

The Influence of Child Vulnerability Status on Households' Involvement in the Care of OVC in Rongai Sub-County

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Abstract: Majority of OVC in Africa including Kenya continues to rely on extended families and kin networks' households for care. Meanwhile, research indicates that some households are not involved in the care of OVC. However, current research has not shed light on what informs households' involvement in the care of OVC. This study sought to examine the influence of child vulnerability status on households' involvement in the care of OVC In Rongai Sub-County. The study was guided by three specific objectives namely; [1] orphans and vulnerable children's physical disability on households' involvement in care provision [2] orphans and vulnerable children's mental disability and households' involvement in care provision, [3] orphans and vulnerable children's visual impairment and households' involvement in care provision and [4] orphans and vulnerable children's hearing impairment and households' involvement in care provision in Rongai Sub-County of Nakuru County, Kenya. The study was informed by Attachment and Social Exchange theories. The study was anchored on explanatory sequential design, a type of mixed method research design in which quantitative data is collected first, followed by qualitative data. The study engaged a sample size 221 selected through stratified and purposive sampling methods. Two methods of data collection namely questionnaire and semi-structured interview was employed. Quantitative data was analyzed by use of descriptive and inferential statistics. Qualitative data was analyzed through thematic analysis method. Results of the study are presented in graphs, tables and quotes. Vulnerability status of OVC that had the greatest influence on households' involvement in care giving were physical disability and visual impairment. These findings underscore the need for the government to tailor its social assistance programs for OVC to the level of need of vulnerable children and also introduce free specialized healthcare services to vulnerable children so as to lessen the burden of care giving shouldered by households. Findings of the study have broadened existing scholarly knowledge on the role of the informal institutions in care giving to OVC.

Keywords: Orphans and Vulnerable Children, Physical Disability, Mental Disability Children, Visual Impairment, Hearing Impairment, Households, Involvement.

1. INTRODUCTION

Kenya's Cash Transfer for Orphans and Vulnerable Children [CT-OVC] defines orphaned and vulnerable children as children aged 0-17 years old with at least one deceased parent, or a parent who is chronically ill, or whose main caregiver is chronically ill. Although orphaned and vulnerable children is a phenomenon affecting the entire world, the problem is more profound in Sub-Saharan Africa. For instance, it is estimated that there are 140 million OVC globally. Sub-Saharan Africa has an estimated 60 million orphaned and vulnerable children, which accounts for 42.8% of all the cases in the World [1]. The high prevalence of orphaned and vulnerable children in sub-Saharan Africa is attributed to loss of parents to HIV/AIDS, civil wars, maternal deaths and teenage pregnancies. In Kenya, it is estimated that 3.6 million children are orphaned or are vulnerable. This represents about 20% of the total population aged 18 years and below. It is projected that the number of orphans and vulnerable children will continue to rise given the high prevalence of HIV/AIDS (the leading cause of death in adults in Kenya) and low uptake of antiretroviral therapy (ART).

The growing numbers of OVC phenomenon around the globe has called for public and communal response to the crisis. OVC in the developed world are cushioned by robust public assistance programs and institutional homes unlike majority of their counterparts in Africa [2]. Although some African Countries have established social assistance programmes for OVC, the number of children covered by these programs remains low [3]. Further, the emergence of institutional homes for OVC has also offered negligible relief since less than 1.5% of the children are enrolled in these homes [4]. Further, most of the institutional homes are situated in urban areas, thus excluding majority of the children from rural areas. It is clear that public assistance programs for OVC in Africa is not only weak and inadequate but also excludes majority of these children in rural areas. This implies that most of the OVC in Africa will continue to rely on communal care.

Communal care refers to traditional arrangement in which OVC are taken care of by their relatives and well-wishers in the community. In Africa, the extended family and community is considered well placed to provide stable and balanced care for children in the absence of biological parents, meeting their psychosocial, emotional, and physical needs [5]. Thus, studies show that 90% of communal care for orphans and vulnerable children is offered by the extended family and kin networks [6]. A study conducted in Africa at the height of orphans' crisis in the continent recommended informal care system under the guidance of extended families and kin networks [7]. The study observed that informal care system enabled orphans and vulnerable children to be raised in a familiar socio-cultural environment. Further, the study noted that informal care system also allowed orphans and vulnerable children to develop a strong cultural identity with siblings, members of the extended families and kin networks. The documented study underscores the significance of communities' involvement in care provision for orphans and vulnerable children in society.

Empirical evidence from around the world points to the involvement of extended family and community in care provision for orphaned and vulnerable children. For instance, [8] document the involvement of family members in the provision of emotional, financial and physical protection of orphaned and vulnerable children. A regional study by [9] UNICEF on care giving of orphaned and vulnerable children highlight the critical role played by both nuclear and extended family members in care provision for HIV/AIDS orphan children in sub-Saharan Africa. Further, studies by [10] and [11] in Southern and East Africa and Uganda respectively have also reported the involvement of grandparents and other relatives in provision of care to orphaned and vulnerable children. In Kenya, research has equally revealed that the burden of care giving to orphaned and vulnerable children is shouldered by close relatives such as grandparents, uncles and aunts [12]. The documented studies affirm the involvement of members of the community in care provision for orphaned and vulnerable children in society.

Although majority of the extended families and kin networks are still involved in care provision for orphans and vulnerable children, studies indicate that some households are not involved at all in care provision for these children [13]. This has resulted in destitution of these children, which exposes them to the risk of abuse, exploitation, school dropout and development of delinquent behaviour. From the foregoing, it is evidently clear that some extended family's households are involved in care provision for orphans and vulnerable children while others are not. However, the documented studies have not revealed what informs involvement or none involvement of households in care provision for these children. An understanding of what informs involvement of households in care provision for orphans and vulnerable children is important given that the extended family remains the primary provider of care and protection for these children. Furthermore, it is predicted that the number of OVC will continue to rise given the rising cases of communicable diseases, lack of vaccine for HIV/AIDS, teenage pregnancy, drugs and substance abuse and single motherhood.

There are 3317 children who suffer from various forms of disability ranging from hearing impairment, physically impaired and visually impaired in Rongai sub-County [14]. Children born by teenage mothers and those under the care of chronically ill HIV/AIDS patients are also classified as vulnerable children. Available data shows that there were 870 cases of teenage pregnancies and 6,131 HIV/AIDS infections, with 2,441 being categorized as chronically ill in the Sub-County. Based on the above data, the study estimates the number of orphans and vulnerable children in Rongai Sub-County to be 6,628 (children with disability, children under the care teenage mothers and chronically ill HIV/AIDS patients). However, the actual number of OVC in the Sub-county could be higher given lack of concrete data on orphans, abandoned children and those under the care of parents experiencing other forms of incapacitation such as poverty, drugs and substance dependence among others.

2. OBJECTIVES OF THE STUDY

The study examined the influence of [1] orphans and vulnerable children's physical disability on households' involvement in care provision [2] orphans and vulnerable children's mental disability and households' involvement in care provision, [3] orphans and vulnerable children's visual impairment and households' involvement in care provision and [4] orphans and vulnerable children's hearing impairment and households' involvement in care provision.

3. MATERIALS AND METHODS

3.1 Research Design:

This study employed mixed method research design. Mixed methods research design is used in studies that seek to collect both quantitative and qualitative data in order to draw more meaningful conclusions [15]. The study was anchored on explanatory sequential design. This is a type of mixed method research design in which quantitative data is collected first, followed by qualitative data. This design is appropriate when further explanation to quantitative data is essential with additional qualitative information. This research design was appropriate for the study since it combines the strengths of qualitative and quantitative data, thereby deepening and enriching qualitative results with quantitative data and validating quantitative findings with qualitative data. The study began by collection of quantitative data through the administration of questionnaires followed by in-depth interview and observation. The questionnaires were used to get overall view of household's involvement in care provision for OVC. In-depth interviews were used to explore the underlying dynamics of households' involvement in care provision for OVC.

3.2 Data Collection Methods:

The study employed two methods of data collection namely questionnaire, Semi-structured interview. Questionnaires were used to collect quantitative data, with semi-structured interview being used for the collection of qualitative data. The study used a structured questionnaire. The questionnaires were responded to by household heads. Researcher administered method was preferred since some respondents could neither read nor write. The respondents were required to use the set of response alternatives and the response format provided on the questionnaire to respond to various statements, which were on a five-point Likert scale. The Likert scale statements are preferred since it enables data to be transformed from qualitative to quantitative [16]. Interviews targeted selected household heads, social workers, teachers of OVC and other professionals. The study employed a semi-structured interview guide containing some pre-determined questions for the respondents. Interviews offered respondents the opportunity to express their diverse opinions towards issues under inquiry.

3.3 Sampling Methods:

This study used stratified and purposive sampling methods. Stratified random sampling is a method of sampling that involves the division of a population into smaller sub-groups known as strata [17]. In stratified random sampling, the strata are formed based on population's shared attributes or characteristics [18]. In this study, stratification was based on types of disability. Stratified sampling enabled the study to draw sample from households with children of different types of vulnerabilities. Purposive sampling method was used to select key informants. Key informants engaged in the study included selected households, social workers, child counsellors, teachers of OVC and other professionals. The study engaged 10 Key Informants, and 221 household heads. The sample size for the general informants was determined using [19] formula for sample size calculation.

3.4 Data Analysis:

Descriptive and inferential statistics were used to analyze quantitative data after appropriate data coding. Descriptive statistics generally is used to describe patterns and general trends in a data set. Descriptive statistics used were frequencies and percentages. Data analysis was aided by use of SPSS (Version 24). The study used frequencies and percentages for descriptive analysis. Pearson's correlation was used to analyze data after appropriate data coding. Pearson's correlation was used to test if there was significant association between type of vulnerability and households' involvement in care provision for orphans and vulnerable children. The results of the study were summarized and presented in tables, pie charts and graphs. Qualitative data was analyzed thematically.

4. RESULTS AND DISCUSSIONS

4.1 Physical Disability and Households' Involvement in Care Provision

The study sought to establish whether children with physical disability as a form of vulnerability status influenced households' involvement in their care. Table 1 below shows that majority (72%) of the respondents generally agreed (Strongly Agree 26.7% and Agreed 45.3%) that physical disability influenced households' involvement in care provision for orphans and vulnerable children. However, 5.2% and 12.1% of the respondents strongly disagreed and disagreed respectively that physical disability influenced households' involvement in care giving to orphans and vulnerable children.

Further, 10.8% were not sure whether physical disability as a form of vulnerability influenced households' involvement in care giving to orphans and vulnerable children.

Table 1: Physical Disability and Households Involvement in Care Provision

Response	Frequency	Percent
Strongly Disagree	12	5.2
Disagree	28	12.1
Not Sure	25	10.8
Agree	105	45.3
Strongly Agree	62	26.7
Total	232	100.0

The study engaged an orthopaedic, children's officer and households' heads to provide more clarity about households' involvement in care giving to children with physical disability. A Nakuru based orthopaedic categorized children with physical disability into three namely mild, moderate and severe disability. According to him a child with mild physical disability can walk, play and engage in many activities that physically able children engage in. He also observed that mild physical disability requires minimal and occasional support. With regard to moderate physical disability, the informant pointed out that it imposes mobility challenges on children but the child still easily moves when supported.

According to the informant, a severe physical disability is a case of complete dependence since it significantly limits a child's ability to execute daily activities due to difficulty in movement and weak stamina. He cited cerebral palsy, muscular dystrophy, arthritis, limb differences (includes conditions like missing limbs, shortened limbs and malformed limbs), traumatic brain injury (often results from serious injuries) and spinal cord injuries as some of the examples of severe physical disability.

The study was informed that children with physical disability required various kinds of care depending on the severity of their condition. For instance, households with children suffering from severe physical disability highlighted that they assisted the children to access toilets, bathrooms and schools among other places. They also bathed them, washed their clothes and groomed them. The children were also taken for regular medication and specialists for medication evaluation, assisted to walk and also regularly massaged to strengthen their limbs.

While households generally vouched for care for children with physical disability in view of the challenges they faced in life, the study noted reluctance by some households to get involved in care provision for these children. Constant and continuous care resulting in physical and mental exhaustion of the care giver was cited as one of the reasons behind low involvement of households in care giving to children with physical disability.

"It is difficult to take care of children with severe physical disability. It requires one to be there for them all the time to help them with toiletry, bathing and even feeding. They also need someone to take them to school in the morning and bring them home from school in the evening. Some require assistive devices such as wheelchairs and prosthetics. It is really a tough job taking care of a child with severe physical ability. Only members of immediate families of these children are ready to do that", (Female in her Mid-40s).

Disinterest in care giving to children with severe disability was also emerging even among close relatives including biological parents of these children. An informant, Children officer familiar with cases of child neglect in the study area, highlighted a few cases of child abandonment on account of physical disability.

"I have received about three peculiar cases of child neglect in the last five years. In one case, a mother of a physically challenged child abandoned the child with the child's paternal grandmother and disappeared. She stated that she was finding it difficult taking care of the child due to constant attention and several hospital visits that the child required. She stated that at one time she spent three months when the child was admitted at Moi Teaching and Referral Hospital. The other two cases involved fathers who had abandoned their spouses on learning that the children born had cerebral palsy", (Rongai Sub-County, based Children's Officer).

The documented cases of child abandonment by biological parents highlight the enormous challenge of care giving to children with physical disability. While households were generally receptive to care giving to children with physical disability, there was a general sense of reluctance by households to get involved in care giving to children with severe cases of physical disability. Children with severe physical disability required constant attention, regular medication and specialized social exercises, which makes the cost of childcare expensive and mentally demanding.

4.2 Mental Disability and Households Involvement in Care Provision

Mental disability was yet another form of disability status for orphans and vulnerable children that the study sought to establish whether it influenced households' involvement in care giving to orphans and vulnerable children. The results of the study on the influence of mental disability on households' involvement in care provision for orphans and vulnerable children are presented in Table 2 below. It is evident from the tabulated results that majority or 66.9% (Strongly Agree 21.6% and Agree 45.3%) of the respondents affirmed that mental disability as form of disability status for orphans and vulnerable children influenced households' involvement in care giving to orphans and vulnerable children. Mental disability as form of disability for orphans and vulnerable children did not influence households' involvement in care giving to orphans and vulnerable children. This was according to 17.7% (Strongly Disagree 6.9% and Disagree 10.8%) of the study respondents. However, 15.5% of the respondents neither agreed nor disagreed that mental disability as a form of vulnerability influenced households' involvement in care giving to orphans and vulnerable children.

Table 2: Mental Disability and Households Involvement in Care Provision

Response	Frequency	Percent
Strongly Disagree	16	6.9
Disagree	25	10.8
Not Sure	36	15.5
Agree	105	45.3
Strongly Agree	50	21.6
Total	232	100.0

The existence of children with mental disability in the study area was confirmed by key informants and government officials. This was mentioned by ²/₁₀ of the key informants. Further, area children's officer also stated that there were mentally challenged children in the study area. However, she did not give the actual number of mentally challenged children. The existence of mentally challenged children in the study area is documented in the Nakuru county integrated development plan (2018-2022), which identifies 3317 children who suffer from various forms of disability including mental disability.

It was noted that a few households were involved in care provision for children with mental disability. Their involvement entailed assisting the children with personal hygiene, feeding, clothing and helping them in other activities of daily living. Households involved in care provision for children with mental disability also highlighted imparting of decision and problem-solving skills, and communication through nonverbal means as other roles they played in the lives of these children. Households also mentioned taking these children to schools as other activities undertaken. Besides these direct roles, households also ensured that the home environment was safe for these children in view of the challenges they faced.

"This child is so dependent and you have to do virtually everything for him. You have to clean, feed and clothe him. He does not even know how to button his shirt or clean himself after attending the toilet. You also have to constantly watch his movement in the house. He is very hyper and rarely settles down. You may think that he is in the house only to be alerted by the neighbour that he is outside the compound. You have to be watchful all the time. But doctors tell me that his condition will improve as he ages. So am hopeful that he will be better with time," (Female in her early 30s with a child with mental disability).

Care giving to children with mental disability was fraught with numerous challenges. A father with a mentally challenged child highlighted some of the challenges associated with care giving to a child with mental disability.

"There is so much stress and anxiety due to constant responsibility of caring for kids with mental disability. You experience burnout because you have to be there virtually all the time except when she is a sleep. It is also very expensive taking care of her because I have to regularly take her for physiotherapy for speech training, physical and social

exercises. The worst all of the challenges is that some people associate mental disability with some evil practices. They think that God is punishing you for having done something wrong. The fact that mental disability is a problem like any other problem experienced by human beings is not clear to all. It is very absurd," (Father of a girl with mental disability).

There was a clear pattern of intra-household care giving, where care giving to children with mental disability was predominantly being offered by biological parents or immediate family members. Parents of the children of mental disability also narrated the difficulties they faced in convincing other households to even temporary take custody of their children for a few hours to enable them pursue outdoor errands.

"It is very difficult to convince a neighbour to take care of my daughter just for a few hours so that I can even go to the market. There is only one household out of about ten households in the neighbourhood that normally heeds my request. The rest give so many excuses that clearly shows their lack of willingness to assist. Otherwise, most of the time I only attend to other activities over the weekend when my husband and the other children are available," (Mother of a girl with mental disability).

Apathy towards care giving to children with mental disability extended to paid labour. An informant, a mother of a girl with mental disability narrated the reluctance by house girls to work in households with children with mental disability. Further, the few who were willing to work often cited a much higher salary, arguing that working in such a household had inherent significant challenges.

"It is hard to find a house girl who is willing to work in my household. Three out four house girls that have been referred often change their minds as soon as they learn that I have a child with mental disability. They often argue that it is risky working in such a household since they will be held responsible if something bad happens to child with mental disability. Some ask for double or triple the salary paid to their counterparts working in households without a child with mental disability. Turnover is also very high among house girls that work in a household with a child with mentally disability." (Mother of a girl with mental disability).

While informants appreciated the vulnerability of children with mental disability and further underscored the need for households' involvement in their care, the study noted low involvement of households in their care. The study also noted that care giving to children with mental disability was not only emotionally draining but also required significant financial inputs. This study therefore attributes low involvement of households in care giving to children with mental disability to challenges associated with their care.

4.3 Visual Impairment and Households Involvement in Care Provision

Visual impairment as a form of vulnerability was cited by 70.2% (Strongly Agree 24.1% and Agree 46.1%) as a determinant in households' involvement in care giving to orphans and vulnerable children. On the contrary, 15% generally disagreed (Strongly Disagree 4.7% and Disagree 10.3%) that visual impairment as a form of vulnerability affected households' involvement in care giving to orphans and vulnerable children. Whether or not visual impairment as a form of vulnerability affected households' involvement in care giving to orphans and vulnerable children could not be confirmed by 14.7% of the respondents as presented in Table 3 below.

Table 3: Visual Impairment and Households Involvement in Care Provision

Response	Frequency	Percent
Strongly Disagree	11	4.7
Disagree	24	10.3
Not Sure	34	14.7
Agree	107	46.1
Strongly Agree	56	24.1
Total	232	100.0

A Nakuru based ophthalmologist observed that visual impairment was a common problem, with causes ranging from genetic, infections to nutritional.

“Visual impairment can be classified into three categories namely partial blindness, congenital blindness and complete blindness. Partial blindness is when an individual has some vision but not powerful enough. Congenital blindness is poor vision that an individual is born with. Complete blindness is when an individual cannot see or detect light at all and it is relatively very rare condition. In terms of prevalence, the common one is partial, followed by congenital and then total blindness”, (Nakuru based ophthalmologist).

The existence of visual impairment as a form of disability was confirmed by three out of ten key informants who stated that they had children with visual impairment in their households. However, all the key informants stated that they had interacted with children with visual impairment in one way or the other. Care giving to children with visual impairment included mobility training especially for severe cases, and provision of a safe environment to minimize hazards and obstacles.

The study found that children with visual impairment were at a greater risk of accidents and injuries due to inability to recognize obstacles and hazards on their way.

“A visually impaired child does not see where he/she is going. He cannot recognize hazards such as fire, stair case, depression and holes on the ground. It is also impossible for him to recognize sharp objects on the ground and floors. Some time he fails to accurately locate seats and ends up falling. Chances of him getting injured through falls and accidents are also very high. I have to be vigilant at all times”, (Mother of visually impaired boy).

While many households appreciated the plight of visually impaired children, the intention to get involve in care giving to these children outside the nuclear family was low. For instance, only one in ten informants responded in the affirmative when asked to state if they were willing to take care of a child with visual impairment who is not a member of the immediate family. Indifference towards care giving to children with visual impairment emanated from the dangers these children were prone to such as accidental falls and fires and which requires the presence of caregivers all the time.

“I have never had experience of caring for a visually impaired child. I do not whether I would manage to take care of such a child. It must be a very difficult task given that these children cannot see where they going yet as a kid you still want to play with other children. It means that you have to be there for them guide them as they walk around to ensure that they do not hit objectives and fall. I would be reluctant to take care of such a child unless the child belongs to the immediate family”, (Female in her late 40s).

It was apparent from the informants’ accounts that households’ involvement in care provision for visually impaired children was largely informed by familial relationships. Thus, the intention to get involved in care giving was high where the visually impaired child was a close member of the family. Involvement was, however, low where the level of visual impairment was severe and the visually impaired child was not an immediate member of the family.

4.4 Hearing Impairment and Households Involvement in Care Provision

Hearing impairment was also another form of disability status for orphans and vulnerable children that the study sought to establish whether it influenced households’ involvement in care giving to orphans and vulnerable children. The results of the study are presented in Table 4 below. It is clear from the tabulated results that majority or 70.7% (Strongly Agree 27.8% and Agree 43.9%) of the respondents agreed that hearing impairment as form of disability influenced households’ involvement in care giving to orphans and vulnerable children. However, hearing impairment as form of disability for orphans and vulnerable children did not influence households’ involvement in care giving to orphans and vulnerable children according to 14.4% (Strongly Disagree 4.8% and Disagree 9.6%) of the study respondents. However, 13.9% of the respondents neither agreed nor disagreed that hearing impairment as a form of vulnerability influenced households’ involvement in care giving to orphans and vulnerable children.

Table 4: Hearing Impairment and Households Involvement in Care Provision

Response	Frequency	Percent
Strongly Disagree	11	4.8
Disagree	22	9.6
Not Sure	32	13.9
Agree	101	43.9
Strongly Agree	64	27.8
Total	230	100.0

Households that participated in the study confirmed that children with hearing impairment were some of the vulnerable children under their custody. Majority or $\frac{4}{5}$ individuals engaged in the study confirmed that the children with hearing impairment under their custody were their biological children. Informants noted no major challenge in care giving to children with hearing impairment. They also pointed that they had learnt sign language and thus had no challenge communicating with the children.

“I know how to communicate with my child (referring to the child with hearing impairment) effectively. There is a non-governmental organization that trained us on sign language. My other children and majority of members of the extended family have also through practice learned sign language and therefore have no problem communicating with him. He is enrolled in an inclusive school and so he is doing well,” (Male parent in his late 30s with a child with hearing impairment).

A Nakuru based child counsellor contended that most households are reluctant to take custody of children with speech and hearing difficulties when asked about her views about households’ involvement in care giving to children with hearing problem. This was largely due to lack of tools and skills to communicate with such children.

“Knowledge of sign language is quite low in the general population. In my estimation, only one in twenty adults in Kenya is proficient in sign language. It this low level of knowledge of sign language that is discouraging people from embracing children with hearing problems. They wonder how they would communicate with such children and how they would make meaning of what these children communicate non-verbally,” (Nakuru based Child Counsellor).

The study undertook correlational analysis to test the relationship between disability status of orphans and vulnerable children and households’ involvement in care giving to orphans and vulnerable children. Disability status of orphans and vulnerable children was examined in the context of physical disability, mental disability, hearing impairment and visual impairment. Pearson Correlation was used with basic needs, educational support, personal care and counselling as proxy for dependent variable. The explained variable (dependent variable) was correlated against each of the four dimensions of disability status. The results of the study on the relationship between disability status and households’ involvement in care giving for orphans and vulnerable children are presented in Table 5.

Table 5: The relationship between Disability Status and Households’ Involvement in OVC Care

Disability Status		Households’ Involvement
Physical Disability	Pearson Correlation (r)	149*
	P-Value	.012
	N	232
Mental Disability	Pearson Correlation (r)	035
	P-Value	.098
	N	232
Hearing Impairment	Pearson Correlation (r)	.099
	P-Value	.067
	N	230
Visual Impairment	Pearson Correlation (r)	.104
	P-Value	.057
	N	232

There was a significant relationship between physical disability and households’ involvement in care giving to children with physical disability ($P < 0.05$). The correlation between physical disability and households’ involvement in care provision to children with physical disability was positive ($r = 0.149$). There was no significant relationship between mental disability and households’ involvement in care giving to children with mental disability ($P < 0.05$). The correlation between mental disability and households’ involvement in care giving to children with mental disability was positive ($r = 0.35$).

The relationship between hearing impairment and households’ involvement in care giving to children with hearing impairment was not significant ($P > 0.05$). However, the correlation between hearing impairment and households’ involvement in care giving to children with hearing impairment was positive ($r = 0.067$). It is also clear from the tabulated

results that there was a significant relationship between visual impairment and households' involvement in care giving to children with visual impairment ($P > 0.05$). There was also positive correlation between hearing impairment and households' involvement in care giving to children with hearing impairment ($r = 0.104$).

The results of correlation analysis in Table 5 shows that the more severe physical and mental conditions of children with physical and mental disability the less involved were households in their care. The results concur with the views of key informants, which showed that severity of physical and mental conditions of children discouraged households' involvement in the care. The results of the correlational analysis also show that the severity of hearing and visual impairment neither hindered nor enhanced households' involvement in care giving to children with hearing and visual impairment. The results align with the accounts of majority of key informants, which indicates that households cared for all children with hearing impairment notwithstanding the severity of their condition. However, the results are at variance with qualitative data, which revealed that households' involvement in care giving to visually impaired children decreased with severity of their visual condition.

5. CONCLUSION

Vulnerability status of orphans and vulnerability children that had the greatest influence of households' involvement in care giving were physical disability, visual impairment. Severity of physical and mental conditions of children discouraged households' involvement in care giving to orphans and vulnerable children. Mental disability and hearing impairment had the least influence on households' involvement in care giving to orphans and vulnerable children. Households were involved in care giving to orphans and vulnerable children notwithstanding the severing of children's hearing impairment and mental disability.

6. RECOMMENDATIONS

The study established that the burden of care giving to orphans and vulnerable children differ according to nature of orphanage (single and double orphans), gender, age, type and severity of disability. There is need for the government to tailor its social assistance programs for orphans and vulnerable children to the level of need and burden of care giving to these children.

Although households involved in care giving to orphans and vulnerable children were generally providing satisfactory services to these children, it was clear that they were doing so under serious resource constraints. Currently, government medical scheme for children under the age five is only limited to primary healthcare, yet majority of these children suffer from conditions that require specialized medical care. There is need for the government to extend its medical scheme for children to specialized healthcare given that majority of children under informal care system were required specialized medical care.

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