which social protection systems influence the health of Orphaned and Vulnerable Children. This section presents and discusses the findings from analysis of data obtained from both the caregivers and orphaned and vulnerable children who were interviewed. The section is discussed under sub-sections of nutritional supplementation for OVC, healthcare of the OVC and the relationship between social protection systems and health of the OVC.

4.5.1 Nutritional supplementation for OVC

The caregivers were asked to indicate whether they had ever received nutritional supplements for the OVC they were taking care of. Their responses were as shown in Table 4.11

Table 4.11: Nutritional supplementation for OVC

Received Nutritional supplements	Frequency	Percentage
Yes	13	7.6
No	158	92.4
Total	**171**	**100.0**

The findings indicate that majority of the caregivers (92%) did not receive nutritional supplements for the OVC. Only 8% of the caregivers reported receipt of the supplements. Three percent (3%) and 5% of the caregivers indicated that they had received the supplements "rarely" and "sometimes" respectively.

4.5.2 Healthcare of the OVC

The caregivers were required to indicate how often their children fell sick. Their responses were as shown in Table 4.12 below.

Table 4.12 Frequency of OVC Sickness

Falling Sick	Frequency	Percentage
Rarely	61	35.6
Sometimes	78	45.6
Frequently	32	18.7
Total	**171**	**100.0**

The highest percentage of caregivers (45.6%) indicated that the OVC fell sick "sometimes", 35.6% fell ill "rarely" while 18.7% indicated that the children fell ill frequently. All the caregivers reported that whenever the children fell sick, they were treated at the government dispensaries, where 94% of the respondents confirmed that they paid for the medical services offered compared to only 6% who indicated that they did not pay for the services. When the caregivers were asked to indicate whether the children underwent any kind of organized medical checkup services provided by the

government/private organizations, over half of them (54%) reported that the OVC received the medical checkups while 46% reported that they did not receive the services as shown in Table 4.13.

Table 4.13: Medical Check-up for OVC

Medical check up	Frequency	Percentage
No	78	45.6
Yes	93	54.4
Total	**171**	**100.0**

Twenty three percent (23%) of the caregivers further indicated that the medical checkup services were offered sometimes, 21% indicated that the services were rarely offered while only 4% reported that these services were frequently offered. More than half of the caregivers (53%) did not indicate the frequency with which the services were provided, most of whom had earlier reported that their children did not benefit from such services. A study by Fiszbein and Schady (2009) shows that only some preventive services, including regular check-ups for children, are more likely to be affected by CCTs compared to others. In addition, programmes not directly focused on children have an important role in fostering poor households to increase their OVC's access to health services.

4.5.3 Social Protection Systems and Medical Attention of OVC

The caregivers were asked to indicate how often they had to worry that the OVC would not get medical attention if you they didn't have money to take them to hospital. The responses varied from "never worried" to "frequently worried". Their responses were cross-tabulated with social protection systems benefited from to establish the interaction between the caregivers' optimism about the OVC medical attention and social protection systems. The findings were as shown in Table 4.14

Table 4.14: Social Protection Systems and Medical Attention of OVC

Worried	Social Protection Systems						
	1	**2**	**3**	**4**	**5**	**6**	**Total**
Frequently	(9)	(24)	(4)	-	-	-	**(37)**
	69.2%	47.1%	7.1%	-	-	-	**21.6%**
Sometimes	(4)	(22)	(28)	-	-	-	**(54)**
	30.8%	43.1%	50.0%	-	-	-	**31.6%**
Rarely	-	(5)	(23)	(24)	(5)	-	**(57)**
	-	9.8%	41.1%	70.6%	31.3%	-	**33.3%**
Never	-	-	1	10	11	(1)	**(23)**
	-	-	1.8%	29.4%	68.8%	100.0%	**13.5%**
Total	**(13)**	**(51)**	**(56)**	**(34)**	**(16)**	**(1)**	**(171)**
	100.0%	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

The figures in parentheses () are frequencies

The findings indicate that majority of the caregivers who benefitted from more than 3 social protection systems were either never worried or rarely got about medical attention of the OVC. For instance, 100% of those who benefitted from 6 social protection systems were never worried, 69% of the caregivers whose household benefitted from 5 social protection systems were never worried compared to 31% of their counterparts who rarely got worried about medical attention of the OVC. On the other hand most of the households that benefited from 3 or less social protection systems were either frequently or sometimes worried about the OVC's medical attention as evidenced by 69% of those with only cash transfers for OVC, 47% with the cash transfers and covered by only one more social protection system who were frequently worried about the OVC's medical attention.

4.5.4 Social Protection Systems and Satisfaction with Health of OVC

The study sought to establish the level of caregivers' satisfaction with the health of the OVC in relation to the social protection systems. The caregivers were therefore asked to indicate the extent how satisfied they were with the children's health. Their responses were cross-tabulated with social protection systems benefited from and the findings presented in table 4.15

Table 4.15: Social Protection Systems and Satisfaction with OVC Health

Satisfaction with	**Social Protection Systems**						
OVC Health	**1**	**2**	**3**	**4**	**5**	**6**	**Total**
Not satisfied at all	(4)	(13)	(10)	(4)	-	-	**(31)**
	30.8%	25.5%	17.9%	11.8%	-	-	**18.1%**
Somehow satisfied	(5)	(25)	(37)	(13)	(3)	-	**(83)**
	38.5%	49.0%	66.1%	38.2%	18.8%	-	**48.5%**
Satisfied	(2)	(10)	(8)	(5)	(4)	-	**(29)**
	15.4%	19.6%	14.3%	14.7%	25.0%	-	**17.0%**
Very satisfied	(2)	(3)	(1)	(12)	(9)	(1)	**(28)**
	15.4%	5.9%	1.8%	35.3%	56.3%	100.0%	**16.4%**
Total	**(13)**	**(51)**	**(56)**	**(34)**	**(16)**	**(1)**	**(171)**
	100.0%	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

The figures in parentheses () are frequencies

The highest percentage of the caregivers (49%) were somehow satisfied with the health of the OVC compared with 18% who were not satisfied at all, 17% satisfied and 16% who were very satisfied. Most of those who had benefitted from more than 3 social protection systems reported higher levels of satisfaction with the OVC health indicating that the stronger the social protection systems the better chance the OVC stand to get good healthcare. However, the base value of the medical attention

the OVC receive from the government dispensaries, where medical charges are subsidized for the OVC is depicted in the manner by which even the households with only cash transfers for the OVC report high satisfaction levels with the health of the OVC. Social protection programmes can facilitate access to and utilization of health services for the poor thus enhances prevention and health outcomes for the poor children (Sanfilippo *et. al.,* 2012)

4.5.5 Orphan and Vulnerable Children Concerns on their Health

The OVC were asked to rate their responses on a scale of "None of the time" to "Most of the time" about their concerns on their health. Their responses were s shown in Table 4.16

Table 4.16: OVC's Concerns on their Health

OVC Health	Response				Total
	None of the time	Some of the time	Most of the time	All the time	
My health is good	2.3%	48.6%	30.3%	18.9%	100.0%
I worry about my health	41.7%	40.0%	15.4%	2.9%	100.0%
My caregiver pay for my medical bills	1.7%	51.4%	23.4%	23.4%	100.0%
I go to a medical service provider when am sick	8.0%	54.9%	23.4%	13.7%	100.0%

Forty seven percent (49%) of the OVC indicated that their health was good some of the time, 30% most of the time 19% all the time and 2% none of the time. This indicates the need for medical attention by the OVC, although the highest percentage of 42% and 49% respectively were either not worried about their health or were worried some of the time compared to 15% worried most of the time and 3% who were worried all the time. Slightly more than half of the OVC indicated that their caregivers paid their medical bills some of the time, which was basically consistent with the percentage of those whose health was good some of the time (49%) and hence required medical attention. This was

also part of the 55% OVC who indicated that they sought the services of medical service provider when they fell sick. This was in keeping in tandem with the conditions attached to the cash transfers for the OVC that requires the caregivers to ensure medical attention for the OVC.

4.6 Social protection systems and food security of OVC

The study sought to examine the influence of social protection systems on food security of orphaned and vulnerable children in the study locale. This section presents findings on OVC food security discussed under: the number of meals the OVC gets within a day, food adequacy and nutritional security.

4.6.1 Number of meals per day

The caregivers were asked to indicate the number of meals the children, both those who were school-going and those who were not, got in a day. The findings revealed that more than half (56%) of the caregivers reported that the school-going OVC had two meals in a day, 32% said they had only one meal and 12% indicated that the children had three meals. On the other hand, for those not going to school, 21% of the caregivers in each case indicated that they had three and two meals respectively while, 20% indicated that they had one meal in a day. The findings were as shown in Table 4.17.

Table 4.17: Number of Meals Taken by OVC per Day

No of Meals	School Going Children		Non-School Going Children	
	Frequency	**Percentage**	**Frequency**	**Percentage**
No response	-	-	66	38.6
One	55	32.2	34	19.9
Two	96	56.1	35	20.5
Three	20	11.7	36	21.1
Total	**171**	**100.0**	**171**	**100.0**

Some school-going children do not go back home for lunch and in schools where lunch programmes are ran, the children may benefit from such programmes and thus need only to take breakfast at home and the evening meals, which explains the higher percentage of caregivers who reported that school-going children get two meals in a day. For the OVC who do not attend school and get only a meal or two in a day, this is probably due to inability of the caregivers to provide all the three meals required for healthy living children, limited by their economic circumstances. However, some school-going usually go back home for lunch, thus will have three meals in a day.

4.6.2 Food Adequacy

The study sought to establish whether the OVC households had adequate food. The caregivers were therefore asked to indicate whether, in the previous 30 days before the study was conducted, they had to worry that their household would not have enough food and how often this occurred. Table 4.18 shows the caregivers' responses.

There were more caregivers who were worried about their households getting enough food (75%) than there were those who were never worried (25%). Of the caregivers who were worried, 29% indicated that they often got worried, 24% were rarely worried while 23% were only worried sometimes.

Table 4.18:Caregiver Worried About Food Adequacy

Worried About Food Adequacy	Frequency	Percentage
Yes	129	75.4
No	42	24.6
Total	**171**	**100.0**

Comparatively, most of those who were never worried were the caregivers whose households had benefitted from more than three social protection systems, which implied that the more the social protection systems the more food secure the household were.

4.6.3 Nutritional Diversity

The caregivers were asked to indicate how often their household members were not able to eat the kinds of foods they preferred, during 30 days preceding the study. Their responses were as shown in Table 4.19

Table 4.19: Nutritional Diversity

Unable to eat preferred foodstuffs	Frequency	Percentage
Often (more than 10 times in a month)	43	25.1
Sometimes (3 to 10 times in a month)	65	38.0
Rarely (once or twice in a month)	58	33.9
None (always ate the preferred food types)	5	2.9
Total	**171**	**100.0**

Thirty eight percent (38%) of the caregivers indicated that in the previous 30 days preceding the study, members of their household were not able to eat the kinds of foods they preferred “sometimes”, 34% indicated “rarely”, 25% often while 3% reported that on none of the days were their members unable to eat their preferred kinds of food.

4.6.4 OVC Views on Food Security

The OVC's responses to questions related to food security were as shown in Table 20.

Table 4.20: OVC's Views on Food Security

Food Security	Response				Total
	None of the time	Some of the time	Most of the time	All the time	
I eat at least two meals a day	2.9%	46.3%	39.4%	11.4%	100.0%
I have enough food to eat	2.9%	64.0%	28.0%	5.1%	100.0%
I eat a balance meal at least once a day(protein, carbohydrates, vitamins)	2.9%	86.9%	2.3%	8.0%	100.0%
I go to bed hungry	17.1%	80.6%	-	2.3%	100.0%

The findings indicate that the highest percentage of OVC (46%) reported eating at least two meals in a day some of the time, 39% most of the time, 11% all the time while 3% indicated that they ate at least two meals none of the time. Majority of the OVC reported that they had enough food to eat some of the time (64%), 28% had enough most of the time, 5% all the time and 3% none of the time. With regard to nutritional diversity, an overwhelming 87% reported that they ate a balanced diet at least once a day some of the time, 8% all the time, 3% none of the time wand 2% most of the time. Finally, 81% of the OVC indicated that they went to bed hungry some of the time compared to 17% who never went to bed hungry. The general trend is that the described food security circumstances were experienced only "some of the time", indicating that the OVC were largely food secure. Though the OVC may have reported going to bed hungry sometimes, it is possible that such children, get the lunch time meals at such times that the caregivers consider it enough to enable them go up to the next day, in ensuring that they have at least a ration for each day.

4.7 Social protection systems and family care of Orphan and Vulnerable Children.

The final objective of the study was to determine the influence of social protection systems on family care of orphaned and vulnerable children. Family care was considered as the overall attention and care that the caregiver provides to the OVC receives in terms of psychosocial support and home-based care. This section, therefore, presents findings on the caregivers and OVC's responses to various statements related to care of the OVC and also present an analysis of the ensuing relationship between social protection systems and family care of the OVC.

4.7.1 Family Care for the Orphan and Vulnerable Children.

The caregivers were asked to indicate the responses that best described their respective practices with respect to caring for the children they were taking care of in their households. Scores were adopted for the caregivers' responses to the statements where a score of 4 was adopted for "All the time", 3 for "Most of the time", 2 for "Some of the time" and 1 for "None of the time". The caregivers' responses were analyzed descriptively to determine the means and standard deviations for each of the statements.

The findings indicated that the means of the caregivers' responses ranged from 3.22 (highest) to 2.51 (lowest). The highest mean was related to the statement "As a care giver, I feel that I am able to protect the children I care for from physical abuse all the time" while the lowest mean was obtained from the statement "I have enough time to attend to all the children individually whenever they need my attention". The findings were as shown in Table 4.21.

Table 4.21: Family Care for the OVC

Family Care	Mean	Std. Deviation
I have enough time to attend to all the children individually whenever they need my attention	2.51	.754
I am able to provide the children with all their needs without any problem (school fees, uniform, books, medical bills, food and shelter)	2.57	.743
I have enough time to sit with the children to mentor and advise them as a parent	3.08	.775
I am able to give enough attention, love and support to the children	2.97	.739
As a care giver, I feel that I am able to protect the children I care for from physical abuse all the time	3.22	.873
I am able to provide the children I care for adequate clothing to keep them clean and warm.	2.72	.746

The differences in the means were not significantly high, indicating that the caregivers' practices with respect to care of the OVC were largely related to each other and more or less similar. Since the highest score was 4 and the lowest 1, the means of between 2.51 to 3.22 indicate that the caregivers were able to undertake all the practices "most of the" time thus enhanced family care for the OVC. On the other hand, the standard deviations to al the means were small, indicating that the scores were scattered around the means thus minimal variance in the family care practices between the households with less and more social protection systems.

4.7.2 OVC Views on Family Care

The OVC were required to rate the care they received at their households. Their responses were as presented in Table 4.22.

Table 4.22 OVC's Views on Family Care

Family Care	Response				
	None of the time	Some of the time	Most of the time	All the time	Total
I have a house where I can sleep at night	-	2.3%	19.4%	78.3%	100.0%
I am treated differently from the other children in the household	77.7%	13.1%	9.1%	-	100.0%
At home I have someone to look after me if I get hurt or feel sad	4.0%	10.3%	42.3%	43.4%	100.0%
I have adults I can trust	10.3%	2.3%	34.3%	53.1%	100.0%

The OVC responses indicated none of them lack a place to sleep, and that a majority of the OVC (98%) have a place they can sleep at least most of the time. 78% of the OVC felt that they were treated equally with other children in the households, compared to 13% and 9% who felt that they were treated differently from the other children sometimes and all most of the time respectively. The cumulative percentage of OVC who indicated that they had someone to take care of them if they got hurt or feel sad at least most of the time (86%) compared favorably with their report on having adults I could trust (87%). These findings implied that majority of the OVC received adequate family care.

4.8 Results and discussion on the hypothesis.

Below are the reported results obtained in testing the hypothesis of the study.

H1: SPS and Education of the OVC

Social protection system has no significant relationship with the education of OVC .To test this hypothesis, the Spearman correlation is reported in table 4.23.The correlation was checked between frequency with which the caregivers got worried about the children completing school and how sure the caregivers who never got worried about the children completing school were, that the OVC would

indeed complete the current level of education and enroll at the next level.. The total scores for education and social protection systems were then used to conduct the Pearson's Product Moment Correlation (PPMC) analysis to establish whether there was a relationship between social protection systems and education of the OVC.

able 4.23: Relationship between SPS and Education of OVC

		Social Protection Systems	Education of OVC
Social Protection Systems	Pearson Correlation	1	.437**
	Sig. (2-tailed)		.000
	N	171	171
Education of OVC	Pearson Correlation	.437**	1
	Sig. (2-tailed)	.000	
	N	171	171

***. Correlation is significant at the 0.01 level (2-tailed).*

The PPMC analysis as shown in Table 4.11 revealed that there was a significant positive relationship between social protection systems and education of the OVC ($r=0.44$; $n=171$; $p<0.01$). The relationship was of moderate strength, indicating that completion of education of the OVC was associated with social stronger protection systems, hence the stronger the social protection systems the more likely that the OVC would complete school and enroll at the next education levels. Sanfilippo *et. al*., (2012) reported that receipt of a cash transfer can improve enrolment by helping poor households to overcome the cost barriers to schooling, such as the costs of fees, uniforms and books. In Ethiopia, it was reported that one-third of PSNP beneficiary households enrolled their children in school and over 80% per cent of these beneficial impacts was said to be due to the programme (Devereux *et al.,* 2006). On the other hand, with respect to CCTs, Fizbein and Schady (2009) report quite significantly that virtually every programme that has had a credible evaluation has found a positive effect on school

enrolment. Beneficiaries of other social protection programmes that are not directly related to the education of the OVC may utilize the income from such programmes to pay school fees and provided other school requirements, thus decreasing non-attendance. This has been evident in Namibia where participation of 14 out of 16 students was solely due to their grandparents receiving a pension (Devereux, 2001). A large number of recipients of the basic income grant used the money to pay school fees. As a consequence, a decrease of 42 per cent in non-attendance due to financial reasons was recorded.

H2 .SPS and Health of OVC

The hypothesis stated; there is no significant relationship between Social Protection Systems and Health of the OVC. To test this hypothesis acre were adopted for the caregivers' optimism with the medical attention of the OVC and the levels of satisfaction with the OVC health. With regard to the caregivers' optimism with medical attention, a score of 4 was adopted for "Never", 3 for "Rarely", 2 for "Sometimes" and 1 for "Frequently" worried. On satisfaction levels with the OVC health, a score of 4 was adopted for "Very satisfied" 3 for "Satisfied", 2 for "Somehow satisfied" and 1 for "Not satisfied at all". The scores were then used to conduct the PPMC to establish whether there was a relationship between social protection systems and the two dimensions of OVC health. The findings were as presented in Table 4.24

Table 4.24 Relationship between SPS and Health of the OVC

		Social Protection Systems	Optimism over medical attention	Satisfaction with OVC health
Social Protection Systems	Pearson Correlation	1	.785**	.391**
	Sig. (2-tailed)		.000	.000
	N	171	171	171
Optimism over medical attention	Pearson Correlation	.785**	1	.464**
	Sig. (2-tailed)	.000		.000
	N	171	171	171
Satisfaction with OVC health	Pearson Correlation	.391**	.464**	1
	Sig. (2-tailed)	.000	.000	
	N	171	171	171

***. Correlation is significant at the 0.01 level (2-tailed).*

The PPMC analysis revealed that there was a strong and significant positive relationship between social protection systems and the caregivers' optimism over medical attention of the OVC (r=0.79; n=171; p<0.01). A moderate and significant positive relationship existed between the caregivers' satisfaction with the OVC health and social protection systems(r=0.39; n=171; p<0.01). On the other hand, there was positive correlation between the caregivers' optimism over medical attention and satisfaction with the OVC health (r=0.46; n=171; p<0.01). The positive correlations indicate that OVC health is associated with strong social protection systems, and that the more optimistic the caregivers were over the OVC receiving medical attention on falling sick, the more satisfied with the OVC's health. Conditions attached to social protection systems such as the CCTs force poor people to use health services with regularity, such as in the case of *Bolsa Familia* in Brazil or *Familia in Acción* in

Colombia. Unconditional cash transfers have contributed to an increase in utilization of health services, such as in the case of the Mchinji transfer in Malawi (Yablonski and O'Donnell, 2009). Cash transferred to households allows recipients to afford treatment. In Zambia, for example, incidence of illnesses reduced from 42.8% to 35%; and incidence of partial sightedness reduced from 7.2% to 3.3%, potentially due to the fact that beneficiary households could afford minor eye surgery (MCDSS/GTZ, 2007).

H3. SPS and Food security of the OVC

The hypothesis was stated as; there no relationship between social protection systems and food security of the OVC. The study looked at the various dimensions of food security, that is, number of meals that the OVC got within a day, food adequacy and nutritional diversity. As regards number of meals in a day, scores corresponding to the number of meals the OVC had in a day were adopted: 1 meal= 1, 2 meals = 2 and 3 meals =3, for both school-gong and non-school-going children and then the scores totaled. Items 5.3 and 5.4 on the household caregivers' questionnaire were used to assess food adequacy, where a score of 1 was adopted for a "Yes" response and 2 for a "No" response; a score of 3 was adopted for "rarely worried about enough food", 2 for "sometimes worried about food" and 1 for "Often worried", then the total scores per caregiver obtained. On the other hand, item 5.5 on the caregivers' questionnaire was used to evaluate household nutritional diversity where a score of 4 was adopted for "Always ate preferred food types", 3 for "rarely missed preferred food types", 2 for "Sometimes missed preferred food types" and 1 for "Often missed preferred food types". The total scores for each dimension per caregiver were then used to compute the Pearson product of correlation to establish the direction and magnitude of the relationships between social protection systems and the food security dimensions. As per table 4.23

The PPMC analysis revealed that there was a significant positive relationship between social protection systems and household food adequacy ($r=0.45$; $n=171$; $p<0.01$) and a significant positive relationship between social protection systems and nutritional diversity of the OVC households ($r=0.26$; $n=171$; $p<0.01$). The relationship between social protection systems and number of meals per day was, however, insignificant. The positive correlations between social protection systems and household food adequacy and nutritional diversity indicate that household food security is, to a large

extent, associated with social protection systems. This is further supported by the positive correlation between food adequacy and nutritional diversity (r=0.26; n=171; p<0.01) which implies that a household that has adequate food is also nutritionally secure and vice versa. The findings were as shown in Table 4.25

Table 4.25Relationship between SPS and Food Security of the OVC

		Social Protection Systems	Number of Meals per Day	Household Food Adequacy	Nutritional Diversity
Social Protection Systems	Pearson Correlation	1	-.019	.448**	.256**
	Sig. (2-tailed)		.809	.000	.001
	N	171	171	171	171
Number of Meals per Day	Pearson Correlation	-.019	1	.029	-.079
	Sig. (2-tailed)	.809		.706	.303
	N	171	171	171	171
Household Food Adequacy	Pearson Correlation	.448**	.029	1	.262**
	Sig. (2-tailed)	.000	.706		.001
	n	171	171	171	171
Nutritional Diversity	Pearson Correlation	.256**	-.079	.262**	1
	Sig. (2-tailed)	.001	.303	.001	
	n	171	171	171	171

***. Correlation is significant at the 0.01 level (2-tailed).*

Absence of a significant relationship between social protection systems and number of meals per day may be due to the fact that all households across all levels of social protection may be able to provide a variety of meals given that in most African households, three meals per day for both school-going and non-school-going children is a norm, backed up by the cash transfers which gives them a

starting edge and whose primary purpose is to ensure that the OVC have access to the primary needs especially food. These findings concur with findings of previous studies that have reported that programmes in the form of cash transfers have a positive impact on household food security and nutrition, given that recipient households tend to spend much of the transfer on food (Adato and Basset, 2009; ILO, 2010; DFID, 2011). An evaluation of Malawi's Food and Cash Transfers showed that 75.5% of the transfer was typically spent on groceries (Devereux *et al*, 2006). In Lesotho the number of old age pensioners reporting that they never went hungry increased from 19% before the pension to 48% after it was introduced (Croome and Nyanguru, 2007). As well as increasing the volume of food available, cash transfers lead to an increase in the variety of foods consumed within the household: in Zambia 12% more households consumed proteins every day and 35% consumed oil every day if they received a transfer, compared with those households that didn't (MCDSS/GTZ, 2007).

H4 Relationship between SPS and Family care of the OVC

The hypothesis was stated no there was a significant relationship between Social protection systems and Family care of the OVC. Too test this hypothesis, the total scores for the caregivers in each of the family care statements were computed to obtain a composite score for family care. The total scores obtained were used to conduct a PPMC analysis to determine the relationship between social protection systems and family care of the OVC. The findings were as shown in Table 4.26.

Table 4.26 Relationship between SPS and Family Care of the OVC

		Social Protection Systems	Family Care
Social Protection Systems	Pearson Correlation	1	.355**
	Sig. (2-tailed)		.000
	N	171	171
Family Care	Pearson Correlation	.355**	1
	Sig. (2-tailed)	.000	
	N	171	171

***. Correlation is significant at the 0.01 level (2-tailed).*

There was a significant and moderate, positive relationship between social protection systems and family care ($r=0.36$, $n=171$, $p<0.01$). This indicates that strong family care was associated with more social protection systems, though the baseline ability of the caregivers as a result of cash transfers for OVC significantly influenced family care as depicted by the small variances in the means of family care practices reported in the previous section.

Social protection systems and other family support programs, generally, aim to improve child outcomes by enhancing parenting capacity. Through the social protection systems, the caregivers are able to enhance the care and attention given to the OVC by way of ensuring that the OVC have access to their basic needs which are basically provided in a family set up. As Teresa (2002) argues, the child cannot be separated from its 'family' context, and thus the well-being of the child is dependent on the well-being of the family, supported by the social protection systems. As a result, social security benefits cannot target children in isolation, but use their family, usually the primary care giver, as the channel for reaching the child. While it is hoped that the grant would be spent directly on the child's needs, it is assumed that by increasing the household income, the well-being of the child will be

automatically enhanced (Teresa, 2002). Home-based caregivers have been mooted to serve a relatively high proportion of children with special needs (Paulsell *et al*., 2006; Brandon *et al.*, 2002).

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter presents a summary of findings, conclusions, recommendations and contribution to body of knowledge.

5.2 Summary of Findings

The study utilized data of responses from 171 OVC caregivers and 175 OVC from targeted sample sizes of 178 and 179 caregivers and OVC respectively. This represented an overall response rate of 97%. Out of the 171 caregivers, 74% were female and 26% male, while of the OVC interviewed, 51% of OVC female and 49% were male. Cumulatively, 61% of the caregivers were of youthful age between 25 to 39 years while half of the OVC were aged 11-14 years, 21% were 5-7 years of age, 19% ranged from 8-10 years of age while 10% were 15-18 years of age. With regard to the caregivers' marital status, 47% were married, 44.4% were widowed while 8.2% were divorced. 37% of the caregivers had incomplete primary level education, 29% had completed primary education, 23% completed secondary education and 11% had incomplete secondary level education. Thirty six percent (36%) of the caregivers were farmers, 32% business persons, 28% were involved in fish trade and 4% were government employees. Half of the caregivers reported that they had benefited from free primary education. In addition, 36%, 32%, 31%, 26% and 21% of the caregivers' households had benefited from farm inputs, school fee bursaries, grants for income generating activities, home-based care training and hospital fee waivers respectively, though in different years between 2008 and 2012.

With regard to the influence of social protection systems on the education of OVC, the study established that almost all the OVC were attending school as confirmed by 98% of the caregivers, and an equal percentage of OVC who indicated attending school at least some of the time (37% attended school "some of the time", 36% "all the time" and 25% "most of the time"). There were reported instances when the children failed to go to school as confirmed by 82% of the caregivers and the

reasons for children not attending school regularly included absenteeism to take care of the younger siblings and sickness/illnesses. Majority of the OVC liked their school at least most of the time 73%, with a cumulative 83% reporting that at least most of the time. Only 19% of the OVC indicated that their caregivers paid school levies all the time while more than half reported that the levies were paid only some of the time, which was attributable to FPE policy. There was a significant positive relationship between social protection systems and education of the OVC ($r=0.44$; $n=171$; $p<0.01$), indicating that completion of education of the OVC was associated with social stronger protection systems.

As regards social protection systems and health of OVC, the study established that 92% of the household as reported by the caregivers did not receive nutritional supplements for the OVC. It was established that whenever the OVC fell sick, they were treated at the government dispensaries but 94% of the caregivers confirmed that they paid for the medical services offered compared to only 6% who indicated that they did not pay for the services. More than half of the caregivers (54%) reported that the OVC received free medical checkups compared to 46% who reported that they did not receive the. Forty nine percent of the caregivers (49%) were somehow satisfied with the health of the OVC compared with 18% who were not satisfied at all, 17% satisfied and 16% who were very satisfied. On the other hand, 47% of the OVC indicated that their health was good some of the time, 30% most of the time 19% all the time and 2% none of the time. While 42% and 49% of the OVC respectively were either not worried about their health or were worried some of the time, 15% were worried most of the time and 3% were worried all the time. A strong and significant positive relationship was established between social protection systems and the caregivers' optimism over medical attention of the OVC ($r=0.79$; $n=171$; $p<0.01$) and a moderate and significant positive relationship existed between the caregivers' satisfaction with the OVC health and social protection systems($r=0.39$; $n=171$; $p<0.01$).

With regard to the influence of social protection systems on food security of OVC, the study established that 56% of the caregivers had the school-going OVC get two meals in a day, 32% had only

one meal and 12% had three meals. For those not going to school, 21% of the caregivers in each case indicated that they had three and two meals respectively while, 20% indicated that they had one meal in a day. Majority of the caregivers were worried about their households getting enough food (75%) than those who were never worried (25%). On the other hand, 46% of the OVC reported eating at least two meals in a day some of the time, 39% most of the time, 11% all the time while 3% indicated that they ate at least two meals none of the time. Majority of the OVC reported that they had enough food to eat some of the time (64%), 28% had enough most of the time, 5% all the time and 3% none of the time. With regard to nutritional diversity, 87% of the reported that they ate a balanced diet at least once a day some of the time, 8% all the time, 3% none of the time wand 2% most of the time. The study established that there was a significant positive relationship between social protection systems and household food adequacy ($r=0.45$; $n=171$; $p<0.01$) and a significant positive relationship between social protection systems and nutritional diversity of the OVC households ($r=0.26$; $n=171$; $p<0.01$). The relationship between social protection systems and number of meals per day was, however, insignificant.

Finally, as regards the influence of social protection systems and family care of the OVC, the means of the caregivers' responses to family care practices ranged from 3.22 (highest) to 2.51 (lowest) with the highest mean linked to the statement "As a care giver, I feel that I am able to protect the children I care for from physical abuse all the time" while the lowest mean was obtained from the statement "I have enough time to attend to all the children individually whenever they need my attention. Almost all the OVC indicated that none of them lacked a place to sleep. The cumulative percentage of OVC who indicated that they had someone to take care of them if they got hurt or feel sad at least most of the time (86%) compared favourably with their report on having adults they could trust (87%). Generally, there was a significant and moderate, positive relationship between social protection systems and family care ($r=0.36$, $n=171$, $p<0.01$).

5.3 Conclusions

There is correlation between social protection systems and education of the OVC. The existence of a significant positive relationship between social protection systems and education of the OVC is proof that access to education by the OVC which encompasses enrolment, transition and retention is, to a large extent, associated with social protection systems and that the stronger the social protection systems the higher the educational outcomes for the OVC. Strong social protection systems enable the caregivers to cater for the costs associated with OVC schooling. However, some of the factors that affect the OVC's regular attendance to school include taking care of the younger siblings and sickness/illnesses, which calls for concerted efforts to ensure adequate child care for all the OVC to avoid such instances.

Good health of the OVC is highly associated with comprehensive social protection systems. Significant positive relationships exist between social protection systems and the various aspects of the OVC health such as optimism over medical attention of the OVC and satisfaction with the OVC health. The fact that majority of the OVC can access medical care from government dispensaries has a positive contribution to the health of the OVC as an assurance of accessing health services whenever need arises. However, there is need to consider nutritional supplementation for the OVC which has been associated with prevention of some illnesses by some other studies. On the other hand, the fact that some OVC pay for medical services provided in the government dispensaries may discourage the medical care seeking behavior of the OVC, thus producing counter-productive effects.

Social protection systems targeting OVC have positive results with respect to both food security and nutritional security of the beneficiaries, as indicated by the positive correlation between social protection systems and household food adequacy and nutritional diversity of the OVC households. Cash transfers and income from other social protection programmes are utilized to ensure that there is adequate food for the OVC and to some extent, foods with a variety of nutritional content. In addition,

the OVC are able to receive an appropriate number of meals in a day, which has multiple effects especially related to the health of the OVC.

Finally, it is concluded that when social protection systems holistically address the well-being of the OVC with respect to education, health and food security, the caregivers, within a family set up in which social protection support is provided, have enough time to provide closer parental care to the OVC thus ensuring a loving and caring environment for child development. Therefore, family care is a strong correlate of comprehensive social protection systems for OVC.

5.4 Recommendations

Having considered the theoretical framework, the conceptual framework as well as the literature reviewed and the study findings, the researcher has given the following recommendations:

Social protection systems has contributed to the access, retention and completion of OVC .However this study recommends that further awareness on the importance of education be carried out to the caregivers so as to ensure that children do not miss out of school due to household chores that could be carried out by the caregivers. Secondly ,Social protection systems has enhanced the health care that is received by the OVC enabling caregivers to be less worried over the OVC receiving medical attention on falling sick. However, based on the high cost of medical care, there is need to widen the beneficiary scope especially for preventive purposes for all children as some diseases are highly communicable.

Moreover, the study recognizes the role played by social protection systems in ensuring food security of OVC, there is need assist the caregivers to employ modern farming techniques to boost their proceeds as majority indicated they were farmers or engage in viable business. The study also acknowledges the role played by the caregivers in caring for the OVC .Care seen to be the holistic role played that goes beyond the physical needs of a child. It is therefore important that the caregivers get the adequate support that reduces their uncertainty in providing for the education health and food of the

children. This certainly will ensure that they provide the necessary psychosocial support and home based care.

5.5 Suggestion for further research

This was a descriptive study to examine the influence of social protection systems on Orphans and Vulnerable children well-being in Nyang'oma Division, Bondo District ,so the findings do not necessarily apply to all OVC's in Kenya, therefore the results cannot be generalized to OVC's that were not part of this study. Future research should collect data on a longitudinal basis in order to help draw causal inferences and validate the findings of this study. In view of this, the study makes the following recommendations:

1. The study focused on general components of well-being and how they are influenced by social protection systems, there is need to probe into other variables apart from those that are studied in the present investigation and there influence on OVC well-being.
2. Further study could also specifically undertake an in depth analysis of particular social protection systems and there influence on OVC well-being.
3. The study could also be carried out in other districts of Kenya for comparison purposes.

5.5 Contribution to body of Knowledge

Objective	Contribution to knowledge
To assess how social protection systems influence the education of Orphaned and Vulnerable Children	There is correlation between social protection systems and education of the OVC. Access to education by the OVC which encompasses enrolment, transition and retention is, to a large extent, associated with social protection systems, thus the stronger the social protection systems the higher the educational outcomes for the OVC.

To determine the extent to which social protection systems influence the health of Orphaned and Vulnerable Children	Good health of the OVC is highly associated with comprehensive social protection systems. Significant positive relationships exist between social protection systems and the various aspects of the OVC health such as optimism over medical attention of the OVC and satisfaction with the OVC health. However, payment for medical may discourage the medical care seeking behavior of the OVC, thus producing counter-productive effects.
To examine the influence of social protection systems on food security of Orphaned and Vulnerable Children	Social protection systems targeting OVC have positive results with respect to both food security and nutritional security of the beneficiaries. A positive correlation exists between social protection systems and household food adequacy and nutritional diversity of the OVC households.
To determine the influence of social protection systems on family care of Orphaned and Vulnerable Children	When social protection systems holistically address the well-being of the OVC with respect to education, health and food security dimensions, have enough time to provide closer parental care to the OVC thus ensuring a loving and caring environment for child development, thus family care is a strong correlate of comprehensive social protection systems for OVC.

REFERENCES

Adato, M. and Bassett, L. (2009). Social Protection to Support Vulnerable Children and Families: The Potential of Cash Transfers to Promote Education, Health and Nutrition'. *AIDS Care 21* (1): 60-75.

Aguero, J. M., Carter, M. R., and Woolard, I. (2006). *The Impact of Unconditional Cash Transfers on Nutrition*: The South African Child Support Grant.

Aguëro, J., Carter, M. and I. Woolard (2007). The Impact of Unconditional Cash Transfers on Nutrition: the South African Child Support Grant. *Working Paper 39.* Brasilia: International Poverty Research Centre.

Ahmed, A. (2004). Impact of Feeding Children in School: Evidence from Bangladesh. Washington DC, IFPRI.

Ahmed, A. and Del Ninno, C. (2002). The Food for Education Program in Bangladesh: an evaluation of its impact on educational attainment and food security. *FCND Discussion Paper,* no. 138. Washington DC, IFPRI.

Attanasio, O., Gómez, L.C., Heredia, P., Vera-Hernández, M., (2005). *The Short-term Impact of a Conditional Cash Subsidy on Child Health and Nutrition in Colombia*. Centre for the Evaluation of Development Policies.

Babu, S. (2003). Social Safety Nets for Poverty Reduction in South Asia. Sri Lankan *Journal of Agricultural Economics, Volume 5. Number 1*.

Barrientos, A., Gorman, M. and Heslop, A., (2003). Old age poverty in developing countries: Contributions and dependence in later life; *World Development, vol 3, no 3, pp. 555-570.*

Brandon, R. N., Maher, E., Joesch, J., Battelle, J. M., & Doyle, S. (2002). *Understanding family, friend and neighbor care in Washington State: Developing appropriate training and support.* Seattle, WA: University of Washington, Human Services Policy Center.

Bundy, D., Burbano, C., Grosh, M., Gelli, A., Jukes, M. and Drake, L. (2009). *Rethinking School Feeding: Social safety nets, child development and the education sector.* Washington DC, World Bank.

Buttenheim, A., Alderman, H. and Friedman, J. (2011). Impact Evaluation of School Feeding Programs in LAO PDR, *World Bank Policy Research Working Paper N. 5518.* Washington DC, World Bank.

Collins, D.L. and Leibbrandt, M. (2007). The financial impact of HIV/AIDS on poor households in South Africa, AIDS - Volume 21 – Issue 7: S75-81, Lippincott Williams & Wilkins Inc: Washington

Croome, D. and A. Nyanguru (2007) The Impact of the Old Age Pension on Hunger and Vulnerability in a Mountain Area of Lesotho. Report written for the Regional Evidence Building Agenda (REBA) of the Regional Hunger and Vulnerability Programme (RHVP), Johannesburg.

Department for International Development (DFID), (2006). Using Social Transfers to Improve Human Development, Social Protection Briefing Note Series, No. 3. U.K.: London.

Devereux, S. (2001). Social Pensions in Namibia and South Africa; *IDS Working Paper 379*. Brighton, IDS.

Devereux, S. and Macauslan, I. (2006). Review of Social Protection Instruments in Malawi. Report for DFID. Brighton, IDS.

Devereux, S., P. Mvula and C. Soloman (2006) After the FACT: an evaluation of Concern Worldwide's food and cash transfers project in three districts of Malawi, 2006. Lilongwe: Concern Worldwide.

Devereux, S., Sabates-Wheeler, R., Tefera, M. and Taye, H. (2006). Ethiopia's Productive Safety Net Programme (PSNP): Trends in PSNP Transfers within Targeted Households. Brighton, IDS.

DFID (2011). Cash Transfers Evidence Paper, Policy Division, Department for International Development, London. Available at: http://webarchive.nationalarchives.gov.uk/+/http://www.dfid.gov.uk/Documents/publications1/cash-transfers-evidence-paper.pdf.

Emarita, B. (2006). *Family, friend and neighbor care best practice: How culturally diverse families teach their children to succeed and how early education systems can learn from them. Condensed Report.* St. Paul, MN: Ready 4 K.

Fiszbein, A. and Schady, N. (2009). Conditional Cash Transfers: Reducing present and future poverty, *Policy Research Report*. Washington DC, World Bank.

Gatenio-Gabel, S. and Kamerman, S.B. (2006). Investing in Children, in *Social Service Review,* June, 2006.

German Technical Cooperation (GTZ) (2007). Final Evaluation Report: Kalomo Social Cash Transfer Scheme. Lusaka.

Gertler, P. (2004). Do Conditional Cash Transfers Improve Child Health? Evidence from PROGRESA's Control Randomized Experiment. *American Economic Review*, 94(2): 336-341.

Heinrich, C. J. (2006). *Demand and Supply-Side Determinants of Conditional Cash Transfer Program Effectiveness in LaFollette*. Policy Report, Vol. 16, No. 1. Spring/Summer 2006.

Himaz, M. (2008). Welfare Grants and Their Impact on Child Health: The case of Sri Lanka. *World Development*, 36(10): 1843-1857.

Huerta, M. C. (2006). Child Health in Rural Mexico: Has *Progresa* reduced children's morbidity risks?, *Social Policy and Administration*, 40(6): 652-677.

ILO (2010). Effects of Non-Contributory Social Transfers in Developing Countries: A compendium. *ILO Working Paper*.

Inter-American Development Bank (IADB), (2006). Press Release: Programs of conditional cash transfers seen as effective in reducing poverty and exclusion. April 1, 2006. URL.

Johar, M. (2007). The Impact of the Indonesian Health Card Program: A matching estimator approach. *School of Economics, Discussion Papers 2007-30.* Sydney, University of New South Wales.

Jowett, M. (2001). Voluntary Health Insurance in Vietnam: An evaluation; *Health and Population – Perspectives and Issues*, 24(1): 29-44.

Kaplan, R.M. and Saccuzzo, D.P. (2001). *Psychological Testing: Principle, Applications and Issues (5th Edition),* Belmont, CA: Wadsworth.

Kasomo, D. (2007). *Research Methods in Humanities and Education*. Revised Edition; Zapt Chancery Research Consultations and Publishers.

Kazianga, H., de Walque, D. and Alderman, H. (2009). Educational and Health Impacts of Two School Feeding Schemes: Evidence from a randomized trial in rural Burkina Faso. *World Bank Policy Research Working Paper N. 4976*. Washington DC, World Bank.

Kenya National Bureau of Statistics (2009). *Population Census*. Government Printer, Nairobi.

Krejcie, R.V. and Morgan, D. W (1970). *Determining Sample Size for Research Activities*. Educational and Psychological Measurement.

Lagarde, M., Haines, A. and Palmer, N. (2007). Conditional Cash Transfers for Improving Uptake of Health Interventions in Low-and Middle-Income Countries: A systematic review, *Journal of the American Medical Association*, 298(16), October 2007.

Layzer, J., & Goodson, B. (2006). *Care in the home: A description of family child care and the experiences of the families and children that use it: The national study of child care for low-income families: Wave 1 report.* Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families.

Mascie-Taylor, C., Marks, M., Goto, R., and Islam, R. (2010). Impact of a Cash-for-Work Programme on Food Consumption and Nutrition among Women and Children facing Good Insecurity in Rural Bangladesh; *Bulletin of the World Health Organization*, 88: 854-860.

MCDSS/GTZ (2007) The pilot social cash transfer scheme in Zambia: summary report. 6th edition. MCDSS: Lusaka. http://mcdss.websitedesign.co.zm/media/17.sct_summary_report_6th_.pdf referred from http://www.socialcashtransfers-zambia.org/scheme_reports.php.

Miller, C., Tsoka, M. and Reichert, K. (2008). External Evaluation of the Mchinji Social Cash Transfer Pilot; Report prepared for the Government of Malawi. USAID and UNICEF Malawi.

Mimeo

Ministry of Gender, Community and Social Development (2008) CT-OVC Operational Manual,

Monasch, R. and Boerma, J. T. (2004). *Orphanhood and childcare patterns in sub-Saharan Africa: an analysis of national surveys from 40 countries*, AIDS - Volume 18 - Issue - pp S55-S65, Lippincott Williams & Wilkins Inc: Washington.

Nachmias,C and Nachmias N.(2005).Research Methods in social science. Fifth Edition Arnold Publishers.

NASCOP,(2008) Ministry of Public Health and Sanitation, Kenya. Guidelines for HIV Testing and Counselling in Kenya. Nairobi.

Neubourg, C.D. (2009). A Livelihood Portfolio theory of social protection; Maastricht Graduate School of Governance, Maastricht University, Brussels, December 9th, 1-5.

Omiti, T & T. Nyanamba (2007): Using Social Protection policies to reduce vulnerability and promote economic growth in Kenya: A background paper. KIPPRA.

Paulsell, D., Mekos, D., Del Grosso, P., Rowand, C., & Banghart, P. (2006). *Strategies for supporting quality in kith and kin child care: Findings from the Early Head Start Enhanced Home Visiting Pilot Program evaluation final report.* Princeton, NJ: Mathematica Policy Research, Inc.

République du Sénégal (2006a) *Poverty Reduction Strategy Paper*, September.

Sanfilippo, M., C. de Neubourg and B. Martorano (2012). The Impact of Social Protection on Children: A review of the literature. *Working Paper 2012-06*, UNICEF Office of Research, Florence.

Save the Children UK (2005). *Lessons from cash transfer schemes in east and southern Africa for supporting the most vulnerable children and households*. UK: Save the Children UK, Help Age International and Institute of Development Studies.

Save the Children, Help Age International, and Institute for Development Studies (2005) Making Cash Count.

Sultan, Sonja, & Tamar Schrofer (2008). *Building Support to Have Targeted Social Protection Interventions for the Poorest – the Case of Ghana.* Paper for the Conference on Social Protection for the Poorest in Africa: Learning from Experience, Entebbe, Uganda, 8-10 September 2008.

Teresa, G. (2002). Assessing the Impact of the Child Support Grant on the Well-being of Children in South Africa: A Summary of available evidence. Children's Institute, University of Cape Town. July 2002.

Toni, P., Diane, P., Del Grosso, P., Sarah, A., Rachel, H. and Lee, V. (2010). A Review of the Literature on Home-Based Child Care: Implications for Future Directions. Mathematica Policy Research. Princeton, NJ.

UNAIDS, (2008). *Report on Global AIDS epidemic*. UNAIDS: Geneva

UNICEF (2007). The Impact of Social Cash Transfers on Children Affected by HIV and AIDS: Evidence from Zambia, Malawi and South Africa. Nairobi, UNICEF East and Southern Africa Regional Office.

UNICEF (2011). Progress on Key Indicators. Consolidated Results Report. Programme Cycle: 2006-2010; Minsk, UNICEF Belarus.

UNICEF, (2006). *Thailand Multiple Indicator Cluster Survey December 2005-February 2006 Final Report*. Thailand Country Office

Veras Soares, F., Perez Ribas, R. and Hirata, G.I. (2008). Los Logros y las Carencias de las Transferencias de Efectivo Condicionadass: Evaluación del Impacto del Programa Tekoporã del Paraguay, *Publications Spanish 3*. Brasilia, International Policy Centre for Inclusive Growth.

Walker, S. (2005). *Family-centered principles applied to research and program support to family, friend and neighbor child care providers.* Paper presented at the annual conference of the National Association for the Education of Young Children, Washington, DC.

World Food Programme (2010). Impact Evaluation of WFP School Feeding Programmes in Kenya (1998-2008): A mixed methods approach. Rome, World Food Programme.

Yablonski, J., and O'Donnell., M. (2009). *Lasting Benefits: The role of cash transfers in tackling child mortality*. London, Save the Children UK.

APPENDICES

Appendix I: Table for Determining Sample Size from a Given Population

N	S	N	S	N	S	N	S	N	S
10	10	100	80	280	162	800	260	2800	338
15	14	110	86	290	165	850	265	3000	341
20	19	120	92	300	169	900	269	3500	246
25	24	130	97	320	175	950	274	4000	351
30	28	140	103	340	181	1000	278	4500	351
35	32	150	108	360	186	1100	285	5000	357
40	36	160	113	380	181	1200	291	6000	361
45	40	180	118	400	196	1300	297	7000	364
50	44	190	123	420	201	1400	302	8000	367
55	48	200	127	440	205	1500	306	9000	368
60	52	210	132	460	210	1600	310	10000	373
65	56	220	136	480	214	1700	313	15000	375
70	59	230	140	500	217	1800	317	20000	377
75	63	240	144	550	225	1900	320	30000	379
80	66	250	148	600	234	2000	322	40000	380
85	70	260	152	650	242	2200	327	50000	381
90	73	270	155	700	248	2400	331	75000	382
95	76	270	159	750	256	2600	335	100000	384

Note: "N" is population size

"S" is sample size.

Appendix II: Letter of Transmittal

Department of Extra Mural Studies

University of Nairobi

P. o Box 825, Kisumu.

District Children Officer

Bondo District

Po.Box Bondo

Dear Sir/Madam

Re: Research Study

I am a student of the University of Nairobi, pursuing a Master of Arts Degree in Project Planning and Management. Currently I am in the process of undertaking research on the impact of social protection systems on Orphan and vulnerable children in Nyang'oma Division, Bondo District-Kenya.

The study will involve collecting data from the community in Nyang'oma Division, Bondo District. The purpose of this letter therefore is to request your office to grant me permission to carry out the study in the area.

Yours faithfully,

Joy Adhiambo Otieno.

Appendix III: Household Questionnaire for Caregivers

Hallo, My name is ----------I am a student from the University of Nairobi, I am conducting a survey on the Impact of Social protection systems on the well-being Orphan and Vulnerable children well-being. Despite the recording of the interview responses, the information you give will be kept strictly confidential and will not be disclosed to anyone else. You are under no obligation to answer any question that you feel uncomfortable to answer and I would urge that you provide as honest answers as possible without fear of exposure.

(Signature_____ (Your signature means you have understood and accepted to participate in this survey.

Date_____

Instructions

Please fill in the blanks or tick (√) where appropriate to provide the information requested.

SECTION A: HOUSEHOLD CHARACTERISTIC

S/No	Subject	Response(s)			Comment(s)
1.1	**Respondent's gender?** 1. Male 2. Female				
1.2	**What is your relationship with the household head?** 1. Self 2. Spouse 3. Son/Daughter 66. Other (Specify)				
1.3	**What is your marital status?** 4 Single 5 Married 6 Divorced/Separated 7 Widowed 66. Other (Specify)				
1.4	**How old are you?** 1. Below 18 Years 2. 18 to 24 Years 3. 25 to 29 Years 4. 30 to 34 Years 5. 35 to 39 Years 6. 40 to 44 Years 7. Above 45 Years 88. Don't know				
1.5	**What is the nature of your occupation?** 1. Teacher 2. Business Person 3. Artisan 4. Farmer 5. Government worker 66. Other (Specify)				
1.6	**What is the level of your education?** 1. No formal education 2. Primary level incomplete 3. Primary level complete 4. Secondary level incomplete 5. Secondary level complete 6. Tertiary College 7. University graduate 8. Postgraduate 99. Don't know				
1.7	**How many members of your household are (everybody excluding respondent and spouse):**	***Male***	***Female***	***Total***	**How many are orphans?**
	• Below 5 years old?				
	• 5 to 14 years old?				
	• 15 to 18 years old?				
	• 19 to 25 years old?		99		
	• Above 25 years old?				

SECTON B: Social Protection Programmes

In the last 5 years, which of the following has your household benefitted from the Government/NGO/CBO?

	Benefit	**2008**	**2009**	**2010**	**2011**	**2012**
2.1	Cash transfer for Orphans					
2.2	Older person cash transfer					
2.3	Farm inputs					
2.4	Grant for Income Generating Activity					
2.5	Home based care training					
2.6	Free Primary Education					
2.7	School fee bursary					
2.8	Hospital fee waiver					
2.9						

SECTION C: Social Protection Programmes and Education of the OVC

3.1 Do the children you live with go to school?

☐ Yes ☐ No

3.2 If yes, in the table below, indicate how many are in:

Level of Schooling	**Orphaned**	**Not Orphaned**
i. Nursery		
ii. Primary?		
iii. Secondary?		

3.3. For those children not going to school but are of school age, what are the reasons?

☐ School fees is not affordable
☐ They are disabled
☐ They lack school uniform
☐ They are taking care of other children
☐ Sickness/Illness
☐ Working
☐ Pregnancy
☐ Other (Specify)

3.4 For those children going to school, are there instances when they fail to go to school?

☐ Yes ☐ No

3.5 If you answer in 3.4 is yes, how often are they absent from school?

☐ Rarely ☐ Frequently ☐ Often

3.6 What are the most common reasons for their being absent from school?

_____

3.7 How often have you ever had to worry whether the children will complete school?

☐ Never ☐ Sometimes ☐ Always

3.8 If you have never worried about the children completing school, how sure are you that they will complete and enroll at the next level?

☐ Not sure at all ☐ somehow sure ☐ Very sure

SECTION D: Social Protection Programmes and Health of the OVC.

4.1 Have you ever received nutritional supplements for the children you are taking care of?

☐ Yes

☐ No

4.2 If your answer in 4.1 is yes, how often have they received the supplements?

☐ Rarely

☐ Sometimes

☐ Frequently

4.3 How often does any of the children you are taking care of fall sick?

☐ Rarely

☐ Sometimes

☐ Frequently

7.5 Whenever the children fall sick, which health Centre do they get treated?

☐ Government dispensary

☐ Private dispensary

☐ Not treated at all

7.6 Whenever you take the children to hospital, do you pay for the services?

☐ Yes ☐ No

7.7 If your answer to question 4.5 is yes, what is the source of the money you use to par for the medication?

_____

7.8 If your answer to question 4.5 is no, explain why you do not pay for the services

---

7.9 Do the children undergo any kind of organized medical checkup services provided by the government/private organizations?

☐ Yes ☐ No

7.10 If your answer to question 4.9 is yes, how often do the children receive such services?

- ☐ Rarely
- ☐ Sometimes
- ☐ Frequently

7.11 How often do you have to worry that the children will not get medical attention if you didn't have money to take them to hospital?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Frequently

4.11How satisfied are you with the children's health?

- ☐ Not satisfied at all
- ☐ Somehow satisfied
- ☐ Satisfied
- ☐ Very satisfied

SECTION E: Social Protection Programmes and Food security of OVC

S/No	Subject	Response(s)
5.1	For the children going to school, how many meals do they take in a day?	1. None 2. One 3. Two 4. Three
5.2	For the children **NOT** going to school, how many meals do they take in a day?	1. None 2. One 3. Two 4. Three
5.3	In the past 30 days did you worry that your household would not have enough food? ***If No, Skip to 5.5***	1. Yes 2. No 3. Don't know
5.4	How often did you worry that your household would not have enough food?	1. Rarely (Once or twice in a month) 2. Sometimes (3 to 10 times in a month) 3. Often (More than 10 times in a month)
5.5	In the past 30 days how often were you or any other household member not able to eat the kinds of foods you preferred?	1. Rarely (Once or twice in a month) 2. Sometimes (3 to 10 times in a month) 3. Often (More than 10 times in a month) 4. None (Always ate the preferred food types)

5.6	In the past year, did your household have any days when they had to go without eating anything all day? ***If No, Skip to 5.8***	1. Yes 2. No 3. Don't know
5.7	How often did this happen?	1. Rarely (Once or twice in a year) 2. Sometimes (3 to 10 times in a year) 3. Often (More than 10 times in a year)
5.8	If you or any member of your family went without eating at some point in the past one year, what was/were the reason(s)?	1. Lack of money to buy food 2. Inadequate food at home 3. Lack of the preferred food in the market 4. Market inaccessibility (Long distance) 5. Substituted food with school fees 6. High food prices 66. Other (Specify)

SECTION F: Social Protection Programmes Family Care of OVC

In the table below, indicate with a tick (√) the response that best describes your practices with respect to caring for the children you are taking care of in your household.

	Family care	**All the time**	**Most of the time**	**Some of the time**	**None of the time**
6.1	I have enough time to attend to all the children individually whenever they need my attention				
6.2	I am able to provide the children with all their needs without any problem (school fees, uniform, books, medical bills, food and shelter)				
6.3	I have enough time to sit with the children to mentor and advise them as a parent				
6.4	I am able to give enough attention, love and support to (name)				
6.5	As a care giver, I feel that I am able to protect the children I care for from physical abuse all the time				
6.6	I am able to provide the children I care for adequate clothing to keep them clean and warm.				

Thank you for your time and participation in this survey

Appendix IV: Household questionnaire for OVC

Sex: Boy_____Girl_____Age_____

Administration: Oral_____Self Administered_____

Rate your response based on the following given continuum

	S/N		None Of the time	Most of the time	Some of the time	All the time
Education	1	I attend school				
	2	I like school				
	3	My teachers treat me like the other children				
	4	My caregiver pay my school levies				
Health	5	My health is good				
	6	I worry about my health				
	7	My caregiver pay for my medical bills				
	8	I go to a medical service provider when am sick				
Food	9	I eat at least two meals a day				
	10	I have enough food to eat				
	11	I eat a balance meal at least once a day(protein, carbohydrates, vitamins)				
	12	I go to bed hungry				
Family care	13	I have a house where I can sleep at night				
	14	I am treated differently from the other children in the household				
	15	At home I have someone to look after me if I get hurt or feel sad				
	16	I have adults I can trust				

Appendix V: Confidentiality and consent form.

I am going to ask you some very personal questions .Your answers are completely confidential. Your name will not be written on this form, and will never be used in connection with any of the information you tell me. You do not have to answer any question that you do not want to answer and you may end this interview anytime you want. However your honest answers to this questions will help us understand the circumstances that many people are living with , and we will use the information to create better support programs .We would greatly appreciate your help in responding to this survey .The survey will take about 45 minutes to ask the questions. Would you be willing to participate?

Date and Signature of interviewer_____

Date and Signature of Interviewee_____

Appendix VI: Key informant interview.

Education

1. What is the current Enrollment Rates for Orphans and Vulnerable children in the area?
2. Would you consider the enrollment rates to have improved or not? What factors have contributed to the figures?
3. To what extent has the social protection system has addressed the challenges the community faces? (Probe for retention rates, enrollment and access.

Health

1. What is your opinion on the accessibility of medical support by the OVC in Nyang'oma division?
2. Do you think OVC households in this community are accessing health services from health facilities? Elaborate
3. Do the facilities here offer medical weavers? Which particular group of people are the major beneficiaries?
4. What are the existing support mechanisms on care and support for OVC in this community?
5. What is your opinion on the nutritional status of the community?

Food security

1. What are the main sources of food for OVC in the community?
2. What is the hunger gap in a season and what are some of the coping mechanism?
3. To what extent are the social protection systems addressing the challenges of food security in the region?
4. What are the main food crops available in the community?
5. What is the yield per acre for common crops in the division?

Family care

1. What are the existing support mechanisms on care and support for OVC in this community?
2. To what extent are the OVC receiving psychosocial support in the community?

REPUBLIC OF KENYA

NATIONAL COUNCIL FOR SCIENCE AND TECHNOLOGY

Telephone: 254-020-2213471, 2241349, 254-020-2673550
Mobile: 0713 788 787 , 0735 404 245
Fax: 254-020-2213215
When replying please quote
secretary@ncst.go.ke

P.O. Box 30623-00100
NAIROBI-KENYA
Website: www.ncst.go.ke

Our Ref: **NCST/RCD/14/013/1157**

Date: **2nd July 2013**

Joy Adhiambo Otieno
University of Nairobi
P.O Box 825-40100
Kisumu.

RE: RESEARCH AUTHORIZATION

Following your application dated **24th June, 2013** for authority to carry out research on "***Influence of social protection systems on Orphaned and vulnerable children well being in Nyang'oma Division, Bondo District-Kenya.***" I am pleased to inform you that you have been authorized to undertake research in **Bondo District** for a period ending **30th September, 2013**

You are advised to report to **the District Commissioner and District Education Officer, Bondo District** before embarking on the research project.

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

DR. M. K. RUGUTT, PhD, HSC.
DEPUTY COUNCIL SECRETARY

Copy to:

The District Commissioner
The District Education Officer
Bondo District.

PAGE 2

THIS IS TO CERTIFY THAT:
Prof./Dr./Mr./Mrs./Miss/Institution
Joy Adhiambo Otieno
of (Address) University of Nairobi
P O Box 825-40100 ,Kisumu.
has been permitted to conduct research in
Location Bondo
District Nyanza
Province
on the topic: Influence of social protection systems on orphaned and vulnerable children well being in Nyang'oma Division, Bondo District-Kenya
for a period ending: 30th September, 2013.

Applicant's Signature

PAGE 3

Research Permit No. NCST/RCD/14/013/1157
Date of issue 2nd July, 2013
Fee received KSH 1000

For Secretary
National Council for Science &Technology

CONDITIONS

1. You must report to the District Commissioner and the District Education Officer of the area before embarking on your research. Failure to do that may lead to the cancellation of your permit
2. Government Officers will not be interviewed with-out prior appointment.
3. No questionnaire will be used unless it has been approved.
4. Excavation, filming and collection of biological specimens are subject to further permission from the relevant Government Ministries.
5. You are required to submit at least two(2)/four(4) bound copies of your final report for Kenyans and non-Kenyans respectively.
6. The Government of Kenya reserves the right to modify the conditions of this permit including its cancellation without notice

HARAMBEE

REPUBLIC OF KENYA

RESEARCH CLEARANCE PERMIT

GPK6055t3mt10/2011

(CONDITIONS—see back page)