

**INFLUENCE OF SOCIAL PROTECTION SYSTEMS ON
PROMOTION OF ORPHANED AND VULNERABLE
CHILDREN WELLBEING IN DAGORETTI DISTRICT,
NAIROBI COUNTY, KENYA**

BY

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**A Research Project Report Submitted In Partial Fulfillment of The Requirements For
Award Of Degree of Master of Arts In Project Planning And Management of The
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DECLARATION

This research project report is my original work and has not been presented for the award of any degree in any other university.

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This research project report has been submitted for examination with my approval as the University Supervisor.

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DEDICATION

This work is dedicated to my parents, Mr and Mrs Vincent and Jenipher Owiti, my husband Joe and children Joash, Vincent and Zilpah.

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ABBREVIATIONS AND ACRONYMS

AAC	-	Area Advisory Councils
AIDS	-	Acquired Immune Deficiency Syndrome
BMI	-	Body Mass Index
CCT	-	Conditional Cash Transfers
CRC	-	Convention on the Rights of the Child
DCO	-	District Children Officer
DFID	-	Department for International Development
EFG	-	Equity Group Foundation
FACT	-	Food And Cash Transfers
GTZ	-	German Technical Cooperation
HIV	-	Human Immunodeficiency Syndrome
IADB	-	American Development Bank
LOC	-	Location Orphans Committee
MDGs	-	Millennium Development Goals
NGO	-	Non-governmental Organization
OVC	-	Orphaned and Vulnerable Children
PPMC	-	Pearson's Product-Moment Corelation
PSNP	-	Productive Safety Net Programme
SOPs	-	Standard Operating Procedures
SPSS	-	Statistical Package for Social Sciences
UK	-	United Kingdom
UN	-	United Nations
UNAIDS	-	United Nations Programme on HIV and AIDS
UNCRC	-	United Nations Convention on the Rights of the Child
UNDP	-	United Nations Development Programme
UNICEF	-	United Nations Children's Fund
US	-	United States
WFP	-	World Food Programme
WHO	-	World Health Organization

ABSTRACT

Wellbeing is generally understood as the quality of people's lives. It is a dynamic state that is enhanced when people can fulfil their personal and social goals. It is understood both in relation to objective measures, such as household income, educational resources and health status; and subjective indicators such development, social participation and security. Children suffer a number of devastating effects as a result of orphan hood. Losing 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 cycle of economic hardship. Social protection for poor and orphaned children and widows date from the 16th and early 17th century English Elizabethan Poor Laws. A number of interventions target Orphans and Vulnerable Children (OVC) in Dagoretti District, Nairobi County to improve their welfare but little is known about the influence of these interventions in children wellbeing. The study examines the influence of social protection systems on promotion of OVC wellbeing in Dagoretti District. It assesses how bursaries for education, healthcare support, food security and caregivers of OVC promote their well-being. The study utilized the descriptive survey research design. The target populations for the study included 2,756 OVC households from the 10 locations of Dagoretti District. The study randomly sampled 338 households that care for the OVC in the district. The data collection instruments for the study were household questionnaires with both closed and open-ended items. The validity of the instruments was enhanced through peer review, expert judgment by discussing the items in the instruments with colleagues and supervisors. Data was analyzed using descriptive and inferential statistics with the help of a statistical package for social science (SPSS) version 16.0 for windows. Data collected was processed, organized and analyzed with the aid of the Statistical Package for Social Scientists (SPSS) version 16.0. The study established that bursaries for education promotes access to education which encompasses enrolment, transition and completion an indication that the more the school attendance the higher the educational outcomes. Comprehensive healthcare support due to access to medical care from government facilities leads to positive contribution in terms of physical development and social participation. Food security for OVC has positive results with respect to both food adequacy and nutritional security of the beneficiaries as indicated by the adequacy and diversity. Caregivers within a family set up have enough time to provide closer parental care to the OVC thus ensuring a loving and caring environment for child development. This contributes to their wellbeing in terms of protection from abuse as a result of caregivers taking care of OVC in Dagoretti District County. The study therefore recommends the following; the Ministry of Education allocates more funds for bursaries to contribute to access retention and completion of education by OVC. The government should also increase health care support and hospital fee waivers for OVC to reduce worry of medical attention by caregivers when OVC fall sick. Capacity building for caregivers should be done which would translate to their employability skills for better paying jobs that will enable sufficient provision of OVC basic needs, psychosocial support and family care.

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Wellbeing is generally understood as the quality of people's lives. It is a dynamic state that is enhanced when people can fulfil their personal and social goals. It is understood both in relation to objective measures, such as household income, educational resources and health status; and subjective indicators such development, social participation and security. Concepts such as 'wellbeing', 'life satisfaction' and 'quality of life' are often used interchangeably, and incorporate both objective and subjective aspects of a person's life – both observable facts (such as household income, family structure, educational achievement, health status) and an individual's own feelings about these things and their life in general. Wellbeing indicators, especially those used for cross-national comparisons, have tended to focus on objective data collected by most countries and available in administrative records. For example the UNICEF (2007) comparative study of child wellbeing in rich countries included children living in homes below the poverty line, children in homes where there was no employed adult, and children in homes where there were few education resources, as indicators of low wellbeing within the domain of 'material wellbeing'. However, there has been increasing recognition that objective measures of wellbeing are not sufficient for the development of policy, and that subjective indicators based on individuals' self-reports of aspects of life such as happiness, social connectedness, perceived quality of life and life satisfaction are also needed.

Social protection (social security) for poor and orphaned children and widows dates 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 & Kamerman, 2006). With the trend toward globalization beginning in the 1980s, there has been a growing recognition of the importance of social protection systems.

Thirteen countries in Latin America provide an excellent source of illustrations of social protection for the middle-income countries. These countries 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.

Targeted cash benefits are the social protection policy instrument used most often in Asia, are 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).

Among the families that have taken in OVC in Thailand, 78.6 percent 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).

Social cash transfer pilot programme in Malawi 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).

According to Barrientos et al (2003), 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. This is echoed by Agüero *et al*, (2006) who say there is evidence that this unconditional child benefit boosts the nutrition of poor families' children.

The Productive Safety Net Programme (PSNP) by the Ethiopian Government which was 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. It 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 *et al*, 2006).

In Kenya, informal support from the community continues to dominate social protection, 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 HIV/AIDS. 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

An important distinction is between understandings of childhood wellbeing which adopt a developmental perspective and those that adopt a children's rights perspective (Pollard & Lee, 2003). A developmentalist outlook is more likely to adopt measures associated with deficits, such as poverty, ignorance, and physical illness. While such indicators are important to begin to redress issues of inequalities and social exclusion which negatively impact on children's health and wellbeing, they tend to ignore the potential, attributes and strengths of children.

Children suffer a number of devastating effects as a result of orphan hood. Losing 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 & 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.

Many OVC face financial barriers to school attendance, numerous countries including Kenya have proposed either fee exemptions, bursaries or support in-kind, such as distributing uniforms or textbooks, or waiving the requirement to wear uniform (Orodho 2005). When OVC fall ill they have limited access and support to health/medical services. 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 (Alkire & Suman (2008). According to Carlos & Rodger (2009), numerous households go without meals within a period of one day. The study looked at social protection systems that impact on food security that lead to improved nutritional status and hence positive health outcomes. To avoid

institutionalization of OVC and having orphan headed households, governments encourage that caregivers be charged with the responsibility for a children's welfare (Ikiara 2009).

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. 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 bursaries for education, healthcare support, food security, caregivers of the Orphans and Vulnerable Children. Therefore, this study sought to examine the influence of social support interventions on the Orphans and Vulnerable children well-being.

1.3 Purpose of the Study

The purpose of this study was to examine the influence of social protection systems on promotion of Orphans and Vulnerable Children well-being in Dagoretti District, Nairobi County of Kenya.

1.4 Objectives of the Study

1. To assess how bursaries for education as a social protection system influence the promotion of Orphaned and Vulnerable Children wellbeing in Dagoretti District, Nairobi County.
2. To determine the extent to which health care support as a social protection system influences the promotion of Orphaned and Vulnerable Children wellbeing in Dagoretti District, Nairobi County.
3. To examine how food security as a social protection system influences the promotion of Orphaned and Vulnerable Children wellbeing in Dagoretti District, Nairobi County.
4. To determine how caregivers as a social protection system influence the promotion of Orphaned and Vulnerable Children wellbeing in Dagoretti District, Nairobi County.

1.5 Research Questions

1. How do bursaries for education as a social protection system influence promotion of Orphaned and Vulnerable Children wellbeing in Dagoretti District, Nairobi County?
2. To what extent does healthcare support as a social protection system influence the promotion of Orphaned and Vulnerable Children wellbeing in Dagoretti District, Nairobi County?
3. How does food security as a social protection system influence promotion of Orphaned and Vulnerable Children wellbeing in Dagoretti District, Nairobi County?
4. How do caregivers as a social protection system influence the promotion of Orphaned and Vulnerable Children wellbeing in Dagoretti District, Nairobi County?

1.6 Significance of the Study

The results of the study provide documented evidence informing OVCs stakeholders, key among them being the relevant Government of Kenya departments as they formulate policies and also the non-governmental organizations implementing social protection programs. The study therefore provides opportunity for institutions and the families that take care of OVCs besides providing future researchers with up to date information on this important subject that may positively uplift the well-being of Orphaned and Vulnerable children.

1.7 Basic Assumptions of the Study

The researcher made the assumption that the targeted respondents from the sampled households would be available and that they would provide all the information sought truthfully. It was also assumed that the orphans and vulnerable children would be available at their homes at the time of data collection. As the Table 4.2 shows, there was 95% return rate of the questionnaires indicating an excellent level of cooperation.

1.8 Limitations of the Study

The main limitation of study was its inability to include more households mainly due to time and financial constraints. Additionally, the distance to be covered and congested households of the area in reaching out to the respondents who were spread throughout Dagoretti District also limited the study. To overcome the challenges the researcher made a maximum use of available resources and time to conduct research.

1.9 Delimitations of the Study

This study assessed the influence of social protection systems on OVC's wellbeing with respect to bursaries education, healthcare support, food security and caregivers. The study was conducted in Dagoretti District, Nairobi County and was limited to 1,378 OVC households as per the District Children Officer's (DCO) records in the Dagoretti District. Dagoretti District being one of the areas in Nairobi County with the highest prevalence rate in poverty incidence at 46% against the national prevalence of 44% (Oxfam GB 2009) host a large number of OVC benefiting from social protection programmes, particularly the government initiated cash transfer programme.

1.10 Definitions of Significant Terms the Study

The following are the significant terms of the study.

Bursaries for Education; Refers to the monetary funds provided to students based on financial need and/or academic performance for educational access, enrollment, retention & completion of school.

Caregiver: Refers to the person who is charged with the responsibility for a child's welfare and gives a safe caring home to a child by providing home based care to an OVC in a family set up and psychosocial support

Food Security: Refers to availability of nutritious food all year round, food adequacy and number of meals eaten per day for the OVC.

Healthcare Support: Refers to the medical support accorded to the OVC and their accessibility to the health facilities and quality of services.

Promotion of OVC wellbeing: Involves understanding and addressing child, youth, and caregiver functioning in physical, behavioral, social, and cognitive areas able to freely and fully enjoy their rights to participation, protection, development and survival

Social Protection Systems: refers 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.

1.11 Organization of the study

This research study is organized in five chapters.

Chapter One provides an introduction that include; the background of the study; statement of the problem; purpose of the study; the research objectives; research questions that will guide 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 related to social protection and security systems of OVCs in Kenya and elsewhere in the world. This section also provides the theoretical and conceptual frameworks of the study. Chapter Three is on the research methodology to be used in the study covering research design, target population and the methods of collecting and analyzing the collected data. Chapter Four presents analysis, presentation, interpretation and discussion of data while Chapter Five entails summary of findings, conclusion, recommendations and suggestions for further studies.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter provided theoretical and empirical information from literature on topics related to the research problem. It examined what various scholars and authors have studied/ written about social protection and promotion of OVC wellbeing from global, African and local perspectives. It also presented a theoretical and conceptual framework on which the study is based.

2.2 Promotion of OVC wellbeing

Child well-being measures the quality of children's lives. However, as simple as the concept sounds, there is no unique, universally accepted way of actually measuring child well-being that emerges from the academic literature.

In a recent literature survey, child well-being is defined as “a multi-dimensional construct incorporating mental/psychological, physical and social dimensions” (Columbo, cited in Pollard and Lee, 2003, p. 65). This definition, however, omits a material aspect, which is important in many other studies which consider child poverty or child material deprivation. More recently, Ben-Arieh & Fronese (2007a, p. 1) have offered the following definition, also indicators-based: “Child well-being encompasses quality of life in a broad sense. It refers to a child's economic conditions, peer relations, political rights, and opportunities for development.

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 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, do badly in school or drop out of school; have poor educational, vocational training and employment opportunities (UNICEF 2007).

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).

Many orphans and other vulnerable children 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 or miss enrollment. The child may 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 & Powel 2002).

In its strategic paper on social protection, 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. In the immediate pre-independence period, social protection networking was prevalent in families and communities.' Republic of Kenya, (2005).

According to the Kenya Strategic Paper on Social Protection, 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 (Alkire & Suman). 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. Republic of Kenya, (2005).

Orodho (2005) says that cash transfers are a major component of social protection and 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. Their 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

Large-scale cash transfer schemes have been launched in a growing number of developing countries, including Brazil, Colombia, Honduras, Mexico, Nicaragua, and South Africa from the 1990s. 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 & 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.

Programme districts are selected on the basis of the magnitude of the problem of OVC they present as manifested by their OVC population and their subsequent needs. To qualify a district should thus 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, 2008)

In its operational manual, the Ministry of Gender, (2008) 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 Committee, LOC at the community level.

The OVC 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. In Dagoretti, enrolled caregivers receive a cash payment of KSH. 2,000/= per month paid every two months through Equity Bank and Department of Children Services. Dagoretti District Children Office, (2015).

2.3 Bursaries for Education and Promotion of Orphaned and Vulnerable Children

The UNCRC states that each child has the right to an education, and that this right should be developed on the basis of equal opportunity (art. 28). The UNCRC also commits signatories to providing an education system to develop the child's personality, talents and mental and physical abilities to their fullest potential (art. 29a). Ensuring the highest possible levels of educational achievement for all children addresses this commitment.

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 *et al*, 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). As evidenced in Colombia 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).

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, *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 2007).

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.

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). 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, *et al*, 2006). With respect to Conditional Cash Transfers (CCTs), in their review of the evidence Fizein & Schady (2009) report quite significantly that virtually every programme that has had a credible evaluation has found a positive effect on school enrolment.

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).

When Kenya eliminated fees in 2002, 1.2 million additional students entered primary school (World Bank *et al.* forthcoming). Even with free primary education, orphans are still more likely to lose out on education than other children. In Kenya, 92% of non-orphans and 88% of orphans are in school (Republic of Kenya 2005), and the percentage of double orphans aged 10-14 attending school is 70% lower than that of children living with at least one parent (Government of Kenya 2004). Reasons for this include additional costs of education (such as uniforms and books), inability to go to school full time, and lack of educational capacity and quality (World Bank *et al.* forthcoming).

As a result of Kenya's free primary education policy, primary school enrolment dramatically increased from 5.8 million in 2003 to 8.6 million in 2008. However, only 64% of primary students enter secondary school and even fewer graduate. The low secondary enrolment and completion rates are largely attributed to the costs of secondary education and the need for children from low income households to work and support their families. The MasterCard

foundation's partnership with Equity Group Foundation (EGF) provides comprehensive scholarships to academically gifted, yet economically disadvantaged secondary students in Kenya. The education program, WINGS TO FLY, covers tuition, books, uniforms and stipends for the entire duration of their secondary education. High performers in o-level are given financial support for post-secondary education and are selected for internship at Equity Bank. The fund is managed by Price Water House Coopers Ltd.

The Ministry of Education awarded bursaries worth Ksh.19 million to 534 students in the 2007/08 academic year. Many other students have benefited from the Constituency Development Funds at their constituencies. Education of OVC through social protection will go a long way in promoting their wellbeing. Although the Kenyan government has put much in place such as the Free Primary Education (FPE), much still needs to be done for education to impact on wellbeing of the OVC, given that they experience higher vulnerability compared to other children.

2.4 Healthcare Support and Promotion of Orphaned and Vulnerable Children

Where an understanding of children's rights is central to a concept of wellbeing, indicators and measures tend to focus more on factors which provide opportunities and help them reach aspirations, and which focus on the quality of their lives *now* rather than just in the future (Morrow & Mayall, 2009) Early conceptions of 'wellbeing' emerged from a more general movement to de-medicalise health and encourage governments to consider a wider range of factors which contributed to poor health beyond disease or its absence. The Alma Alta definition of health (WHO 1978) defined health as '*a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity*'. Since then, wellbeing has evolved as an overarching concept which is generally held to describe the quality of people's lives (Rees *et al.*, 2010).

Just like 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 (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).

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).

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 & 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).

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).

The studies highlighted above do not point to any evidence of the influence of the social protection systems on the wellbeing of orphaned and vulnerable children, which this study investigated and to bridge the gap and focused on OVC in Dagoretti District, Nairobi County, Kenya.

2.5 Food Security and Promotion of Orphaned and Vulnerable Children

Hunger has its consequences on children's health and cognitive capacities. Reducing it 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.*, 2006), though its impacts are largely affected by the main features of design. (World Food Programme, 2010) depicts that 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.

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 & Del Ninno, 2002).

Cash transfers programmes in general also have a positive impact, given that recipient households tend to spend much of the transfer on food (Adato & 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 & O'Donnell, 2009).

Aguëro *et al.*,(2007)analyzed anthropometric survey data showed 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).

In Bangladesh, the Cash-for-Work Livelihood programme 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 & Nyanguru, 2007).

School feeding programmes can enable children in general, and orphans and vulnerable children in particular, to access education by addressing hunger and the need to work to survive. Evidence also shows that children who are not hungry are better able to concentrate in class. Take-home rations have been shown to promote the participation, progression, and retention of orphans and vulnerable children in education. They can help close the gender gap and promote the secondary school education of girls (Edström *et al.* 2008). One issue that needs consideration is that school feeding, rather than education itself, can often be the attraction for children coming to school, and enrolment and attendance may fall when feeding programmes stop. This highlights the need to address the education being provided in parallel with the school feeding programme being implemented.

In Isiolo, in Kenya's semi-desert North-Eastern Province, Pepo la Tumaini Jangwani, a community-based organization, is caring for 36 children who have lost their parents to AIDS, and provides nutritional and medical support to 150 households affected by HIV/AIDS. APHIA II Nyanza has achieved wide coverage in care and support for OVC. By the end of March 2009, the project had provided training to 13,675 community health workers, social workers, and liaison officers on care to OVC and their caregivers. The project began by providing care and support to 4,366 OVC. Two years later, that number had climbed to nearly 56,000 within 14,698 households.

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).

2.6 Caregivers and Promotion of Orphaned and Vulnerable Children.

Nurturing relationships are essential to creating and maintaining wellness. Responsive early caregiving from parents and others helps meet children's physical, social, and emotional needs. Such caregiving is expressed through innumerable everyday back-and-forth interactions. The security that results when proper caregiving meets these needs builds up children's wellness reserves.

It is ideal that 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.

According to Teresa, (2002), 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.

The aim of family support programs is typically 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 *et al*, 2010).

The 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.

In the United States, Great Britain, and Canada the meta-analysis of family support programs sought to determine their effects on families and children, as well as to identify the effectiveness of different kinds of programs and services (Layzer & Goodson 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

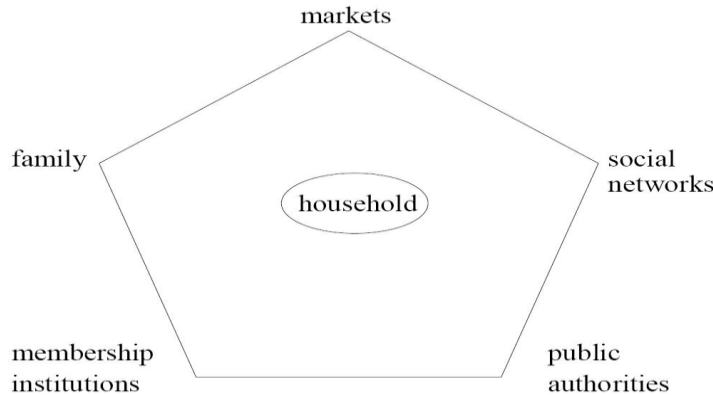
performance, physical development and health, child safety, and social-emotional development). The study found that nearly all the programs had a two-generation focus: they aimed to support parents and promote the healthy development of their children (Layzer & Goodson, 2006).

Initiatives based on a family support approach could have modest effects on outcomes such as care-givers knowledge, behavior, and well-being and on child outcomes as improved social competence, self-regulation, and social skills if caregivers respond to the family support-type services as parents as these studies did, on such. 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 Dagoretti District.

2.7 Theoretical Review

This study was guided by the Livelihood Portfolio Theory Based on the Welfare Pentagon (Neubourg, 2009). The first assumption in Neubourg's theory is that individuals and households maximize income under constraints. Second is that, all households face the risk of becoming poor at a certain point in future. In order to prevent this risk, households' consumptions should be smoothened and resources need to be set apart to finance future consumption. An important factor for well-being is the ability to smoothen consumption. It is individual's capacity to satisfy basic needs tomorrow, despite the existence of risk and occurrence of shocks. In this regard, 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.

Five core institutions namely family, markets, social networks, membership institutions and public authorities are depicted in the welfare pentagon, as shown in Figure 1 below:



:

Figure 1: The Welfare Pentagon

Source: Neubourg (2009)

According to Neubourg 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.

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 Neubourg's 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 Neubourg's 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 & Norton (2002).

2.8 Conceptual Framework

Figure 2 represents the conceptual framework on which the study is based

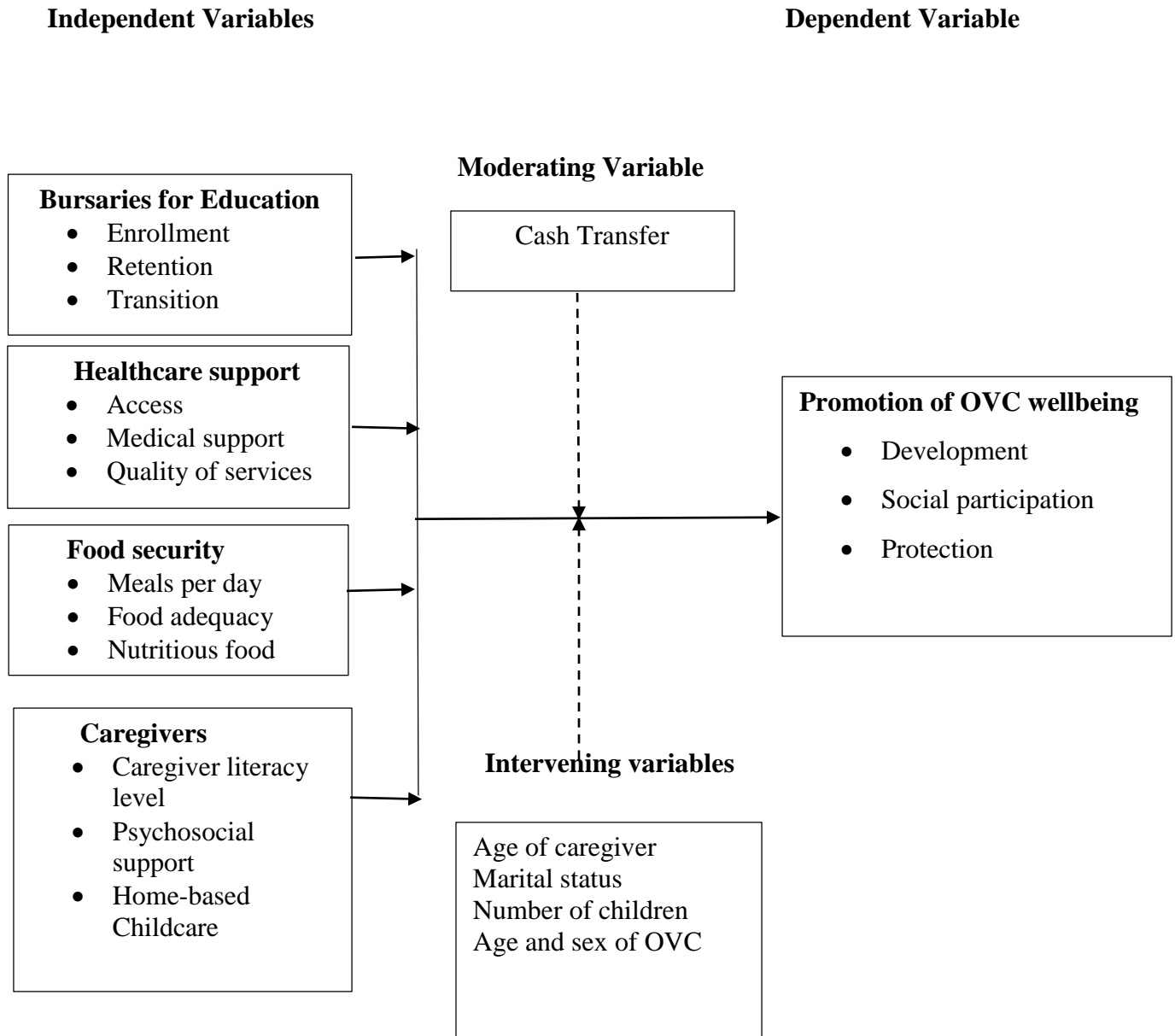


Figure 2: Conceptual Framework

2.9 Research gap

Cash transfer is seen as a moderating variable in the sense that it enables the actualization of the social protection systems to impact on the dependent variables. There are a number of intervening variables which include: caregiver's literacy level, age, marital status, number of children under the care of the care giver, age and sex of the OVC.

It is conceptualized that when OVC are covered by the social protection systems, they will have access to education which is indicated by enrolment and retention in the formal education system. Healthcare support may also be achieved through attendance of school where health programmes exist within the framework of child-friendly schools. Food security will be evaluated on the basis of the number of meals the OVC get within a day, the amount of food in one meal and the other (food adequacy) and nutritional diversity (access to foodstuffs of diverse nutritional content). Under a comprehensive social protection system that impacts on education, health and food security of the households of the OVC, the caregiver's burden is considerably lessened, thus providing them with more time to concentrate on the children, providing them with parental care that comprises psychosocial support and improved child care. A constellation of these dependent variables in a synergy leads to promotion of OVC wellbeing.

From the literature, there exist a gap in terms of the impact of social protection systems on orphan and vulnerable children wellbeing with most of studies and findings based on general conditions of the children. The study therefore will attempt to specifically look at the impact of the social protection systems on OVC's wellbeing in an urban set up in this case Dagoretti District, Nairobi County, Kenya.

2.10 Summary of Chapter

This chapter has reviewed the relevant literature in relation to the research questions presented in the study. The discussion tackled all the research objectives posed and provided a firm theoretical background for the study. The chapter has also discussed how OVC wellbeing is promoted by education, health, food security and family care through social protection system using a theoretical and empirical review.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter presents the methodology used to carry out the study. It focuses on the research design, study location; population of study; sample design data collection, data collection instruments and procedures, the data analysis and finally the operationalization of variables table.

3.2 Research Design

Research design refers to the overall plan used to carry out a research. According to Cooper & Schindler (2003), a descriptive survey design is concerned with finding out the what, where and how of a phenomenon. According to Chandran (2004), a descriptive survey design is concerned with gathering facts or to obtain pertinent and precise information concerning the current status of phenomenon and whatever possible to draw possible conclusions from the facts discovered. The descriptive survey design was deemed appropriate for the study because of its ability to establish facts which result in formulation of important principles of knowledge about populations that are too large to be observed directly (Mugenda & Mugenda (1999). The design was appropriate as it obtained pertinent and precise information concerning the influence of social protection systems on the various dimensions of OVCs wellbeing. It is concerned with the generalized statistics that result when data are abstracted from a number of individual cases (Zikmund, 2009). 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 Dagoretti District.

3.3 Target Population

Target population in statistics is the specific population about which information is desired. According to Ngechu (2004), a population is a well-defined set of people, services, elements, events, group of things or households that are being investigated. Mugenda & Mugenda, (2003), explain that the target population should have some observable characteristics, to which the researcher intends to generalize the results of the study. The study was carried out in all the ten (10) locations of Dagoretti District of Nairobi County that, according to the

Dagoreti District DCO, has a total of 1,378 OVC households receiving cash transfers. From each household, the study targeted two members, namely the care giver and a child aged between 5-18 years, to a total of 2,756 respondents.

The target population was as shown in Table 3.1

Table 3.1: Target population

Location	Target Population
Waithaka	118
Kabiria	130
Uthiru	120
Ruthimitu	146
Ngando	156
Kawangware	840
Gatina	666
Riruta Satelite	124
Mutuini	410
Kileleshwa	46
Total	2,756

3.4 Sample Size and Sampling Procedures

This section gives the sample size for the study and describes systematically the procedures to be used in picking the sample

3.4.1 Sample Size

Kathuri & Pals (1993); Fraenkel *et al*, (1990) 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 2,756 households will give a sample size of 338, since the total target population tends towards N=2800 (Appendix I). The study will, therefore, utilize a sample size of 338 households. To get proportionate sample for each age category a formula by Kathuri (1990) will be used.

$$n_i = N_i \cdot \frac{n}{N}$$

N

n_i = Number of members in the sample for strata I for 1,2,3,4

N_i = Number of members in the population for strata I for 1,2,3,4

N = Numbers of members in the entire population.

n = Sample size.

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 & Wallen, 2000).

Since the target population was not homogenous, stratified random sampling was used to obtain representative households with OVC from each of the 10 locations; Waithaka, Kabiria, Uthiru, Ruthimitu, Ngando, Kawangware, Gatina, Riruta Satellite, Mutuini, Kileleshwa of Dagoretti district.

Proportional 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 10 locations.

The sampling was as shown in Table 3.2

Table 3.2: Target population and proportionate sub- sample sizes.

Administrative location	Number of HH with OVC Multiplied by 2	% of OVC HH of target population	Sample size per sub-location
Waithaka	118	4	14
Kabiria	130	5	17
Uthiru	120	4	14
Ruthimitu	146	5	17
Ngando	156	6	20
Kawangware	840	30	101
Gatina	666	24	81
Riruta Satelite	124	5	17
Mutuini	410	15	50
Kileleshwa	46	2	7
Total	2756	100	338

Source: Dagoretti District Children Office

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).

3.5 Research Instruments

The study used questionnaires to collect data. The questionnaires consisted of open and close ended questions to get information from the respondents. According to Kathuri & Pals 1993 most techniques for measuring social and psychology environment rely on verbal material in the form of questionnaires and interviews. Questionnaires were useful because they were time saving and allowed collection of data from a large sample of individuals.

3.5.1 Pilot testing

To ensure that the instruments used to collect data actually measured what they were intended to measure, the questionnaires were pilot-tested in the field. The instruments were pilot-tested using a sample of 34 OVC households from two of the sub-locations of the neighboring Lang'ata District, where 17 caregivers and 17 OVC were utilized for this purpose. A group of 10% of the sample size is acceptable for pilot testing. The subjects were encouraged to make comments and suggestions concerning the instructions, clarity of questions asked and their relevance (Mugenda & Mugenda, 1999). The procedures used were similar to those used during the actual data collection. The pilot data was not included in the actual study

3.5.2 Validity of Instrument

According to Creswell (2002), validity is the degree by which the sample of test items represents the content the test is designed to measure. Mugenda & Mugenda (2003) contend that the usual procedure in assessing the content validity of a measure is to use a professional or expert in a particular field. For this study the researcher discussed the items in the instrument with the supervisor and colleagues at the University of Nairobi as recommended by Mutai (2000), to ascertain their construct and face validity.

3.5.3 Reliability of Instrument

Reliability is a measure of the degree to which a research instrument yields consistent results or data after repeated trials.

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

$\sum y^2$ =sum of squared y scores

$\sum x^2$ =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 reliability coefficient of 0.70 and above was considered credible enough for the study. Kaplan & Saccuzzo, (2001)

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

$$1+r$$

3.6 Data Collection Procedure

This study collected quantitative data using a self-administered questionnaire. 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 researcher sought prior appointments with the respondents for the interviews.

3.7 Data Analysis Techniques

According to Mugenda & Mugenda (1999) data analysis includes sorting, editing coding, cleaning and processing of data. The researcher used descriptive inferential statistics data analysis technique. The raw data from the field was sorted as per the objectives of the study, coded, analysed and presented in form of tables , frequencies and percentages. Regression analysis was done to establish relationship between the independent and dependent variables.

3.8 Ethical Considerations

The researcher ensured that guarantees to the participants concerning confidentiality were given and strictly observed. The strict standard of anonymity was employed which meant that the participant remained anonymous throughout the study even to the researchers themselves. The researcher strived to maintain truthfulness in reporting data results by ensuring that there was no fabrication, falsehood, or any misrepresentation of data.

3.9 Operationalization of variables

Table 3.3 presents the operationalization table

Table 3.3: Operationalization table

Objective	Variable	Indicators	Measurement	Measurement scale	Tools of analysis	Type of data analysis
To assess how bursaries for education influences the promotion of Orphaned and Vulnerable Children wellbeing in Dagoretti District, Nairobi County.	Independent: Bursaries for Education	Enrollment	Proportion entering schools	Nominal	Mean	Descriptive
		Retention	School attendance and retention	Nominal	Percentage	Regression
		Access	Performance and completion of school	Ordinal		
To determine the extent to which healthcare support influences the promotion of Orphaned and Vulnerable Children wellbeing in Dagoretti district, Nairobi County	Healthcare support	Accessibility to medical care	Nutritional supplementation	Ordinal	Mean	Descriptive
		Medical support	Medical attention	Ordinal	Percentage	Regression
		Quality of services provided.	Adequacy of services	Ordinal		
			Satisfaction with Health of OVC	Nominal		

To examine the influence of food security on promotion of Orphaned and Vulnerable Children wellbeing in Dagoretti district, Nairobi County	Food Security	Meals per day	Number of meals per day	Ordinal	Mean	Descriptive
		Food adequacy	Amount of food taken per meal	Ordinal	Percentage	Regression
		Nutritional diversity	Nutritious food	Nominal		
To determine the influence of caregivers on promotion of Orphaned and Vulnerable Children wellbeing in Dagoretti district, Nairobi County	Caregiver	Caregiver literacy level	Provision of basic needs	Ordinal	Mean	Descriptive
		Psychosocial support	Time for attention	Ordinal	Percentage	Regression
		Home-based Childcare	Protection from abuse	Ordinal		
To assess the influence of social protection on promotion of OVC wellbeing	Dependent: Promotion of OVC wellbeing	Number of OVC whose wellbeing is promoted through social protection systems	Type of OVC wellbeing identified as a result of social protection	Ordinal	Mean Percentage	Descriptive Regression

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 data was analyzed both quantitatively and qualitatively. The data has been presented in forms of tables, and percentages which make the results easy and possible to read.

4.2 Response Rate

The study has designated sample sizes of 169 OVC care givers and 169 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 national (*Swahili*) language without changing the meanings of the questions. Table 4.1 shows the response rates.

Table 4.1: Response Rates

<i>Group</i>	Designated Sample size	Number Achieved	Response Rate
Care givers	169	160	95%
OVC	169	160	95%
Total	338	320	95%

As the Table 4.1 shows, there was 95% questionnaire return rate that is far above the 80% that Mugenda & Mugenda (2003) suggest is adequate for this kind of study.

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	42	26.2	73	45.6
Female	118	73.8	87	54.4
Total	160	100.0	160	100

As shown in Table 4.2, and as perhaps would be expected, most of caregivers, at about 74%, were female. On the other hand, 54% of OVC were female while 46% 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 are presented in Table 4.3.

Table 4.3: Distribution of the Respondents by Age

Age Bracket (Years)	Caregivers		OVC	
	Frequency	Percentage	Frequency	Percentage
4-8	-	-	30	18.9
9-13	-	-	96	60.3
14 -18	-	-	34	20.8
20-24	8	5.0		
25 to 29	34	21.2	-	-
30 to 34	20	12.5		
35 to 39	45	28.1	-	-
40 to 44	44	27.5	-	-
above 45	9	5.6	-	-
Total	160	100.0	160	100.0

As Table 4.3 shows, majority of the caregivers, at 67%, were of youthful age i.e. below 40 years of age meaning that with appropriate support they have the ability to actively take care of OVC needs well and promote their wellbeing.

The findings also indicate that children at various developmental stages were reached by the study, making the information obtained from the children largely representative.

4.3.3 Marital Status of the Caregivers

The caregivers were asked to indicate their marital status. They were also requested to indicate their relationships with the household heads. The distribution of the caregivers by their marital status is presented in Table 4.4.

Table 4.4: Distribution of the Caregivers by their Marital Status

Marital	Frequency	Percentage
Single	36	22.5
Married	75	46.9
Divorced/separated	34	21.2
Widowed	15	9.4
Total	160	100.0

According to Table 4.4, 90.6 % of the caregivers have been married, others widowed or divorced/separated. This finding is important in that the OVC are brought up in a family setup by caregivers who have experience in child rearing. 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 percentage of caregivers who reported being widowed is significantly low and, together with those who were divorced indicates that the vulnerability level of children in the study area is significantly low.

4.3.4 Distribution of the Respondents by their Level of Education

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

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

Level of Education	Frequency	Percentage
No formal Education	29	18.1
Primary Level	42	26.2
Secondary Level	45	28.1
Tertiary College	31	19.4
University Graduate	13	8.1
Total	160	100.0

The findings reveal that the highest percentage (81.9%) of the caregivers who participated in the study had attained at least basic education, that is, secondary level. With such high level of formal education, care givers should be in a position to provide quality care to the children.

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 as presented in Table 4.6.

Table 4.6: Distribution of the Caregivers by their Occupation

Occupation	Frequency	Percentage
Business person	34	28.1
Artisan	17	14
Casual labourer	32	26.5
Watchman	11	9.1
House help	27	22.3
Other Occupations	39	24.4
Total	160	100.0

As seen from Table 4.6, all the caregivers have a form of livelihood that translates to a regular income. This shows that at least each household is able to provide for the basic needs of OVC albeit in a small way. 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 Bursaries for Education and Promotion of Orphan and Vulnerable Children wellbeing.

The first objective of the study was to assess how bursaries for education influence the promotion of orphaned and vulnerable children wellbeing in Dagoretti District. In order to examine the relationship between social protection systems and bursaries for education of the OVC, the study sought to examine education of the OVC in terms of enrolment, retention and access. This section, therefore, presents and discusses the findings on the bursaries for education as a social protection systems and their influence on promotion of OVC wellbeing.

4.4.1 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. Table 4.7 shows the caregivers' responses.

Table 4.7: Attendance of School by OVC

OVC Attending School	Frequency	Percentage
Yes	158	98.8
No	2	1.2
Total	160	100.0

From their responses, as shown in Table 4.7, majority of caregivers indicated that the children attended school. The main reason for not attending school was lack of 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. 2,000 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.

When asked to indicate whether there were instances when the children failed to go to school, majority (75.6%) of the caregivers responded on the affirmative while the rest indicated there were no such cases. It is evident that children missed school due to various reasons at different times and this may affect their performance and subsequently transition to other classes. The OVC responses as to questions related to school attendance are shown in Table 4.

Table 4.8: OVC Responses on School Attendance

<u>School attendance</u>	<u>Response</u>			<u>Total</u>
	<u>All the time</u>	<u>Some of the time</u>	<u>Most of the time</u>	
I attend school	37.1%	27.0%	35.8%	100%
I've been away from school	1.2%	67.5%	31.2%	100%

From Table 4.8 majority of the OVC report that they have been away from school at different times. Reasons for children not attending school regularly included absenteeism to take care of the younger siblings and sickness/illnesses. This left the children vulnerable as they miss school which affects their performance that impacts negatively on their intellectual development.

4.4.2 Bursaries for Education and OVC Completing School

The study sought to establish the extent to which social protection systems influenced the caregivers' certainty that the OVC would complete school. The extent to which the OVC were repeating classes was evaluated. The responses were then cross-tabulated with the number of times a child had repeated class. The findings are as shown in Table 4.9 and 4.10

Table 4.9: Bursaries for Education and OVC Completing School

Repeated Class	No of times repeated		Total
	1	2	
Yes (65)	(53)	(12)	(65)
40.6%	81%	19%	100.0%
No (95)	-	-	(95)
59.4%	-	-	100.0%
Total	(53)	(12)	(160)
	81%	19%	100.0%

The figures in parentheses () are frequencies

The findings in Table 4.9 indicate that majority of the children had not repeated class in the course of their education, and that over 80% of those who had repeated classes had done so only once. The findings show that the OVC were attending classes as expected and transiting to the next levels - a key indicator that their mental and intellectual wellbeing were being promoted.

Table 4.10: Caregiver responses on OVC School Completion

Worry on OVC School Attendance	Response			
	Rarely	Sometimes	Always	Total
Absent from school	39.3%	40.7%	20.0%	100%
Completion	22.9%	42.5%	34.6%	100%

Table 4.10 shows the caregivers who reported that they were always worried about their children completing school and had different reasons for the OVC being absent. Most caregivers said that school fees was not available, while others reported different reasons for why OVC missed school to be taking care of other children disabled, were working, pregnancy and lack of essential school uniforms. These findings implied that caregivers from households that benefitted from bursaries for education, the OVC were rarely absent from school were more optimistic of the OVC's education completion than were those from households that had not benefitted from bursaries for education, thus the stronger the bursaries for education as a social protection systems the more likely are OVC to access education.

According to the findings as per the Spearman correlation reported in Table 4.11, OVC wellbeing is promoted by their educational access, retention and enrollment. 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 bursaries for education and promotion of OVC wellbeing 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.

Table 4.11: Relationship between Bursaries and Promotion of OVC wellbeing

		Bursaries for Education	Promotion of OVC wellbeing
Bursaries for Education	Pearson Correlation	1	.437**
	Sig. (2-tailed)		.000
	N	160	160
Promotion of OVC wellbeing	Pearson Correlation	.437**	1
	Sig. (2-tailed)	.000	
	N	160	160

***. Correlation is significant at the 0.001 level (2-tailed).*

The PPMC analysis in Table 4.11 shows that there was a significant positive relationship between social protection systems and education of the OVC ($r=0.44$; $n=160$; $p<0.01$). The relationship was of moderate strength, indicating that completion of education of the OVC was associated with social stronger protection systems, hence the higher the bursaries for education the more likely that the OVC would complete school and enroll at the next education levels. Education is important for every child to realize their full potential. Bursaries promote access to education for OVC thereby enabling them to develop mentally and intellectually, an important indicator of OVC wellbeing.

4.5 Healthcare Support and Promotion of OVC wellbeing

The second objective of the study sought to determine the extent to which social protection systems influence the health of Orphaned and Vulnerable Children. The section is discussed under sub-sections of nutritional supplementation for OVC, healthcare of the OVC and the relationship between Healthcare support as a social protection systems and promotion of OVC wellbeing.

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 are as shown in Table 4.12

Table 4.12: Nutritional supplementation for OVC

Received Nutritional supplements	Frequency	Percentage
Yes	9	25
No	151	75
Total	160	100.0

The findings in Table 4.12 indicate that majority of the caregivers (75%) did not receive nutritional supplements for the OVC. This is a good sign that most of the OVC are receiving adequate and appropriate nutrition that promotes their health. It indicates that the caregivers are able to provide OVC with basic needs such as food within the households thus the children become physically healthy and strong as a result of food and nutrition hence no need for supplements.

4.5.2 Health of the OVC

The caregivers were requested to indicate how often their children fell sick. Their responses are as shown in Table 4.13.

Table 4.13 Frequency of OVC Sickness

Falling Sick	Frequency	Percentage
Rarely	58	38.4
Sometimes	66	43.7
Frequently	27	17.9
Unanswered	9	
Total	160	100.0

According to Table 4.13 all the caregivers indicated that the OVC fell sick and they reported that whenever the children fell sick, they were treated at the government health centers or private clinics for medical services. This is an indication that the OVC were taken to hospitals and that caregivers sought medical facilities and accessed medical support.

The care givers responses on payment for medical services for OVC treatment is as shown in Table 4.14

Table 4.14: Payment for Medical services for OVC

Pay for Medical Service	Frequency	Percentage
No	41	25.6
Yes	119	74.4
Total	160	100.0

Table 4.14 depicts that majority of the caregivers (74%) confirmed that they paid for the medical services offered. This depicts that there are government health facilities available within Dagoretti District where OVC can be attended to when they become ill and that the caregivers take them there for treatment. The fact that the caregivers pay for OVC treatment shows that they are caring and loving toward them.

4.5.3 Health care support 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. 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 results are as shown in Table 4.15.

Table 4.15: Health care support and Medical Attention of OVC

Worried	Frequency	Percentage
Frequently	24	15
Rarely	53	33.1
Sometimes	52	32.5
Never	31	19.5
Total	160	100.0

The findings in Table 4.15 indicate that majority of the caregivers (79.5%) worried about medical attention of the OVC if they did not have money to take them to hospital. On the other hand 19.5% never worried about the OVC not getting medical attention if they lacked money.

This clearly shows that the caregivers truly had the best interest of the OVC and would not want them to suffer or lose their lives to sickness. They want the OVC to have good health and this definitely promotes the wellbeing in terms of physical development.

4.5.4 Healthcare Support 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 4.16

Table 4.16: Health care support and Satisfaction with OVC Health

Satisfaction with OVC		
Health	Frequency	Percentage
Not satisfied at all	39	24.4
Satisfied	99	61.9
Very satisfied	22	13.8
Total	160	100.0

From Table 4.16 it is evident that the highest percentage of the caregivers (75.7%) were satisfied with the health of the OVC compared with 24.4% who were not satisfied at all. Most of those satisfied reported higher levels of satisfaction with the OVC health indicating that the more the healthcare support the better chance the OVC stand to get good healthcare. However, the medical attention that the OVC receive from the government dispensaries, where medical charges are subsidized is depicted in the manner by which the households report high satisfaction levels with the health of the OVC.

4.5.5 Orphan and Vulnerable Children Concerns on Adequacy of Health Services

The OVC were asked to rate their responses on a scale of “Very Adequate” to “Very Poor” about their concerns on their health. Their responses are as shown in Table 4.17

Table 4.17: OVC's Views on their Adequacy of Health services

Treatment Services	Response					Total
	Very Adequate	Adequate	Average	Poor	Very Poor	
Yes	(9) 5.6%	(42) 26.2	(42) 26.2	(35) 21.9%	(19) 11.9%	(147) 92.1%
No	-	-	-	-	-	(13) 7.9%
Quality of staff	(16) 9.1%	(37) 23.8%	(55) 36.4%	(28) 16.8%	(24) 11.9.5%	(160) 100%
Attitude of staff	(8) 3.5%	(37) 23.8%	(66) 44.1%	(26) 16.8%	(23) 11.9%	(160) 100%

The figures in parentheses () are frequencies

As shown in Table 4.17 majority of the OVC indicated that the health services received were above average while the rest said the services were not adequate. This indicates that the existing government health facilities can adequately provide quality healthcare support to the population in the district. 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.

The research findings indicate that there is a significant relationship between Healthcare support as a Social Protection Systems and promotion of OVC wellbeing. The findings are as presented in Table 4.18

Table 4.18 Relationship between Healthcare Support and Promotion of OVC wellbeing

		Health care support	Medical attention	Satisfaction with OVC health
Healthcare support	Pearson Correlation	1	.785**	.391**
	Sig. (2-tailed)		.000	.000
	N	160	160	160
Medical attention	Pearson Correlation	.785**	1	.464**
	Sig. (2-tailed)	.000		.000
	N	160	160	160
Satisfaction with OVC health	Pearson Correlation	.391**	.464**	1
	Sig. (2-tailed)	.000	.000	
	N	160	160	160

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

From Table 4.18 the more the healthcare support as a Social Protection System the better chance the OVC stand to get good health services. A moderate and significant positive relationship existed between the caregivers' satisfaction with the OVC health and social protection systems ($r=0.39$; $n=160$; $p<0.01$). On the other hand, there was positive correlation between the caregivers' optimism over medical attention and satisfaction with the OVC health ($r=0.46$; $n=160$; $p<0.01$). The positive correlations indicates that OVC wellbeing is associated with strong healthcare support as social protection systems, and that the more optimistic the caregivers were over the OVC receiving medical attention on falling sick, the more satisfied they were with the OVC's health. It is evident that access to healthcare is key in enhancing good health which promotes OVC wellbeing in terms of physical development. Healthcare support should therefore be compulsory and subsidized for all.

4.6 Food Security as a Social Protection Systems and Promotion of OVC wellbeing

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 were as shown in Table 4.19

Table 4.19: Number of Meals Taken by OVC per Day

No of Meals	All Children	
	Frequency	Percentage
No response	2	1.2
One	4	2.5
Two	112	70.0
Three	42	26.2
Total	160	100.0

As portrayed in Table 4.19, most (96.2%) of the caregivers report that the OVC had at least two meals in a day. However, it is known that most school-going children do not go back home for lunch and that many schools have lunch programmes, thus ensuring that most of the OVCs get the required three meals per 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 4.20 shows the caregivers' responses.

Table 4.20: Caregiver Worried About Food Adequacy

Worried About Food Adequacy	Frequency	Percentage
Yes	108	69.2
No	52	30.8
Total	160	100.0

In Table 4.20 comparatively, there were more caregivers who were worried about their households getting enough food (69.2%) than there were those who were never worried (30.8%). Most of those who never worried were the caregivers whose disposable household incomes were relatively higher and so they were able to provide the OVC with three meals daily.

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 are as presented in Table 4.21

Table 4.21: Nutritional Diversity

Unable to eat preferred foodstuffs	Frequency	Percentage
Often (more than 10 times in a month)	65	40.6
Sometimes (3 to 10 times in a month)	70	43.8
None (always ate the preferred food types)	16	11.9
No response	6	3.8
Total	160	100.0

Table 4.21 indicates that majority (84.4%) of the caregivers reported that in the previous 30 days preceding the study, members of their household were not able to eat the kinds of foods they preferred. This shows that although caregivers are able to provide the OVC with food on a daily basis, it may not be the kind of foods they would love to eat e.g fish, meat, and chicken among others. The important thing is that the households are able to access food daily to sustain themselves and therefore provide OVC with food to eat.

4.6.4 OVC Views on Food Security

The OVC's responses to questions related to food security are as shown in Table 4.22.

Table 4.22: OVC's Views on Food Security

Food Adequacy					
Very Adequate	Adequate	Average	Inadequate	Very Inadequate	Total
(13)	(59)	(48)	(22)	(18)	160
8.1%	36.8	30%	13.7	11.2%	100%

The findings shown in Table 4.22 indicate that the most of the OVC reported eating at least three meals in a day which was adequate. With regard to nutritional diversity, most reported that they ate a balanced diet. The general trend is that the described food security indicated that the OVC were largely food secure. The OVC said that they went to bed with full stomachs showing that they were fed adequately.

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. The caregivers' were requested to share on the household nutritional diversity. Their responses are as shown in Table 4.23

Table 4.23 Relationship between Food Security as SPS and promotion of the OVC wellbeing

		Food Security as a SPS	Number of Meals per Day	Household Food Adequacy	Nutritional Diversity
Food security as a SPS	Pearson Correlation	1	-.019	.448**	.256**
	Sig. (2-tailed)		.809	.000	.001
	N	160	160	160	160
Number of Meals per Day	Pearson Correlation	-.019	1	.029	-.079
	Sig. (2-tailed)	.809	.706	.303	
	N	160	160	160	160
Household Food Adequacy	Pearson Correlation	.448**	.029	1	.262**
	Sig. (2-tailed)	.000	.706		.001
	n	160	160	160	160
Nutritional Diversity	Pearson Correlation	.256**	-.079	.262**	1
	Sig. (2-tailed)	.001	.303	.001	
	N	160	160	160	160

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

According to Table 4.23 the relationship between food security 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 ($r=0.26$; $n=160$; $p<0.01$) which implies that a household that has adequate food is also nutritionally secure and vice versa.

The study has established that food adequacy and nutritional diversity promotes OVC wellbeing by ensuring their physical development, which results into social participation.

4.7 Caregivers as SPS and promotion of Orphan and Vulnerable Children wellbeing.

The final objective of the study was to determine the influence of caregivers as a social protection system on promotion of orphaned and vulnerable children wellbeing. Caregivers of OVC were considered as the overall attention and care that the guardian provides to the OVC 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 caregivers as a social protection systems and promotion of OVC wellbeing.

4.7.1 Caregivers 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. The caregivers' responses were analyzed descriptively to determine the means and standard deviations for each of the statements. The findings are as shown in Table 4.24

Table 4.24: Family Care for the OVC

Family Care	Std.	
	Mean	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 all 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 Care givers

The OVC were required to rate the care they received at their households. Their responses were as presented in Table 4.25.

Table 4.25 OVC's Views on Caregivers

Caregivers	Response	
	Frequency	Percent
Loving/ caring	99	64.7%
Uninvolved	61	35.3%
Total	160	100%

The OVC responses depicted in Table 4.25 indicated that majority of them felt that their caregivers were loving and or caring while the rest, less than half felt otherwise. The cumulative percentage of OVC who indicated that they spent time with their caregivers were in households where the caregivers were said to be loving or caring. Most of the OVC spent time with their caregivers at home. These findings imply that majority of the OVC receive adequate family care which in turn promote their wellbeing as they were protected from any form of abuse.

The study shows that there is a significant relationship between caregivers as a social protection systems and promotion of OVC wellbeing. Most of the caregivers reported that they were able to give enough attention, love and support to the children which enhances a

sense of security and protection from abuse. 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 are shown in Table 4.26.

Table 4.26 Relationship between Care givers as a SPS and promotion of OVC wellbeing.

		Caregivers as a Social Protection Systems	OVC Wellbeing
Caregivers as a Social Protection Systems	Pearson Correlation	1	.355**
	Sig. (2-tailed)		.000
	N	160	160
OVC wellbeing	Pearson Correlation	.355**	1
	Sig. (2-tailed)	.000	
	N	160	160

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

There was a significant and moderate, positive relationship between caregivers as a social protection systems and promotion of OVC wellbeing ($r=0.36$, $n=160$, $p<0.01$). 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.

The findings portray that the caregivers are an integral part of Orphans and Vulnerable Children in society. Children need to be taken care of by responsible adults who should provide them with basic needs in life and protect them from physical harm and abuse. These are things that promote the wellbeing of OVC.

CHAPTER FIVE

SUMMARY OF FINDINGS, DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter presents a summary of the key findings of the study, discussion of the findings against literature, conclusion of the whole study, recommendations and suggestions for further research.

5.2 Summary of findings

The following is the summary of the findings from the study as per the variables and their influence on promotion of OVC wellbeing.

5.2.1 Influence of Bursaries for Education as a Social Protection System on Promotion of OVC wellbeing

The study has established that due to availability of bursary funds, among other factors, almost all the OVC were attending school as required and that very few of them repeated classes. The failure to attend school by the few was blamed on sickness or being assigned duties to take care of younger siblings. The study concludes that bursaries were key not only to the OVC completion of current schooling, but also enhanced their ability to proceed to the next education levels.

5.2.2 Influence of Healthcare Support as a Social Protection System on Promotion of OVC wellbeing

The study established that most OVC access government hospitals and dispensaries for medical services within their locality whenever they fall sick and thus being assured satisfactory level of health services. This fact is also confirmed by the fact that majority of the household did not need or seek nutritional supplements for the OVCs.

5.2.3 Influence of Food Security as a Social Protection System on Promotion of OVC wellbeing

The study established that in general the OVC were adequately fed. Not only did they receive two meals a day at home, but those who went to school also had lunch at the institutions. It was also established that generally, and apart from the stated adequacy, nutritional diversity of the OVC households was also guaranteed as a result of care givers ability to provide OVC with meals easily.

5.2.4 Influence of Caregivers as a Social Protection System on Promotion of OVC wellbeing

The study has established that the care givers gave the needed parental care and love to the OVCs under their care by providing a conducive home for the children growth and development. This fact is demonstrated by among others the care givers' availability, giving attention and support to the children that enhanced a sense of security and protection from abuse. This total acceptance of their parental role is attributed to their high levels of empowering education that also is enhanced by the care givers ability to have a steady means of income that enables them to provide for OVCs needs.

5.3 Discussion of key findings

This section discusses the key findings from the study against literature from the other studies as per the variables.

5.3.1 Influence of Bursaries for Education as a Social Protection System on Promotion of OVC wellbeing

The study indicates that completion of education of the OVC is associated with access to bursaries for education, hence the more the bursaries for education 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).. 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.

5.3.2 Influence of Healthcare Support as a Social Protection System on Promotion of OVC wellbeing

According to the study healthcare support gives the OVC a better chance to get good health services as they are able to receive services from the government health facilities in the District. Most OVC access government hospitals and dispensaries for medical services within their locality whenever they fall sick and thus being ensured satisfactory level of health. Majority of the caregivers are satisfied with the health of OVCs and are optimistic over medical attention when the OVC fall sick. 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).

5.3.3 Influence of Food Security as a Social Protection System on Promotion of OVC wellbeing

According to the study majority of the OVC got adequate and balanced meals for their needs. 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).

5.3.4 Influence of Caregivers as a Social Protection System on Promotion of OVC wellbeing

The study indicates that love and care for the OVC is associated with strong family care. The model of caregivers as a Social Protection Systems and other family support programs, generally, aim to improve child outcomes by enhancing parenting capacity. 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)

5.4 Conclusion

The study concludes that the wellbeing of OVC in Dagoretti is holistically taken care of through bursaries for education, healthcare support and food security by caregivers. The OVC were given bursaries that enabled them to access education at different levels and also complete their schooling that was necessary for their progression academically. They also received adequate medical services in government facilities near their homes. To crown it all, the OVCs were guaranteed the usual parental care and love that would be expected in normal homes and thus being assured of protection from abuse.

5.5 Recommendations

From the findings it is recommended that:

1. Ministry of Education should allocate more funds for bursaries to contribute to the access, retention and completion of education for OVC. 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.
2. The government should increase health care support and hospital fee waivers to enhance the health care that is received by the OVC so that caregivers can worry less over the OVC receiving medical attention on falling sick.
3. The government should provide capacity building to the caregivers to increase their employability skills in order to get better paying jobs that boost their disposable household incomes. This will enable them provide education, health and food and other basic needs to the OVC and other kenyan with similar needs.
4. Care is seen to be the holistic role played that goes beyond the physical needs of a child. It is therefore important that OVC are allocated caregivers to provide them parental love and care within a family setup. They will provide the OVC with the necessary psychosocial support and adequate home based care for promotion of mental development.

5.6 Suggestion for further research

The following areas are recommended for further research

1. A study can be carried out to assess the difference in livelihood between OVC enrolled in social protection programmes and those not in such programmes
2. A study should be undertaken to determine the sustainability of the Cash Transfer programme for OVC.

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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: Introduction Letter

Department of Extra Mural Studies

University of Nairobi

Dear Respondent

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 Dagoretti District-Nairobi County-Kenya.

Attached is a questionnaire that is a requirement for my completion of the program. Kindly give the required information which will be used for academic purposes only.

Strict confidentiality will be observed.

Your cooperation is highly appreciated.

Thank you,

Agnes Airo

Appendix III: Research Questionnaire

Instructions

Household No: _____

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

SECTION A: CAREGIVER CHARACTERISTICS

1.1 Respondent's gender?

Male Female

1.2 What is your relationship with the household head?

Self 2. Spouse 3. Son/Daughter 66. Other

1.3 What is your marital status?

Single 2. Married 3. Divorced/ Separated Widowed 5. Other (Specify)

1.4 How old are you?

1. 18 to 24 years 2. 25 to 29 years 3. 30 to 34 years
4. 35 to 39 years 5. 40 to 44 years 6. Above 45 years

1.5 What is the nature of your occupation?

1. Teacher 2. Business Person 3. Artisan 4. Casual labourer
5. Government worker 6. Other Specify _____

1.6 What is the level of your education?

1. No formal Education 2. Primary level 3. Secondary level 4. Tertiary College
5. Secondary level Complete 6. Tertiary College 7. University graduate
7. Postgraduate

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?				
	• Above 18 years old?				

SECTION B: Bursaries for Education as a social protection system and promotion of OVC wellbeing

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 taking care of other children
 They are disabled Working
 They lack school uniform Pregnancy

Other (specify) _____

3.4 For those children going to school, are there times when they do not go?

Yes [] No []

3.5 If yes, how often are they absent from school?

Rarely Frequently Often

3.6 Why do they become absent from school?

3.7 How often do you worry whether the children will complete school?

Never Sometimes Always

3.8 How has the children's education contributed to their wellbeing?

Intellectual Development Mental development
 Social participation Protection from abuse

SECTION C: Healthcare support as a social protection system and promotion of OVC wellbeing

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

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

Government dispensary Private dispensary Not treated at all

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

Yes No

4.6 If 4.5 is yes, what is the source of the money you use to pay for the medication?

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

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

Rarely Sometimes Frequently

4.9 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 Sometimes
 Rarely Frequently

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

Not satisfied at all Satisfied Very satisfied

4.11 How has the childrens' health impacted on their wellbeing?

Intellectual Development	<input type="checkbox"/>	Mental development	<input type="checkbox"/>
Social participation	<input type="checkbox"/>	Protection from abuse	<input type="checkbox"/>
Steady body Growth	<input type="checkbox"/>	Slow body growt	<input type="checkbox"/>

SECTION D: Food security as a social protection system and promotion of OVC wellbeing

How many meals do the children take in a day take in a day?

One [] Two [] Three []

5.1 In the past 1 month did you worry that your household would not have enough food? *If No, Skip to 5.4*

Yes [] No [] Don't know []

5.2 How often did you worry that your household would not have enough food?

Rarely (Once or twice in a month) [] Sometimes (3 to 10 times in a month)[]
Often (More than 10 times in a month) []

5.3 In the past 1 month how often were you or any other household member not able to eat the kinds of foods you preferred?

Sometimes (3 to 10 times in a month) [] Often (More than 10 times in a month) []
None (Always ate the preferred food types)[]

5.4 In the past year, did your household have any days when they had to go without eating anything all day? *If No, Skip to 5.7*

Yes [] No [] Don't know []

5.5 How often did this happen?

Rarely (Once or twice in a year) [] Sometimes (3 to 10 times in a year) []
Often (More than 10 times in a year) []

5.6 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)?

Lack of money to buy food [] Inadequate food at home []
Lack of the preferred food in the market [] Market inaccessibility (Long distance) []
Substituted food with school fees [] High food prices []

5.7 What kind of foods does the family eat? Tick the boxes

Ugali [] Meat [] Githeri [] Beans [] Vegetables []
Fish [] Milk [] Potatoes [] Others (specify)_____

5.8 How has food security contributed to promotion of OVC wellbeing?

Intellectual Development [] Mental development []
Social participation [] Protection from abuse []
Steady body Growth [] Slow body growth []

SECTION E: Caregivers as a social protection system and promotion of OVC wellbeing

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.

		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.				

6.7 How has family care impacted on children’s wellbeing?

Intellectual Development Mental development

Social participation Protection from abuse

Steady body Growth Slow body Growth

Thank you for your time and participation in this survey

Appendix IV: Household questionnaire for OVC Household No. _____

Administration: Oral [] Self-Administered []

Sex: Boy [] Girl [] Age [] Weight [] Height []

1. How regular do you attend school?

All the time [] Sometimes [] Most of the time []

2. Have you been away from school for at least 1 term before? Yes [] No []

3. Have you ever repeated a class before? Yes [] No []

4. If yes, how many times have you repeated? _____

5. In which class(es) did you repeat? _____

6. What are the available health facilities in this location?

7. When you fall sick do you go to the hospital? Yes [] No []

8. How long does in minutes does it take you to get the nearest health facility? _____

9. How long does it take for you to be attended to once you reach the facility? _____

10. How would you gauge the adequacy of the treatment services provided?

Very adequate [] Adequate [] Average [] Poor [] Very Poor []

11. Explain your answer above _____

12. In the past one year have there been times you have gone to the health facilities and not received treatment? Yes [] No []

13. When treatment is done how is the medicine availed to you?

Given for free [] Bought from hospital Pharmacy []

Bought from other chemist [] Other specify _____

14. When drugs are prescribed how available are they?

Always [] Few times [] Very few times []

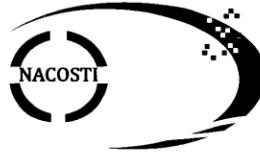
15. How would you rate the general quality of service you receive?

Very good [] Good [] Average [] Poor [] Very poor []

16. How would you rate the general attitude of the staff?

Very good [] Good [] Average [] Poor [] Very poor []

17. On average how many meals do you have in a day?
 One [] Two [] Three [] More than three []
18. Are there days that you have missed food? Yes [] No []
19. If yes which meal was it? Breakfast [] Lunch [] Supper []
20. How would you rate the adequacy of the food you eat?
 Very adequate [] Adequate [] Average [] Inadequate [] Very
 inadequate []
21. How often do you eat a balanced diet at least once a day? _____
22. In a week how many times do you eat fruits? Once [] Everyday [] 3-6 days []
23. How would you describe your caregiver? Loving/ caring []
 Uninvolved []
24. In one day how long do you spend time with your
 caregiver? _____
25. If yes, how? _____
26. To what extent are you given a chance to participate?
 High [] Average [] Low []
27. Who is the most important person whose opinion is important in deciding your
 Self [] Mother [] Father [] Other Specify _____



**NATIONAL COMMISSION FOR SCIENCE,
TECHNOLOGY AND INNOVATION**

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9th Floor, Utalii House
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NAIROBI-KENYA

Ref: No.

Date:

20th July, 2015

NACOSTI/P/15/3143/6828

Agnes Atieno Airo
University of Nairobi
P.O. Box 30197-00100
NAIROBI.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on *“Influence of social protection systems on promotion of orphaned and vulnerable children well being in Dagoretti District, Nairobi County-Kenya,”* I am pleased to inform you that you have been authorized to undertake research in **Nairobi County** for a period ending **4th December, 2015.**

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

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


DR. S. K. LANGAT, OGW
FOR: DIRECTOR-GENERAL/CEO

Copy to:

The County Commissioner
Nairobi County.

The County Director of Education
Nairobi County.

**THIS IS TO CERTIFY THAT:
MS. AGNES ATIENO AIRO
of UNIVERSITY OF NAIROBI, 0-200
nairobi, has been permitted to conduct
research in Nairobi County**

**Permit No : NACOSTI/P/15/3143/6828
Date Of Issue : 20th July,2015
Fee Recieved :Ksh 1,000**

**on the topic: INFLUENCE OF SOCIAL
PROTECTION SYSTEMS ON PROMOTION
OF ORPHANED AND VULNERABLE
CHILDREN WELL BEING IN DAGORETTI
DISTRICT, NAIROBI COUNTY-KENYA**

**for the period ending:
4th December,2015**



**.....
Applicant's
Signature**

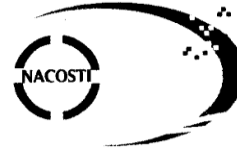
**.....
Director General
National Commission for Science,
Technology & Innovation**

CONDITIONS

1. You must report to the County Commissioner and the County Education Officer of the area before embarking on your research. Failure to do that may lead to the cancellation of your permit
2. Government Officers will not be interviewed without 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) hard copies and one(1) soft copy of your final report.
6. The Government of Kenya reserves the right to modify the conditions of this permit including its cancellation without notice.



REPUBLIC OF KENYA



National Commission for Science,
Technology and Innovation

**RESEARCH CLEARANCE
PERMIT**

Serial No. A 1234567890

CONDITIONS: see back page