CAPACITY BUILDING OF COMMUNITY CARE AND SUPPORT FOR ORPHANS AND VULNERABLE CHILDREN: A STUDY OF GRASSROOTS SELF-HELP INITIATIVES IN PUMWANI SLUM AREA, NAIROBI.

BY

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Project Paper Submitted to the Institute for Development Studies, University of Nairobi in Partial Fulfilment of the Requirements for the Degree Master of Arts in Development Studies of the University of Nairobi.

INSTITUTE FOR DEVELOPMENT STUDIES

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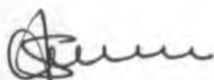
DECLARATION

This research project paper is my original work and has not been submitted to any other university.



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This research project paper has been submitted for examination with our approval as University Supervisors.

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DEDICATION

This research project is dedicated to my parents; siblings Collins, Aggrey, Roselyne, Patrick and Charles; and lastly, to all persons sincerely committed to addressing the problem of Orphans and other Vulnerable Children (OVC).

ACKNOWLEDGEMENTS

First, I am deeply indebted to all the respondents who voluntarily provided the information that informed the study. I also wish to extend my special appreciation to Lucy Ashioya and Andrew Omondi for your logistical support during fieldwork.

I wish to acknowledge all the stakeholders and practitioners in childcare for your cooperation and assistance during fieldwork. My special thanks go to the Children's Office and Social Development Office - Kamukunji District, St. John's Community Centre (SJCC), Undugu Society of Kenya (USK), the Association for the Physically Disabled of Kenya (APDK), Kenya Network for Women Living with HIV/AIDS (KENWA), Mother and Child with HIV/AIDS Support Organization (MOCASO), and Child Survival Organization to mention a few.

I am grateful to all friends who shared my vision and for their encouragement during this journey. Special thanks go to Daniel Omuka and Aden Edney Ismail. Your friendship and moral support was simply unwavering.

I am thankful to the IDS academic staff and students for your insightful reviews, critique and technical support that greatly enriched this document. Special mention is made of my academic supervisors, Prof. Patrick Odera Alila and Mr. John Murimi Njoka; and all my course-mates (2009 Class). Special mention is also made of IDS non-academic staff for your administrative support during the entire period of my graduate studies.

Finally, my sincere gratitude goes to my family for your moral, spiritual and financial support. Above all, to God be the glory for making it happen!

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LIST OF ACRONYMS AND ABBREVIATIONS

AAC	Area Advisory Council
AIDS	Acquired Immuno-Deficiency Syndrome
APDK	Association for the Physically Disabled of Kenya
ASAL	Arid and Semi-Arid Lands
CBO	Community Based Organization
CDF	Constituency Development Fund
CSO	Civil Society Organizations
DAAC	District Area Advisory Council
DFID	Department for International Development
FBO	Faith Based Organization
FGD	Focus Group Discussion
FKF	Football Kenya Federation
GOK	Government of Kenya
HIV	Human Immuno-deficiency Virus
IHA	International HIV/AIDS Alliance
IJM	International Justice Mission
KCBONET	Kamukunji Community Based Organization Network
KENWA	Kenya Network for Women Living with HIV/AIDS
KHRD	Kamukunji Human Rights Defenders
KII	Key Informant Interviews
LAAC	Location Area Advisory Council
MOCASO	Mother and Child with HIV/AIDS Support Organization
MOGCSD	Ministry of Gender, Children and Social Development
MOYAS	Ministry of Youth Affairs and Sports
NACC	National Aids Control Council
NGO	Non Governmental Organization
NPO	Non-Profit Organization
OVC	Orphans and other Vulnerable Children

PYGRON	Pumwani Youth Groups Network
SHG	Self Help Groups
SIDAREC	Slums Information Dissemination & Recreation Centre
SSA	Sub- Saharan Africa
STI	Sexually Transmitted Infections
SJCC	St. John's Community Centre – Pumwani
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNRISD	United Nations Research Institute for Social Development
USAID	United States Agency for International Development
USK	Undugu Society of Kenya
VCO	Volunteer Children Officer
YEDF	Youth Enterprise Development Fund
YIKE	Youths Initiative Kenya

ABSTRACT

Capacity building of community grassroots OVC initiatives is crucial for effective and sustainable service delivery. This study examines how and the extent the capacities for care and support of community-level Self-Help OVC initiatives in Pumwani are being strengthened. The study explores the nature and scope of the OVC care and support; types of capacity building organizations and strategies; outcome of capacity support on service delivery; and lastly, community grassroots perception of change in OVC care and support.

This study adopts a case study strategy with a qualitative research approach. Maximum variation, snowballing and purposive sampling techniques are used to select the units of analysis and the respondents. The study utilizes primary and secondary data; and thematic analysis technique of data analysis.

The study draws six conclusions based on findings. First, the Self-Help OVC initiatives are heterogeneous institutions in constant transformation to complex organizations and with potential for OVC care and support. Second, youths and children have emerged as new actors in OVC care and support. This is accompanied by emergence of new services such as talent development, sanitation, and legal assistance. Third, the main capacity building organizations are Non-Profit Organizations (NPO) and government agencies. Participation by the for-profit sector in capacity support for community OVC initiatives remains limited. Fourth, training in key programmatic areas is the most sustainable capacity building strategy. Other strategies such as resource support (financial and material), on-site support visits, exchange visits, partnerships, and networking are less prominent and their support unsustainable. Moreover, the implementation of capacity support is largely fragmented and tends to focus more on improving care and support programs rather than strengthening the OVC organization. Fifth, capacity support resulted to improved service delivery by the OVC initiatives. However, overall the initiatives remain generally weak to provide comprehensive and sustainable care and support. Finally, despite community grassroots perception of improved OVC care and support, the services provided are perceived as inadequate. In addition, OVC with disability are still disadvantaged in accessing care and support services.

The study suggests five key recommendations for policy and further research. First, there is need for policymakers and practitioners in OVC care and support to design an integrated capacity support implementation framework that also incorporates initial capacity assessment of the OVC initiatives. Second, the study recommends the need for the stakeholders and practitioners to review capacity support approaches to equally focus on strengthening the OVC organization. Third, the study recommends the need for policymakers to review the National OVC Policy and the National Plan of Action to enhance participation by the for-profit sector in capacity support of community-level OVC initiatives.

Additionally, the study suggests two recommendations for further research. First, there is need to investigate the new institutions in OVC care and support in Pumwani Slum Area such as the Children's Parliament and the grassroots Child Rights Clubs to establish their roles and effectiveness. Second, conscious to contextual dynamics, this study recommends need for replication of the study in other settings across the country to establish variations in capacity building organizations, strategies employed, and the outcome of capacity support on service delivery.

CHAPTER ONE

INTRODUCTION

Capacity Building of community grassroots OVC initiatives is considered crucial for effective and sustainable service delivery. This study aimed to examine how and the extent the capacities for care and support of community-level Self-Help OVC initiatives in Pumwani are being strengthened. This report is divided into six chapters. Chapter one presents the background to the study, the problem statement, research questions, research objectives, and the justification for the study.

Chapter two presents literature review, the theory and conceptual framework. Literature review focuses on overview of the OVC, the concept of capacity building, and community care and support for OVC. The theoretical framework discusses the social systems and institutions theories that underpin the study.

Chapter three describes the study site and methodology. The methodology focuses on the research design, unit of analysis, population, and sampling techniques. Additionally, the chapter describes the data sources and collection methods; data processing and analysis; and finally the field challenges.

Chapter four presents discussion of findings on child vulnerability and the nature of OVC care and support in Pumwani Slum Area. The chapter focuses on factors contributing to child vulnerability, description of OVC, and stakeholders in OVC care and support. In addition, the chapter discusses the Self-Help OVC initiatives focusing on their typology, history of establishment, principles of operation, services provided, and limitations.

Chapter five discusses findings on the capacity building organizations, strategies and outcome on service delivery. The chapter further presents the perception of change on OVC care and support in Pumwani and the factors attributed to the change.

Finally, chapter six presents summary of findings, conclusions and recommendations. The recommendations focus on both policy and areas for further research.

1.1 BACKGROUND

The current global situation for children shows that millions of children have become vulnerable as a result of political, economic and socio-cultural dynamics occurring in countries across the world. Global estimates indicate that about 145 million children have been orphaned and made vulnerable due to various causes (Biemba et al., 2010).

In developing countries, it is the interrelated impacts of HIV/AIDS in particular and deepening poverty among other factors that have had devastating consequences on children as a group precisely because many have been left orphans and millions more made vulnerable (UNICEF, 2006, 2008; Foster et al., 2008). Out of the estimated 130 million Orphans and Vulnerable Children (OVC) in developing countries, sub-Saharan Africa region is most affected with about 12% of the OVC compared to 7% in Asia (Larson, 2010). In Kenya, estimates indicate that about 2.4 million OVC are in need of care and support (NACC, 2010; MOGCSD, 2008).

The high rate of child vulnerability has in turn necessitated action to provide care and support to the children. In response to the crisis of OVC in sub-Saharan Africa, various notable approaches adopted comprise: residential-based approach where OVC are cared for in orphanages, children homes and rehabilitation centres; public service organised approach that entail state-sponsored social protection programmes such as social cash transfer for OVC; and grassroots local level approach which is usually a response by individuals, family members, faith-based and local community-based organizations (Foster, 2004; Adato and Bassett, 2008; Alviar and Pearson, 2009).

In the recent past, community-based responses which combine socio-economic contributions by the extended families, relatives, friends and neighbours within the local communities have been recognized as the most effective sources of support (Foster, 2004; Kaare, 2005; UNICEF, 2008). This is mainly because of their ability to reach households in greatest need; respond rapidly to crisis; are cost efficient; address local needs using available resources; draw from specialized knowledge of community members; and provide financial and psychosocial support (UNRISD, 2009). Opare (2007) observes that such organizations organize local development, forge community solidarity, and generate social capital. Although not a panacea to totally eradicating

the OVC problem, given the foregoing record and when supported, community-based OVC care and support initiatives remain the most viable options for addressing the complex problem of OVC. This is especially so in situations of high incidences of HIV/AIDS and the deteriorating socio-economic trend in the sub-Saharan Africa region.

The strengthening of capacity of community-based OVC initiatives has consequently become widely acknowledged as an effective strategy to support and protect the growing number of OVC (Phiri and Tolfree, 2005; Foster et al., 2008; UNICEF, 2004, 2008). This is in part due to the realization that the initiatives are experiencing worsening capacity strain as a result of HIV/AIDS pandemic and the deteriorating socio-economic situation in most households. This has been compounded by increasing complexity of OVC needs due to the socio-economic challenges facing the households affected by the HIV/AIDS pandemic; and the declining external donor support that has necessitated domestic assistance and support through income generating activities.

In Kenya, Pumwani Slum Area in Nairobi has witnessed proliferation of community Self-Help OVC initiatives that address the needs of the large number of OVC within Pumwani Slum Area. This support is considered critical and intended to enable the OVC acquire capability to help community members evade poverty trap or break from the poverty cycle in future. Thus, to ensure effective care and support of OVC, several organizations established capacity building programmes that sought to strengthen the capacities of community level Self-Help OVC initiatives. Based on this background therefore, this study sought to examine the effect of capacity building support on service delivery by Self-Help OVC initiatives in Pumwani.

1.2 PROBLEM STATEMENT

In the sub-Saharan Africa region, community-based care and support for OVC has continued to gain popularity. This is not only due to its emphasis on providing care and support to OVC within family settings and immediate community of mostly relatives; but also for their remarkable resilience, flexibility and innovative strategies in addressing the myriad needs of the growing numbers of OVC (Foster, 2004; Phiri and Tolfree, 2005, Shenk, 2009).

Despite this record, the initiatives have been strained by the growing numbers of OVC resulting particularly from interrelated impacts of HIV/AIDS and deteriorating socio-economic situation affecting most households (Kidman and Heymann, 2009; Nyambedha, 2010). Nevertheless, many have not collapsed but instead continued to exist through designing more innovative support strategies (Foster, 2004, 2005; Omwa and Titeca, 2011). In Kenya, this is evidenced by the steady rise of community level Self-Help OVC initiatives in Pumwani Slum Area.

According to SJCC-Pumwani, a faith-based NGO working in the area, an assessment of grassroots Self-Help OVC initiatives conducted by Kindernothilfe in Pumwani in 2005 revealed that most of the OVC initiatives had the potential to address the complex needs of the growing number of OVC in the area. However, most were characterized by lack of adequate capacity to effectively provide care and support. For instance, many lacked capacity to write proposals, reports or meet financial accounting standards. This realization therefore necessitated efforts towards strengthening their capacities. Several stakeholders in childcare thus initiated programmes to enhance the capacity of the grassroots Self-Help OVC initiatives to effectively and sustainably provide OVC care and support. Despite this development, most of the initiatives have not been able to provide comprehensive care and support with most children within Pumwani Slum Area still deprived of required care and support. The efforts also do not seem sustainable.

Most studies on OVC conducted in Pumwani Slum Area have focused generally on effectiveness of methods employed by Community-Based Organizations (CBO) in providing care and support to OVC (Githinji, 2008; SJCC, 2005 in Githinji, 2008). Kanga (2008) explored community rehabilitation approaches adopted by the SJCC, an NGO working in Pumwani Slum Area. The critical concern however, is that there is apparently hardly any study that has focused on capacity strengthening of grassroots Self-Help OVC initiatives. Thus, knowledge is limited on how the support offered by the capacity-building stakeholders has influenced the ability of the OVC initiatives to effectively and sustainably provide the required care and support. This concern is further echoed in the revived and ongoing OVC care and support advocacy and awareness creation in the media initiated by a partnership of the GOK, the USAID APHIAplus, and Pathfinder International among other stakeholders.

This study therefore sought to fill this knowledge gap by examining how and the extent of capacity building support and its outcome on service delivery by the Self-Help OVC initiatives in Pumwani Slum Area. It is the hope that these grassroots organisations can be institutionalized and become sustainable.

1.3 RESEARCH QUESTIONS

Broad Research Question

How and to what extent are capacities for care and support of community-level Self-Help OVC initiatives in Pumwani Slum Area being strengthened?

Specific Research Questions

1. What is the nature and scope of community OVC care and support initiatives?
2. What types of organizations provide capacity building support to Self-Help OVC initiatives?
3. What strategies are employed in capacity building of the Self-Help OVC initiatives?
4. What is the outcome of capacity building on service delivery by the Self-Help OVC initiatives?
5. What is the community grassroots perception of change in OVC care and support?

1.4 RESEARCH OBJECTIVES

Broad Research Objective

To examine how and the extent the capacities for care and support of community-level Self-Help OVC initiatives in Pumwani are being strengthened.

Specific Objectives

1. To document the nature and scope of community OVC care and support initiatives.
2. To determine the types of organizations that provides capacity building support to Self-Help OVC initiatives.
3. To find out the strategies employed in capacity building of Self-Help OVC initiatives.

4. To establish the outcome of capacity building on service delivery by the Self-Help OVC initiatives.
5. To ascertain the community grassroots perception of change in OVC care and support.

1.5 JUSTIFICATION FOR THE STUDY

Studies have shown that the number of Orphans and Vulnerable Children (OVC) is growing rapidly due to political, social and economic challenges facing many developing countries. Kenya is not exempted. These children need care and support to protect them from factors that deprive them of their physical, social, mental, spiritual, educational, and general well-being. Effort is already being directed at strengthening the capacity of community coping mechanisms that have been found to have potential for helping OVC break the poverty cycle. This study is therefore geared towards an in-depth understanding, first on how and the extent to which the capacity for care and support of community-level Self-Help OVC initiatives are being strengthened and second, its outcome on care and support service delivery.

Secondly, even though this study is being undertaken in Pumwani Slum Area, its findings will be useful in informing policymakers and practitioners on policy design for capacity support of community-level OVC initiatives. This is especially in the wake of growing recognition of the potential of community coping mechanisms in addressing diverse local level development challenges. To respond to the rapidly growing number of OVC should be no exception.

Lastly, despite the recognition of the potential of community-based initiatives in addressing the OVC problem, little attention has been given to analysis and development of strategies to strengthen community safety nets (Foster, 2005). Findings from this study will highlight these and thus, the role of the community in this recent but fast growing disadvantaged children phenomenon in national development crisis may be properly understood. The problem, above all, should be appropriately addressed by both policymakers and practitioners.

CHAPTER TWO

LITERATURE REVIEW AND THEORY

2.1 INTRODUCTION

This chapter presents review of literature focusing on an overview of OVC, the concept of capacity building; and the nature and scope of community OVC care and support. The chapter further discusses the theoretical framework within which the study is grounded and the conceptual framework.

2.1.1. OVERVIEW OF ORPHANS AND VULNERABLE CHILDREN

Review of literature on Orphans and Vulnerable Children (OVC) indicate that definitions vary between countries (Smart, 2003; Wakhweya et al., 2008; Biemba et al. 2009). UNICEF et al. (2004) considers an orphan as a child below 18 years who has lost one or both parents through any cause. It further classifies orphans as maternal for those who have lost their mother, paternal for those who have lost their father; and double orphans for those who have lost both parents. This variation implies variations in the form of care and support for each category of orphan-hood. In the sub-Saharan Africa (SSA), literature reviewed indicates that paternal orphans are more prevalent than maternal orphans (Campbell et al. 2008; Gillespie et al., 2005; Wakhweya et al., 2008). Campbell et al., (2008) quoted in Nyambedha (2010) found that even though prevalence of orphan-hood is higher in urban areas, majority live in the rural areas. In Kenya, Lesotho, Malawi and Rwanda the same study showed that majority of orphans are paternal with double orphans as the second largest category.

A 'vulnerable child' on the other hand has remained a complex concept to define thus resulting to various definitions (Smart, 2003; Miller, 2007). According to Wakhweya et al., (2008), definition of child vulnerability is context specific since it is modified according to political, legal, cultural and economic contexts in particular settings. Nevertheless, Miller (2007) considers 'vulnerable children' as children with ill parents or caregivers, children in poverty or conflict; and children without caregivers. This definition implies that a 'vulnerable child' is a concept that covers a wide range of children both orphans and non-orphans.

The devastating impacts of HIV/AIDS epidemic, deteriorating socio-economic situation, conflicts and natural disasters in SSA has disadvantaged OVC in several ways. Although most of the OVC live with the surviving parent, grandparents, adopted caregivers, siblings and non-relatives, Miller (2007) observes that many OVC lack adequate care, undergo psychological trauma and are also affected by the socio-economic impact of parental illness or death. This has in turn subjected them to challenges such as poor health due to interconnected biological, economic and care giving reasons; high mortality rates especially at an early age; exposure to sexual health and high-risk activities; reduced access to education; and child abuse and exploitation.

In Kenya, OVC are prevalent in both urban and rural areas. However, in the urban areas most OVC are usually found in informal settlements that are characterized by high HIV/AIDS prevalence, high poverty levels and weak social welfare infrastructure, high crime rates; and child abuse and exploitation. As Casillas (2010) observed, children in slums live in overcrowded places with poor sanitation and sewage disposal facilities, are exposed to a wide variety of infections and malnutrition, and also suffer depression. High rates of child vulnerability in urban slums has consequently resulted to urban slums being classified under high priority areas by the OVC National Plan of Action alongside areas with high prevalence of drug abuse; and Arid and Semi-Arid Lands (ASAL) (MOGCSD, 2008).

2.1.2. THE CONCEPT OF CAPACITY BUILDING

In the last two decades, the term 'capacity building' has continued to gain popularity among practitioners in government and NGOs (Hartwig et al. 2008; McPhee and Bare in Vita and Flemming 2001). However, this does not imply that it is a new concept. According to Backer (2001) capacity building activities of foundations in western countries date back to the 1970s most of which were in form of philanthropic efforts.

Wing (2004) argues that the term 'capacity building' exists at a high level of abstraction and therefore takes a large area. This has in turn complicated attempts towards a conventional definition. As Hartwig et al. (2008) observes, there exist many definitions of capacity building. They conceive 'capacity building' to imply development of sustainable and robust systems.

Wing (2004) considers capacity building as increasing the ability of an organization to fulfil its mission. Backer (2001) considers the concept as efforts towards strengthening nonprofits so that they can achieve their missions. These definitions therefore imply that capacity building refers to interventions that seek to develop an organization's ability to achieve its mission sustainably.

According to Crisp et al. (2000), there are four approaches to capacity building. First is the Bottom-Up Organizational Approach. This entails development of technical expertise to plan, implement and evaluate programmes and is usually achieved through training of members of an organization to equip them with necessary skills and knowledge. The second is Top-Down Organizational Approach and it entails organizational restructuring to improve efficiency in coordination and mobilization of resources. Partnerships Approach entails development of partnerships between organizations or groups of people with limited working relationship. Finally, Community Organizing Approach that entails working with the community to transform individuals from passive recipients of services to active participants in a process of community change through raising their knowledge awareness and skills.

The main areas usually targeted for capacity building in non-profit organization include: administration, finance, human resources and facilities (Backer, 2001). However, according to UNDP, the priority areas for capacity building especially in HIV/AIDS-related organizations include: Leadership development; policy research and advocacy; information access, use and dissemination; building alliances, coalitions and networks; and financial sustainability (Phiri et al. 2001). Organizations offering capacity building support range from government agencies, foundations, non-profit organizations, service providers (consultants), professional associations and intermediary organizations. However, intermediary organizations have been recognized for playing a crucial strategic role in the development and expansion of HIV/AIDS programs of CBO and NGOs (Phiri et al. 2001; IHA, 2002).

Capacity building involves three main types of activities. As Backer (2001) points out, the first activity is assessment of both inside the organization and the community environment. However, he argues that the latter should precede internal assessment in order to understand the organizations needs, assets and readiness to change. The second main activity is intervention

which can be categorised into three types: management consultation which focuses on process issues like building strategic plans; training of staff to learn specific skills to run the organization; and technical assistance which entails site-based support. Lastly, direct financial support is the other main capacity building activity and comprise core operating support which is general funding not earmarked for any specific purpose; specific grants to fund special projects; and working capital which are usually loans with favourable repayment terms to meet both short and long-term financial needs.

IHA (2002) pointed out several capacity support strategies for most community OVC initiatives in East and Southern Africa. They include: training in key programmatic areas such as organisational development and financial management; facilitation of exchange visits for participants to learn from each other and share experiences; and support visits that entail offering advice, practical assistance, mentoring, monitoring, encouragement and constructive criticism. Other strategies comprise networking with related initiatives and like-minded partners through joint meetings or sharing documentation; and monitoring and evaluation. In a study in Ghana, Opare (2007) identified leadership development, networking with both local and external organizations, and registration with public agency as the most sustainable capacity support strategies for community based organizations.

Phiri et al. (2001) observed that many capacity building activities especially in HIV/AIDS-related programmes emphasize establishment and improvement of programmes and activities rather than the organization. This is mainly because few NGOs have skills to assess organizational capacity of other organizations. This implies that capacity building should not only focus on its programmes and activities but also the organization itself. Wing (2004) concludes that organizations are organic combination of both people and systems and argues that capacity building should focus on the two dimensions.

2.1.3. COMMUNITY CARE AND SUPPORT FOR OVC.

The problem of OVC in the sub-Saharan Africa has largely been attributed to the impact of HIV and AIDS pandemic on the socio-economic wellbeing of most households. To address this situation, community-based responses have been widely recognized as crucial especially in the

provision of care and support for escalating number OVC (Ninan and Delion, 2008). However, literature reviewed on community OVC care and support indicates that most of the responses to OVC situation are incorporated in community-based responses to HIV/AIDS (Attawell, 2010; Birdsall and Kelly, 2005). Most of these initiatives are also hardly known beyond their settings (Phiri et al., 2001; Ninan and Delion, 2008; Foster et al., 2008). Understanding the nature and scope of these initiatives is therefore important especially in strengthening their capacity.

In sub-Saharan Africa, OVC receive care and support from a broad spectrum of community organizations (Birdsall and Kelly, 2005; Mathambo and Richter, 2007). According to Attawell (2010), most of these responses can be generally grouped into Civil Society Organizations (CSO) and Government agencies. CSO is a wider group that comprise Community-Based Organization (CBO), Non-Governmental Organizations (NGO); Faith-Based Organizations (FBO) and indigenous community initiatives such as mutual support groups, neighbourhood association, saving club, informal counselling groups, traditional support mechanisms, faith-based congregations and self help groups. The Government constitutes government staff, institutions and departments.

Compared to CBO, FBO, NGO and government agencies that are more formalised, the indigenous community initiatives are less formalised and usually built on traditional systems. Thus they are considered more efficient and sustainable in dealing with complex issues of children affected by HIV and AIDS (Mathambo and Richter, 2007). Since they are mostly initiated from within the community, their members are strategically positioned to understand severely affected households and the appropriate assistance required (Ninan and Delion, 2008).

Most indigenous OVC initiatives result from small groups of concerned individual such as extended families, neighbours or groups out to address a need within the community (Phiri et al., 2001; Foster, 2002). However, some emerge as a result of seeing and adapting to OVC activities of other communities while others result from community mobilisation efforts of entities outside the community (IHA, 2002). They also operate on the principles of reciprocity, consensus-based decision making, volunteerism, local leadership, innovation; and self-reliance in resource mobilization (Foster, 2002; Ninan and Delion, 2008). However, IHA (2002) points out that

whereas most of the support comes from local stakeholders such as churches, business people, traditional and political leaders, some of the support such as technical assistance, advice on programme needs and financial support are usually external.

Community OVC initiatives offer a wide range of services. Attawell et al., (2010) gives five categories of the range of activities and services provided. They include: prevention, treatment, care and support, impact mitigation, and advocacy and networking. However, as noted in IHA (2002), the range of services an initiative provides depends on preferences and motivation of leaders and volunteers of the initiatives, local needs, local resources, and whether the initiative is located in an urban, peri-urban or rural setting.

Nevertheless, the specific services include: Support to carers including extended families looking after orphaned children; home visits to OVC households; youth-to-youth counselling and support; OVC support integrated into home-based care for the sick; gardening for nutrition and social integration of OVC; material support provided by neighbours and other community members; and spiritual support and counselling. Other services comprise income-generating projects; provision of school fees, uniforms and school supplies; establishment of community schools, life skills education including HIV/AIDS/STI information and awareness; referral services to public sector agencies (social welfare and health); advocating on behalf of children (on issues of school fees, rent, legal issues, sexual and physical exploitation, and involvement of the police); and assistance with 'succession planning' – such as memory books, wills and inheritance; and provision of day care centres (IHA, 2002; Foster, 2004; Kidman and Heymann, 2009).

Community OVC responses play both leading and supporting role depending on aspects considered important. Attawell (2010) argues that the responses play the leading role where such aspects as face-to-face interaction, knowledge of the community, and peer influence and support are considered important. Supportive role is played where the involvement of the government and other agencies is emphasized.

Despite the potential of community OVC initiatives, they cannot be seen as alternative to the state because of various limitations. These include: resource constraints, limited outreach,

inadequate consultation and engagement of community members, and dependency on external funding for sustainability. In addition, the initiatives are characterized by dependency on mostly women volunteers and inadequate representation of marginalized groups especially in heterogeneous communities (Birdsall and Kelly 2005; Mathambo and Richter, 2007; Ninan and Delion, 2008).

2.1.4. STUDIES ON COMMUNITY OVC INITIATIVES IN PUMWANI.

Studies on community care and support for OVC in Pumwani Slum Area have hardly explored the link between capacity building and the grassroots Self-Help OVC initiatives. This is despite indications of capacity building support to the initiatives.

In a study conducted in the area, Githinji (2008) evaluates the effectiveness of the methods employed by CBOs in providing OVC care and support. Kanga (2008) explores the rehabilitation approaches adopted by SJCC; an NGO in Pumwani Slum Area. Both studies neither discussed the role played by local Self-Help OVC initiatives in OVC care and support nor how they are being supported to enhance capacity for service delivery. Therefore, information on capacity building of the Self-Help OVC initiatives in Pumwani Slum area and the extent to which the support has influenced service delivery remain limited. Examining this relationship and filling this knowledge gap hence became the concern of this study.

2.2. THEORETICAL FRAMEWORK

This study employed social systems and institutions theories as its theoretical underpinning. Quoted in Appelbaum (1970) Talcott Parson's conceives the society as a social system in a larger system within which exist other sub-systems that are interrelated and interdependent. This implies that change in any one of the sub-systems triggers change in other sub-systems ultimately effecting change in the whole system. Such changes however take a longer time span to occur which Alila (1978) notes that is a characteristic of this perspective.

According to Parsons, every social system is confronted by four functional problems if they are to remain stable and functioning: adaptation, goal attainment, integration and pattern maintenance. He further argues that addressing these challenges entails plurality of individual

actors interacting within a defined setting. Dill (1958) in Thompson (1967:27) refers to this setting as the 'Task Environment' which comprises those parts of the environment relevant to goal setting and goal attainment.

The task environment within which an organization operates comprises endogenous and exogenous elements. According to Thompson (1967), endogenous elements are elements involved in organizational action when it conforms to an open system logic that exposes it to environmental influences. Such elements include: constraints which are the fixed conditions the organization must adapt to; contingencies which refers to factors over which the organization has no control; and lastly, variables which entail factors that can be controlled by the organization.

Exogenous elements are considered factors that cause environmental fluctuation that penetrate the organization thus requiring the technical core to alter its activities. As noted by Alila (1978), these factors can either be remote to the organization such as world market prices or even closer such as government's foreign aid policies.

Institutions are constraints devised by humans to structure political, economic and social interaction (North, 1991). They consist of three dimensions: informal constraints that include sanctions, taboos, customs, traditions and codes of conduct; formal constraints such as constitution, laws and property rights; and enforcement that entails cost associated with imperfect enforcement (Slantchev, 2001). However, Alila (2012) argues that there is no a clear distinction between formal and informal institutions.

North (1991) argues that institutions are structured to create order and reduce uncertainty in human exchange through lowering transaction and production costs to enable actors realize potential gains from the interactions. Slantchev (2001) however observes that the stable structure of human exchange institutions create is not necessarily efficient. This is because institutions are designed by people with different bargaining powers and are not necessarily created to be socially efficient. They also serve the interest of actors with the bargaining power to devise new rules. This implies that patterns of interaction between institutions and organization may therefore yield mixed results.

In this study, the OVC initiative is considered an institution in the larger system within which are other institutions such as government agencies, NGOs, Federations, Trusts, FBOs, CBO/SHG, private sector, and community members among others. These institutions are interrelated and interdependent in the setting and attainment of the overall goal of comprehensive and sustainable OVC care and support. Realization of this goal however depends on the patterns of interaction between the institutions within the task environment. The patterns of interaction between capacity support agencies and community OVC initiatives in Pumwani Slum Area is that of actors with different bargaining power maximizing objectives based on the opportunities created by the institutional structure. Therefore, depending on an actor's supreme objective, the patterns of interaction may result to mixed results in the outcome of capacity support. This could be an improvement, stagnation or decline in the ability of the OVC initiatives to provide comprehensive and sustainable care and support.

2.3. CONCEPTUAL FRAMEWORK

In this study the dependent variable is the community-based OVC organization operationalized as Self-Help OVC initiative in Pumwani Slum Area. Capacity building is the independent variable operationalized as support meant to improve the capacity of the OVC initiative. They include: training, resource support (financial and material) exchange visits, on-site support visits, networking, partnership, and monitoring and evaluation.

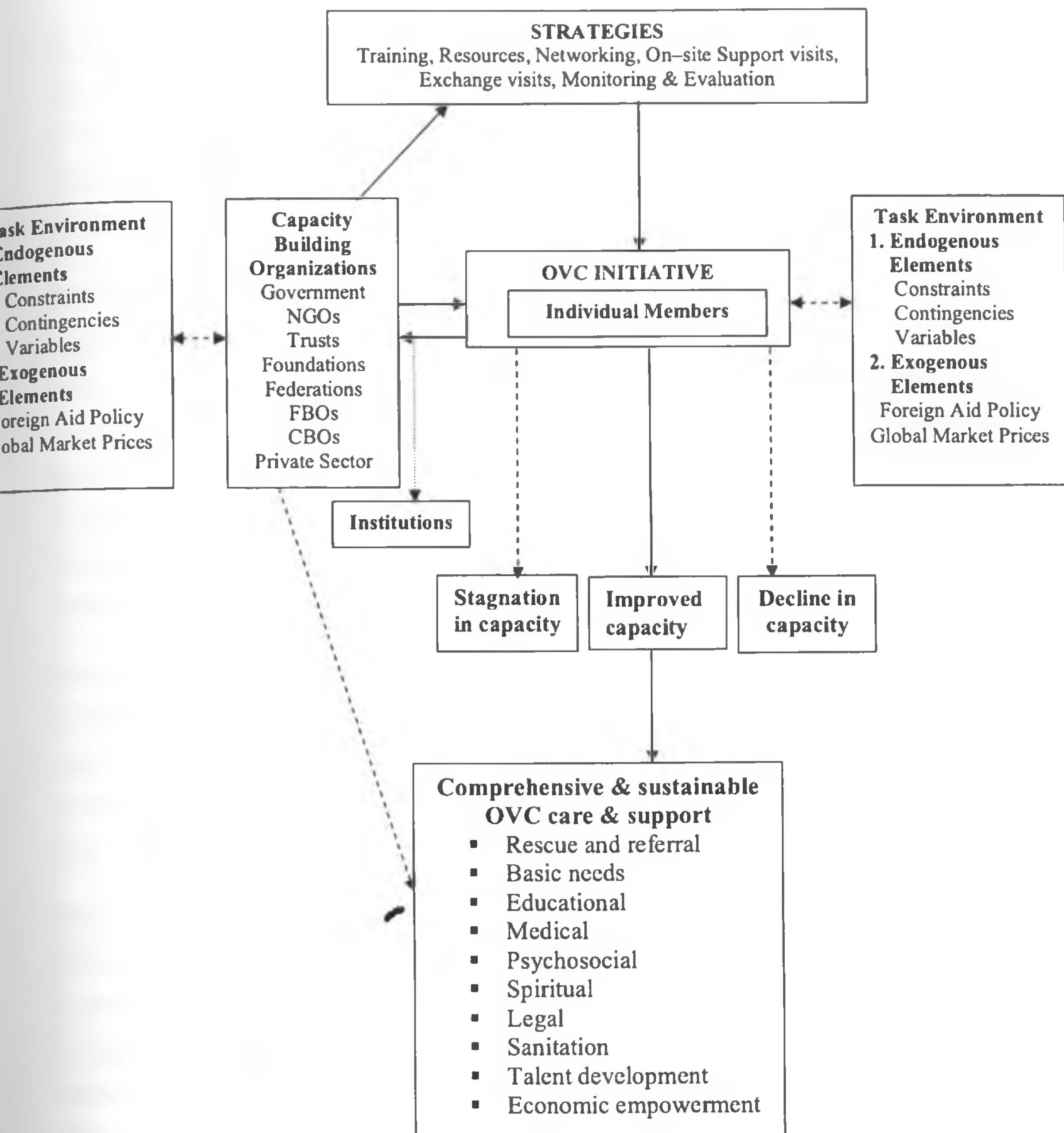
This conceptual framework is based on the assumption that OVC initiatives in Pumwani Slum Area receive capacity strengthening support from multiple capacity building organizations. The support is envisaged to enhance the attainment of the overall goal of providing comprehensive and sustainable care and support for the OVC. This study noted that the capacity building takes place at two levels; individual level comprising staff of the Self-Help OVC initiatives and at the organizational level.

However, the effectiveness of capacity building support depends first, on how the actors cope with the elements in the task environment and second, the structure of interaction institutions create between the capacity building agencies and the OVC initiatives. The endogenous elements in the task environment comprise constraints such as socio-economic factors, population

dynamics, settlement patterns and attitude towards OVC; contingencies such as political forces and government OVC policies; and variables such as resources secured by the organization. Exogenous elements on the other hand comprise factors that cause variation in the resources available to the OVC organization such as government Aid policies or global market dynamics.

In light of this argument, the nature of the existing structures of interactions within each organization and between the capacity building organizations and the OVC initiatives in Pumwani Slum Area influences the ability of the OVC initiatives to deal with their task environment. Stable and efficient structures of interaction result to success in coping with task environment and therefore improved capacity to service delivery by the OVC initiatives. This ultimately leads to comprehensive and sustainable OVC care and support. On the flipside however, unstable and inefficient structures of interaction may cause inability of the OVC initiatives to cope with their task environment thereby resulting to stagnation or decline in capacity to improve service delivery.

Figure.1: Conceptual Framework



NB: Author's conceptualization

CHAPTER THREE

STUDY SITE AND METHODOLOGY

This chapter presents the study site and methodology. The first section describes Pumwani Slum Area, which was the research site. This is followed by an overview of the research design in the second section. The third section discusses the unit of analysis, population and sampling techniques. Thereafter, data sources and collection methods is presented in the fourth section. Section five describes data processing and analysis. The last section presents the field challenges.

3.1. DESCRIPTION OF STUDY SITE

Pumwani Slum Area is an informal settlement situated within Pumwani Division, Kamukunji district in Nairobi County. The slum area stretches across Pumwani and Eastleigh South Locations. The national OVC policy classifies informal settlements as high priority areas (MOGCSD, 2008). The researcher's rationale for selecting the study site was based on knowledge of the area, high level of child vulnerability, and availability of grassroots initiatives that provide OVC care and support. In addition, the area hosts several organizations that collaborate with community OVC initiatives.

Pumwani Division has a population of 261,855, (136, 920 Male and 124,855 Female), 75,555 households with a population density of 21,605 (GOK, 2010). The division has five locations namely: Bahati, Eastleigh North, Eastleigh South, Kamukunji and Pumwani. Pumwani has two sub-locations; Gorofani/Bondeni and Majengo. Eastleigh South Locations also has two sub-locations namely Kiambiu and Gitwamba.

Pumwani Slum Area has a size of about 123.4 km^2 with an average household size of eight persons (Githinji, 2008). The area is composed of six sections popularly referred to as *vijiji* (villages). They include: Majengo (*largest*) Kiambiu/City Carton (2nd largest), Kitui, Kanuku, Kinyago, and Motherland (*smallest*). Within the neighbourhood is the Gikomba Market, Machakos Country Bus Station and estates such as Eastleigh, Kariokor, Buruburu, Bahati, Uhuru, Shauri Moyo, Ziwani, Starehe and Kimathi (Nairobi Inventory, (n.d).

The population in the area is multi-ethnic and multicultural with majority being Christians of various denominations followed by members of the Muslim faith. The households in the area are mostly headed by women and children. Majority of the residents are low income earners whose main economic activities include: casual labour in the Industrial Area; household labour in the neighbouring estates; hawkers; water and food vendors; and loaders at the Gikomba Market. Many also operate small scale businesses at the Gikomba market while some operate small shops within the slum villages. The slum area is also characterized by high levels of poverty, high unemployment rates, inadequate shelter and infrastructure services, high incidences of alcoholism and substance abuse, high crime rates and high incidences of commercial sex workers.

Initial communication with the Children's Office and AAC representatives established that Pumwani Slum Area hosts several Non-Profit Organizations (NPOs) that implement childcare programmes. They include: St. John's Community Centre, the Undugu Society of Kenya, Slums Information Dissemination & Recreation Centre (SIDAREC), Association for the Physically Disabled of Kenya (APDK), Kenya Network for Women Living with HIV/AIDS (KENWA), and Mother and Child with HIV/AIDS Support Organization (MOCASO). Other community-based organizations include: Kamukunji Community-Based Organization Network (KCBONET), and Kamukunji Human Rights Defenders (KHRD) among others.

The NPOs collaborate with various government ministries such as the Ministry of Gender, Children and Social Development (MOGCSD); Ministry of Provincial Administration and Internal Security; Ministries of Public Health and Medical Services; Ministry of Education; Ministry of Youth Affairs and Sports (MOYAS); Ministry of Special Programmes; and Ministry of Local Government among others. Collaborations extend to such agencies as the National Aids Control Council (NACC).

The slum area has three public primary schools and three non-formal basic education schools. Private-owned early childhood centres and primary schools are also evident across the slum area. The most notable child care activities in the area include: day care centres, home-based care support, outreach/school feeding, formal and non-formal basic educational assistance (Early

childhood, primary and secondary), medical assistance and referrals, legal assistance, and income generating activities. Other notable activities comprise talent development through sports and creative arts, spiritual and psychosocial support, and sensitization and awareness creation on HIV/AIDS, Child Rights, Reproductive Health Education and environment among others.

3.2. RESEARCH DESIGN

Punch (1998) describes a research design as the overall plan for a research study outlining the strategy, conceptual framework; and subjects and content to be studied. It also outlines data collection instruments and analysis of empirical materials. This study used a case study strategy and adopted mainly qualitative research approach. Yin (2003) considers a case study as an empirical investigation of a contemporary phenomenon in its natural setting especially where there is no clear boundary between the phenomenon and the context; and where multiple sources of evidence are used. Punch (1998) points out that a case could be an individual, small group, an organization, community or a nation. This study focused on multiple cases of grassroots Self-Help OVC initiatives located within Pumwani Slum Area, Nairobi.

Creswell (2009) argues that qualitative research approach is preferred when a complex and detailed understanding of an issue is required and which can only be established by talking to people within their contexts. The nature of research questions on the cases to be studied therefore justified the use of the approach as it sought to obtain detailed information from stakeholders in OVC care and support to address the research objectives.

The study conducted Key Informant interviews first to gather information on care and support for OVC within the slum area and to obtain views on change and dynamics in OVC care and support arrangements. This was followed by in-depth interviews with members of the Self-Help OVC initiatives. This order was designed to facilitate detailed interviews with members of the OVC initiatives after ascertaining the key issues and problem areas. FGDs were conducted last to corroborate information obtained and gather community perception on change manifest in OVC care and support.

3.3. UNIT OF ANALYSIS, POPULATION AND SAMPLING TECHNIQUES

3.3.1. Unit of Analysis

The Self-Help OVC initiative is the main unit of analysis in this study. The analysis was conducted at two levels; organization and individual members of the initiatives. Justification for these levels was the realization that capacity building of an organization occurs and is best understood at both the levels.

3.3.2. Population and Sampling Techniques

At the organization level, the study targeted 15 active and registered community-based Self-Help OVC initiatives in Pumwani Slum Area, Nairobi. In addition, the initiatives were particularly those that considered care and support for OVC as a core element.

The study initially conducted reconnaissance meetings with the Children's Department-Kamukunji District and the Area Advisory Council (AAC) representatives from each of the six sections of Pumwani Slum Area popularly referred to as, *vijiji*[1]. These aimed at ascertaining the total number of community level Self-Help OVC initiatives and then focus on those that were active. This was guided by a set of open-ended questions on the history of establishment, active status, scope of activities and partnership with organizations that provide capacity building support.

Snowballing method was used to identify a sampling frame of 15 initiatives. Berg (2009) describes snowballing as a procedure that entails identification of several units that display particular attributes of interest to the researcher for interview and the same units identify others with the similar attributes. The rationale for the choice of the method was due to lack of a sampling frame particular of initiatives with OVC care and support as a core objective. Majengo, the largest section of the slum area was the start point before snowballing.

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[1] Term commonly used to refer to the slum sections in Pumwani Slum Area

The study used maximum variation sampling strategy to purposively select the six Self-Help OVC initiatives for in-depth analysis. The strategy entails purposive and non- random selection of a set of cases that exhibit maximal differences on the variables of interest (Mugenda, 2008). Punch (1998) points out that the strategy enables the researcher to capture possible variations among the cases being studied. Berg (2009) describes purposive sampling as a technique that allows the investigator to use their special knowledge about some group to select cases that represent a population. The study specifically targeted independent initiatives considered the most active across the slum area and that had been in existence for period not less than two years. Active status was emphasized as it enabled the researcher to get initiatives that consistently received capacity building support. The study considered two years period as adequate to establish change resulting from capacity building support. This yielded two categories of the OVC initiatives; three youth-led and three non-youth-led. In the latter category, two initiatives targeted OVC with disability.

At individual level, the study targeted 122 members from the six sampled OVC initiatives out of which 18 members (14%) were purposively sampled for in-depth interview. Three respondents were selected from each OVC initiative as units of observation for capacity building at the organization level. They included one executive member and two non-executive members. The six executive members selected provided information on salient organizational characteristics such the history of establishment for respective initiatives.

The study considered several factors during selection of respondents. These included: duration of active membership in the initiative, the number of years the member had been in OVC-related work, knowledge on capacity building support within the initiative, and finally their availability for interview. The individuals purposively selected for interview were those that had more than two years experience in general OVC-related work and at least a year of active membership in respective initiative. The criterion was aimed at to minimize bias that would come with selection.

The study purposively selected 17 Key Informants that the researcher considered key stakeholders in OVC care and support in Pumwani Slum Area. This was arrived at based on the information obtained from the Children's Department and AAC representatives during the

reconnaissance meetings. Additionally, the sample size was also justified based on the researcher's judgement that the Key Informants selected had the information required to enable an in-depth understanding of the context within which the capacity for the OVC initiatives in the slum area was strengthened. The Key Informants included: the District Children Officer – Kamukunji, three Volunteer Children Officers (VCOs) working at grassroots level, the District Social Development Officer-Kamukunji, four Programme Officers from OVC-related agencies within Pumwani, one head teacher from public primary school, two head teachers from non-formal schools within Pumwani Slum Area, one provincial administration official, two OVC beneficiaries, one women groups representative, and one youth groups representative.

Participants in the FGDs were purposively selected. Bryman (2008) argues that a range of 6 to 8 discussants is appropriate as it is easy to manage and to sustain an effective discussion. The FGDs discussants comprised four groups: six OVC beneficiaries (3 girls & 3 boys) aged 11-17 years, seven parents and/or caregivers (3 male & 4 female) whose children were beneficiaries of the care and support services by the Self-Help OVC initiatives, eight community members proposed by the six OVC care and support initiatives, and six AAC members each representing a slum section.

3.4. DATA SOURCES AND COLLECTION METHODS

Field data collection began on 27th June, 2012 and was completed on 28th August, 2012. The timing was appropriate as it coincided with school holidays and therefore possible to interact with most OVC. It was also the time most OVC care and support activities become visible. The study collected both primary and secondary data.

3.4.1. Data Sources

Both Primary and secondary data was collected. Primary data was obtained from four main sources. These included: the 18 members from the six sampled Self-Help OVC initiatives, Key Informants (17), participants (27) in the four FGDs, and the study site.

Secondary data was collected earlier and continued for the entire period of the research. Sources included both published and unpublished relevant materials. This was aimed at to build the

study's background, and the theoretical and empirical basis for the study. Published materials included: books, government reports, electronic academic journals, websites articles, United Nations articles and reports. Unpublished data sources such as assessment reports, theses, policy briefs, working papers, and discussion papers were also reviewed. Theoretical literature reviewed in this regard entailed overview on OVC, the concept of capacity building, and community care and support for OVC in the sub-Saharan Africa. This also included review of Social Systems and Institutions theories that underpinned the study. Review of empirical literature on capacity building and grassroots OVC care and support initiatives in Pumwani Slum Area informed the knowledge gap the study sought to fill.

3.4.2. Data Collection Methods

Key Informant Interviews (KII), In-depth Interviews (II), FGDs and non-controlled direct observation were the four main methods of data collection. The interview guides for Key Informant Interviews, In-depth Interviews and FGDs were all in English and translated to Swahili whenever deemed necessary. The researcher's fluency in both English and *Sheng*[2] enabled the researcher to conduct the interviews with ease. This was further enhanced by the researcher's experience as English-Swahili translator and as a skilled interviewer in both qualitative and quantitative research approaches.

The researcher used focused interview technique to obtain information from the Key Informants and members of the Self-Help OVC initiatives. According to Yin (2003), the technique entails an open-ended interview with a respondent for about an hour in which the discussion assumes a conversational manner but follows a certain set of questions. The respondent's explanations were recorded against corresponding questions in note pads designed in a two-column Word table interspersed with rows. This helped the researcher to focus on the information relevant to the study. The researcher complemented the face-to-face interviews with telephone calls especially for additional information and to clarify issues. Non-controlled direct observation method was used to verify information obtained from the respondents.

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[2]Localized swahili commonly used in Pumwani Slum Area

Respondents from the six sampled OVC initiatives mainly provided information on the nature and scope of Self-Help OVC initiatives; the agencies that provide capacity building support and the strategies employed; and outcome of enhanced capacity on service delivery, and change manifest in OVC care and support. The information was collected using the In-depth Interview guide administered by the researcher.

The Key Informant interviews were conducted using a Key Informant Interview guide. Discussion questions were developed so as to provide answers to the study's research questions. The questions asked varied depending on the type of Key Informant. Information obtained from the Key Informants mainly included: the state of child vulnerability in Pumwani Slum Area, history and role in OVC care and support in the area, common reactions and responses to OVC care and support, and lastly, views on change and dynamics in OVC care and support arrangements.

A total of four FGDs were conducted guided by an FGD Interview guide and moderated by the researcher. Kothari (2004) argues that such a discussion enables the investigator to understand what a specific set of populace perceive and feel about a particular issue. The objective was to obtain information on the community role in OVC care and support; state of child vulnerability, and community perceptions on change manifest in OVC care and support in Pumwani Slum Area. The first FGD was with OVC beneficiaries. This was followed by another with parents and/or caregivers. The third FDG was with eight general community members and finally concluded with FGD for AAC members.

A few probe questions were used during the discussions to follow up on participants' opinions and explanations, to clarify questions not well understood by the participants, and to bring on participants who refrained from contributing to the discussions. The information obtained was used to cross-check and complement information obtained from the Self-Help OVC initiatives and the Key Informants.

Non-controlled direct observation method enabled the researcher to corroborate information obtained from various respondents. This method entails a less systematic and flexible observation that takes place in a natural setting in which the researcher blends with the

background of his subjects and observes them in order to get the spontaneous depiction of their life (Kothari, 2004; Balso and Lewis, 2001). The researcher recorded the observations on note pads as soon as it was possible to avoid unintended misrepresentation. The information observed included: the slum environment; common forms of livelihoods, workspaces and projects by the OVC initiatives; and the OVC beneficiaries. This method was also used to capture non-verbal communication of the respondents to enrich the information obtained during interviews.

3.5. DATA PROCESSING AND ANALYSIS

This study adopted reliance on theoretical propositions as its analytic strategy. According to Yin (2003), this strategy enables the researcher to focus attention on data considered relevant to their study and disregard other data. Thematic analysis technique was used to analyse data from In-depth interviews, Key Informants and FGDs. Thematic analysis is a model of narrative analysis in which emphasis is more on what was said rather than how it was said (Bryman, 2004). This was guided mainly by La Pelle (2004) approach to qualitative data analysis using Microsoft Word application and Yin (2003) approach to multiple-case studies.

In this study, processing data for analysis begun at data collection phase during which raw data was recorded directly in English in note pads designed in a two-column Word tables. The first column contained the guide questions and corresponding respondents' utterances in the second column. In some cases, the notes had to be re-written to facilitate data entry. Information obtained at each stage informed subsequent interviews and helped to corroborate information already acquired.

Analysis of the data collected was an on-going process. This involved several steps. First, the raw data collected was transcribed into a four-column Word data table. The four columns captured the respondent and/or organizational identification codes, theme code, participant's response, and the sequence respectively. For in-depth interviews, the researcher merged the respondent's and the organization's ID and also incorporated face sheet data such as gender of the respondent and designation to maintain the four columns. For Key Informants, only gender was incorporated in the ID. Each participant utterance was entered in a row of the table and was interspersed with moderator's questions in separate rows. The moderator questions were in bold

to make them visible. The table format enabled the researcher to move directly into using word for analysis.

The second step was development of a theme codebook. As Bryman (2004) points out, coding involves reviewing raw data and giving labels to parts that are of theoretical importance. This entailed reading raw data in the data tables and noting recurring themes and those that were significant to the study. The researcher adopted open coding type and used numerical codes to label the theme categories. Punch (1998) notes that this type of coding is associated with examining the data closely to identify conceptual categories and theoretical possibilities embedded within the data. The researcher used up to three levels codebook to capture the major themes and minor themes beneath where possible.

The third step was to do thematic coding in the theme code column of the four-column data table. The moderator question was given the highest level theme code to ensure that it was preceded by the corresponding responses upon sorting. Decimal numbers were used for both theme code and sequence column to allow for further segmentation where necessary. In cases where the same utterance contained more than one major theme, a new row was inserted using the Insert Row function and the same utterance inserted and given an appropriate code. However, sub-themes within a major theme were inserted into different rows.

The fourth step was sorting the data by desired theme code categories to establish emerging patterns. Sorting was done using the Word table/Sort function. The numeric theme code column was used as the primary key; respondents ID as the secondary key; and finally, the sequence number as the tertiary key. The sequence number was the lowest level sort key to ensure a chronological order of the sorted data. The study preferred sorting by ascending so that it presents the major theme and minor them in a chronological order.

However, in some instances, the researcher used the direct counting method for instances of themes that emerged from the data set. This was used especially with some forms of data that were unsuitable for the coding method. This was done by tallying up the number of instances within a theme category and establishing the number of informants that generated the instances.

The counts were tabulated accordingly from which tables, charts and graphs were later designed to complement the explanations.

The next step after sorting was code validation and correction. This entailed the researcher reading through the text segments for each code to ascertain correctness in coding of the data set. The errors noted were corrected appropriately and the data-table re-sorted to reflect the changes.

Finally, the relationship between the various emerging theme categories was sought. At this stage, brief individual case reports were prepared and then cross-case conclusions drawn from the data set. Interpretations and discussions were then presented as sub-headings under the study's predetermined broad themes. They included: nature and scope of community OVC initiatives; Capacity building agencies; the strategies employed in capacity building; outcome of enhanced capacity on service delivery; and communal grassroots perception on change in OVC care and support. Quotations from respondents were also imbedded within the passages. This was aimed at to create a comprehensive picture of their collective experience as well as understanding the context of the utterance.

3.6. FIELD CHALLENGES

The researcher experienced several challenges during fieldwork. First, frequent changes in the availability of respondents compounded by delays in getting approvals for interviews from organizations prolonged the duration of data collection. The researcher however exercised patience and reached all the respondents sampled.

Second, in few instances the study had to rely on members of the initiatives who were available and willing to be interviewed. Some of respondents turned to have limited information on various aspects of their organization. In this regard, the researcher therefore relied mostly on information obtained from the executive members. On the same line, some respondents were impatient during the interviews. The researcher acknowledged time limitation but kindly explained the importance of completing the interview.

Finally, availability of the field contact personnel was inconsistent. This was particularly attributed to frequent rescheduling of interviews on the request of the respondents. On such

occasions, the researcher proceeded with the data collection but when deemed necessary called back on the respondents to gather more information.

In summary, this chapter described the study site and the methodology adopted for the study. The methodology included the research design; unit of analysis, population and sampling; data sources and collection methods; data processing and analysis; and challenges experienced during fieldwork. The next chapter presents the study findings.

CHAPTER FOUR

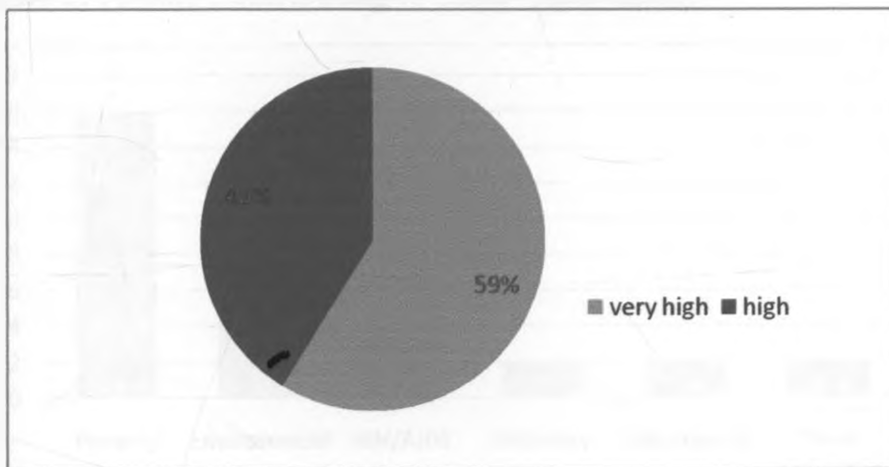
CHILD VULNERABILITY AND NATURE OF OVC CARE AND SUPPORT

This chapter discusses the nature and scope of grassroots OVC care and support initiatives in Pumwani Slum Area. The first section presents an overview of child vulnerability and the contributing factors, descriptions of OVC in Pumwani slum area, and a highlight of the stakeholders in OVC care and support. The second section discusses the features of the Self-Help OVC initiatives.

4.1. CHILD VULNERABILITY IN PUMWANI SLUM AREA

Key informants interviewed and the participants in FGDs described child vulnerability in the slum area as highly undesirable. Findings established that out of the 17 Key Informants interviewed, ten (59%) considered child vulnerability as very high while seven (41%) described it as high. None considered the situation good or fair as shown in *Figure 2.*

Figure 2: Child Vulnerability in Pumwani Slum Area



Source: Field data (2012)

Participants in the focus group discussions also expressed similar views on child vulnerability. This was illustrated by a discussant in the FGD with AAC members that said, *"Child vulnerability is very high and the community cannot sit back because the situation in the slums is not safe for children..."* FG2F.

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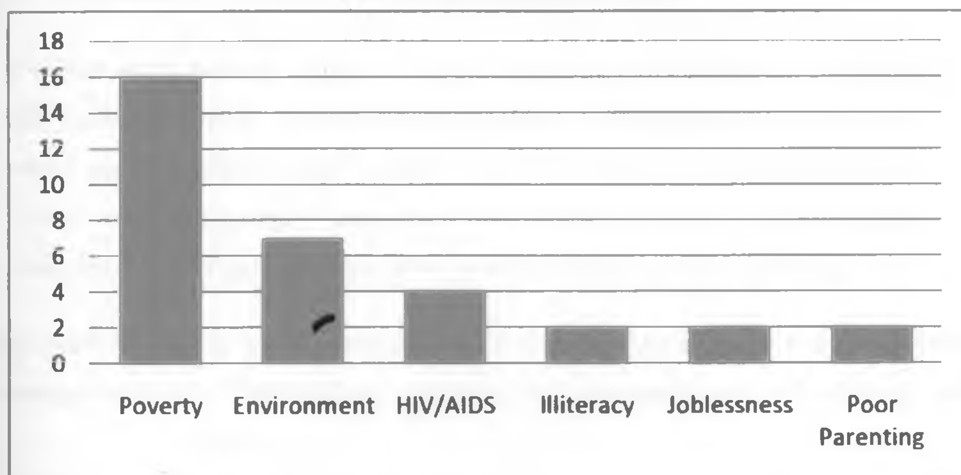
This finding confirmed the study's assumptions that child vulnerability in the slum area was generally high. It also reaffirmed the MOGCSD (2010) categorization of informal settlements as high priority areas for OVC care and support programmes. The challenge for capacity building agencies therefore would be designing strategies to address factors that aggravate the welfare of children in the area. These factors are discussed in the next section.

4.1.2. FACTORS RESPONSIBLE FOR CHILD VULNERABILITY

The study established the factors responsible for child vulnerability indicated as shown in *Figure 3*. In interviews with Key Informants (17), poverty emerged with the highest frequency (16/17). This was attributed to low levels of income among majority of slum residents that aggravated the welfare of the children. A Key Informant interviewed said:

> *High poverty level has worsened the situation more so for single parent families most of who earn very little income from casual jobs which hardly give them time to care for their children.* K6M.

Figure 3: Factors Contributing to Child Vulnerability



Source: Field data (2012)

Poverty was found to be a major factor that exposed children to abuse. This finding echoed findings in postulated in literature (UNICEF, 2006, 2008; Foster et al., 2008). Most respondents conceived poverty as the inability to access the minimal income to provide for basic needs such as food, clothing and shelter. As observed by a key informant, some caregivers used children to

complement household income. She explained, *"Some parents use children to do illegal business especially scrap metal business and allow them be employed in selling second-hand clothes."* K8F.

The slum environment had the second highest frequency. Among the 17 Key Informants interviewed, seven (7) attributed the alarming situation to the environment within which children reside. A Key Informant from the Children's Department explained:

> *The informal settlements children live in makes them more vulnerable...high rates of criminal activities, tiny small rooms, cosmopolitan nature of the business community around like the Gikomba market*[3] and the *Machakos Country Bus Station*[4] *among others.* K1F.

Other depictions of the environment were overcrowding, high incidences of drug and substance abuse, and commercial sex activities. These were recurring responses across four Key Informants and were corroborated by discussants in all the focus group discussions. The researcher also confirmed the descriptions of the slum environment through observation during fieldwork activities. For instance, the researcher witnessed in Majengo area:

> *It is late in the evening, about six and the congested neighbourhood is booming with activities. Busaa*[5] *is seen brewed and drunk in the open next to households where young children aged between 4 and 10 years are seen playing. Fifty metres away are brothels associated with commercial sex workers. Outside some are depicted ogling at would-be clients* (Observed on July 4'2012).

High crime rate in the area has exposed children to criminal activities due to difficult household socio-economic situation. This has been worsened by the rampant drug and substance abuse. A

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[3] Largest public open air market in Nairobi

[4] Largest country bus terminus in Nairobi

5 Traditional beer brewed from maize flour and yeast.

beneficiary (OVC) pointed out that drug and substance abuse by parents and caregivers at the household level significantly jeopardized the welfare of the child. This is because it drives them into child labour. He said, *"High rate of drug abuse especially by parents and caregivers has forced children to engage in petty trade especially selling plastic and scrap metal."* K14M.

The study findings established HIV/AIDS as another major factor that contributed to the high levels of child vulnerability. This was mentioned by 4/17 Key Informants interviewed. This revelation confirmed findings postulated in literature (UNICEF, 2006, 2008; Foster et al., 2008). HIV/AIDS contribution to child vulnerability was explained by among other factors interlinks between high poverty levels, high incidences of commercial sex activities and the cosmopolitan nature of the business community in the area. High poverty level in the households was reported to drive female residents into commercial sex work, an activity that in turn thrived in the cosmopolitan business community nearby.

Findings showed that illiteracy contributed to child vulnerability in Pumwani Slum Area. This factor had a frequency of two from 17 Key Informants interviews. Illiteracy occasioned by low education level among most parents/caregivers was a recurring explanation for the gaps in child protection. Respondents observed that some parents/caregivers were not well acquainted with child rights and protection issues. Consequently, they became gullible and therefore vulnerable to those violating the rights of the child. One Key Informant observed, *"...most parents and caregivers are ignorant on the need to protect children most of whom have been exposed to sexual abuse and child labour with their consent."* K7M.

Poor parenting emerged as another factor responsible for the high child vulnerability. This was mentioned by two Key Informants. The respondents observed that some parents were irresponsible and hardly monitored their children. This in turn encouraged children to engage in such activities as child labour that further exposed them to exploitation and abuse. This was observed to be particularly serious for households in which the parents/caregivers were alcoholics. Some parents/caregivers were alleged to support their children engagement in activities that are harmful to their wellbeing.

Lastly, joblessness particularly among young people in the slum was observed to be another factor in this regard. It also scored a frequency of two from the 17 Key Informants interviews. The respondents noted that joblessness caused idleness and frustrations among the people who in turn abuse children. One Key informant said, *"Most youths are jobless and just sit idle here in Gikomba. So to nurse their frustrations they take advantage of unsuspecting children."* K16M

In summary, the finding has shown that several factors contribute to the high child vulnerability. These factors also do not operate in isolation but are interlinked in a complex way. Poverty, environment, and HIV/AIDS emerged as the major factors. Illiteracy, joblessness and poor parenting were other factors. With high child vulnerability therefore, many OVC categories are bound to emerge. The categories are highlighted in the next section.

4.1.4. DESCRIPTION OF OVC IN PUMWANI SLUM AREA

The study considered it important to understand the depictions of OVC in the slum area. The rationale was that it reflected the changing needs and informed the scope of assistance required. A comprehensive picture of OVC would therefore inform on capacity building areas in order to address OVC needs comprehensively and sustainably.

Findings from interviews with Key Informants, members of the OVC initiatives and participants in FGDs revealed a multifaceted description of OVC as outlined in *Box 1*. They included: single and double orphans, child heads, children infected and affected by HIV/AIDS, children under foster care, abandoned children, children with special needs, children of ill caregivers, children out of wedlock, destitute children, children of parents with special needs, children in drug abuse, an children living in the slum area. This broad range supported Smart (2003) and Miller (2007) argument on the complexity of conceptualizing a 'vulnerable child.' Communities have been found to define child vulnerability according to their own contexts (Wakhweya et al., 2008). This has in turn broadened the concept of OVC to include both orphans and non-orphans. The study established this to be the case in Pumwani Slum Area.

This study found quite significant the classification of all children in the slum as OVC. This was a common response across Key Informants. This finding clearly reflected the high level of child vulnerability in the informal settlement.

Box 1: Description of OVC in Pumwani Slum Area

- Single orphans
- Double orphans
- Child-heads
- HIV positive
- Young boys and girls
- Children affected by HIV/AIDS
- Children under foster care/relatives (grandparents)
- Abandoned children
- Children with special needs
- Children of ill caregivers/parents
- Children living within the slum area
- Children out of wedlock
- Destitute children
- Neglected children
- Children of parents with special needs,
- Children in drug abuse

Source: Field Data (2012)

Findings further revealed variations in vulnerability among the OVC. Interviews with the Key Informants elicited three groups considered most at risk in the slum area. They included: young boys and girls; children with special needs; and children from single parent families. A series of responses pointed out that small boys and girls are easy targets for sexual abuse and defilement and many a times with the people they know and trust. This similarly applied to children with special needs who also suffer other multiple complications.

The broad range of OVC and variations in their vulnerability posed a major challenge to stakeholders in OVC care and support. The broad range indicated changing needs for emerging categories and therefore the challenge of prioritization.

4.1.4. STAKEHOLDERS IN OVC CARE AND SUPPORT

Study findings revealed several categories of stakeholders involved in OVC care and support. As seen in *Table 1*, these included: Government ministries, departments, and institutions; International organizations; local NGOs; Federation; FBOs; CBOs/SHG, and the community of beneficiaries, caregivers, and business community.

Table 1: OVC Stakeholders in Pumwani Slum Area

Category	Description (Most notable)
Government (ministries, departments & institutions)	Ministry of Gender, Children and Social Development; Ministry of Internal Security and Provincial Administration; Ministry of Education, Ministry of Youth Affairs and Sports; Ministry of Local Government; Office of the President's Ministry of Special Programmes; Ministries of Public Health and Medical Services; National Aids Control Council (NACC), and Constituency Development Fund (CDF) Committee.
NGOs	SJCC, KENWA, APDK,USK,SIDAREC, MOCASO, Inuka Kenya Trust, MORAA New Hope Foundation, Youth Initiative Kenya (YIKE)
International agencies	SOS, International Justice Mission (IJM), USAID Aphia Plus, Andersen's Norway
Federations	Football Kenya Federation (FKF)
FBOs	Churches and Mosques
CBO/SHG	Mama Fatuma Children's home, Child Survival Organisation, KCBONET, PYGRON, KHRD, Youth Groups, Women Groups.
Community Members	Parents/caregivers; children, and the business community

Source: Field Data (2012)

Findings established a network of interrelationships between the stakeholders in attainment of their objectives. Findings showed that the stakeholders are engaged in both vertical and horizontal relationships depending on objectives to be attained and the stakeholders involved. A respondent affirmed:

Relationship with most NGOs is vertical though depends on the office and activities. With most CBOs relationship is horizontal especially during joint activities like outreach programs and campaigns although linkages remain weak. G2BM.

Respondents from all the initiatives reported similar views. In this regard, findings revealed that stakeholders could play both supportive and leading role. For instance, CBO/SHG and the community were more likely to play a leading role in OVC identification, rescue and monitoring; and community mobilization in which case capacity support agencies provide a supportive role such as facilitation of logistics. This implies that the nature of the relationship defined the roles each stakeholder played; supporting or leading. This finding was in conformity with Attawell (2010).

Similarly, the study revealed that the same role identified for CBO/SHG and the community becomes a supporting role in the context of broader OVC care and support objectives mainly held by capacity support agencies. The findings therefore supported Attawell (2010) argument that community-based initiatives play both leading and supporting role as demanded by the aspect of the task.

The stakeholders collaborate to provide a wide range of OVC care and support services as outlined in *Box 2*. However, the most common forms of collaboration that emerged include: facilitation of program activities; advocacy and sensitization campaigns; outreach activities; joint planning and implementation of activities; exchange programmes; and information sharing.

In an evaluation of the relationship between the various stakeholders, findings showed mixed results. Most respondents interviewed acknowledged improved relationship particularly on increase in number of stakeholders and their inclusion in key institutions. A key informant remarked:

There has been improved working relationship especially through joint stakeholders meetings, inclusion of stakeholders in District Area Advisory Council, and enhanced financial and material assistance from stakeholders. K1F.

Box 2: Stakeholders' OVC Support Services in Pumwani Slum Area

Training Support: Child Rights Protection, HIV/AIDS & Reproductive Health & Education, Counselling & Psychosocial Support, peer education, Theatre Skills, Business skills, Leadership & Organizational Development skills, Sports coaching and officiating, Sexual Gender Based Violence (SGBV), Paralegal, and Vocational Training. **Educational support**: Formal (public & private) and Non-Formal schools; Special needs schools, scholarship, educational material and stationeries, infrastructure etc. **Medical Assistance**: General medication to the sick, vaccinations, Occupational Therapy, Home-based care, Identification, Rescue & referrals. **Legal assistance**: seeking justice for violation of child rights **Basic needs**: food assistance (relief and school feeding), clothing, beddings, shelter; **Economic Empowerment:** income generating activities and Cash Transfer OVC-Disability; **Spiritual Support; Recreation support; Sanitation programs; Talent Development:** Sports (soccer, basketball) cultural arts (Theatre, Music & Dance groups); **Advocacy & Sensitization**; and **Capacity Building** of OVC support initiatives.

Source: Field Data (2012)

However, the improved relationship was characterized by tones of discontent and strain. Two Key Informants remarked:

> *Working relationship is not as good. There is a lot of tension hidden within, lack of trust and openness between various stakeholders. There is a lot of self-centredness and championing for self interest, biasness in offering support assistance such that the most deserving do not necessarily get the required assistance.* K5F.

> *Cooperation between the various stakeholders is not harmonious as such. Support to each other is low. For instance, the VCOs work without portfolio and do not even have identification documents like an ID. This makes it very had to be effective at work especially in a slum area like this.* K4F

The foregoing discussion reveals a complex network of relationships between the different stakeholders. The stakeholders play both supporting and leading role depending on the nature of the task. This information could be crucial for capacity building agencies when designing support strategies. The next section describes the Self-Help OVC initiatives.

4.2. THE SELF-HELP OVC INITIATIVES

This section presents Self-Help OVC initiatives in Pumwani Slum Area. The section was inspired by the study's assumption that the nature of the OVC initiative determines the type of capacity building strategy and by extension, its effectiveness. It presents the typology of the initiatives, history of establishment, principles of operation, services provided, and limitations.

4.2.1. TYPOLOGY OF THE OVC INITIATIVES

Pertinent to this study, the researcher used leadership and gender elements to categorize the OVC initiatives. The Six initiatives sampled resulted to two major categories; youth-led and non youth-led OVC initiatives. Youth-led initiatives comprised three organizations (G1, G2 and G4). The non youth-led initiatives further yielded two gender categories; women-led initiatives (G5 and G6) and one initiative (G3) led by a man.

The youth-led and non youth-led OVC initiatives shared several characteristics. For instance, both incorporated all gender in their membership, shared similar principles of operation and lastly, both have internal source of fund through members' contributions. However, comparatively youth-led OVC initiatives exhibited more innovative leadership structures (G2 and G4), offered innovative OVC services such as legal assistance and talent development, and had more diverse sources of funding including loans and grants.

4.2.2. HISTORY OF ESTABLISHMENT

Interviews with members of the OVC initiatives showed a steady rise in the establishment of new initiatives in the recent times. The study established that the initiatives were formed between the year 2000 and 2010. Out of the six initiatives, only two (G2, G4) had been in existence for more than five years. All the other four (G1, G3, G5 and G6) had existed for three years. This

finding confirms argument in literature that such initiatives have continued to be resilient even in the wake of strain from socio-economic challenges and HIV/AIDS (UNRISD, 2009).

It was established that initiatives that have been in existence longer exhibited improved capacity. Study finding established that youth-led initiatives had been in existence longer than the non youth-led and scored strongly in capacity strength. One initiative (G2) that had been in existence since the year 2000 showed the strongest indications of enhanced capacity. The initiative had established its own permanent office and had several income generating activities.

The study findings further established that two youth-led OVC initiatives (G1, G4) were formed and rolled out operations before formal registration. In such a case, the initiative operated under another initiative's name until they were ready to become independent. This therefore enabled the initiatives to access capacity support assistance. The study therefore established that the legal status of an initiative did not necessarily hinder access to capacity building support but was remained necessary.

The study established that both youth-led and non youth-led OVC initiatives were formed in order to address a community need. This was reported by four OVC initiatives (G2, G3, G4, and G5). One respondent remarked, "*The aim of the group was to engage idle youths involved in crime to reduce crime in the society.*" G2AM. This finding supported arguments in Phiri et al. (2001) and Foster (2002).

Resource mobilization was another reason reported across three initiatives (G1, G3, and G6) was. One respondent said:

> *The mission at the time was to assist people with disability mobilize resources and also advocate for the rights of the people with disability including exposing children with special needs who remain hidden in households.* G3AM.

Findings further revealed that five initiatives (G1, G2, G4, G5 and G6) were formed through members' own initiative. Only one initiative (G3) was influenced by a member of staff from an NGO in the area. The study considered the finding a demonstration of the community's

consciousness and decisiveness in seeking solutions to address the OVC problem in the slum area.

Significant to this study was the comparison of the Self-Help OVC initiatives' based on origin. Findings indicated that youth-led OVC initiatives either started as sports club (G2 and G4) or cultural arts club (G1). The study established that this placed them at a strategic position to reach more OVC in need of care and support. The non youth-led initiatives (G3, G5 and G6) were found to have started as savings groups before incorporating OVC care and support activities.

4.2.3. PRINCIPLES OF OPERATION

Findings established that the OVC initiatives majorly operated on the principles postulated in literature (Foster, 2002; Ninan and Delion, 2008). These included: Consensus decision-making, local membership and leadership, spirit of volunteerism, innovation, and self-reliance.

4.2.3.1. Consensus Decision-Making

All the initiatives were found to uphold the principle of consensus decision-making. This was evident particularly in planning for the project activities. Findings established that this was decided by members during the initiative's meetings. A respondent interviewed confirmed this finding when he said, "*We usually plan our activities in meetings at the start of the year. Members decide on what is to be done, initiate the project and thereafter look for support.*" G2AM. Implied in this response is that the approach recognizes members' ideas and opinions in setting organization's goals and objectives. This in turn enhances participation and inculcates a sense of organization ownership and group solidarity in the members.

Consensus decision-making was also evident in recommendation of members for training opportunities. This was reported in all the initiatives. The study established that this was aimed at to ensure fairness and objective selection. The OVC initiatives recognized that training not only equipped members with knowledge and skills to implement project activities. It enhanced their capacity to effectively participate in decision-making processes.

4.2.3.2. Local Membership and Leadership

Across initiatives, findings showed that most members including leaders were drawn from the local community. Membership comprised children, youth, women, men, and old people of diverse socio-cultural backgrounds. This finding challenges earlier findings in Mathambo and Richter (2007) and Ninan and Delion (2008) who observed that such initiatives were characterized by dependency on women volunteers. Although women-led initiatives (G5 and G6) had more female members, it was closely rivalled by that of male. In contrast, youth-led OVC initiatives (GI, G2, and G4) reported more male members than their female counterparts. Most initiatives had a membership of 14 – 25 except one initiative (G2) that had 40 members.

Educational level of members across initiatives ranged from primary completed to tertiary level. However, education levels were higher for youth-led OVC initiatives with most having completed secondary education while few others had attained some tertiary level training. Most members also reported to have skills in peer education, computer literacy, paralegal, and proposal development. Youth-led OVC initiatives had age limit for membership with most ranging between 18 to 35 years. This exempted one initiative (G4) that reported parents as membership. However, for the non youth-led initiative membership was open provided one was above 18 years. In terms of religious backgrounds, the findings show that the initiatives had both Christians and members of the Muslim faith. However, Christians were the majority across the groups interviewed.

Inclusion of marginalized groups in the membership was evidently limited. Except for initiatives for people with disability (G3 and G5), only one initiative (G6) out of four reported to have incorporated a person with special need in its membership. This finding confirms an argument in the literature that marginalized groups are inadequately represented especially in heterogeneous communities (Birdsall and Kelly 2005; Mathambo and Richter, 2007; Ninan and Delion, 2008). This is explained by the emergence of initiatives that mainly focus on people with special needs. An example is *Bubujika Women Self-Help Group,* a six months old women-led group from *Majengo* whose membership is dominated by people with physical disability.

4.2.3.3. Volunteerism

Findings confirmed that the OVC initiatives operated on the basis of spirit of volunteerism. This was reported in all the initiatives with most volunteers working part-time. However, for two youth-led OVC initiatives (G2 and G4), the findings established that executive members worked fulltime. The study further established that initiatives whose executive members worked fulltime reported greater capacity strength. In all the initiatives the executive members comprised the Chairman, Secretary and Treasurer. However, one initiative (G2) had a Coordinator as part of its executive.

Findings on the membership further revealed that the initiatives employed both open and closed membership policy. Out of the six OVC initiatives interviewed, the study established that four (G1, G3, G4, and G5) had open membership where new members could join. In contrast, two initiatives (G2 and G6) adopted closed membership policy. For G2, one must have joined the initiative as a minor and rose up the organization's ranks to become a member. In G6 only those who had started with the initiative would be considered for membership. The study established that the rationale was to retain members who were committed to the objectives and goals of the initiative. One respondent said:

> *We have no opening for more members. Most members started with the organization and one joins the organization at a tender age and is recruited as a member through the ranks.* G2BM

4.2.3.4. Innovation

Findings revealed innovation in programme implementation strategy, resource mobilization, and organizational structures. Findings established that during peer-education activities one initiative (G1) reached OVC through three public primary schools. This enabled the initiative to reach many OVC most of whom reside in the slum area. In addition, the strategy enabled monitoring and therefore enhanced the impact of the program activity.

Two initiatives (G2 and G3) demonstrated innovation in resource mobilization. The study findings established that G2 operated a public toilet as an income generating activity that

doubled up as a significant component of its sanitation program. The children within the area facility had a free access to the facility. It was reported that this had helped improve sanitation standards in the area particularly open defecation. Another OVC initiative (G3) reported to be in the process of initiating a similar project. The study considered this a relatively sustainable way to protect children from environmental health hazards.

The youth-led OVC initiatives demonstrated innovation in existing leadership structures. In G2 for instance, OVC beneficiaries are categorized into different age groups within which are children clubs. For G4, the organization is divided into three tiers; Major Counsel for parents, Senior Counsel for youth, and Junior Counsel for captains and child club leaders. The clubs in turn helped in OVC monitoring. These structures demonstrate how innovation, which is a characteristic of such initiatives, is no longer a preserve for programme activities. Organizational structures must be appropriate for the initiative to sustainably achieve its goals and objectives.

4.2.3.5. Self-Reliance

The study findings revealed efforts towards self-reliance. The initiatives mobilized resources locally, nationally and internationally to run operations. All the initiatives reported to have a savings initiative in which members make weekly contributions. Average monthly contribution for most OVC initiatives (G1, G2, G3, G4 and G5) was Ksh.100 with only one initiative (G6), mainly a savings group, reporting the highest with Ksh. 1000.The funds were managed by the executive members (Chairperson, Secretary and Treasurer) through a joint bank account. This finding confirmed Kanyinga et al. (2007) findings that Self-Help community groups mainly relied on own contributions from members.

However, two initiatives (G2 and G3) reported to have mobilized financial resources at national level while one initiative (G2) had mobilized funds at international level as summarized in *Table 2*. For majority of the initiatives however, the study established self-reliance in resource mobilization remained weak to effect a significant change in OVC care and support. Dependency on external financial support was evident across all initiatives.

Table 2: Resource Mobilization by Self-Help OVC initiatives

Source	Local	National	International
Initiative	ALL	G1, G2, G3	G2
Forms	Contributions Fundraising	Loans Grants	Grants

Source: Field Data (2012)

Findings showed that only one initiative (G2) owned a permanent office with appropriate office equipment from which programmes were coordinated. Other initiatives however did not have permanent workspaces. Two initiatives (G1 and G3) used meeting facilities at the chief's camp while three others (G4, G5 and G6) reported meeting in a member's house. The researcher verified this through direct observation during field visits.

4.2.4. SERVICES PROVIDED BY SELF-HELP OVC INITIATIVES

Findings established that the initiatives provided a wide range of services to OVC as shown in *Box 3*. These included: training, basic needs, psychosocial support, educational support, medical support, sanitation services, talent development, sensitization and awareness, spiritual support, identification and rescue, and income generating activities. Findings supported evidence in Foster (2004), and Kidman and Heymann (2009).

Box 3: OVC Services by Self-Help OVC initiatives

Training (peer education, theatre & leadership); basic needs (food, clothing & shelter); psychosocial support; sanitation services (environmental cleanup & public toilet); education assistance & referral; medical assistance & referral; talent development (sports & cultural arts); awareness and sensitization; spiritual support; identification, rescue and referral; and income generating activities.

Source: Field Data (2012)

This study however identified new dimensions in OVC care and support services. Some members from youth-led initiatives (G1, G2 and G4) were trained as paralegals and consequently enabled the initiatives to provide general legal assistance to OVC as required. Talent development was another new dimension of OVC care and support service. This was reported in four initiatives (G1, G2, G3 and G4). This was through sports activities as well as cultural arts like theatre and dance. Related to this was provision of training in life skills. All initiatives except one (G5) reported providing community sanitation services through environmental cleanup activities.

4.2.5. LIMITATIONS OF SELF-HELP OVC INITIATIVES

Study findings established limited resources, weak human resource capacity and inactive members as the most common challenges for the Self-Help OVC initiatives in Pumwani Slum Area. This confirmed findings postulated in literature (Birdsall and Kelly 2005; Mathambo and Richter, 2007; Ninan and Delion, 2008).

Lack of volunteer spirit among members of the initiatives was a common strand in the three youth-led initiatives (G1, G2 and G4). One respondent interviewed remarked, *"...Some members do not want to volunteer but only come for activities that have funding."* G1AF. This finding was corroborated by discussants in FGDs with AAC members who observed that money-mindedness was a characteristic of most young people in the slum area.

Limited outreach was evident across all the OVC initiatives. Although there were indications of growth in scale of coverage, most still confined their activities within the slum sections. Enhanced outreach was clearly depicted in sensitization and awareness campaigns. For some initiatives, limited outreach seemed unavoidable. One respondent said:

> *There is difficulty of movement for people with disability [on a wheelchair] and this limits assistance. Some areas are also inaccessible for people with disability.* G3AM.

A new strand of challenges external to the initiatives emerged from two non youth-led initiatives (G3 and G5). Community's attitude towards disability was reported to hinder achievement of the initiatives' objectives. Despite improvement in the last few years, the initiatives observed that the extent to which community's appreciation of people with disability was still wanting. One respondent explained:

> *...cases of hidden OVC with disability are still there that some have even been burnt in houses. Community attitude towards children with disability and people with disability still bad and some take advantage of them.* G5AF.

In summary, the discussion revealed that child vulnerability in Pumwani Slum Area remains high. This resulted from several factors such as poverty, environment, HIV/AIDS, illiteracy, joblessness, and poor parenting. The description of OVC has been broadened to generally include all children living within the slum and its environs. The discussion also revealed a relatively wide range of stakeholders and services in OVC care and support despite limited integration in service delivery. The stakeholders include: the government, local and international NGOs, educational institutions, business organizations, federation, FBOs, CBO/SHGs and the local community members. The discussion further described the Self-Help OVC initiatives. This focused on their typology, history of establishment, principles of operation, services provided, and limitations. The discussion revealed two main categories; youth-led and non youth-led OVC initiatives with variations in complexity. The next chapter discusses capacity building agencies, strategies, outcome, and community perception of change in OVC care and support.

CHAPTER FIVE

CAPACITY BUILDING ORGANIZATIONS, STRATEGIES AND OUTCOME.

This chapter discusses the types of capacity building organizations and the strategies employed in capacity building. Further it presents discussion on outcome of enhanced capacity on service delivery by the OVC initiatives, and community perception of change in OVC care and support.

5.1. CAPACITY BUILDING ORGANIZATIONS AND STRATEGIES

Study findings established that Self-Help OVC initiatives in Pumwani Slum Area received capacity support from a range of organizations. These included: Non-Profit Organizations (NPOs), government ministries and departments, and business organizations. This finding supported literature in Phiri et al. (2001) and IHA (2002) on the typology of capacity building organizations. The NPOs categories included: NGOs, Foundations, Trusts, Federations, and Self-Help OVC Initiatives.

The notable capacity building NGOs in Pumwani Slum Area comprised St. John's Community Centre (SJCC), the Kenya Network for Women Living with HIV/AIDS (KENWA), the Association for People with Disability of Kenya (APDK) and the Youth Initiatives-Kenya (YIKE). Other NPOs included: Inuka Kenya Trust, MORAA New Hope Foundation, Football Kenya Federation and Self-Help initiatives. Government ministries and departments comprised the Children's Department-Kamukunji, the Ministry of Youth Affairs and Sports (MOYAS) and the National Aids Control Council (NACC). The most notable business organization was Andersen's Norway, an international business company.

SJCC scored the highest frequency (4/6) across the OVC initiatives in Pumwani slum area. Four initiatives (G1, G2, G4 and G6) acknowledged capacity building support from the organization. The SJCC mostly provided training to members of the OVC initiatives on peer education and theatre skills; community mobilization; organization leadership and project management; business management skills; child rights and protection; HIV/AIDS and reproductive health; and psychosocial support. Other capacity building assistance included material support notably through facilitation of project activities and on-site support visits. The latter strategy mainly

entailed providing technical assistance at project site to enable the initiative to achieve its objectives. The study findings established that most of its support visits were provided during sensitization and awareness activities.

Other capacity building NGOs were KENWA, APDK and YIKE. KENWA provided training on peer education, HIV/AIDS and reproductive health; and psychosocial support. The organization also provided material resources and support visits. This was reported by one initiative (G1). APDK provided material resources (mostly assistive devices for people with disability), training on identification, rehabilitation and early intervention of OVC with physical disability, and home-based support visits. This was reported by two initiatives (G3 and G5). Lastly, YIKE mainly provided capacity support through training on entrepreneurship and project planning and management. This was confirmed by one initiative (G1).

The three NGOs (KENWA, APDK and YIKE) however recorded lower frequency across the OVC initiatives compared to SJCC. This was mainly due to the OVC categories the organizations targeted. For instance, APDK was mostly concerned with OVC with special needs (physical disability) whereas KENWA mainly assisted OVC infected and affected by HIV/AIDS. The study established that YIKE mainly focused its activities in other informal settlements.

Inuka Trust-Kenya provided training in community mobilization. This was reported by one initiative (G1). Findings revealed that MORAA New Hope Foundation provided training on entrepreneurship and project planning and management. This was confirmed by one initiative (G2). However, overall, the two organizations recorded the lowest frequencies across the Self-Help OVC initiatives. Both were reported by only two initiatives (G1 and G2) out of the six sampled.

Another notable capacity building organization was the Football Kenya Federation (FKF). The federation mainly provided training on sports coaching (soccer) and officiating. This finding was however confirmed by only one initiative (G2). The federation scored a low frequency across the OVC initiatives mainly because it mainly targeted youth-led initiatives implementing sports activities particularly soccer.

Findings established that Self-Help initiatives also provided capacity building support. This was mainly through partnerships with each other, networking and exchange visits. Partnership strengthens an organization's capacity to deal with development challenges while networking helps in complementing strategies and increasing negotiating power (Stavros, 1998). The OVC initiatives reported improved capacity through partnership and networking with other initiatives within and outside the slum area. Two youth-led initiatives (G2 and G4) confirmed the finding. Exchange visit was acknowledged by two initiatives (G2 and G3). For instance, one initiative (G2) reported to have had exchange visit with a youth group in Mathare Valley[6] while the other (G3) had had an exchange visit to a Self-Help initiative based in Mukuru Kwa Njenga.[7]

However, networking was evidently weak across all the OVC initiatives. For instance, only two youth-led initiatives (G2 and G4) reported to be in a network. The study further established that partnerships between the OVC initiatives and capacity building organizations was only manifested during capacity building activities and joint implementation of program activities.

The government's role in capacity building of Self-Help OVC initiatives was evident. The most notable this regard comprised the Children's Department, Ministry of Youth Affairs and Sports (MOYAS) and the National Aids Control Council (NACC). All the OVC initiatives acknowledged receiving capacity support from the Children's Department. This was mainly because the department had the mandate to coordinate all child protection activities in Kamukunji District including the slum area. The department mainly provided training on Child protection and resource mobilization. The study found out that MOYAS facilitated loans through the Youth Enterprise Development Fund (YEDF). This was confirmed by two youth-led initiatives (G1 and G2). NACC provided financial support but mostly in form of grants. This was confirmed by one initiative (G3).

Study findings revealed lower frequency for MOYAS (2/6) and NACC (1/6) compared to the Children's Department. This was mainly because of the nature of the initiatives targeted and

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[6] A section of Mathare Slums in Nairobi

[7] A slum in the East of Nairobi

types of programs activities implemented. For instance, MOYAS mainly targeted youth-led initiatives while NACC mostly targeted initiatives implementing HIV/AIDS-related activities.

Finally, study findings established that Andersen's Norway provided capacity support through material and financial resources. This was reported by one youth-led initiative, (G2). This finding supported IHA (2002) argument that although most grassroots initiatives get capacity building support from local organizations, support such as financial assistance are mostly external.

The study findings however did not establish any organization that provided capacity support in monitoring and evaluation. Monitoring and Evaluation (M & E) provides the management with information to address project implementation issues and assess progress and fulfilment of objectives. This support would help Self-Help OVC initiatives improve documentation of success indicators in OVC care and support. Findings revealed that the concept was vague to most members of the OVC initiatives with most associating it with auditing of financial accounts. This was observed in all the Self-Help OVC initiatives. A respondent from one of the initiatives confirmed the revelation. He said, *"...we feel there is need for more capacity development in monitoring and evaluation because it's still not well understood by most members."* G2AM.

This discussion revealed that the training opportunities targeted key programmatic areas. This supported findings in IHA (2002). However, the executive members of the OVC initiatives attended most training opportunities. This was a common response in all the OVC initiatives. A respondent from one of the initiatives confirmed the observation:

> *I represent the organization in most of the trainings usually on assisting people with disability and their rights, reproductive health education and child protection through VCOs.* G3AM.

The findings further established that in one initiative (G2) officials were specifically targeted for second level training. The advantage of this approach is that it equips the leadership with the necessary knowledge and skills to manage affairs of the initiatives. On the flipside however, this

approach may deny capacity development opportunities to non-executive members within the initiatives. This ultimately results to limited improvement the quality of service delivery.

5.2. OUTCOMES OF CAPACITY BUILDING ON SERVICE DELIVERY FOR OVC.

Study findings revealed several manifestations of improvement in OVC service delivery as a result of capacity building as outlined in *Box 4*. Interviews with members of the OVC initiatives reported that there was improved confidence in delivery of OVC care and support services. This was a common response across all the OVC initiatives. In particular, members of the OVC initiatives reported improved knowledge and skills in various aspects of child protection including procedures for addressing cases of child abuse.

Box 4: Outcome of Capacity Support on OVC Service Delivery

- Improved confidence in OVC service delivery
- Ability to provide own training to members
- Improved quality of sensitization and awareness
- Improved talent development
- Improved OVC identification and rescue
- Improved sanitation
- Improved education assistance

Source: Field Data (2012)

Second, the study findings further revealed that the members of the OVC initiatives were equipped with the necessary capacity to facilitate their own training to non executive members within the initiatives and to the public during awareness and sensitization campaigns. This was reported by four initiatives (G1, G2, G3 and G4). A respondent from one of the initiatives remarked, *"Personally, I have been able to train others in our organization especially on life skills, paralegal information, and in Reproductive Health and HIV/AIDS."* G4AM

Third, findings established improved quality of sensitization and awareness particularly on child protection, reproductive health and sanitation. This was a recurring response across all the OVC initiatives. This was mainly attributed to training of trainers (TOT) courses that enhanced knowledge, skills and capacity of the initiatives to provide own training, and financial and material assistance. However, most initiatives could not quantify the number of OVC or people reached during the sensitization and awareness campaigns. Only one initiative (G3) reported to have reached about 2500 people during HIV/AIDS sensitization activities. Through awareness on disability, the initiative also managed to integrate 113 OVC in public primary schools.

Fourth, most Self-Help OVC initiatives reported improvement in talent development. Findings showed that four initiatives (G1, G2, G3 and G4) had developed talents particularly in sports activities and cultural arts. This resulted from training received in theatre arts and in sports coaching and officiating. One initiative (G3) had developed talents in disability dance that saw them receive invitations to perform in many forums and functions. One initiative (G2) developed talents in soccer that saw it participate in the provincial football league and also won about ten OVC secondary education scholarships.

In addition, the initiative (G2) developed skills in embroidery and bead-making for a few OVC that enabled them improve household income. All the youth-led initiatives (G1, G2 and G4) also reported developing talents in theatre arts that saw them win cash awards in competitions.

Another service that recorded improvement was OVC identification and rescue. This was a recurring response across all the initiatives. Findings revealed that all the OVC initiatives through partnership and networking with other stakeholders had identified and rescued many OVC and referred them for assistance. However, most initiatives could not quantify the number of OVC they had identified and rescued. Only one initiative (G3) had rescued 30 OVC with disability. Unavailability of data to quantify the number of OVC rescued confirmed the observation made by a Program Officer on limitation of working with the Self-Help initiatives. She said, *"The main problem with these groups is documentation. There is poor documentation of what Self-Help Groups are doing on children issues."* K15F.

Finally, the study findings established that awareness on environmental cleanup activities conducted in collaboration with other stakeholders also contributed to improvement in sanitation. This was a common response across all the Self-Help OVC initiatives. Findings further established that improvement in sanitation was enhanced by projects such as public toilet and bathrooms most of which are managed by youth groups. For instance, one initiative (G2) allowed all OVC free access to the facility which resulted to a drastic reduction in cases of open defecation. OVC participants in FGDs also acknowledged free access to such facilities across the slum area. However, from the researcher's observation, the general state of sanitation across the slum area was unsatisfactory to guarantee protection of OVC from diseases and infections. For instance, there was no clear garbage collection system across the slum area as dumping of waste remained haphazard. In addition, open sewers run the front of most houses.

Despite the foregoing improvements in service delivery, few services posted limited improvement across all OVC initiatives. For instance, findings revealed that only two initiatives (G3 and G5) had the capacity to provide direct medical assistance (occupational therapy) to OVC with disability. All the other OVC initiatives mostly provided generally medical referral services. A Program Officer from one of the organization implementing OVC programs in the slum area confirmed the limitation. He pointed out, "*Most initiatives lack the technical knowhow to implement some of the programs we have such as home-based care and therefore we prefer to use Community Health Workers.*" K2M.

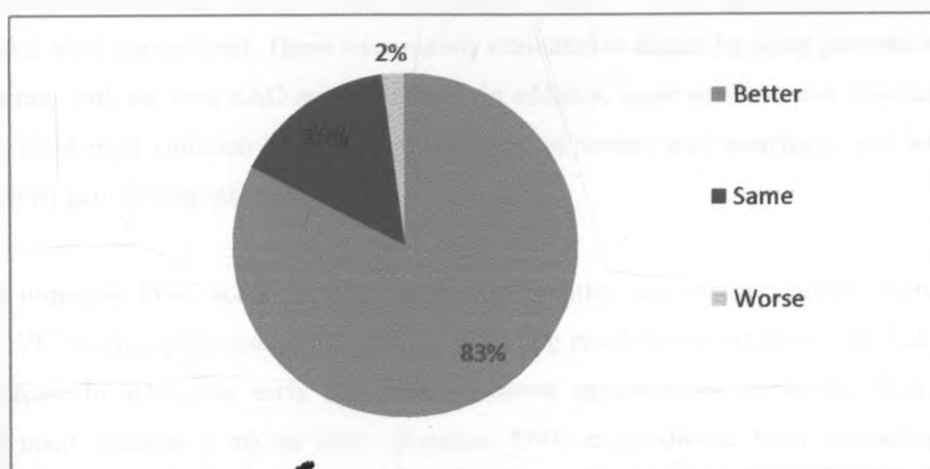
Study findings also revealed limited improvement in provision of basic needs across all the OVC initiatives. Findings established that food and clothing assistance was common in all the OVC initiatives but was most evident during annual outreach activities. Only one initiative (G2) provided shelter to eight OVC in secondary school. Nevertheless, most OVC initiatives reported improved educational assistance especially in referrals. Besides paying holiday tuition fee for OVC candidates in primary schools, one initiative (G2) assisted about 300 OVC under its care to continue with education by establishing a community library and resource centre. Another initiative (G4) reported having assisted about 250 children to get scholarship for secondary education while another (G3) had facilitated the integration about 113 OVC with disability into formal public schools.

astly, the establishment of income generating activities recorded limited improvement across ost OVC initiatives. Findings established that only two initiatives (G2 and G3) had established come generation projects (public toilets and bathrooms). All the other initiatives (G1, G4, G5 d G6) were yet to establish any income generating projects although intention to do so was ident. At the time of this study, G2 had its project already operational while for G3 the project as near completion. These were all verified by the researcher during fieldwork.

3. PERCEPTION OF CHANGE IN OVC CARE AND SUPPORT

an evaluation of change in the outcome of OVC care and support for the past five years, study ndings established that out of the 46 respondents interviewed, 38 (83%) indicated it was better, even (15%) indicated it had remained the same while only one respondent (2%) observed that e situation had worsened. This is illustrated in *Figure 4*.

Figure 4: Perception of Change in OVC Care and Support



Source: Field data (2012)

espondents interviewed reported three main themes as manifest of the change as outlined in *ox 5*. The first was significant reduction in incidences of child right violation and abuse. This as a common strand across most respondents, an observation that was confirmed by articipants in the focus group discussions. Findings established improvement in reporting of hild right violation and abuse cases particularly child defilement and sodomy. This was unlike arlier years when most of such cases were settled locally within the community at the peril of he survivor. One VCO interviewed confirmed the reduction. She said:

...Cases are identified fast enough and attention given. For instance, between August and December 2011, over 200 cases were identified for care and support in Kiambiu but in the last six months only 100 cases were identified. K3M.

Box 5: Manifestations of Change in OVC Care and Support

- Reduction in incidences of child right violations cases and abuse
- Improved access to basic educational opportunities
- Establishment of community level child-based institutions

Source: Field Data (2012)

However, the development was marred by a few drawbacks. The study findings established that few incidences of child violations continued to be reported across the slum sections. Further, few incidences of abandoned children and unreported cases of child rights violation that went unattended were also evident. These were mainly attributed to failure by some parents/caregivers to cooperate with the area AAC representatives. In addition, some parents were reported to hide cases of child right violation for fear of prosecution, to protect their marriages, and sometimes for financial gain among other reasons.

Second, improved OVC access to educational opportunities was another notable improvement. Many OVC had joined formal public schools including re-admission of those who had dropped out. Increase in affordable early childhood education opportunities across the slum sections enabled many children to access basic education. OVC in non-formal basic education schools also got registered for primary level national examinations while a few others had got scholarship for secondary education. An OVC beneficiary illustrated the effect of the improvement:

Hope has been revived in life now and many OVC are now attending school some even in boarding schools. Many are now able to think outside the box and are getting ready for future challenges in realizing their dreams. K13M.

The major setbacks in this regard however were lack of adequate learning facilities in most educational institutions and deteriorating household socio-economic situation. Findings revealed that the factors were responsible for the reported cases of OVC school drop-out and consequently engaging in child labour particularly scraps metal and plastic trade. In addition, integration of OVC disability into public educational institutions remained a challenge. The study established that some schools avoided admission of such pupils because of lack of technical capacity to provide the required educational assistance.

Lastly, establishment of community level child-based institutions such as the Children's Parliament and Child Rights Clubs across the slum area was another notable manifestation of improved OVC care and support. This was a common response across interviews with key informants and participants in the focus group discussions. Study findings revealed that the institutions empowered OVC by providing forums to voice issues regarding their protection. The study further established that the Children's Parliament had a free helpline and reported directly to the Children's department. The main issue however was that OVC with special needs were hardly represented in the membership of the institutions. This therefore implied that the institutions could not adequately address matters pertinent to the wellbeing of OVC with special needs.

In a comparative evaluation of the change in care and support across the different OVC categories, study findings revealed that OVC with disability were still disadvantaged. First, the respondents interviewed observed that very few stakeholders in OVC care and support had established programmes that targeted OVC in this category. For instance, APDK was the only notable NGO in the slum area that specifically targeted OVC with physical disability. Although the study could not establish the total number of Self-Help OVC initiatives in the slum area that targeted children with disability, out of the six initiatives interviewed, only two (G3 and G5) targeted children in this category.

Second, the study established that OVC with disability hardly accessed the specialized assistance required. For instance, the community observed that although this category of OVC had been integrated into public schools, most failed to receive specialized classroom attention to

effectively compete with other learners. Further, it was observed that although this category had received medical assistance from various stakeholders, other important medical needs remained unattended. One respondent interviewed illustrated the challenge. She said:

> *OVC with disability have multiple complications. Some are both physically challenged and epileptic at the same time. So, attending to one of the problem does not help much. Most parents also cannot buy epilepsy drugs without a letter from a doctor, and this costs money so you wonder what you will do.* G5AF.

The finding pointed out to the existing legislation that impedes access to the specialized assistance. Most parents/caregivers also reported difficulty in accessing cash transfer for people with disability. They argued that that would help in addressing some of the unmet needs. Interviews with members of two OVC initiatives (G3 and G5) established that most members did not know the criteria used to disburse the funds in Pumwani Slum Area. One respondent said:

> *The SDO's office registers disability cases for consideration for the disability fund but we do not understand what exactly they look for when disbursing the funds because so far none has received the funds in this group.* G5AF

5.3.1 FACTORS ATTRIBUTED TO IMPROVED OVC CARE AND SUPPORT

Study findings established several factors responsible for the improved OVC care and support as outlined in *Box 6*.

Box 6: Factors Attributed to Improved OVC Care and Support

- Enhanced sensitization and awareness on child protection
- Inclusion of more stakeholders in OVC Care and Support
- Participation of local community members
- Improved reporting of child violation cases

Source: Field Data (2012)

First, enhanced sensitization and awareness on child protection issues scored the highest frequency. Out of the 36 Key Informants and members of the OVC initiatives interviewed, 23 (63%) attributed the improved change to sensitization and awareness activities. The study established that the activities empowered members of the community with knowledge, skills and also imparted the required conscience that helped improve child right protection. According to a respondent, the activities had helped improve the communal attitude towards OVC and people with disability:

> *Status has improved especially through awareness in trainings and seminars that has made the community to appreciate people with disability. For instance children with disability are no longer hidden as used to be the case earlier but are now coming out and getting assistance.* G3AM

Second, inclusion of more stakeholders in OVC care and support played a key role despite the existing weak collaboration. This was a common response across most respondents and further verified by participants in the focus group discussions. Study findings showed that inclusion of more stakeholders was crucial particularly in identification and referral of OVC cases for assistance. Most notable in this regard was the inclusion of schools to assist in OVC monitoring, inclusion of more stakeholders in the Location Area Advisory Council (LAAC) and the District Area Advisory Council (DAAC). For instance, a few members of the Self-Help OVC initiatives had been incorporated in the expanded LAAC membership while a few NGOs in the area had been incorporated in the DAAC membership.

Participation of the local community in OVC care and support was another factor. Findings from interviews with Key informants and members of the OVC initiatives established that the local community responded positively in activities such as environmental cleanup, sensitization and awareness, and resource mobilization especially fundraising. The community also assisted in identification, referral, and monitoring of OVC. In some cases, well-wishers from the community donated food and non-food items such as clothing, beddings, and educational materials. This support demonstrated the local community's consciousness towards protecting and improving OVC care and support.

Finally, study findings established that reporting child violation cases to the relevant authorities for action played a significant role in improving the status of OVC care and support. This observation was a common strand among key informants and was verified by participants in the focus group discussions. Most respondents observed that reporting incidences of child rights violation for action had helped deter offenders and consequently the reduction of cases of child abuse and exploitation. This is also attributed to the devolved reporting points at the grassroots level. The reduction was confirmed by Key Informant from the Children's Department. She observed, *"There has also been a dramatic reduction of child rights violation cases being reported to this office. I am just informed on actions that have been taken."* K1F

In summary, this chapter discussed the most notable types of capacity building organizations in Pumwani Slum Area. These comprised Non Profit Organizations such as NGOs, trusts, foundation, federations and local CBOs/SHGs; the government agencies; and business organization. Although each organization employed its own capacity support strategies, training in key programmatic areas stood out as the most common strategy. This finding confirmed literature in IHA (2002). The programmatic areas included project development, peer education, sports management, and cultural arts. Strategies such as resource support, on-site support visits, exchange visits, partnerships, networking; and monitoring and evaluation recorded limited prominence. The chapter further discussed the outcome of enhanced capacity on service delivery. The discussion revealed variations in the overall improvement across the OVC initiatives. Finally, the chapter concluded with discussion on community perception of change in OVC care and support and attributive factors. The discussion revealed general perception of improved OVC care and support but OVC with disability were still disadvantaged. The next chapter presents the summary of study findings, conclusions and recommendations.

CHAPTER SIX

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

This chapter presents the summary of study findings, conclusions and recommendations. The first section presents summary of findings based on the five key research objectives. The second section presents conclusions drawn from the study findings. Lastly, the chapter concludes with presentation of recommendations for policy and areas for further research.

6.1. SUMMARY OF FINDINGS

This study mainly sought to examine how and the extent the capacities for care and support of community-level Self-Help OVC initiatives in Pumwani are being strengthened. This was guided by five key study objectives. The first objective sought to document the nature and scope of community OVC care and support. The study established that 59% (10) of the respondents perceived child vulnerability as very high while 41% (7) perceived it as high as earlier illustrated in *Figure 2*. This resulted from several factors such as poverty, the slum environment, HIV/AIDS, illiteracy, joblessness, and poor parenting.

The study established a broad description of OVC. They comprised: single orphans, double orphans, child-heads, HIV positive, young boys and girls, children affected by HIV/AIDS, children under foster care/relatives (grandparents), abandoned children, and children with special needs. Others comprised children of ill caregivers/parents, children living within the slum area, children out of wedlock, destitute children, neglected children, children of parents with special needs and children in drug and substance abuse.

The study revealed a relatively wide range of stakeholders and services in OVC care and support despite limited integration in service delivery. As earlier shown in *Table 1*, the stakeholders include: government agencies, local and international NGOs, educational institutions, business organizations, federation, FBOs, CBO/SHGs and the local community members. As earlier outlined in *Box 1*, the care and support services provided comprised training, education, medical assistance, psychosocial support, legal assistance, basic needs, and capacity building. Others services included spiritual support; recreation support; sanitation support; talent development, advocacy and awareness, and economic empowerment.

On the nature of Self-Help OVC initiatives, the study established two main typologies; the youth-led and non youth-led OVC initiatives. Both categories operated on the principle of consensus decision-making, local membership and leadership, volunteerism, innovation, and self reliance. Some initiatives however sought external assistance particularly in funding.

The OVC initiatives provided a range of services as earlier outlined in *Box 3*. These included: Training (peer education, theatre and leadership); basic needs (food, clothing and shelter); psychosocial support; sanitation services (environmental cleanup and public toilet); education assistance; medical assistance; talent development (sports and cultural arts); awareness and sensitization; spiritual support; identification and rescue; and income generating activities.

Finally, the study established various limitations that characterize the OVC initiatives. These comprised; lack of volunteer spirit in members, limited outreach, limited resources, weak human resource capacity, and inactive membership.

The second research objective sought to determine the types of capacity building organizations. The notable NGOs included St. John's Community Centre (SJCC), the Kenya Network for Women Living with HIV/AIDS (KENWA), the Association for People with Disability of Kenya (APDK) and the Youth Initiatives-Kenya (YIKE). Others were Inuka Kenya Trust, MORAA New Hope Foundation, Football Kenya Federation (FKF) and CBOs/SHGs. The notable government agencies included the Children Department, Ministry of Youths and Sports (MOYAS); and the National Aids Control Council (NACC). The only notable business organization was Andersen's Norway.

The next study objective sought to find out the strategies adopted for capacity support. The findings established that the strategies varied across the organizations. The most notable was training in project development, peer education, sports management and cultural arts. However, other noted strategies such as resource support (financial and material), on-site support visits, exchange visits, partnerships, and networking recorded limited prominence.

The fourth research objective sought to establish the outcome of capacity building support on service delivery by the OVC initiatives. Findings established mixed results on improvement in

service delivery. As earlier outlined in *Box 4,* the improvement in outcome of capacity support on OVC service delivery comprised improved confidence in delivery of OVC care and support, ability to provide own training, and improved quality of sensitization and awareness. Others included improvement in talent development, OVC identification and rescue, sanitation services, and education assistance. However, improvement in services such as medical assistance, basic needs, and economic empowerment was limited.

Finally, the fifth research objective sought to ascertain the grassroots community perception of change in OVC care and support. As earlier illustrated in *Figure 4*, the findings established that 83% (38) perceived care and support as better while 15% (7) perceived it as having remained the same. Only 2% (1) observed that the situation had worsened. As earlier outlined in *Box 5,* the manifestations of the change comprised reduction in incidences of child right violation, improved access to basic education, and establishment institutions such as the Children's Parliament and Child Right Clubs in the slum area. As shown earlier in *Box 6*, this was attributed to several factors such as enhanced sensitization and awareness, inclusion of more stakeholders in OVC care and support, improved participation of the local community members, and lastly, improved reporting of incidences of child violation cases.

6.2. CONCLUSIONS

Based on the summary of findings in the previous section, this study drew seven major conclusions. First, child vulnerability in Pumwani Slum Area remained very high. This resulted from the interplay of factors such as high poverty levels, the environment, HIV/AIDS, illiteracy, joblessness, and poor parenting among others. Consequently, all children living within the informal settlement were considered OVC. This was in light of the multiple needs of the growing variations of OVC.

Second, the Self-Help OVC initiatives were heterogeneous institutions that demonstrated a state of continuous transformation in response to new challenges and opportunities. Although generally characterized by weak capacity, the initiatives also showed potential for OVC care and support and therefore arguably the most reliable in addressing the changing needs of OVC at the grassroots level. Manifestation of their potential comprised: continued operation on existing

family structures; dynamism to change; provision of social networking; innovation, and utilization of local knowledge and leadership. This enhanced acceptability in the community and therefore sustainability. The potential however varied across the initiatives. For instance, the youth-led OVC initiatives exhibited remarkable degree of innovation, flexibility, and multi-talent compared to non youth-led OVC initiatives.

Contrary to past studies that documented women groups as traditionally the key players in grassroots OVC care and support, new players such as youths and children have emerged. This was manifested in the youth-led initiatives and child-based institutions such as the Children's Parliament and grassroots Child Right Clubs. The introduction of new players in turn resulted to new dimensions of OVC care and support services. Examples included talent development particularly in sports and cultural arts; provision of sanitation services through privately-owned sanitary facilities; and legal assistance provided by paralegals.

Fourth, the main capacity support agencies for community OVC initiatives were Non Profit Organizations (NPOs) and the government. The NPOs comprised NGOs, trusts, foundations, federations and community-based initiatives. Most of the agencies were also the key stakeholders in OVC care and support. Despite recognition of private service providers among key capacity support groups for community-level initiatives (Phiri et al. 2001; IHA, 2002), this study concluded that participation of the for-profit sector in capacity support of community OVC initiatives was clearly a limited.

Fifth, the capacity building strategies adopted varied across the agencies. Although the strategies are interrelated and interdependent, their integration at implementation was weak. Most support was provided in a fragmented manner. This exposed the capacity support to risks of duplication and wastage. Across the strategies, training remained the most prominent and sustainable strategy in capacity support of community OVC initiatives. However, other strategies such as resource support (financial and material), on-site support visits, exchange visits, partnerships, and networking were less prominent and the support unsustainable. Further, despite recognition in literature of monitoring and evaluation as a capacity support strategy, this was hardly evident for OVC initiatives in Pumwani Slum Area.

Sixth, capacity support provided resulted to improvement in service delivery by the OVC initiatives. The outcome also varied across the initiatives. However, overall this study observed that most initiatives were generally weak in capacity to provide comprehensive and sustainable OVC care and support. Training emerged the most effective strategy in capacity support. This affirmed that sustainable capacity support strategies are more effective in improving OVC service delivery. This study also noted that the capacity support provided emphasized more on the improving OVC support programs rather than the OVC organization itself. This risked improving service delivery at the expense of capacity of the OVC initiatives.

Finally, the Pumwani Slum Area community acknowledged a general improvement in OVC care and support in the recent years. A key finding was a greater awareness on child protection within the public conscience. Stakeholders and the general public also demonstrated a renewed recognition of OVC with disability. However, the OVC support services provided were generally deemed to be insufficient and inadequate. In addition, the community observed that OVC with disability remained disadvantaged in accessing quality care and support services. .

6.3. RECOMMENDATIONS

This study made several recommendations for policy and areas for further research.

6.3.1. Recommendations for Policy

First, this study observed that capacity support was provided in a fragmented manner across the agencies thereby risking duplication and wastage. Some capacity supports were also found to be unsustainable. To ensure efficiency and sustainability, interdependence of the capacity support strategies cannot be ignored. This study therefore recommends the need for policymakers and practitioners in OVC care and support to design an integrated capacity support implementation framework that also incorporates initial capacity assessment of the OVC initiatives.

Second, the study observed that capacity support efforts emphasized improving the OVC care and support programs at the expense of the OVC organization itself. This weakens the organization thus rendering it unsustainable. In this regard therefore, this study recommends the

need for stakeholders and practitioners to review capacity support approaches to equally focus on strengthening the OVC organization.

Finally, this study observed limited participation of the private sector in capacity support for community OVC initiatives. This study argues that the involvement of the sector would be important in complementing for gaps noted in capacity support. This would hence ensure their sustainability. This study therefore recommends the need for policymakers to review the National OVC Policy and the National Plan of Action to enhance participation by the for-profit sector in capacity support of community-level OVC initiatives.

6.3.2. Suggestions for Further Research

First, this study noted the inclusion of new institutions such as the Children's Parliament and grassroots Child Rights Clubs in OVC care and support in Pumwani Slum Area. However, given that the institutions are relatively recent phenomena this study recommends further research into their role and effectiveness in OVC care and support.

Second, this study specifically examined capacity support of community OVC initiatives in Pumwani Slum Area. Conscious to contextual dynamics, this study recommends a replication of the study in other settings across the country to establish variations in capacity building organizations, strategies employed, and the outcome of capacity support on service delivery.

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APPENDICES

APPENDIX A: INTERVIEW GUIDE FOR SELF-HELP OVC MEMBERS.

Hello. My name is Stephen, a student researcher from the Institute for Development Studies (IDS), University of Nairobi. I am conducting an academic study on: ***Capacity Building of Community Care and Support for Orphans and Vulnerable Children (OVC): The Case of Grassroots Self-Help Initiatives in Pumwani Slum Area*** *as a fulfilment of the requirements for an award of degree of Master of Arts in Development Studies. Your participation in this study is voluntary and all the information provided shall remain confidential and used for purposes of this research only.*

Name of the Organization		
Contact Address *(P.O. Box, Tel. No., Email, Fax, website, street/road)*		
Location(s) of Work		
Designation / Position		
Age of Respondent		
Years in OVC-related work *(General)*		
Duration in Organization *(Active membership)*		
Gender of Respondent	Male	Female
Education Level Completed		
Technical Skills *(OVC-related, computer skills, proposal writing etc.)*		

SECTION A: PROFILE OF THE ORGANIZATION

1. Please describe the main characteristics of your organization? *(Women group, youth group, faith-based group, registration status? Constitution? etc.)*

2. Briefly tell me the history/origin of your organization? – *Establishment, Goals, mission, growth, etc.*

3. Briefly outline the kinds of OVC care and support services/activities your organization provides. *(How many OVC do you reach with different activities?)*

4. How are these services planned and provided? *(Planning and proposal development? Strategies for intervention?)*

5. Briefly describe the criteria employed by your organization to identify OVC and their needs? *(Criteria for targeting e.g. age, gender, type of orphanhood, religion, disability etc.)*

6. Please describe how your organization coordinates activities for OVC care and support? *(staffing, offices, office equipment etc)Staff and structure-who manages, fulltime, parttime, volunteers? Technical advisor?*

7. Describe the background and work of volunteers in your organization. *(Age, Gender, educational backgrounds, religion, ethnicity, experience in OVC work etc.)-*

8. Describe how volunteers are identified and recruited to work for your organization. *(Application? Requested? Staff development?)*

9. Please explain how activities of your organization are monitored and evaluated; and the purpose of the evaluation. *(External, internal? Documented M & E system?).*

10. What are the funding sources for your organization? *(Financial, material, or in-kind support received from a) within the community; b) outside the community.(How are the funds managed? Bank accounts, book keeping? Supporting documentation? receipts, invoices, reports)*

11. Please describe and comment on your organization's relationship with links and partner organizations. *(Local, national, international)(Who in each case?)(Vertical/horizontal?)(What activities- advocacy? etc?)*

12. What are the major successes/highlights/challenges experienced by your organization in the provision of care and support to OVC? *(problem/issues)*

13. What are your organization's future plans? *(priorities/scaling up plans)*

SECTION B: ORGANIZATIONAL DEVELOPMENT

1. With whom does your organization work? *(Stakeholders/partners?)*
2. (a) Describe how your organization collaborates with other Self-Help OVC care and support initiatives in Pumwani Slum Area? *(Joint ventures, assistance etc.).*

   (b) In what ways has the collaboration(s) influenced the ability of your organization to improve care and support services to OVC?
3. Describe the forms of support your organization receives from capacity enhancing organizations / agencies? *(Type of capacity building activities, organization?)(How is capacity building information shared in your organization?)(Target persons for capacity building within the organization?)*
4. (a) Evaluate the forms/mechanisms used to provide this support? *(Approach, scope, frequency? Are they sustainable?)*

   (b) In what ways has support received influenced the ability of you/your organization to improve the scope of OVC care and support?
5. (a)What role do the community members play in your organization? *(Participation in organizations activities- OVC, parents/guardians, women, men, youth groups, disabled?)*

   (b) How does the organization communicate with the community? *(involvement in activities? Gender concerns?)*
6. Assess objectively, the current capacity of you/your organization to provide comprehensive care and support to OVC.*(Leadership and strategy, Resource management, project design and management, technical capacity, Networking and advocacy).*

APPENDIX B: KEY INFORMANT INTERVIEW GUIDE

District Children Officer / Social Development Officer / Volunteer Children Officer

Hello. My name is Stephen, a student researcher from the Institute for Development Studies (IDS), University of Nairobi. I am conducting an academic study on: ***Capacity Strengthening of Community Care and Support for Orphans and Vulnerable Children (OVC): The Case of Grassroots Self-Help Initiatives in Pumwani Slum Area*** *as a fulfilment of the requirements for an award of degree of Master of Arts in Development Studies. Your participation in this study is voluntary and all the information provided shall remain confidential and used for purposes of this research only.*

1. Describe child vulnerability in Pumwani Slum Area?
2. Describe OVC in Pumwani Slum Area?
3. Please explain OVC care and support mechanisms in Pumwani Slum Area.
   (i) Identify the various stakeholders in OVC care and support activities.
   (ii) What are roles of the stakeholders in improving care and support for OVC?
4. Explain the role of your office in the provision of care and support for OVC.
5. Comment on the working relationship between various stakeholders in OVC care and support activities.
6. Evaluate the role of community-based Self-Help OVC care and support initiatives in OVC care and support.
7. Highlight your office's support/ with community-based Self-Help OVC care and support initiatives in Pumwani Slum Area. *(Conferment of legal status? Process? Requirements?)*
8. Describe the challenges community-based Self-Help OVC care and support initiatives experience.

9. Describe the challenges your office experiences in working with community-based Self-Help OVC care and support initiatives in Pumwani Slum Area.

10. Objectively comment on the status of care and support for OVC in Pumwani Slum Area.

Thank you for your time.

APPENDIX C: FOCUS GROUP DISCUSSION INTERVIEW GUIDE

Community Members / AAC Members / Beneficiaries.

Hello. My name is Stephen, a student researcher from the Institute for Development Studies (IDS), University of Nairobi. I am conducting an academic study on: ***Capacity Strengthening of Community Care and Support for Orphans and Vulnerable Children (OVC): The Case of Grassroots Self-Help Initiatives in Pumwani Slum Area*** *as a fulfilment of the requirements for an award of degree Master of Arts in Development Studies. Your participation in this study is voluntary and all the information provided shall remain confidential and used for purposes of this research only.*

1. Please comment on child vulnerability in Pumwani Slum Area.
2. Please describe OVC in Pumwani Slum Area.
3. Describe community's attitude towards OVC in Pumwani Slum Area.
4. Please outline stakeholders in OVC care and support in Pumwani Slum Area.
5. Explain OVC care and support mechanisms in Pumwani Slum Area.
6. Please outline the kinds of OVC care and support services in Pumwani Slum Area.
7. Explain your role in OVC care and support. *(Responses/collaborations?)*
8. (a) Objectively evaluate the change in outcome of OVC care and support in Pumwani Slum Area in the last five years. *(Indicators? Quality, Quantity etc.)*

   (b) Please explain factors to which you would attribute this change.

Thank you for your time.

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