

**Accessibility and Utilization of Basic Health Care Services by Orphans
and Vulnerable Children (OVC) in Lurambi Division, Kakamega
District, Western Kenya**

By

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Degree of Master of Public Health**

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DECLARATION

STUDENT

This thesis is my original work and has not been submitted for award of a degree or diploma in any other institution of higher learning.

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DEDICATION

This work is dedicated to my beloved wife Martha Munoko, children Brian Pombo, Stanslaus Mang'oli, Melody Andisi, Immaculate Akumu, and Evyete Munyima for their support and being there for me and giving me their strength and morale to go on.

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ABSTRACT

Global estimate shows that Orphans and Vulnerable Children (OVC) comprise at least 15 percent of all children less than 15 years. In Kenya, approximately 2.6 million (12 percent), of children below 18 years of age are OVC, with majority being in western Kenya. A rapid assessment, analysis and action planning process (RAAAP) revealed that out of an estimated 10.6 million OVC in seventeen (17) countries in sub-Saharan Africa, only 8.6% were receiving one essential service as health care, psychosocial support or protection. Health, like education, is among the basic capabilities that give value to human life, by contributing to both social and economic prosperity. This can enable OVC to enjoy their potential as human beings; as better health translates into greater and more equitably distributed wealth by building human and social capital and increasing productivity. In Kakamega district, only 27% of OVC utilize basic health care services. This indicates that many of the OVC don't access and utilize basic health care services a situation that may make them unhealthy in the community set up. Unhealthy OVC may not attend school and therefore these children are in turn unproductive in the society. Consequently, there is need to investigate factors that contribute to low utilization of basic health care services in Lurambi by OVC. Another gap that OVC encounter is the challenges they face in rural parts of Kenya in accessing and utilizing the basic health care services which are little known. A cross-sectional study was therefore carried out in Lurambi division, Kakamega Central District, to determine the socio-economic and demographic characteristics of OVC, their knowledge and attitudes towards basic health care services, assessed the availability of basic health care services and their accessibility to OVC and eventually their utilization. Information from this study will be useful to OVC policy makers to design comprehensive strategies targeting OVC needs in the study area and other similar affected areas elsewhere. The formula $n = Z^2 (pq)/d^2$ was used to calculate a sample size of 385 OVC aged 10-18 years. Simple random, multistage and cluster sampling techniques were used as the sampling procedures. Quantitative data were collected using a questionnaire, whereas qualitative data was collected from key informants using a semi-structured interview schedule. Quantitative data were analyzed using Statistical Package for Social Sciences (SPSS) Version 16 to generate frequencies, cross tabulations and odds ratios (OR) to determine the association between individual independent and dependent variables. Qualitative data were transcribed and analyzed by thematic areas. The findings show more than half (53.5%) were paternal orphans and unemployed ones were likely not to access basic care. Majority of OVC (86.2%) knew what constitutes basic health care services, and had positive attitudes towards health care services and their providers, OR 39, (95%, Confidence Interval [CI]: 5.4-54.4), $p=000$ and OR 218 (95% CI: 95; 2-501.2); $P=000$ respectively. The available services were identified as immunization, maternal and child health, therapeutic nutrition, treatment of diseases, VCT, health education and safe water supply. Eighty one point three percent (81.3%) accessed the services, of which (72.8%) utilized them. Those who neither accessed nor utilized cited lack of information, long distance, stigma, discrimination, lack of privacy/confidentiality as reasons. It is recommended that strategies that will address physical inaccessibility such as outreach programmes and those addressing stigma, discrimination and payment waiving have potential to enhance accessibility and utilization of basic health care services in the study area.

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OPERATIONAL TERMS

In the context of this study, the following definitions were used:

Accessibility: The ability of an Orphan and Vulnerable Child to gain entry and receive basic health care services.

A child: A person aged 10-18 years old

An Orphan: A child (10-18 years-old) bereaved of a parent. This could be a *maternal orphan* a child who has lost a mother, *paternal orphan*, a child who has lost a father or a *double orphan*; *i.e.*, a child who has lost both parents.

An Orphan and Vulnerable Child (OVC): is an orphaned child and or a child whose vulnerability is as a result of the parents/caregivers morbidity, mortality, household poverty or other socio-economic problems that render the child unable to receive basic needs.

Attitude: A state of an OVC to respond to basic health care services favourably or unfavourably.

A vulnerable child: is one who faces the risk of physical, emotional or mental harm and whose survival, well-being and development is threatened.

Basic health care: A package of primary lifesaving interventions. They include: Immunizations, Maternal Child Health including deliveries, Reproductive Health, Family Planning, Health Education, Treatment of Minor Ailments (basic out-patient services) including referral services, Nutrition and safe water supply.

Health: is the state of physical and emotional well-being that provides an opportunity for individuals to achieve their greatest potential.

Knowledge: the state of an OVC being aware of basic health care services

Poverty: A state of a person living on less than one US dollar per day

Stigma: The self-feeling of guilty and/or unwanted by being negatively discriminated against by some prejudiced people.

Utilization: The outcome of the interaction between OVC and Basic Health Care Services.

ACRONYMS/ABBREVIATIONS

AAP:	American Academy of Pediatrics
ADEA:	Association for the Development of Education in Africa
AIDS:	Acquired Immune Deficiency Syndrome
BHCS:	Basic Health Care Services
CAFO:	Christian Alliance for orphans
ECBO:	Elite Community Based Organization
FBOs:	Faith Based Organizations
FHI:	Family Health International
GAA:	Global AIDS Alliance
GoK:	Government of Kenya
GoR:	Government of Rwanda
GoU:	Government of Uganda
HIV:	Human Immunodeficiency Virus
IDP:	Internally Displaced Persons
IFRC:	International Federation of Red Cross
IOM:	International Organization for Migration
KESSP:	Kenya Education Sector Support Program
KMTC:	Kenya Medical Training College
KNBS:	Kenya National Bureau of Statistics
MoDP:	Ministry of Devolution and Planning
MoGCSD:	Ministry of Gender, Children and Social Development
MoH:	Ministry of Health
MoPHS:	Ministry of Public Health and Sanitation
NACC:	National AIDS Control Council
NASCOP:	National AIDS and STI Control Program
NGO:	Non-Governmental Organization
OVC:	Orphans and Vulnerable Children
PATH:	Program for Appropriate Technology in Health
RAAAP:	Rapid Assessment, Analysis and Action Planning
SPSS:	Statistical Package for Social Sciences

UN: United Nations
UNAIDS: United Nations Program on HIV and AIDS
UNCRC: United Nations Commission for Human Rights of Children
UNICEF: United Nations Children's Fund
USAID: United States Agency for International Development
WB: World Bank
WFP: World Food Program
WHO: World Health Organization

CHAPTER ONE: INTRODUCTION AND BACKGROUND

1.1 Introduction

1.1.1 Definition of OVC

Some authors refer to Orphans and Vulnerable Children (OVC), as children who have lost a father, a mother or both parents (Hunter and Williamson, 2000). On the other hand, others refer only to children who have lost a mother or both parents (UNAIDS and UNICEF, 1999). Hence, the more inclusive the definition is, the higher the number of OVC. The more exclusive the definition is, the smaller the number of OVC. Other definitions consider different age ranges. Some schools of thought define an OVC as a child younger than 18 years who has lost one or two parents (Foster, *et al.*, 1997; UNAIDS and UNICEF, 1999).

1.1.2 Overview of OVC Situation

In 2010, UNICEF estimated that 153.3 million children worldwide aged 0 to 17 years old were orphaned, of which 17.8 million children had lost both parents (“double orphan”), while the remaining had lost one parent (“single orphan”). Of those who were single orphans, 34.5 million were maternal while 101 million were paternal orphans respectively.

There are currently an estimated 53.1 million orphans in sub-Saharan Africa. Of those children, 15.9 Million (30%) lost parents to the AIDS epidemic. In addition, there are currently 68.9 million orphans in Asia, giving this region the largest absolute number of orphans in the world (UNICEF, 2010).

Nationally, the current official data reveal that approximately 2.6 million (12 percent), of Kenyan children below 18 years of age are orphans and vulnerable children (Kenya National Aids strategic plan [KNASP] III). Approximately 1.2 million of the 2.6 million (46.2 percent) have been orphaned due to HIV and AIDS, and this number is expected to increase in the future (UNAIDS, 2010). At the national level, the Department of Children Services (DCS) under the Ministry of Gender, Children and Social Development plays a major role in coordinating various sectors and stakeholders in

responding to the OVC issues in Kenya. At the regional level, the DCS is represented through Provincial and District Children's Offices which are responsible for coordinating community efforts in close collaboration with Area Advisory Councils (AACs) and Locational OVC Committees (LOC). Lurambi division has the highest OVC population at 13,850, accounting for 36.5% of OVC in Kakamega Central District NACC, 2006; GOK, CBS, 2009; Ministry of Devolution and Planning [MoDP], 2013).

1.2 Background

According to Christian Alliance for Orphans (2015), there are many inherent limitations to any data that claims to be truly "global" in nature. While such inadequate data can help us gain a clearer picture of the size and scope of need, it can also be misleading. Current global orphan statistics are projections based upon data drawn from household surveys, which include only orphans that are currently living in homes. Thus, they do not include children that are not currently residing in a household. They do not count the estimated 2 to 8+ million children living in institutions. Nor do current estimates include the vast number of children who are living on the streets, exploited for labor, victims of trafficking, or participating in armed groups. Thus, global orphan statistics significantly underestimate the number of orphans worldwide and fail to account for many children that are among the most vulnerable and most in need of a family. Many of these children who live in orphanages or on the streets are known as "social orphans." Although one or even both of their parents may be alive, social orphans rarely see their parents or experience life in a family. Global orphan statistics shed virtually no light on the reality of the vast number of social orphans who have one or more living parents, yet experience life as if they did not.

Many millions of other children can be described as vulnerable, due to the effects of illness and poverty. There are many reasons for this situation, including conflict, disease, and accidents. However, a significant cause of the increase in orphans and vulnerable children has been the impact of the HIV pandemic (USAID, 2008).

Estimating the number of vulnerable children is a much more difficult task. As has been discussed, their extent depends upon their definition. In addition, countries' ability to monitor the extent of so broad a category of people is highly limited. It may be safe purely to say that number of vulnerable children is likely far to exceed that of orphans. Consequently, it may be difficult to plan specifically for these children as the statistics are not definite. This implies that most of these OVC are left out in all plans in relation to accessibility and utilization of health care services.

Global estimates reveal nothing about the distinct needs of individual children. Losing one or both parents increases a child's vulnerability greatly. But seeking the best outcome for each child requires knowing much more than orphan status alone. To help OVC, President George W. Bush signed into law the Assistance for OVC in Developing Countries Act in 2005 to ensure that all children have access to health care, nutrition, and education and support services (Global AIDS Alliance [GAA], 2005). All the 10% of HIV and AIDS funding from President Bush kitty is allocated to OVC programs to enable them access and utilize health care services (GAA, 2005).

1.2.1 Socio-economic and Demographic Characteristics of the Respondents

OVC, as an example of poor people are a global phenomenon. They (OVC) include children with increased vulnerabilities of all causes (USAID/UNICEF/UNAIDS/WFP, 2005). The number of these children is growing rapidly due to chronic poverty, armed conflict and famine (Pathfinder International, 2008). Many children in Africa have become orphaned and vulnerable as a result of HIV/AIDS (UNICEF, 2006; Andrews *et al.*, 2006). By 2010, it was estimated that about 18 million children below the age of 18 in sub-Saharan Africa would be classified as OVC due to HIV/AIDS (UNICEF, 2005, Amoako-Johnson *et al.*, 2010).

The future of OVC is at stake, especially regarding their access to and utilization of basic health care services. The survival, growth and development of OVC are greatly threatened as these children are subject to social neglect and discrimination (UNICEF, 2004a). Studies show that OVC are vulnerable in all aspects of their lives (Odiwuor

2000; World Bank (2002a). The loss of parents has far reaching and lasting consequences to orphans and vulnerable children. They are more likely to face malnutrition (Nyambedha *et al.*, 2001; UNICEF, 2003), have poor physical (Kamali *et al.*, 1996) and mental health (Foster and Williamson, 2000; Makame *et al.*, 2002; Nostlinger *et al.*, 2006), experience educational disadvantages (Ainsworth *et al.*, 2005; Case and Ardington, 2006); be exploited for child labour (UNICEF, 2003; UNICEF, 2004b); have elevated risks of HIV infection and sexually transmitted infections (STIs) (Gregson *et al.*, 2005; Juma *et al.* 2007); suffer from stigma and social exclusion (Gilborn, 2002; UNICEF, 2006); reduced access to healthcare and other services; face problems associated with poverty (Andrews *et al.*, 2006; Miller *et al.*, 2006) and lack adult care (Heymann *et al.*, 2007).

Major global causes of orphanhood and vulnerability include malaria, AIDS, tuberculosis, war/tribal conflicts, injuries, fires, natural or manmade disasters among other causes (GAA, 2005; WHO, 2006). Orphanhood due to HIV and AIDS is a global crisis (World Bank, 2002a). The number of children orphaned by the HIV pandemic is ever increasing. Thus, AIDS has been noted to be a major cause of orphanhood and vulnerability among children aged below 18 years (UNICEF, 2002). They lack basic assets and work for wages in order to make the ends meet. The OVC experience break-up of the nuclear family, leading to new living arrangements such as continuation of family units sometimes headed by as young as 10 or 12 years old, or living on the streets (World Bank, 2002a; KMTC, 2002). The existing gap is that the mindset of these OVC may not be well developed; therefore, they may have limited knowledge on the existing available basic health care services in the community. Consequently, might not be able to access and utilize these services. An OVC of 10 or 12 years old or those living on the streets may not relate the importance of basic health care services to his/her growth and development without guidance and direction of an adult. Thus, this may lead to the failure of utilizing these crucial services. In turn, these children may lead unhealthy and unproductive live in the community. When these children work for wages, may in most cases mistreated since some of them have no one to complain to or have no where to go.

Muula and others, (2003) reported that many orphans are being cared for by their grandparents or they take care of themselves. Some families are headed by children 10 years old or younger and this has led to a declining standard of care for these children. Orphan care in Kenya lacks the resources to provide adequate services such as education and healthcare to most orphans. These orphans will in the future translate into diminished human capital and less disposable income once they start working. As a result, Kenya's economy will not expand as fast as it would have done without the orphan crises, creating a challenge to realization of MDGs and Kenya's Vision 2030 (UN, 2002; GoK, 2010a).

Regarding socio-economics, the main reasons for low utilization of these basic health care services by OVC may be attributed to high levels of poverty, cost of services, negative attitudes that led to stigma and discrimination experienced by OVC (UNAIDS, 2002; Boler and Carrol, 2003; WHO, 2006; MoDP, 2013). Lack of access to information and the presence of an environment that does not guarantee the privacy and confidentiality of OVC have further increased the gap of non-utilization of essential health care services (Family Health International [FHI], 2006; Pathfinder International, 2008). According to the study findings in Kakamega district, 30% of OVC sleep on floor without a cover (Elite Community Based Organization [ECBO], 2011). This may be associated with poor socio economic status of the community, an indication that they may not afford cost sharing fee for services.

1.2.2 The Knowledge and Attitudes of OVC towards Basic Health Care Services

OVC are categorized as a group with special needs in order to track down their welfare (UNAIDS, 2002). This categorization is important for identification of the specific cause of vulnerability or orphanhood. However, it is again contested that such categorization inadvertently leads to the risk of increased stigmatization and discrimination that may be a barrier to the utilization of essential basic health care services (UNAIDS, 2002; Boler and Carrol, 2003). Categorization consequently may lead to finger pointing by some prejudicial members of the community for it may be easy of being singled out and labeled OVC for what ever purpose.

In Kenya, the age of 18 years is considered as a dividing line between a child and an adult (GOK, 1963; GOK, 2001; GOK, 2010b; GOK, 2012). UNAIDS and UNICEF include only children younger than 15 years (UNAIDS and UNICEF, 1999). This leaves out the whole group of OVC aged above 15 years to 18 years (WB, 2002b). It is further noted that it is difficult in collecting reliable data on children orphaned or made vulnerable especially by AIDS due to the stigma associated to the condition. Most studies report very little about the OVC enumeration methods (WB 2002a). Because of stigma attached to being an OVC in most communities, many people would not like to be counted as belonging to this group.

Several studies (Atwine, *et al.*, 2005; Cluver and Gardner, 2006; Zhao, *et al.*, 2007; Boris *et al.*, 2008) show many OVC to have symptoms of depression, anger, hopelessness, loneliness, low self-esteem, and suicide ideation, delinquency, increased sexual activity, withdrawal and difficulties concentrating in school. Without adequate intervention, such behaviors will place an entire generation of OVC at increased risk for further harm. UNICEF (2006) estimates that $\leq 10\%$ of children orphaned and made vulnerable by AIDS are receiving any type of support. Notably, existing gap is that traditionally, OVC were mainly supported by their extended families and communities; however, this traditional social safety net is under severe threat due to social and economic strains. As a result, these entities have critically become weak and their capacity to continue providing care, protection, and assistance for these children may non existence. No study on assessment of accessibility and utilization of basic health care services has been conducted in the area, despite recorded high number of OVC in the district. There is need for designing and promoting appropriate safety nets for care, protection and support to OVC through community participation.

1.2.3 Availability of Basic Health Care Services to OVC

Healthcare is one of the main social services essential for the well-being of OVC. It includes preventive measures which involves actions aimed at preventing or avoiding illnesses; and curative care which is centered at actions which are taken once a person falls ill or is injured to reduce or completely remove pain (Pathfinder International,

2008). Healthcare services can be available within a walking distance but it has been observed that this particular population may have limited knowledge in most of available health care services crucial for their well-being. This is contrary to the Convention on the Rights of the Child which includes specific rights regarding health (FHI, 2006; Pathfinder International, 2008). Examples of these rights which should be accessed and used by the child among them OVC include, right to: medical care, confidentiality, informed consent and access to basic health care services (GoK, 2010b). In many situations, orphans and other vulnerable children do not enjoy the benefits of these rights (UNICEF, 2005).

Basic health care services include immediate curative and preventive health care for the beneficiaries (International Federation of Red Cross and Red Crescent Society [IFRCRC], 2008). Basic health care services also include provision of basic outpatient services, maternal-child health (including deliveries), community health outreach, immunization and nutritional surveillance, safe and sufficient water supply for washing, bathing and extra for cleaning and; therapeutic feeding treatment and referral services for further specialized management of more serious cases to other hospitals (International Federation of Red Cross and Red Crescent Society [IFRCRC], 2008).

In the study area (Lurambi division), most of the health facilities offer outpatient services including: immunization, maternal and child health and treatment of common diseases (Ministry of Devolution and Planning [MoDP], 2013). The main problem noted is that these services available may mostly not be suitable for the OVC population under study. Consequently, these children are forced to cover long distances in search of services suitable for their age like VCT, specialized treatment, nutritional foods for those who are HIV and AIDS positive; and reproductive health in those facilities located far away from Lurambi division. These long traveling distances require money for transport which may not be available and therefore becoming a hindrance to service utilization by OVC.

1.2.4 Accessibility of Basic Health Care Services to OVC

One of the five most important principles of Primary Health Care (PHC) is the universal coverage of the population or people's access for the health services (WHO, 1978). Accessibility implies “the continuing and organized supply of care that is geographically, financially, culturally and functionally within easy reach of the community” (Bhatti 2005). The geographical accessibility means “the distance, travel time and means of transportation are acceptable to the community”.

In the healthcare context, ethics require that a principle of ‘access according to need’ and ‘equal access for equal need’ is followed (Mooney, 1992 cited in Gillström, 2001). Access being defined as the ease with which health care is obtained (Agency for Health Care Policy and Research 1995 cited in Lawthers *et al.*, 2003) or the freedom to use healthcare (Thiede, 2005). However, the consistently inequitable nature of health systems limits the access of quality healthcare to the poor who mostly are the OVC who need them most (Gwatkin *et al.*, 2004). Health systems are frequently ineffective in reaching the OVC, generate less benefit for the poor than the rich, and impose regressive cost burdens on poor households (Fabricant *et al.*, 1999). Neglect, abuse and marginalization by the health systems are part of their everyday experience (WHO, 2002; Ministry of Devolution and Planning [MoDP], 2013). Experience suggests that OVC, will be effectively excluded unless services are ‘geographically accessible, of decent quality, fairly financed and responsive (Narayan *et al.*, 2000).

These disadvantaged children are not distinctively identified in funding of flagship projects of Kakamega County (MoDP, 2013). The notable gap is OVC are grouped together in Youth Enterprise Fund targeting all youth groups in business for financing registered groups in Income Generating Activities (IGA) for self-reliance. This indicates that a larger proportion of OVC who may not be in youth groups are left out in these IGA funding and therefore, may have no source of income to pay for cost sharing fee for utilization of health care services.

Vital disparities persist in the capability of the world's nations to provide a basic level of needed services to enhance the life chances of those who are the most vulnerable; the poor, the sick and the disadvantaged. The reality of these deep human scars is immense. In the context of these wide spread disparities within and among nations, the percentage of the population that does not receive health services on a permanent and continuous basis is on the increase and their problems are becoming more serious. This indicates that a larger proportion of this disadvantaged population may not be accessing and utilizing health care services.

1.2.5 Utilization of Basic Health Care Services by OVC

Utilization of health care services by the OVC is globally low. Findings of the Rapid Country Assessment, Analysis, and Action Planning (RAAAP), revealed that out of an estimated 10.6 million OVC in seventeen (17) countries in sub-Saharan Africa, only 8.6% were receiving one essential service as health care, psychosocial support or protection (USAID, 2005). This is an indication that majority of the OVC don't use these essential health care services in the community. The low utilization of these services may be due to high levels of poverty, cost of services, stigma and discrimination experienced by OVC; and lack of access to information and environment that does not guarantee the privacy and confidentiality of OVC. Consequently, non utilization may lead to unhealthy living that in turn promotes high rates of mortality from preventable diseases like diarrhea.

A study by the American Academy of Pediatrics [AAP], (1997) established that as many as 75% of the OVC have dental carries on their first screening in the dental clinic than other children who were attended to in the same clinic. It was further observed that nutritional disorders among OVC are common and are at increased risk of being deficient in meeting anthropometric measures as height-for-age and weight-for-age measures (AAP, 1997). These disorders were due to inadequate intake of a balanced diet. It has been observed that provision of reproductive health and family planning information and services are critical to the wellbeing and future health of OVC (Pathfinder International, 2008). This is another gap which these OVC face. It reveals that most of these children

fail to seek treatment than other children who may have parents to take care of them, a situation that may be associated with limited information and lack of direction on the importance of available health care services.

The current official data in Kenya reveals that approximately 2.6 million (12 percent), of Kenyan children below 18 years of age are orphans and vulnerable children (Kenya National Aids strategic plan [KNASP] III). Approximately 1.2 million of the 2.6 million (46.2 percent) have been orphaned due to HIV and AIDS, and this number is expected to increase in the future (UNAIDS, 2010). At the national level, the Department of Children Services (DCS) under the Ministry of Gender, Children and Social Development plays a major role in coordinating various sectors and stakeholders in responding to the OVC issues in Kenya. At the regional level, the DCS is represented through Provincial and District Children's Offices which are responsible for coordinating community efforts in close collaboration with Area Advisory Councils (AACs) and Locational OVC Committees (LOC).

In the period 2007-2010 there was the development of National Plan of Action (NPA) for OVC that provides the framework for a coordinated multi-sectoral and sustainable approach to supporting OVC in Kenya. The NPA identifies the need for OVC programs to ensure access for OVC to essential services, such as food and nutritional support; shelter and care; protection; health care; psychosocial support; education and vocational training and economic opportunity/strengthening. In 2009, the GOK merged all separate national policies on various profiles of children into the Kenya Children Policy which provides the framework for addressing issues related to children's rights and welfare in a holistic and focused manner. It includes the establishment of social and child protection mechanisms as a specific policy objective.

In Kenya, basic health care services are available but their utilization is low (Ministry of Health [MoH]), 2006. This is contrary to the National Plan of Action (NPA) which provides the framework for a well guided national response to OVC who require utilization of quality services that will significantly guarantee their transition to

responsible adulthood (Zhou, 2012). Currently, it is unclear why most OVC do not use these available basic health care services. Even in urban areas where physical accessibility is not considered a major constraint, 25% don't utilize basic health services (MoH, 2006). According to the study done in Rarieda and Gem districts in Nyanza Province, accessibility to basic health services was high but utilization was low (Van Eijk, *et al.*, 2006). Use of professional service providers was low, almost 1 out of 5 of this disadvantaged group delivered unassisted (Van Eijk, *et al.*, 2006). This findings indicate that a significant proportion (80%) of this vulnerable group fail to seek and or utilize professional service providers. This may increase their risk to complications and even deaths under such situations.

In addition, low utilization (27%) of these services in Lurambi division, Kakamega Central district may be attributed to costs involved, language and cultural barriers, fear of identification and severe shortage of service providers where one doctor and one nurse serve 34,916 and 2,658 patients respectively in the county (Ministry of Devolution and Planning [MoDP], 2013). The ratios are contrary to the recommended national ratios of 1:6250 and 1:654 respectively; as well as the WHO recommended ratios of 1:2778 and 1:281 respectively (WHO, 2010). Staff shortages lead to long queues, overcrowding and congestion which turn away would be OVC clients in need of these services. As a result, they may not access and utilize these live saving services.

1.3 Statement of the Problem

Kakamega District, like other districts in Kenya has not been spared by the high numbers of OVC. In the study area, OVC population was estimated to be 36,000 in 2001 and increased to 38,000 in 2006. Lurambi division has the highest OVC population at 13,850, accounting for 36.5% of OVC in Kakamega Central District. These OVC, face social and development challenges. Only 27% of this population access and receive basic health care services. The reason why majorities (73%) don't access health care is unknown. This non-accessibility to healthcare exposes OVC to illnesses that make them unhealthy in the community increasing their risk of morbidity and mortality; and it diminishing their opportunity to attend school. In addition, those who are ill cannot work productively

in the society, while some of them suffer from mental stress. Thirty percent of OVC sleep on floor without a cover. This may be attributed to poor socio-economic status where most of them live below poverty line and may not have money to buy beddings.

Twenty percent (20%) of the OVC head households and may not receive basic health care services like provision of basic outpatient services, maternal-child health (including deliveries), community health outreach, nutritional surveillance and balanced diet to prevent illnesses arising out of malnutrition, sanitation and safe and sufficient water supply for washing, bathing and extra for cleaning from prevention and; therapeutic feeding treatment, access to bed nets and other accessories of common diseases such as malaria, information about adolescent sexual and reproductive health and dental care and referral services for further specialized management of more serious cases to other hospitals. Tremendous time and energy are wasted in search of health care services that are scarce in the area, as they are situated far away from their homes. Long distances covered to access and utilize health care services may require money for transport in the form of motor bikes, or taxis which may not be readily available.

It is against this background that this current study was therefore designed to investigate factors influencing access to and utilization of basic health care services in Lurambi division, Kakamega district, an area highly prevalent of OVC in the District. Information from this study will be useful to OVC policy makers to design comprehensive strategies targeting OVC needs such as addressing reasons for inaccessibility and non-utilization of basic health care services in the study area and other similar affected areas elsewhere.

1.4 Objectives

1.4.1 Broad Objective

To investigate determinants of accessibility to and utilization of basic health care services by OVC in Lurambi division, Kakamega Central District.

1.4.2 Specific Objectives

- i. To determine socio-economic and demographic characteristics of the study respondents
- ii. To determine the knowledge and attitudes of OVC towards basic health care services
- iii. To assess the availability of basic health care services to OVC
- iv. To assess the accessibility of basic health care services to OVC
- v. To establish the utilization of basic health care services by OVC

1.5 Research Questions

- i. What socio-economic and demographic factors affect accessibility and utilization of basic health care services by OVC?
- ii. What is the knowledge and attitudes of OVC towards basic health care services?
- iii. To what extent do OVC access basic health care services?
- iv. Which basic health care services are available to OVC?
- v. What is the level of utilization of basic health care services by OVC?

1.5 Justification of the Study

OVC needs are often unmet as a result of a care giving gap that currently exists in many communities. Available evidence show that 20% of these children are heads of households and live on their own (Elite Community Based Organization [ECBO], 2011) or are taken care in households headed by grandparents, who, because of their own health limitations, are unable to provide adequate care and support (Gbadebo *et al.*, 2003). There is high incidence of child labor where these children are herding cattle (in the case of boys) or are house girls.

The proposed study area has the highest number of OVC than other divisions in the study district. They number 13,850 accounting for 36.5% of the 38,000 OVC in Kakamega Central District. Those who head households accounting to 20% are unlikely to access and utilize the basic health care services (GOK, 2002; NACC, 2006; ECBO, 2011). This exposes OVC to morbidity and mortality resulting from preventable diseases making them unhealthy in the community and ill OVC may not attend schools. Those who are ill cannot work productively in the society. Despite the government's efforts to provide health care services to its entire people, the proportion of OVC utilizing these services in Lurambi division is only 27%. This indicates that a larger proportion of this disadvantaged group don't enjoy these lifesaving services.

The majority of OVC are mostly neglected by economic and social empowerment initiatives. Study findings in Lurambi division, Kakamega district established that 30% of OVC sleep on floor without a cover. This is an indication that they cannot afford money for beddings. No any income generating activity for self-sustainability has been initiated for them (Elite Community Based Organization [ECBO], 2011). Limited studies on access to and utilization of basic health care services have been conducted in the area. Donors, implementers and policymakers in Government require sound data to make decisions about how to effectively improve quality of life of families affected by AIDS without inadvertently causing harm, and to derive lessons for how best to manage and deliver interventions. Developing and scaling-up effective interventions to mitigate the impacts of HIV among children without further jeopardizing their rights requires evaluation, including seeking input of community members and stakeholders. This study was therefore carried out to assess the living situation of orphans, specifically with regard to access to and utilization of basic health care in Lurambi division, Kakamega Central District in western Kenya.

The findings of this study will be useful to policy makers on issues affecting OVC to design comprehensive strategies addressing needs of OVC including their inaccessibility to basic health care services. The study will also generate baseline information that may be used to set priorities and operationalize OVC programs and allocation of resources to

OVC. It is also anticipated that the findings will provide information that will stimulate discussion by the Government, local community, partners and other stakeholders that may influence OVC to enjoy more equitable access to health care and improve their overall wellbeing through utilization of basic health care services in the study area and other similar resource constrained areas elsewhere devastated by OVC challenges.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This chapter reviews literature based on the study objectives. It covers socio-economic and demographic characteristics of the study respondents, their knowledge and attitudes towards basic health care services; looks at the availability of basic health care services to OVC, their accessibility of basic health care services and lastly their utilization.

2.2 Socio-economic and Demographic factors that Hinder Utilization of Basic Health Care Services by OVC

Orphans and vulnerable children face a long series of essential service deprivations (UNICEF/IRC, 2008). Among them is diminished access to health care services. It has been argued that the problem of public care for OVC has been compounded by dismantling of the free health care systems in most sub-Saharan Africa due to World banks, structural adjustment programmes (UNICEF/IRC, 2008). The changes in health financing systems have promoted the non-utilization of basic health services. Out-of-pocket payments have risen sharply and increases in user fees (cost-sharing) correlate with decreased service utilization by the OVC. Excessive cost of health services has made the accessibility and utilization of health services decline and so has hospitalization for this vulnerable group (UNICEF/IRC, 2008).

In developing countries, attempts have been directed towards promoting accessibility and utilization particularly among the OVC, but success has been limited. Free medical services as a means of improving utilization through the elimination of financial barriers has formed a major issue of political activism. Success in this direction has been limited due to inappropriate structures that result from not tuning planning and management activities towards utilization (Oladipo, 2014). This situation is compounded by other existing problems including. This is due to rapid population growth, increasing demand for health services against dwindling resources and faulty allocation of limited resources. Internal inefficiency of government health care programs and health services due to civil wars and inadequate support infrastructural facilities like water, electricity and good roads

Generally, a wide range of factors limit OVC's access to health care services (UNICEF and POLICY Project, 2004c). While other children may have easy access to health care services, these disadvantaged children may not. This is due to: poverty resulting from low resource base and lack of basic credit and employment facilities in most rural communities, distance, gender and age, attitude of parents/caregivers to the value of education and health care services. Most OVC, have increased chances of becoming malnourished and abandoned due to the fact that no one really cares what happens to them (UNICEF and POLICY Project, 2004c).

It has been reported that vulnerability poses unique stress on children and families (AAP, 1997). For instance, vulnerability includes separation from support systems, disparities between social, professional, and economic status; and ongoing depression, grief, or anxiety resulting from traumatic events that may have occurred. It is also noted that OVC have health problems that are often undiagnosed including tuberculosis, parasitic infections, HIV infection and lack of immunization and other health issues. OVC may exhibit different health care-seeking behaviours for they are without adults who can provide information about their medical and social history. Some OVC join families with whom they have no common language or physical similarities or might be adopted by parents who have no experience with child-rearing, exposing them to more risks (AAP, 1997).

According to other reports, many OVC today lack family, medical and community care, and bear responsibilities beyond their ability and experience (United Nations, 2008). Other reports show that many are forced into high-risk labor, including commercial sex work, to support or to enable them access health care services. This increases morbidity and mortality resulting from social diseases like HIV and AIDS among the OVC. Some of them become physically disabled and remain unproductive to the community in the rest of their lives (United Nations, 2008; IOM, 2010).

Studies have also established that OVC may have reduced chances of accessing basic health care services because there is little or no money for cost-sharing, stigma and

discrimination due to common misperceptions surrounding HIV/AIDS (ADEA, 2003). These children may be placed in foster care of extended family members, who themselves might be poor (Amoako-Johnson *et al.*, 2010). In many cases, OVC are cared for by their grandparents, who might be too old and illiterate that they may not value basic health care (World Bank, 2002b). Sometimes due to lack of a parent, the household may be headed by a fellow child. A child cannot provide social transition from one age group to another as the child himself/herself requires direction on social life that generally lacks in child headed households (Earnshaw *et al.*, 2009) or may be taken to orphanages. This orientation of the child's life may impact negatively on their social wellbeing (WB, 2002b). Anecdotal evidence has it that the opportunity cost of health increases and related stigma and discrimination in the community on the part of peers and parents poses a challenge to the OVC that may hinder their utilization of health services (Boler and Carrol, 2003). Erosion of family values exposes OVC to rape, incest, depression, lack of protection, stress, gender-based violence and HIV/AIDS (WB, 2002b).

The problem of increasing accessibility to health care services is being addressed in some countries like Uganda through abolishing of cost-sharing in public health facilities since 2001 as it had been found that 43% of the people in rural and 36% in urban areas do not seek health care services due to lack of money (UNICEF/IRC, 2008; GoU, Ministry of Gender, Labour, and Social Development [MGLSD], 2008).

Study findings have also established that problems encountered by OVC of ages 13-18 years were psychosocial, trauma coupled with ostracism, discrimination and stigma as a result of their being categorized as OVC (Hunter and Williamson, 1997; Gilborn, *et al.*, 2001). Psychosocial trauma makes them unhappy in communal environment and are often less likely to attend health care services. To avoid the inadvertent stigmatization to this disadvantaged group, it has been suggested that sensitivity awareness of orphanhood and vulnerability need to be undertaken to save this group (Boler and Carrol, 2004).

It has been observed that 180,000 orphans in Lesotho whose estimated population is 1.8 million have access to quality health and psychosocial support (UNICEF, 2007). This

figure was predicted to increase to 210,000 by 2010. There is no current data exhibiting on either category of vulnerable children including abandoned, children with disabilities, and sexually exploited (UNICEF, 2007). Increasing numbers of orphans results in their increased burden of being heads of households and caregivers (UNICEF, 2007).

The loss of an adult, at an early age especially a father will reduce house hold income and assets, while increasing expenditure on health care services, funerals and memorials and increasing the dependency ratio in the home (Birdthistle, 2004). When a parent dies, the amount of resources available for basic health care services diminishes. As a result, OVC are more likely not to use basic health services due to the levies in terms of cost-sharing. Hence, health services become unaffordable and due to reduced income and increased expenditure, money allocated for health expenses is also reduced (Boler and Carrol, 2003; Smart *et al.*, (2003).

OVC remain most intractable of all issues related to care and support (Smart, *et al.*, 2003). The increased spiral of adult's deaths in many countries in sub-Saharan Africa means that the number of children orphaned each day is expanding exponentially. When most children with their parents receive adult love, guidance, and protection, OVC with child headed households lack adult love, guidance, and protection and in turn, fail to access and utilize basic health services. Political leadership in Kenya has observed that special attention must be given to the needs of the millions of orphaned children in Africa, for instance the need for parental care, food, shelter, education and, health care (Kibaki, 2003, Government of Kenya [GoK], 2010).

The rapidly growing number of OVC presents a major challenge to sub-Saharan African health systems. The loss of wage earners in the family can result in poverty exacerbating the situation of orphan's non-utilizing of health care services. Supporting the direct and indirect costs of other basic health care services becomes increasingly difficult as medical and funeral expenses absorb family resources (ADEA, 2003).

The death of one or both parents affects OVC in many ways, causing setbacks in education, health, nutrition, and psychosocial wellbeing as well as increased vulnerability

to HIV and sexually transmitted infections (Fisher, *et al.*, 2002). It has been observed that operation research studies are urgently needed to identify cost-effective models for assisting OVC utilize health and nutrition among other needs (Fisher, *et al.*, 2002, Kidman *et al.*, 2007).

Silence surrounding death in many societies in Africa leads to emotional problems which later impact negatively on the child's health (Boler and Carrol, 2003). OVC thus need access to bereavement counselors to improve their motivation for wellbeing due to depression and anxiety.

According to the study findings in Kakamega district, 30% of OVC sleep on floor without a cover (Elite Community Based Organization [ECBO], 2011). This reveals that a larger population lives below poverty line of one US dollar per day. As a result, they may not access and utilize basic health care services where they are required to pay cost sharing fee. No study has been conducted in the study area, assessing socio-economic related factors that have potential to influence accessibility and utilization of basic health care services to inform interventions target to this vulnerable group, hence the need for this study.

2.2.1. Gender Perspectives

Expectations about what it means to be a man or a woman, which are an integral part of the socialization process, leave many youth and adults ill prepared to deal with their sexuality or protect their health. Gender influences sexual behaviour, especially when stereotypical assumptions are considered (Ministry of Planning, 2003).

In most African communities, the girl child OVC is discriminated against and due to reduced income and increased expenditure, money allocated for health expenses is also reduced. The forced early marriage of OVC girls to older men, as well as more willing unions between young people is prevalent in some parts of the world including Kenya (Ministry of Planning, 2003; UNICEF and POLICY Project, 2004c; ; MoDP, 2013).

The existing gap is that the OVC girl is given out in marriage as young as 12 years old in quest of dowry from husbands against her wish. This is to either reduce the financial and social burden of the child on the caregivers, or used as a source for the family to raise fund for other family commitment including payment of educational bills for other siblings, especially the male ones. When she refuses, she is threatened with death.

Stereotypes of submissive females and powerful males restrict access to health information, hinder communication between young couples, and encourage risky behaviour among young women and men in different, but equally dangerous ways that in turn limits utilization of health care services (Ministry of Planning, 2003). Ultimately, these gender disparities increase adolescents' vulnerability to sexual health threats such as gender-based violence, intergenerational sexual exploitation, unplanned pregnancy, unsafe abortion and sexually transmitted infections including HIV/AIDS (Adaji *et al.*, 2010).

Another gap is the power imbalances between men and women which sometimes may make it difficult for adolescent OVC girls to refuse unwanted or unprotected sex, negotiate condom use, or use contraception against a partner's or husband's wishes. Gender roles may impinge one from accessing or utilizing basic care especially if community or health care providers are insensitive to gender when offering services and there is need for a study to address this aspect in the study area, known for high prevalence of OVC.

2.3 The knowledge and Attitudes of OVC towards Basic Health Care Services

2.3.1 The Knowledge of Basic Health Care Services by OVC

Consistent with the Andersen model, knowledge has been identified as a determinant of accessibility and utilization of basic health care services. The interrelationship between knowledge and attitudes is apparent and difficult to disentangle (Andersen, 1995).

Within the knowledge domain, several themes emerged: the content and amount of information available, the source of the information, and the accessibility of the

information. Gaps in knowledge were commonplace among both African-American and white participants, who reported inadequate information about the types of services offered, eligibility rules, legal and regulatory issues (for instance, licensing and supervision requirements), and financial coverage for different services (Andersen, 1995). Sources of information varied greatly and included family, friends, social workers, other medical professionals, lawyers, and clergy. Accessibility of information included its attainability and its comprehensibility. Knowledge was hypothesized to have a direct effect on use of health care services.

Basic health care services include immediate curative and preventive health care for the beneficiaries (International Federation of Red Cross and Red Crescent Society [IFRCRC], 2008). They include provision of basic outpatient services, maternal-child health (including deliveries), community health outreach, immunization and nutritional surveillance, safe and sufficient water supply for washing, bathing and extra for cleaning and; Therapeutic nutrition for malnourished children and/or children who are taking antiretroviral drugs and referral services for further specialized management of more serious cases to other hospitals, Prevention of Mother to Child Transmission (PMTCT), Voluntary Counseling and Testing (VCT) and Antiretroviral therapy (ARV) for HIV/AIDS infected children/parents, education and prevention against infancy related diseases, Education and prevention against other diseases and pandemic diseases, hygiene education and reproductive health and prevention against HIV/AIDS, nutrition education, Social assistance to children and optimal shelter (International Federation of Red Cross and Red Crescent Society [IFRCRC], 2008; GoR, 2009).

The knowledge of OVC on basic health care services provided by various organizations in the community in Zambia is high. They identified psycho-social support, food and nutrition, health care, shelter and care and child protection (USAID, 2009). It was further established in in-depth interviews that most of these services have concentrated on the age group of 6-17 years with little focus on OVC under 5 years and those above 18 years. There are few or no services targeted at vulnerable youths after the age of 18 years when they are no longer OVC (USAID, 2009).

A study by GoU, Ministry of Gender, Labour, and Social Development [MGLSD], 2008) on OVC service provider at Kampala, Uganda through Focused Group Discussion with OVC, established that OVC have sufficient knowledge and are aware of the basic health care services they require. On the other hand, some service providers lack knowledge on OVC issues. They cannot therefore sensitize the OVC in order to raise their level of understanding on what they may require like health care services. In return, those who are to use the services will not use them because they are not aware of their importance and existence within the community. Those service providers who have knowledge on OVC issues empower them with information to raise the level of knowledge in all that affects them in line with basic health care services (GoU, MGLSD, 2008).

The OVC know that they are categorized alone in order for them to benefit in terms of provision of services like basic health care services among others in order to track down their welfare (UNAIDS, 2002; Boler and Carol, 2003). However they also noted that continued categorization of OVC may lead to increased stigmatization and discrimination. For effective intervention beneficial to OVC in the study area, there is need for this study to assess knowledge, attitude and practice regarding health care services and their providers in order to design effective information education and communication strategies targeted to OVC.

2.3.2 The Attitudes of OVC towards Basic Health Care Services

OVC perceive levies such as cost-sharing as a hindrance to utilization of health care services (WB, 2002a; Nath and Garg, 2008). Studies from Zambia, El Salvador, the United States and the United Kingdom have shown that OVC have negative attitudes towards staff from public health care facilities because these service providers are unwelcoming and judgmental (PATH, 2004). OVC further view service providers very negative as they don't treat them with respect, while others don't consult them at all. OVC are never involved in decision making as most of them are viewed as law breakers especially the street children (GoU, Ministry of Gender, Labour, and Social Development [MGLSD], 2008). Health care service providers may be prejudiced against them (Pathfinder International, 2008).

The attitude towards basic health care services is negative because they get embarrassments when they go for the services. The service provision sites lack privacy and public clinics may not open when services are most needed as majority of them don't operate during weekends and public holidays (PATH, 2004; MoDP, 2013). It was further reported that OVC preferred places with shorter or no waiting periods, no intimidating waiting rooms, more accessible and friendly staff, no consultation or counseling fee, more anonymity and convenient locations in neighborhoods where they live (Beitz, 2004; Nath and Garg, 2008).

The number of OVC who have little or no access to basic health services will significantly increase unless immediate action is taken. This will lead to the stagnation of socio-economic development of most countries for many years to come (World Bank [WB], 2002b). In addition, improved documentation of approaches is required in order to share successful experiences of orphanhood and vulnerability. Communities and families are doing much to care for the orphaned children by providing foster care for them (WB, 2002a). But they will be increasingly unable to cope with the ever-growing numbers of the same in sub-Saharan Africa (WB, 2002a; Oladipo, 2014).

Most of the OVC feel different from others especially when they are discriminated and categorized as OVC (ADEA, 2003). This disadvantaged group needs service providers who treat them with dignity and respect; and addressed and referred to in a manner that is not demeaning. That is, negative attitudes being displayed towards them ((ADEA, 2003; GoU, MGLSD, 2008; GoK, 2010c; MoDP, 2013). The gap here is, while the other children who are non-OVC may use health care services freely, OVC may avoid utilization of health care opportunities due to social frustrations. These children change homes more than once. They lack adult love, guidance, and protection. They incur teasing, isolation, gossip, and even neglect and abuse. These circumstances lead to shame, withdrawal, depression, grief and sadness, fear and anxiety and "acting out" which may lead to anti-social behaviour that in turn may block their accessibility and utilization of basic health services.

There are limited interventions targeting OVC in Lurambi. There is need for proper interventions to optimize service delivery targeted to OVC. Hence, it was important for this study to be carried out in the area to gauge OVC attitude towards health care services in order to relate the impact of their attitude to health care access and utilization.

2.4. The Availability of Basic Health Care Services for OVC

Most health care facilities are located in urban centres with scarcity in rural areas (Pathfinder International, 2008). OVC face many social, economic and cultural “barriers” to health care in both urban and rural areas (Pathfinder International, 2008). Health care service providers in health facilities where services are available may be prejudiced against them. OVC also face inconvenient and inflexible service delivery, financial, legal and policy barriers, lack of privacy and confidentiality, poor quality of care, including judgmental and unfriendly service providers in addition to punitive attitudes towards them that block their access to available essential health services (Pathfinder International, 2008).

The available health care services especially preventive services are underutilized by OVC. Such services include sexual and reproductive health and dental care (American Academy of Pediatrics [AAP], 1997; IOM, 2010). This may be attributed to cost sharing levies paid by those served in the health facilities and since most of the OVC may not have money, they may not access the services like the non OVC who may be paid for by their parents. Language, cultural barriers and fear of identification may further deny these disadvantaged children to access these services. The existing gap here is that the staff offering the services may not understand the local language while the OVC may not be fluent in official or national languages used as media for communication in the available facilities. These may further contribute to OVC delay seeking care or clog their access to the available health care services for minor conditions until those conditions become more serious. A complicating factor to providing access to care by OVC especially the immigrant families is the possibility that various family members may have different immigration status (Pathfinder International, 2008; IOM, 2010). When one member of the family is in a country illegally, the entire family may limit access to available health

care services for fear of triggering investigation (AAP, 1997, IOM, 2010). Some OVC may have become so due to tribal conflicts, war or prosecution of their parents. Therefore, they may be in need of mental health and social services with careful attention to possible posttraumatic stress disorder warranted. This may not be readily available in the dispensaries in the study area where some service providers may be unfunctional professionals and unqualified subordinate staff.

The existing health care facilities in rural areas are inadequate. Most of these facilities offer outpatient services including immunization, maternal and child health and treatment of common diseases (Ministry of Devolution and Planning [MoDP], 2013). Kakamega County has a doctor: population ratio of 1:34,916, while the nurse: population ratio is 1:2658. This is contrary to the national ratios of 1:6250 and 1:654 respectively, while the WHO recommended ratios are 1:2778 and 1:281 respectively (WHO, 2010). Staff constraints coupled with shortages and irregular supply of drugs poses serious challenges in the efforts to fight common illnesses such as malaria, cholera, upper respiratory tract infections and common cold in rural communities using the available scarce health care facilities (MoDP, 2013). Another gap which exists is that community dispensaries if any may always be severely understaffed and in most cases served by only one qualified nurse assisted by one Community Health Worker offering outpatient services. Staff shortages may lead to long queues in most health facilities turning away would be users among them OVC.

The impact of this staff shortage on availability of basic healthcare services in the study area is not known and needs to be elucidated. Another gap that OVC aged 10 – 18 years old face is unavailability of suitable basic healthcare services in most local healthcare facilities as they are dispensaries which only offer out patient services among them, immunizations only suitable for the children under five years and expectant mothers. As a result, they are compelled to cover longer distances in search of services like VCT, nutritional foods, deliveries and specialized health care services.

2.5 Accessibility to Basic Health Care Services by OVC

Millions of OVC do not have access to appropriate health care services despite concerted efforts to push the cause forward ((UNICEF/ Innocenti Research Centre [IRC], 2008), Offorma, 2009). Hazardous work environment, exploitative child labour, poverty and lack of sponsorship, erosion of family values, quest for wealth, bereavement truancy, broken homes, engagement of children as house helps are factors or clogs in the wheel of OVC access to health care services in Nigeria (Offorma, 2009).

Every child including an OVC has a fundamental right to reasonable access to health services, water, and infrastructure; information and public transport as enshrined in the constitution (GoK, 2010). It is further stipulated that the child has a right to compulsory education, basic nutrition, shelter, and health care; to be protected from abuse, neglect, harmful cultural practices, all forms of violence, inhuman treatment and punishment and hazardous and or exploitative labour (GoK, 2010). To the contrary, it has been noted that many Governments make all legal provisions for the health care services for their citizens, but most provisions do not take cognizance of the peculiarities of the OVC (UNICEF/ Innocenti Research Centre [IRC], 2008). There is little programmatic guidance as to how best to ensure that OVC have access to basic health care services that can enable they realize their goal to healthy and adulthood wellbeing while ensuring their human rights (UNICEF/IRC, 2008). In that case, the OVC may not have access to basic health care services which is a fundamental human right as always stipulated in these legal provisions. This indicates that even though Governments make all legal provisions for the health care services for their citizens, there may be none specifically targeting OVC on health care services.

Geographical accessibility, availability, affordability, and acceptability are the four major challenges to access, all of which must be addressed when reassessing Kenyan health policy. Distribution of the health services is known to affect access to health care services (Bhatti, 2005; UNICEF/ Innocenti Research Centre [IRC], 2008). Their utilization can be scaled up if the infrastructure equitably extends to both rural as well as urban areas. A study finding in Pakistan using cross sectional design established that the

shorter the distance to the health service, the more the accessibility. It was found that 3km was accessible distance but not all those people within this walking distance access the services and the health facility utilization decreased as the distance increased to more than 5km by foot (Bhatti, 2005). This reveals a gap in the geographical access patterns that a distance of 5km may not be accessible to rural OVC in seeking health care services. This is an indication that most of those OVC in the study area (Lurambi division) who reside more than 5km a way and are supposed to seek basic health care services at Kakamega County Referral hospital and Navakholo sub-County hospital may not access them due to transportation logistics.

Despite reproductive health being a major cause of morbidity and mortality once other needs have been met, reproductive health care has been a neglected element of emergency health care service for OVC especially in refugee camps or Internally Displaced Persons (IDPs), (UNICEF/Innocenti Research Centre [IRC], 2008). Disaggregated urban data where available show that OVC face much health challenges and have very limited access to health care services like safe motherhood, family planning; prevention and response to gender based violence, sexually transmitted infections and ante-natal care due to their scarcity in such setups (Pathfinder International, 2008). It is also noted that OVC may be less able to access health care services than other children due to lack of information, stigma and discrimination associated with being categorized as OVC (Family Health International, 2006; Dias *et al.*, 2006).

In a number of OVC Rapid Country Assessment, Analysis, and Action Planning (RAAAP) countries, OVC reviews found that donors, government and NGOs were unable to track the number of OVC receiving health services and support or how much money was earmarked for them (USAID, 2005). This was due in part to decisions made to protect them from stigma and discrimination by funding agencies for OVC into such general aid categories as HIV and AIDS children and youth. Funding of such poor categories encourage calls into question as to how effectively youth and children are

being prioritized within national HIV and AIDS places and human rights covenant are genuinely being upheld (USAID, 2005).

It has been established that lack of high quality birth and death registration systems make it difficult for OVC to obtain official documents proving them to be in the vulnerable group (USAID, 2006). As a result, millions of OVC are ineligible to receive public benefits such as free medical care. Further to this, most governments lag behind in enforcing child protection and human rights laws. These gaps in protection make OVC and their caregivers more susceptible to poverty, stigma and discrimination including being barred from accessing public OVC benefits. Lack of enforcement of women's and children's rights is threatening the well-being of orphans and their caregivers (USAID, 2006). In other cases, instead of OVC funds being earmarked for them, the funds are rather merged into much broader aid categories such as HIV and AIDS or Youths. It cannot be ascertained whether OVC are in fact served (USAID, 2006).

Uganda has shown remarkable commitment with regard to the care, treatment and support of OVC in its policy arena (USAID, 2005). Included here is a national anti-retroviral (ARV) policy specifying priority groups for ARVs, national condom distribution guidelines, a policy for HIV/AIDS in the work-place, a national policy and implementation plan for the care of OVC and a national VCT policy. This has enabled a number of OVC to be supported (USAID, 2005). Addressing the health of OVC not only improves their well-being, but also contributes towards social and economic development of the entire community.

An individual's access to and use of health services is considered to be a function of knowledge of availability of basic health care services, able to overcome socio-economic barriers such as cost and distance to facility. Once accessed, cost of care at facility and/or attitude of staff at the facility or operations of the facility can affect utilization. Many OVC lack the basic necessities for survival, and receive inadequate psychosocial and economic support (GOK, 2002; GOK, CBS, 2009). The situation is worsened by the little income earned at family level which is spent on treatment and funerals. This leaves little

or no support to the surviving family members especially in paying cost sharing charges at health facilities (GOK, 2002; GOK, CBS, 2009). Direct (e.g., geographical) and indirect (e.g., cost sharing and stigma) factors and how they affect accessibility in the study area is unknown. To address some of the factors that may hinder access and use of basic health services, there was need for this study in the study area to assess what could be constraining accessibility to basic health care services by OVC.

2.6 The Utilization of Basic Health Care Services by OVC

The global utilization of basic health care services by OVC is low. According to a study finding by RAAAP, out of an estimated 10.6 million OVC in sub-Saharan Africa, only 914,000 (8.6%) were receiving minimal essential services like health care, psychosocial support and protection (USAID, 2005). In Pakistan, many OVC had problems accessing and using health care services due to distance, financial, cultural, and functional factors resulting in only 8.34% of utilization of basic health services (Bhatti, 2005). It was established that those OVC who resided in villages situated at by foot of one kilometer had utilization rate of 1.2 per person per year but those at a distance of more than 3km had very low utilization rate ranging from 0.01 to 0.04 per person per year instead of the mandatory 3 visits per person per year. Notably, the gap is that utilization dropped as the distance increased 1km to 3km and at a distance of 5km, utilization rate become negligible for these OVC. Consequently, it reflects that by foot pattern of access was the best access for populations living within 3km.

Utilization of basic medical services by OVC is often episodic and frequently occurs in settings such as emergency rooms. This factor limits the provision of comprehensive, longitudinal care. Issues of day-to-day survival that include security, lack of food, clothing, and shelter often override other concerns like basic health care services except for emergency services such as labour and delivery but not for preventive and promotive services like ante-natal and well-being care (AAP, 1997). It was noted that some OVC may harbour infectious diseases that local clinicians may be inexperienced in diagnosing, for which they are not necessarily screened at birth such as hepatitis A and B (AAP, 1997; Family Health International, 2009).

The on-going HIV and AIDS epidemics, tribal conflicts and despotic governments have contributed to non-utilization of health care services (Okeke *et al.*, 2008). Constant monitoring of the well-being of these children is needed. OVC call for linkage particularly in difficult circumstances to other relevant services which meet specific needs (Smart, *et al.*, 2003). Poor community organizational structure and lack of effective and trusted leadership have promoted non utilization of these basic health care services (UNICEF and POLICY Project, 2004c).

Limited access to information and services by OVC contribute to their low levels of health care service use. Unemployment and high levels of poverty have hindered the utilization of basic health care services (Pathfinder International, 2008). Provision of reproductive health and family planning information and services are critical to the well-being and future health of OVC. These young people are highly vulnerable to exploitation of all kinds, including sexual coercion or transactional sex for survival among others (Pathfinder International, 2008).

Some OVC avoid closest to their homes to reduce transportation costs and save on time. Others travel long distances because the medicine they need may not be available at the nearest provider or mostly those whose nearest facility was privately owned, and the cost was too high while others question the staff qualifications at their nearest facility. More reasons for Avoiding Nearest Health Care are referral, quality of care, availability of medicine, staff qualifications and cleanliness, privacy, staff attitudes, unavailability of beds, and long waiting time; and bypassing for economic reasons (to get free or lower-cost services) (Central Bureau of Statistics, Kenya. 2003; Kenya National Bureau of Statistics. 2008).

OVC in the urban areas express more loyalty to a provider, whereas those in the rural seem to be fascinated by those qualities that were lacking in the facilities located in their areas (Oladipo, 2014). This reduces utilization of the essential health care services by this disadvantaged group. It could be suggested that the absence of doctors in the rural

clinics, the lack of bed facilities, and the impossibility of obtaining service at home or as inpatient do not mould the right perception of the health care delivery systems. The notion that facilities in urban settings have the best service providers than rural areas may hinder service utilization. The issue of quality of care is the major variable under health services factors which indicate that OVC were conscious of the importance of the service equipment and other paramedical services needed to treat them. That is why they seek for services provided away from them.

Kakamega Central District has an OVC population estimated to be 36,000 in 2001 and increased to 38,000 in 2006 (CBS-Ministry of Planning, Kenya 2009). Lurambi division has the highest OVC population at 13,850, accounting for 36.5% of OVC in Kakamega Central District (NACC, 2006). These OVC, face social and development challenges. They also suffer from preventable diseases like malaria, diarrhea, intestinal worms, and tuberculosis more than non OVC due to lack of money for cost sharing needed in early diagnosis and prompt treatment. Most of the OVC in Kakamega County don't use these services (MoDP, 2013). Recent data indicate that only 27% of OVC utilize the available health care services. This indicates that a large proportion of this group does not access and use these live saving services in Lurambi division. In turn, this may make a larger proportion unhealthy and unproductive to the community. They lack the basic necessities for survival. Many head households and are unlikely to receive basic health care services like provision of basic outpatient services, maternal-child health (including deliveries), community health outreach, immunization and nutritional surveillance safe and sufficient water supply for washing, bathing and extra for cleaning and; therapeutic feeding treatment, sexual and reproductive health and dental care. This could be due to cost, language, cultural barriers and referral services for further specialized management of more serious cases to other hospitals (NACC, 2006; MoDP, 2013). OVC suffer from withdrawal syndrome and may have difficulties concentrating in school. Some of them drop out of school contrary to MDG on universal education which must be achieved by the year 2015. However, most of these OVC don't access and receive health care services (NACC, 2006). The reasons for their non-accessibility to basic health care

services are unknown. In addition, whether those who access health care receive services (utilization) is also unknown, hence the need for this study in the study area.

2.7 Conceptual Framework

Based on preceding literature review, factors influencing accessibility and utilization of basic health care services by OVC in this study have been summarized and put in conceptual framework. This conceptual framework is based on Andersen (1995) Behavioral Model of Health Services Utilization (Andersen, 1995) (Figure 2.1).

The conceptual framework illustrates the theoretical relationship between independent/dependent determinants, which influence the accessibility and utilization. Background factors are independent, thus they are not manipulated by the proximate or outcome factors. Instead they influence the proximate factors to produce the outcome. They are thus assessed for their cause/influence on the outcome.

Need Factors: Need has been described as a central determinant of accessibility and utilization of basic health care services. "Perceived need" will better help to understand care-seeking and adherence to a medical regimen (Andersen, 1995). Thus, a perceived need is how people view their own general health and functional state, as well as how they experience symptoms of illness, pain, and worries about their health and whether or not they judge their problems to be of sufficient importance and magnitude to seek professional help.

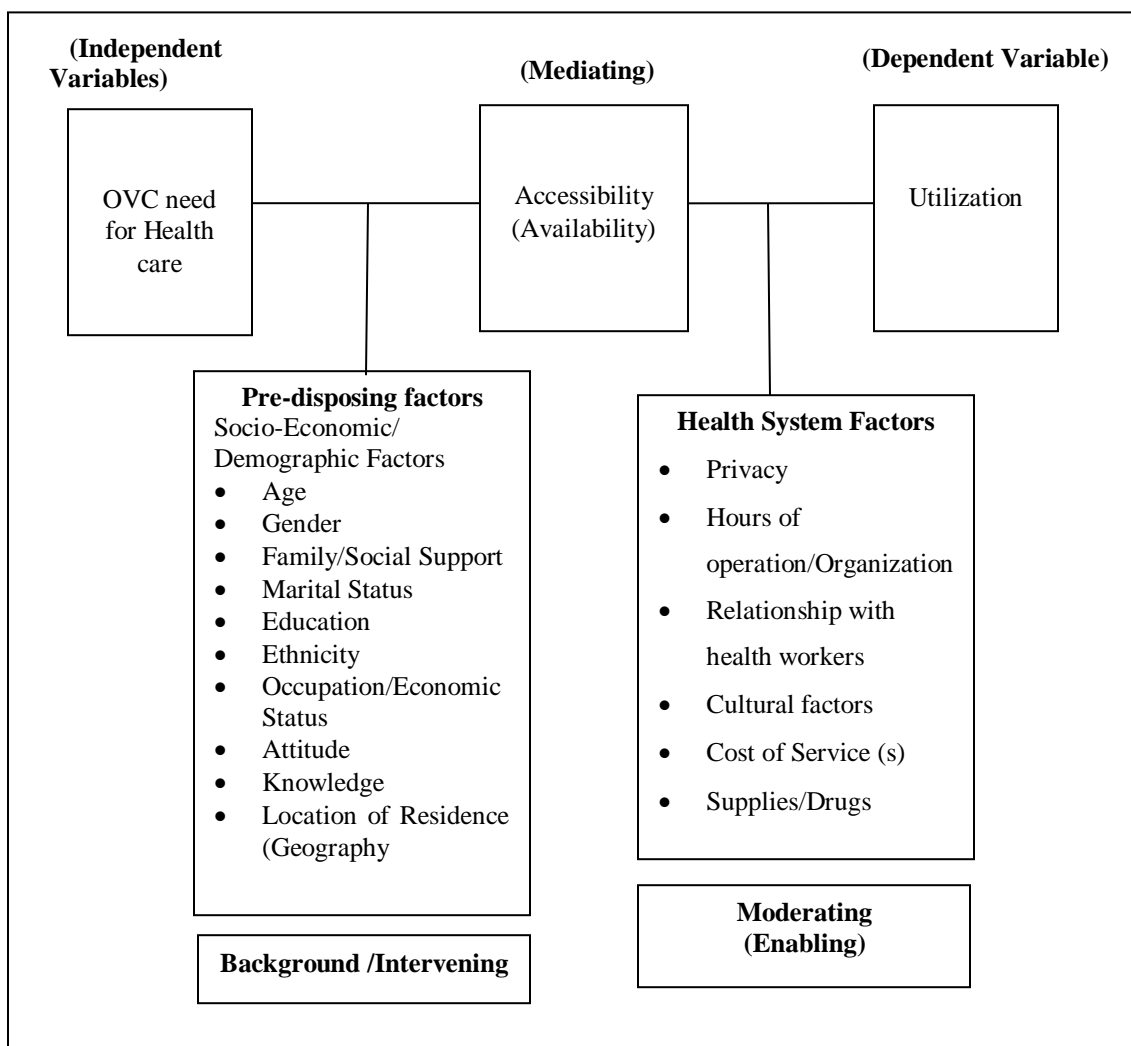


Figure 2.1: A Conceptual Frame Based on Andersen (1995) Behavioral Model of Health Services Utilization

According to this model (Andersen, 1995), an individual's access to and use of health services is considered to be a function of three characteristics. First there has to be need for health care. Need includes individuals' perceived symptoms, and general state of health. To seek for care one has to attend to predisposing factors such as age, sex, marital status, education, race/ethnicity, and occupation, as well as a set of beliefs (e.g., attitudes toward health services, knowledge about disease, and values). Mediating factor(s) refer to accessibility (availability). Once a facility has been accessed moderating (enabling)

factors *i.e.*, health system factors need addressed for one to able to utilize health services, upon access (Figure 2.1).

1) Pre-disposing (Background) Factors: Once a perceived need has been expressed, the socio-cultural characteristics of individuals that exist prior to their illness come into play. For example social support/norms included two themes: the decision makers who participants considered legitimate sources of authority (*i.e.*, referents), and a set of norms of behavior. Referents and norms of behavior were hypothesized as having a direct effect on long-term care service use.

- Others are social Structure: Education, occupation, ethnicity, social networks, social interactions, and culture
- Health Beliefs: Attitudes, values, and knowledge that people have concerning and towards the health care system
- Demographic: Age and Gender

2) Mediating Factor(s): This refers to accessibility of available health services/facility.

3) Moderating (enabling) Factors: Example self-determination and privacy, which reflect on concerns related to the factor of self-determination and one of its dimensions is privacy. Privacy at facility and hours of operation, youth friendly services among others have been also identified as enabling factors associated with staff attitudes, stigma and discrimination.

Financial Resources: Financial resources and availability of supplies at facilities will also determine utilization.

Attitudes: Attitudes of service providers were described as personal views concerning the utilization care services. Attitudes were described as having a direct effect on intended care service use. Interpersonal skills included trustworthiness, comfort or compassion, and listening and communication skills.

Affordability: This can be payment to access health facility or for care (drugs and supplies).

2.8 Operational Framework

The operational framework presented below demonstrates the link between the background factors, proximate factors, and outcome factors (Figure 2.2). The figure shows how the knowledge and attitude of OVC are likely to affect their accessibility and utilization of basic health care services.

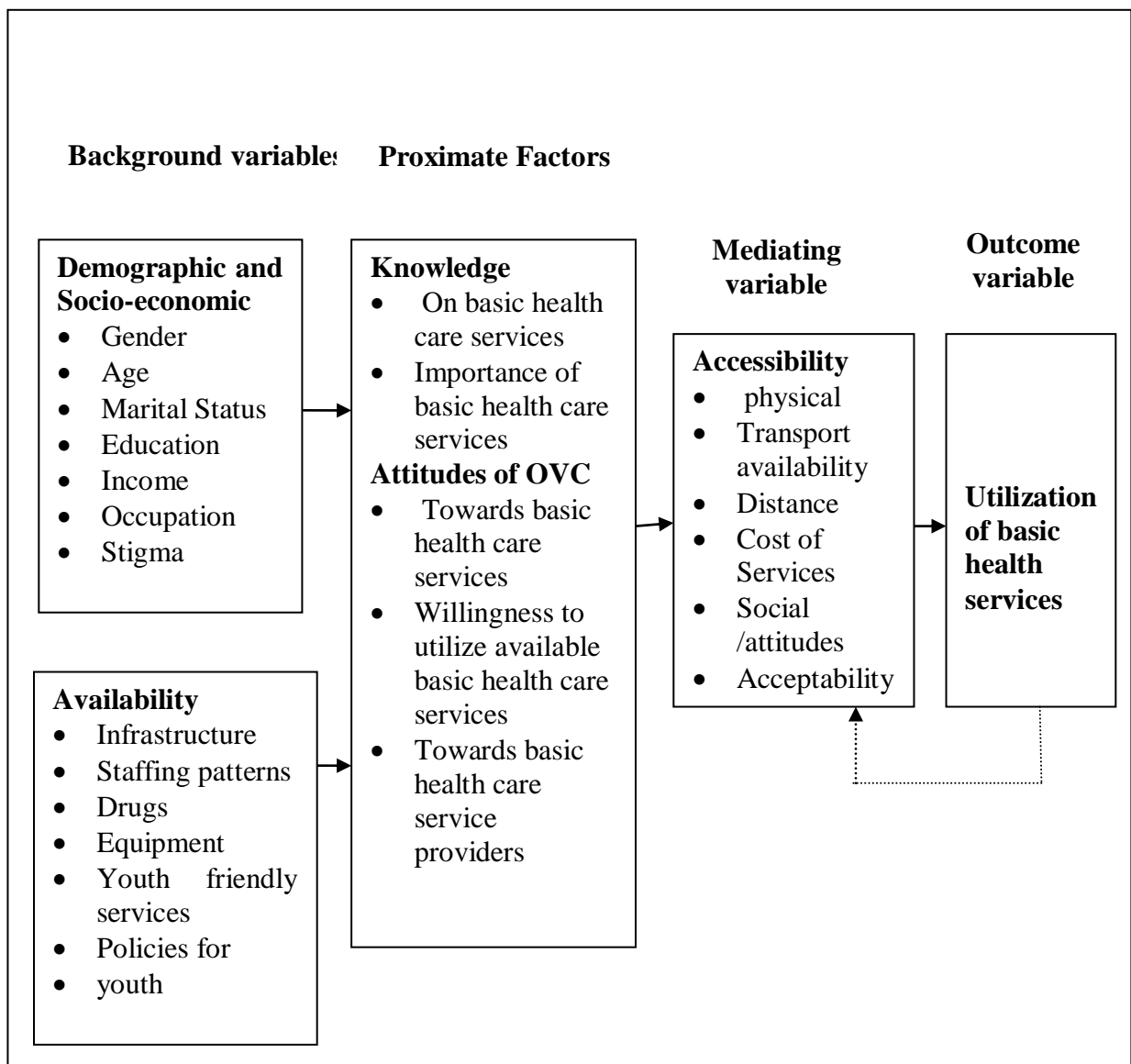


Figure 2.2: Operational Framework

The operational framework adopted in this study guided the data collection from the OVC and key informants in Lurambi division, Kakamega district. It focused on accessibility and utilization of basic health care services measured by the frequency of interacting with these services by the study participants. Described herein include socio-economic and demographic characteristics of OVC, knowledge and attitude of OVC, availability and accessibility to basic health care services and utilization of basic health care services.

Baseline characteristics such as age, gender, marital status, and residence are known to play a key role in accessibility and utilization of basic health care services by OVC. Level of education, source of income and stigma can provide enabling environment for or demand and use basic health care services or improve their utilization. This enabling environment can be through ability to pay cost sharing levies, awareness creation or protection mechanisms where the OVC can be exempted, waived from cost sharing levies and or protected against social stigma by empowering the community on the plight of this disadvantaged group. Excessive cost of health services reduces accessibility to and utilization of these life saving services by OVC. The situation is worsened by high level of poverty in the community. The girl child is in turn given out in marriage at an early age either to reduce financial burden on the care givers or used as a source for the family to raise funds for other family commitments and once married, she cannot now be called a child any more, but an adult.

Most of the quality health infrastructures are geographically situated in urban areas making OVC cover longer distances from rural areas which require transport to access basic health services. Shortage of staff and drugs in health facilities coupled with lack of diagnostic equipment and youth friendly services affect the use of these health services.

Knowledge of OVC on basic health care services is vital to the utility of these services. Inadequate or lack of it on the importance of these health care Services hinders their utilization. The attitude of OVC having a tendency of viewing basic health care services and service providers favourably or unfavourably is crucial to their frequency of utilizing the services. Positive attitude enables OVC with a need to access and utilize the services, while negative attitude discourages.

CHAPTER THREE: STUDY METHODOLOGY

3.1 Introduction

This chapter presents the study methodology and procedures that were used during the execution of the research. Explained herein is study area, the study design, the study participants (OVC), study variables, sampling procedure and sample size determination. Methods of data collection, management and analysis, ethical considerations are also highlighted.

3.2 Study Area

The study was carried out in Lurambi Division of Kakamega Central District (Appendix VI). Kakamega Central District is one of the nine (9) districts that make up Kakamega County; Western Kenya. Purposive selection of the study area was done from the three (3) administrative divisions forming the district. The study site was selected because it had the highest (36.5%) population of OVC in the district and no study on access to and utilization of basic health care services had ever been conducted in this area. Over the last decades, there has been an investment in the basic health care facilities in the area with emphasis on increasing the available health care services and encouraging all including OVC to use them. However, accessibility and utilization has not improved appreciably which may be due to socio- economic and demographic factors coupled with the attitudes of OVC towards these services.

Kakamega Central District borders Butere and Mumias Districts to the west, Kakamega East District to the East, Kakamega South District to the South, and Kakamega North District to the North. The district lies between Longitudes 34° 20' and 35° East and Latitudes 0° 15' and North of the equator (CBS, 2009). Kakamega Central District has the highest population of OVC in the province numbering 38000 out of the 256,000 OVC in the Province (GOK, KNBS, 2009; GOK, CBS, 2009; NACC, 2006). Lurambi division has 4 locations and 14 sub-locations. Politically, it has one (1) parliamentary constituency, namely, Lurambi (NACC, 2006; GOK, KNBS, 2009; GOK, CBS, 2009; Ministry of Devolution and Planning [MoDP], 2013). Lurambi division has the highest OVC population of 13,850, accounting for 36.5% of OVC in Kakamega Central District.

The district has a total population of 297,394 with an annual growth rate of 2.12 per cent, compared to 2.98% per annum in the preceding years (GOK, KNBS, 2009). The reduction in the intercensal growth rate was attributed to the negative impact of HIV and AIDS which is one of the leading causes of orphanhood and vulnerability in the district (GOK, CBS, 2009). The average population density of the district is 709 persons per square km (GOK, CBS, 2009). Lurambi division covered an area of 194.1Km.² with a population density of 591 persons per square km (GOK, CBS, 2009; GOK, MoDP, 2013).

The district has about 65,121 households with an average household size of 8. Female headed households are 39.8% while child headed households were 4.7% (GOK, KNBS, 2009). The number of geographically challenged children is 60,342 while the number of children in need of special protection was 17,562. Poverty levels are high with absolute poverty among the rural being 53.5% and urban being 46.8%. This contributes to a 5.9% of national poverty. Dependency ratio is 100:108. The number of households with access to piped water is 1032 (1.6%) while those with access to potable water are 41,285 (63.4%). Average distance to potable water point is 500m. Number of ventilated Improved Pit latrines is 438 (GOK, CBS, 2009; GOK, MoDP, 2013).

3.2.1 Socio-economic Characteristics of the Study Area

The main socio-economic activity in Lurambi Division is subsistence farming of maize, bananas, sweet potatoes and beans. Thirty percent (30%) of the study area is under cultivation with cash crops being mainly sugar cane. Small scale livestock rearing is also practiced. The animals kept include cattle, sheep, goats, pigs, and poultry (GOK, CBS, 2009; GoK, MoDP, 2013).

3.2.2 Health Indicators

Kakamega district has 2 Hospitals, namely: Kakamega provincial general hospital and Navakholo sub-district hospital (Table 3.1). The average distance to the nearest health facility (rural) is 10km while in urban areas it's a half a kilometer (1/2km) (MOH, 2007; GOK, CBS, 2009; GoK, MoDP, 2013).

The top ten (10) most prevalent diseases in the district are malaria, pneumonia, tuberculosis, AIDS, acute respiratory infections, diarrhea, skin diseases, injuries, eye infections, chicken pox and intestinal worms. HIV prevalence rate is 7%. This is higher than National prevalence of 6, 5% (KNBS and ICF, 2010). Kakamega County has a doctor: population ratio of 1:34,916, while the nurse: population ratio is 1:2658 (MODP, 2013). This is contrary to the national ratios of 1:6250 and 1:654 respectively. The WHO recommended ratios are 1:2778 and 1:281 respectively (WHO, 2010).

Crude birth rate is 44/1000, crude death rate was 14.3/1000, infant mortality is 110.9/1000, and child mortality rate 62/1000, under-five mortality rate was 169/1000. Life expectancy is 53.2 for males while 58.7 for females. Total fertility rate is 5.7 while population growth rate is 2.1%.

Lurambi division has 13 health facilities; two (2) Health centers (Bushili and Bukura), 9 dispensaries (public) and 2 mission dispensaries (Ingotse dispensary sponsored by Church of God and St. Anne Eshisiru dispensary sponsored by Catholic Church) (MOH, 2007; GOK, CBS, 2009; MoDP, 2013), see Appendix VII.

3.3 Study Design

The study design was cross-sectional descriptive survey to assess the accessibility and utilization of basic health care services among OVCs. It involved the collection of both quantitative and qualitative data. This design gave a snapshot state of utilization of basic health care services by OVC in the study area. Conditions that existed at the time of the study were recorded, described and reported (Fink and Kosecoff, 1998).

3.4 Study Population

The Study Population was 385 OVC aged 10-18 years. This age set was purposively selected because at 10 years, it is assumed the child is able to internalize his or her environment while 18 years is the age distinguishing a child from an adult. Other respondents were Key Informants within Lurambi division. The key informants included a Chief, Assistant-Chief, Village Elder, and a Church minister, a Chairperson of local

NGO, and local Professionals who included a Public Health Officer/Technician, in Charge of a health facility and a head teacher of the local school.

Specifically, the Chief, Assistant-Chief and a Village Elder were selected because they reside in this community. They in most cases interact with these community members and handle their local problems including those of OVC. A Church minister provides some material assistance; counseling members with social problems pray for the sick including OVC and bury the dead. The Chairperson of local NGO provides support to community members in need by giving material assistance and pay fees for some OVC. The local NGO has a mission hospital that offer health care services like maternal child health and family planning, immunization, and treatment of local ailments. A Public Health Officer(PHO) works in the community advising on utilization of health care services in prevention and control of diseases for better wellbeing, while the in charge of health facility provide medical care services and also collect cost sharing fees on behalf of the facility of which the OVC are also obliged to pay. The head teacher handles OVC learning issues in school including school fees among others.

3.5 Sampling and Sample Size Determination

3.5.1 Sample Size Determination

The sample size calculation was based on an infinite population using the method as explained by Fisher *et al.*, (1998) formula given below as cited by Mugenda and Mugenda, (2003).

$$n = \frac{Z^2 pq}{d^2}$$

Where n = desired sample size (if the target population is greater than 10,000).

z = the standard normal deviate, set at 1.96 corresponding to 95% confidence interval.

p = proportion of study population utilizing basic health care services assumed to be 50% (Mugenda and Mugenda, 2003)

$$q = 1.0 - p$$

d = degree of accuracy desired set at 0.05%, corresponding to 95% confidence interval.

Therefore,

$$n = \frac{1.96^2 \times 0.5 \times 0.5}{0.05^2}$$

$$n = \frac{3.8416 \times 0.25}{0.0025}$$

$$= \frac{0.9604}{0.0025}$$

$$= 384.16$$

$$= 385.$$

The desired sample size was 385.

3.5.2 Sampling Procedure

The study area was purposively sampled by the researcher due to having a high proportion of OVC who account for 37% of the total 256,000 OVC in Kakamega central district (NACC, 2006) and the researcher's prior knowledge on the plight of OVC in the division.

Multistage sampling method was used (Korn and Grauband, 1991). In the first stage, a simple random sampling was used at divisional level to select two (2) Locations; North Butsotso and Central Butsotso out of the four (4) Locations; namely: North Butsotso, South Butsotso, Central Butsotso and East Butsotso Locations. The list of four (4) locations was compiled. A table of random numbers was drawn using a computer. Numbers 1 to 9 were generated. The name of each location was assigned a number 1 to 4 representing that location. This was the sampling frame at location level. The researcher then blindly pointed at any number in the random number of tables and the location represented by the number pointed at in the row and column of the table was then selected. Thus, 2 and 4 were pointed at representing North Butstotso and Central Butsotso which was selected respectively to represent the division.

In the second stage, this was at location level, where the same process was applied to select the four (4) sub-locations using the same table of random numbers. The names of all the eight (8) sub-locations in the two selected locations were assigned 1-8. That is, 1

representing Shinoyi, 2 for Esumeyia, 3 for Shikomari, 4 for Matiha, 5 for Ingotse, 6 for Shisiru, 7 for Shiyunzu and 8 representing Shibuli. The researcher blindly pointed at these numbers. Number 1, 4, 7 and 8 were pointed at representing Shinoyi, Matiha, in North Butso while Shiyunzu and Shibuli in Central Butso location respectively. The third stage was to find out the total number of OVC to be interviewed in each sampled sub-location. The total population of eligible OVC in the four (4) selected areas was 3587 (Table 3.1).

Table 3.1: Cluster Name and Number of OVC Eligible for Interview, Lurambi, Kakamega District, Western Kenya, September 2010.

Serial number	Sub-location	Number of eligible OVC
1	Matiha	709
2	Shinoyi	591
3	Eshibuli	1197
4	Shiyunzu	1090
Total		3587

(Source: District Officer, 2010).

For equal representation, proportion of the total eligible OVC was determined. This involved dividing the total eligible OVC in each of four areas using the following formula (Koul, 1984; Fisher *et al.*, 1999);

$$n_i/N \quad \text{Where } n_i = \text{total eligible OVC in area } i$$

$$N = \text{total eligible OVC in the 4 selected areas}$$

The proportion in each area was multiplied by the desired sample size (385), and the number of OVC interviewed in each sub-location is as respectively summarized below.

$$\text{Matiha sub-Location} = 709/3587 \times 385 = 76$$

$$\text{Shinoyi sub-Location} = 591/3587 \times 385 = 63$$

$$\text{Eshibuli sub-Location} = 1197/3587 \times 385 = 129$$

$$\text{Shiyunzu sub-Location} = 1090/3587 \times 385 = 117$$

The following is the number of OVC interviewed in each of the four (4) selected clusters (Table 3.2).

Table 3.2: Number of OVC targeted for interview, Lurambi, Kakamega District, Western Kenya, September 2010.

Serial number	Sub-location	Number of eligible OVC	Selected Sample
1	Matiha	709	76
2	Shinoyi	591	63
3	Eshibuli	1197	129
4	Shiyunzu	1090	117
Total		3587	385

3.6.1 Inclusion Criteria of Study Participants

All OVC aged 10-18 years, willing to participate in the study and had stayed in the study area for at least six (6) months before the date of interview, and had provided informed consent or assent from their parents or guardians to participate in the study were considered eligible and enrolled in the study.

3.6.2 Exclusion Criteria of Study Participants

OVC who were not willing to participate, those who had stayed in the study area for less than 6 months, those outside the age bracket of 10-18 years and those whose parents or guardians declined to provide assent for participation or very sick or mentally challenged OVC were all excluded.

3.7 Training of Study Assistants

Before the commencement of data collection, eight (8) research assistants were recruited. They had fourth form level of education. The criterion for selection of these research assistants was that one had to be a form four level of education, able to speak and read English. He or she had to communicate in Kiswahili and Luhya languages. In addition, they had to be above 18 years of age. They were then taken through one day training process. The training included: comprehension of the data collection tool, consenting

process, interviewing techniques and overcoming fieldwork challenges, including keeping confidentiality of information. After the training, the researcher and the research assistants pre-tested the tool in the neighboring division (Navakholo) using 10% of the sample size that resulted to 38.5 but rounded off to 40 and two (2) key informants. The pre-testing was in line with Mutema (1981); Kangethe, *et al.*, (2008) observations which showed that in many pilot studies, it is possible to get feed-back from the research subjects and other persons involved that leads to important improvements in the main study. Navakholo has similar characteristics regarding OVC that closely resemble those of Lurambi. Based on the pr-test, final data collection tool was developed after minor corrections that ensured no ambiguity in the tool.

3.8 Data Collection

A semi-structured questionnaire for OVCs, an interview schedule for key informants and observation checklist were used as data collection instruments from OVC and community leaders respectively.

3.9 Quantitative Data

Using village elders in the study area, households with OVCs were identified, from which a sampling frame was developed, giving a total of 3587 OVC (Table 3.1). From the developed frame, a proportionate random sample of 385 OVCs was selected (Table 3.2). Appointments for interviews with OVCs or their caretakers were arranged in advance by community mobilizers, who were village elders and were well known in the area. Research assistants who were also from the study area guided the researcher to the households where the mobilizers had visited and set an appointment. Data was collected through face-to-face interview with the OVC using a semi structured interview questionnaire.

If in the unlikely event that an OVC or caretaker was not present at the time of the scheduled interview, the research assistants along with the village elder made three additional attempts to include the OVC in the survey. By the third attempt, all selected participants were found and participated by being interviewed. Thus, using this method, no participant missed to be interviewed. Consequently, all the required sample of 385

participants was successfully interviewed. Written consent to participate in the survey was obtained from all interviewees or their caregivers. The questionnaires were translated and administered in both English and Luhya languages to participants.

A questionnaire was administered to collect data on the following explanatory (independent variables) age, sex, residence, marriage, and religion, knowledge on basic health care services and attitudes towards the provision of basic health care services by OVC. Information on socio-economic factors included income, education, occupation and cost and how they relate to accessibility and utilization (the dependent variables) of basic health care services by OVC. In addition, information was collected on infrastructural factors such as availability and accessibility to basic health care services.

3.10 Qualitative Data

Some key informants a Chief, Assistant-Chief, Village Elder, and a Church minister, a Chairperson of local NGO, and local Professionals *i.e.*, a Public Health Officer/Technician, an in-Charge of a health facility and a head teacher of the local school were also included to provide additional information to reinforce information from the quantitative data.

Specifically, the Chief, Assistant-Chief and a Village Elder were selected because they reside in this community. They in most cases interact with these community members and handle their local problems including those of OVC. A Church minister provides some material assistance; counseling members with social problems pray for the sick including OVC and bury the dead. The Chairperson of local NGO provides support to community members in need by giving material assistance and pay fees for some OVC. The local NGO has a mission hospital that offer health care services like maternal child health and family planning, immunization, and treatment of local ailments. A Public Health Officer(PHO) works in the community advising on utilization of health care services in prevention and control of diseases for better wellbeing, while the in charge of health facility provide medical care services and also collect cost sharing fees on behalf

of the facility of which the OVC are also obliged to pay. The head teacher handles OVC learning issues in school including school fees among others.

Qualitative data was collected using a prepared interview guide for Key Informant Interview schedule comprising of leaders (Chiefs, Assistant-Chiefs, Village Elders, Church ministers, Chairpersons of local NGOs, and Local Professionals) and also included were health professionals. Thus, a Public Health Officer/Technician in charge of Butso Central, In Charge of Bushili health centre and the head teacher of the local school (Shinoyi primary school). A total of eight (8) Key Informant Interviews (five males and three females) were conducted through face-to-face discussion between the investigator and the specific individual key informant. Two (2) key informants from each of the selected study sites were selected for the interview. Notes were taken by the investigator and discussion was audio recorded using Sony IC Recorder. The number of eight (8) key informants was arrived at in line with Sherry and Marlow (1999) who observed that 8-12 people with particular knowledge and expertise should be sufficient number to get sense of environment and to identify themes around the community needs and areas of strength and weaknesses of the group.

Each key informant was assigned a code: M1, M 2, M3, M4 and M5 for male key informants whereas F1, F2 and F3 for female key informants. Each of the information the interviewee reported; his or her code was put against that information. Key issues were reported using these codes. This was according to Oishi (2003) and Podrasky (2006).

3.11 Data Analysis Plan

Quantitative data was manually checked for internal consistency, accuracy and completeness at the end of each day by the researcher as a measure of quality control to ensure correctness of the data and that they were dully completed before being entered into the computer. Errors were checked out manually and cross-checked at the end of the exercise. Data were then cleaned, coded and analyzed using Statistical Package for Social Sciences (SPSS) version 16. Statistical analysis involved both descriptive and inferential. Descriptive statistics namely: frequencies and cross tabulations between variables were undertaken. Data was presented using tables and graphs (bar charts and pie charts).

This study utilized cross tabulations for purpose of displaying row and column percentages. Given that row and column percentages do not allow for quantification and testing of the relationship between variables, an index that measures relationship between dependent and independent variables was needed. Further analysis of the data involved testing the combined effect of the significant factors accessibility and utilization. This involved the use of multiple regression analysis. This technique measured the combined effect of the independent variables on accessibility and utilization While Odds Ratio (OR) was used to compute relationships between independent variables; and accessibility and utilization of basic health care services. According to the Knowledge, Practice and Coverage Survey (KPC) (2000+), ODDS Ratio is most appropriate in determining relationships where behaviour is the outcome or dependent variable as it also shows the direction of the relationship. OR also gives a confidence interval (CI) which shows the relationship between the two variables and also shows the chi-square value for the two variables being compared.

When computing OR, if the CI includes 1, then the association is not significant but if the CI is greater than 1, then there is a positive relationship the variables but if it is less than 1, the relationship is negative. OR is used to compute relationship where the two variables of study are categorical and have two answers, for example ownership of a Bore hole for a clean water supply gives an answer as YES or NO. In this study, some of the variables computed were: Sex, Age, place of birth, education level, employment and attitude of OVC towards basic health care services.

Qualitative data were analyzed manually by summarizing and categorization of verbatim response of participants and highlighting emerging themes. Quotes from respondents were presented to paraphrase opinions.

3.12 Measurements of Variables

OVC's knowledge on basic health care services was measured by the total number of responses to the five (5) items on knowledge in each question with a minimum score of 0 and maximum of 10. To measure the knowledge, it was categorized based on the percent of knowledge of the distinct characteristics of basic health care services as: "high" for

those who knew 80% and above, “moderate” for those who knew 60% - 79% and “low” for those who knew less than 60% (Alemayehu, *et al.*, 2011).

On attitude of OVC towards basic health care, Likert Type Scale was used where questions were presented in matrix form. Besides each of the statements or questions that were presented, the same set of response categories were shared using the numerical rating scale. The numbers were ordered in such a way that they indicated direction and or intensity of the feelings of the respondent. They were as follows: Either

1 = Not useful, 2 = fairly useful, 3 = Neutral, 4 = Useful and 5 = Very useful or

1 = Not friendly, 2 = fairly friendly, 3 = Not sure, 4 = Friendly and 5 = Very friendly (Mugenda and Mugenda, 2003). Numbers 4 and 5 were taken to indicate positive feelings of the respondent while 1 and 2 negative feelings.

The study then finally measured the attitude of the OVC by assigning two categories: Positive Attitude – those who scored above the mean to the correct answers from attitude measuring basic health care services or service providers’ questions. Negative Attitude - those who scored the mean and below the mean to the correct answers from attitude measuring basic health care services or service providers questions as applied by Alemayehu, *et al.*, (2012) in Mekele, Tigray in Ethiopia.

Availability of these crucial services was measured through facility – based review of health facilities, location, health services available, staffing pattern, youth friendly services, drugs mostly available, basic equipment and policies for the youths as used by Bhatti (2005).

Accessibility to health care services was measured by the distance and means of transportation used by the community. This information was obtained from the respondents and was corroborated by key informants. Measurement of distance from the sub-location to the health facility or service included measurement of distance by rural paths through speedometer reading of the car used during data collection. The distance was measured from the main gate of the health facility to the church in the sub-location. While mode of travel to health services was collected through probing of key informants (Bhatti, 2005).

Utilization or non-utilization of basic health care services by OVC was set as binary outcome variable (Alemayehu, *et al.*, 2012).

3.13 Ethical Considerations

This research involved the handling of human subjects, principally through interviews. Thus ethical considerations were applied, based on the subjects being exposed to minimal personal risk as a result of sharing some personal information through participation in the project. Thus, authority to conduct this study was sought and granted from the District Commissioner, of the study area (appendix 1).

Ethical obligation was met through the following techniques:

- i. The project did not elicit any information about intimate private details of the participants;
- ii. Participants (or their legal guardians or care takers) were well-informed of the aims, focus, value and benefits of the project, and were provided with background material to permit them to make an informed judgment on whether to participate or not
- iii. Informed and voluntary consent was obtained from participants (or their legal guardians or care takers) prior to the start of interviews;
- iv. Participants (or their legal guardians or care takers) who agreed to be interviewed were able to withdraw at any time or refuse to answer any questions;
- v. Anonymity and confidentiality of participants was strictly maintained to avoid attributing any particular point of view or comments to a single individual except to the extent that participants consented to such disclosure in the development of case studies (*e.g.*, making a quote from a key informant to clarify an issue, but no name of individual was used) and,
- vi. The data collected was kept confidential, and accessed only by the researcher
- vii. The instruments used in preparing for and conducting interviews are appended (Appendices I-VII).

3.14 Study Limitations

Some of the responses could not be verified as they were based on only what the respondents stated, and the study avoided intrusive questions as much as possible for ethical reasons.

3.15 Dissemination of the Study findings

The study findings will be disseminated to the community members, the provincial administration, children officials, church leaders, heads of CBOs, FBOs and the political leaders from the study area in the form of copies of comprehensive report and Chief's 'baraza' and workshops. This will be after the defense of the thesis. Papers will be presented in local and international conferences and published in peer reviewed journals for wider readership.

CHAPTER FOUR: FINDINGS

4.1 Introduction

This section presents results of the study as figures, tables, and narratives. In total, 385 OVC participated in the study. The response rate was 100%. The findings are as per the specific objectives: Socio-Demographic attributes of the respondents, the knowledge and attitudes of OVC towards basic health care services, accessibility of basic health care services to OVC and utilization of basic health care services by OVC

4.2. Socio-economic and Demographic Study Respondents

The socio-demographic characteristics that were assessed included sex, age, place of birth, type of OVC, relationship to head of household and religious affiliation (Table 4.1).

Mean age of study participants was 14.4 with a standard deviation (SD) of 2.4 years. Slightly more than a half 197 (51.1%) were aged 14 years and below while 188 (48.9%) were aged above 14 years. Of the study OVC, 214 (55.6%) were males whereas 171 (44.4%) were females. Majority were born in Lurambi division 358 (93%), 17 (4.4%) were born outside Kakamega district while 10 (2.6%) were born in Kakamega district but outside the Lurambi Division, study area. Slightly more than half 206(53.5%) were paternal orphans, 96 (24.9%) total orphans while 67 (17.4%) were maternal orphans; and 16(4.2%) were vulnerable children due to various reasons. Majority 359 (93.3%) were of Christian denomination, with Protestants being 267 (67.8%) whereas Catholics were 98 (25.5%), Muslims were 14 (3.6%) while other smaller denominations were 12 (3.1%). Regarding level of education, 288 (74.8%) were pupils in primary schools, 63 (16.4%) were in secondary schools while 34 (8.8%) had nil education (Table 4.1).

Analysis of the relationship of the respondents to the household head showed that 202 (52.5%) had their parents as household heads, 84 (21.8%) had grandparents, while 55 (14.3%) had aunts or uncles, 27 (7%) had siblings as household heads and lastly 17 (4.4%) were household heads themselves. Regarding occupation, majority 311 (80.8%) were students, 57 (14.8%) casual/temporary workers and others were 17(4.4%) (Table 4.1).

Table 4.1. Socio-Demographic Characteristics of the Participants

Characteristics		N	%
Mean Age \pm SD (range) years		14.4 \pm 2.4 (10- 18)	
Age \leq 14 years		197	51.1
Age > 14 Years		188	48.9
Gender	Male	214	55.6
	Female	171	44.4
Place of Birth	Lurambi Division	358	93.0
	Kakamega district (outside Lurambi division	10	2.6
	Outside Kakamega District	17	4.4
Type of OVC	Paternal Orphan	206	53.3
	Total orphan	96	24.9
	Maternal Orphan	67	17.4
	Others (Vulnerable child)	16	4.2
Relationship of head of household to OVC	Parent	202	52.2
	Grand parent	84	21.8
	Aunt /Uncle	55	14.3
	Sibling	27	7.0
	Self	17	4.4
Religious Affiliation of OVC	Protestant	261	67.8
	Catholic	98	25.5
	Muslim	14	3.6
	Others	12	3.1
Educational Level of OVC	None	34	8.8
	Primary	288	74.8
Occupational of OVC	Secondary	63	16.4
	Student	311	80.8
	Casual/Temporary Worker	57	14.8
	Others	17	4.4.

4.3 The knowledge and attitudes of OVC towards basic health care services

4.3.1.1 OVC Knowledge on the meaning of the phrase orphans and vulnerable children

The study determined the knowledge of respondents on the Meaning of the phrase orphans and vulnerable children. The findings indicate that 290 (75.3%) knew the phrase OVC meant children who are orphans while 270 (70.1%) children with increased vulnerabilities and 82 (21.3%) knew the phrase OVC to mean children whose parents are living with HIV and AIDS. Others 32 (8.3%) stated that it meant children who are homeless and street children (Table 4.2).

Table 4.2: Knowledge of the respondents on the meaning of the phrase OVC

The understanding of the term orphan and vulnerable children	N = 385	
	N	%
Children with increased vulnerabilities regardless of cause	270	70.1
Children who are orphans	290	75.3
Children whose parents are living with HIV and AIDS	82	21.3
Others	32	8.3

*This was a multiple response question

4.3.1.2 OVC Knowledge of Basic Healthcare Services

The study assessed the knowledge regarding OVC on basic healthcare services. The findings shows that majority of OVC, 332 (86.2%) knew basic health care services to be either preventive or curative health services. Others viewed them as all hospital services 259 (67.3%), care and protection given to maintain health 228 (59.2%) or as lifesaving health services 208 (54.0%) (Table 4.3). All OVC gave more than one response.

Table 4.3: The OVC understanding of Basic Health Care Services

What do you understand by the term Basic Health Care Service?	N = 385	
	n	%
Preventive and curative health services	332	86.2
All hospital services	259	67.3
Care and protection given to maintain health	228	59.2
Lifesaving health services	208	54.0
Multiple responses		

When key informants were asked what they understood by basic health care services, they reported that all hospital services are basic health care services and most of them could not understand why some services were not being offered to OVC in the nearby health facilities in the study area, as in the example narrated below:

“... all *hospital services are basic health care services*” (M4).

“*I cannot just understand why some services are not offered in the facilities near these disadvantaged children*” (F2).

“... *basic health care services means preventive and curative health care services*” (M1).

These narratives show a lack of knowledge on the expected basic health care services provided in whatever facility visited by key informants in the community.

Asked if they knew or did not know of any effect of one being categorized as an OVC majority of respondents 295 (76.6%) had the view that there is an effect of one being categorized as an OVC, whereas 90 (23.4%) said there is no effect. Those who were aware of the effects, identified stigmatization 177 (60%) as the major effect, and that it may lead to increased isolation 163 (55.3) (Table 4.6). On the contrary, some were positive, stating that their welfare was being addressed 174 (59.0%) or can directly be assisted 161 (54.6%) (Table 4.4).

Table 4.4: Some effects of being categorized as OVC

Response	N = 295	
	N	%*
It can help track their welfare	161	54.6
Categorization can aid in directing OVC interventions to the rightful beneficiaries	174	59.0
Can lead to increased stigmatization and isolation	163	55.3
Can lead to finger pointing and discrimination	177	60.0
Others	19	6.4

*This was a multiple response question, hence total do not add to 100%.

This was corroborated by key informants who stated: “...OVC are often discriminated and isolated as a result of being identified as OVC” (M3).

One female and one male key informant were positive and each reported that: ...“Categorization has helped OVC when aid such as relief food is brought their way” (F3). Another key informant stated: “they are easily identified as OVC who are in need of assistance like bursaries” (M2).

4.3.2 The attitude of OVC towards basic health care services

The attitude of study participants towards basic health care services in the study area was analyzed using Likert scale of measurement. Less half 179 (46.5%) of the participants consider the basic health care services provided in the area useful, 105 (27.3%) very useful and 77 (20.0%) fairly useful while 24 (6.2%) find them not useful (Figure 4.5).

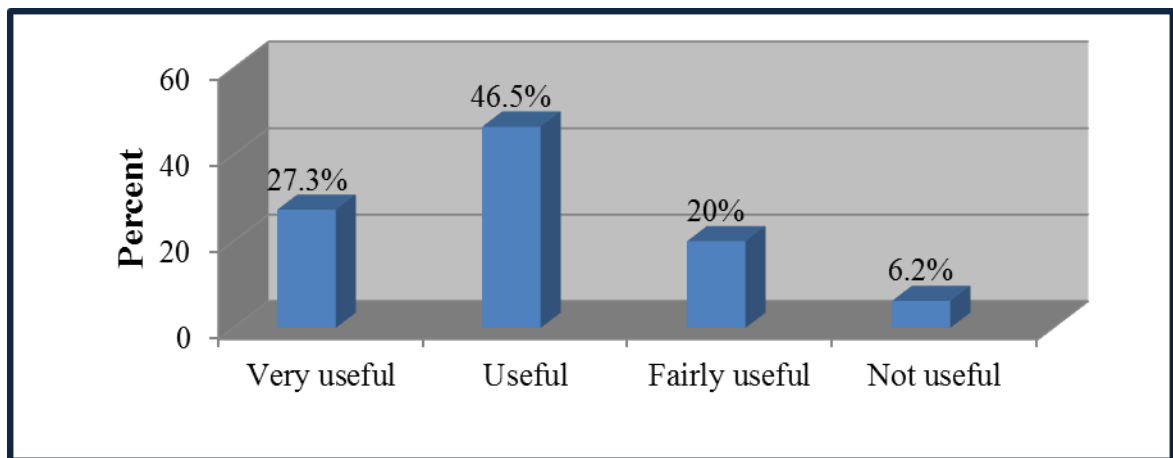


Figure 4.1: The Attitude of OVC towards Basic Health Care Services in this Community

When key informants were asked about their attitudes towards basic health care services offered to OVC, they reported that OVC find the existing basic health care services useful:

“... the services offered to the OVC are indeed useful. For good health, these disadvantaged children need treatment of diseases, reproductive health, water, VCT for those who are HIV/AIDS positive” (M1).

“Some services offered are tailored to only meet a normal family requirement (immunization) as compared to nutritional support or free treatment of diseases ...” (F2).

The views of OVC regarding attitude of healthcare providers towards them was assessed (Figure 4.2). The findings indicate 158 (41%) of the OVC view the basic health care service providers as friendly, 117 (30.4%) as fairly friendly and 72 (18.7%) as very friendly while 38 (9.9%) find them not friendly (Figure 4.2).

The figure below shows the attitude of OVC towards basic health care service providers.

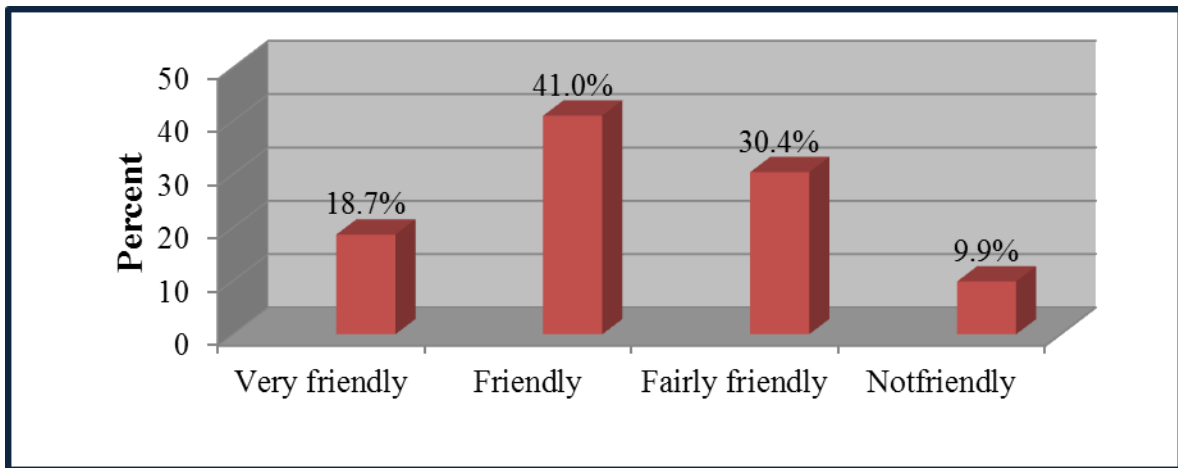


Figure 4.2: Attitudes of OVC towards the treatment by the providers of basic health care services

When Key informants were asked about their views on the attitude of health care providers towards OVC, they reported that the service providers were friendly, fairly friendly, and very friendly whereas some reported that they were not friendly:

“... health care service providers are friendly. They usually welcome their clients, and get them seated before attending to them” (M2). “... Service providers are very friendly. They first greet you before they start attending to you” (M5).

Some Key informants reported that some of the service providers are fairly friendly to the OVC: *“these people (service providers) are sometimes not considerate. They are not sympathetic to the plight of the OVC. They offer them same treatment as other children “if no cost sharing fee, then no services, yet most of these OVC are not able to pay because of their poverty status” (F2).*

Some informants further felt that the providers view OVC as a burden since they are usually not able to pay for services and therefore treat them unkindly: “... *service providers are not friendly. They are arrogant to OVC especially for those not able to pay for cost sharing. They harass those people they are supposed to serve especially in maternity* (F2).

4.4. Availability of Basic Health Care Services

The available basic health care services identified in the study area included immunization 327 (84.9%), maternal and child health services 222 (57.7%), provision of therapeutic nutrition 46 (11.9%). Other services such as treatment of diseases, VCT, health education and safe water supply services were also mentioned 63 (16.4%) (Figure 4.3).

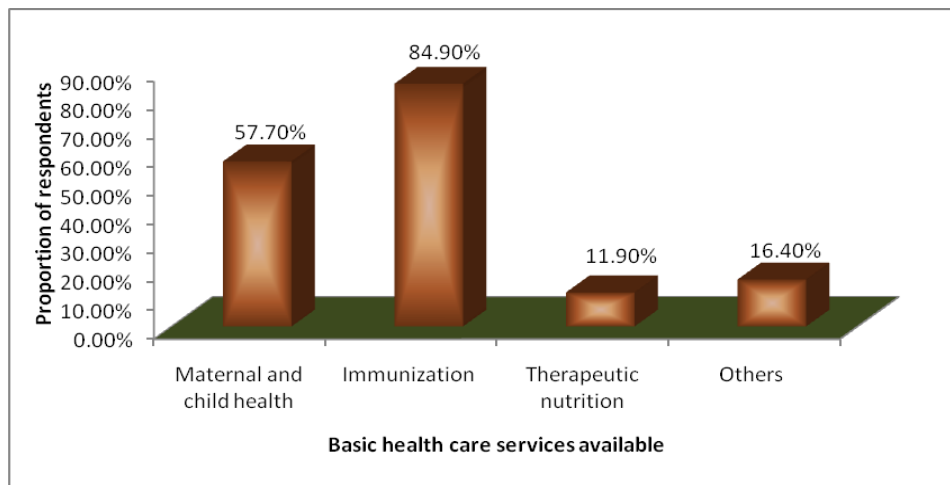


Figure 4.3: Basic health care services available (N=385)

Despite the availability of services, some of them were not suitable for the OVC. This came out among the key informants.

“... Services such as immunizations usually offered in every health centre are not suitable to older OVC being targeted (10-18 years). Immunization services are for young children aged below 5 years old” (F1).

“Nutrition program only supports targeted malnourished children or people living with HIV and AIDS registered in the Comprehensive Care Centre (CCC) at the Kakamega provincial hospital” (F3). Older OVC are likely to benefit from health education, reproductive health, VCT services among others.

“Services that are suitable for the OVC include youth friendly clinics, reproductive health and treatment of illnesses, provision of shelter, clean water, maternal and child health care, VCT, Family Planning and health education” (M1).

On availability of basic health services in the study area, the findings indicate that these are in most of the twelve (12) health care facilities available in the area within walking distance (Table 4.5). Of the 12 facilities available, 2 (16.7%) are health centres and 10 (83.3%) are dispensaries. Of the 10 dispensaries, 8 (80%) are public dispensaries while 2 (20%) are private. Services offered in these public dispensaries are treatment of diseases, health education and immunizations, while private dispensaries offer treatment of diseases, health education, immunization, referral of patients and MCH; and health centres offer Treatment of diseases, Health education, Immunization, MCH, family planning, Referral of patients, maternity, VCT and in patient services. There were no health policies for the youths displayed on walls in all the health facilities (Table 4.5).

Table 4.5: Check list in Health facilities on availability of basic Health Care Services in Lurambi division

Study Location	Health facility	Health Service	Staffing	Youth Friendly Service	Drugs mostly available	Basic Equipment	Policies for youths
North Butso	Bushiri health and demonstration centre	Treatment of diseases Health education Immunization MCH Family Planning Referral of patients Maternity VCT In patient services	1 Clinical officer 5 Nurses 2 Public health officers 1 Medical Laboratory technologist 1 CHEW 1 Support Staff	Treatment of diseases treatment of STI and management of HIV/AIDS. Family planning. Health education, Antenatal and post natal Child Delivery	Anti malarials especially Artemether Lumfantrine (AL) Pain Killers i.e., aspirin, paracetemols, anti biotics amoxil, septrine, achromycin, ampicillin, ampiclox, Anti acids, Anti helminthesnatoz, Flagyl, Quinine	Blood pressure machine, a Microscope A, Thethoscope, Thermometer Foetalscope	Nil
	Shihongo Dispensary	Treatment of diseases, health education, Immunization	2 Nurses, 1 Public health officer 1 CHEW 2 Support Staff	Treatment of diseases, Treatment of STIs, Health Education	Anti malarials especially Artemether Lumfantrine (AL) Pain Killers i.e. aspirin, paracetemols, anti biotics amoxil, septrin, achromycin, ampicillin, ampiclox, Anti acids, Anti helminthesnato	Foetalcope Blood Pressure Machine, Stethoscope, Thermometer	Nil
North Butso	Matiha Dispensary	Treatment of diseases, Health Education immunization.	3 nurses, 1 public health technician 1 CHEW 2 Support Staff	Treatment of diseases, Treatment of STIs, Health Education	Anti malarials especially Artemether Lumfantrine (AL) Pain Killers i.e. aspirin, paracetemols, anti biotics amoxil, septrine, achromycin, ampicillin, ampiclox, Anti acids, Anti helminthesnatoz, Flagyl, Quinine	Blood pressure machine, a Microscope A, Thethoscope, Thermometer Foetalscope	Nil

Study Location	Health facility	Health Service	Staffing	Youth Friendly Service	Drugs mostly available	Basic Equipment	Policies for youths
	Ingotse dispensary (mission)	Treatment of diseases, Health education, Immunization, referral of patients MCH	1 Clinical officer 1 Nurse 1 Support staff	Treatment of diseases, Treatment of STIs, Health Education, Ante natal	Anti malarials especially Artemether Lumfantrine (AL) Pain Killers i.e. aspirin, paracetamol, anti biotics amoxicillin, septrine, achromycin, ampicillin, ampiclox, Anti acids, Anti helminthesnato	Foetalcope Blood Pressure Machine, Stethoscope, Thermometer	Nil
South Butso	Bukura Health and demonstration Centre	Treatment of diseases, health education, immunization, MCH, Family planning, Referral of patients, VCT, In Patient services and maternity	2 clinical officers 5 nurses 2 Public Health officers 1 medical laboratory technologist 1 CHEW 1 Public health officer 1 records officer 1 Support Staff	Treatment of diseases, Treatment of STIs and management of HIV/AIDS, family planning, health education, Ante natal and post natal, children delivery.	Anti malarials especially Artemether Lumfantrine (AL) Pain Killers i.e. aspirin, paracetamol, anti biotics amoxicillin, septrine, achromycin, ampicillin, ampiclox, Anti acids, Anti helminthesnatoz, Flagyl, Quinine	Blood pressure machine, a Microscope A, Thethoscope, Thermometer Foetalcope	Nil
	Eshirembe Dispensary	Treatment of diseases, Health education, immunization, referral of patients MCH	2 Nurses, 1 public health officer 1 medical laboratory technologist 2 support staff	Treatment of diseases, Treatment of STIs, Health Education	Anti malarials, (AL), pain killers, i.e. anti biotics, anti-acids, anti-helminthes, flagyl,	Blood pressure, machine, astethoscope, thermometer	Nil
	Matioli dispensary	Treatment of diseases, health education, immunization, referral of patients MCH	3 nurses, 1 public health officer 1 CHEW	Treatment of disease, treatment of STI, health education.	Anti malarials, (AL), pain killers, i.e. anti biotics, anti-acids, anti-helminthes, flagyl,	Blood pressure, machine, astethoscope, thermometer	

Study Location	Health facility	Health Service	Staffing	Youth Friendly Service	Drugs mostly available	Basic Equipment	Policies for youths
South Butso	Isumba dispensary	Treatment of disease health education immunization, referral of patients MCH	1 Nurse 1 support staff	Treatment of diseases, treatment of STIs, Health Education	Anti malarials, (AL), pain killers, i.e. anti biotics, anti-acids, anti-helminthes, flagyl,	Blood pressure, machine, astethoscope, thermometer	Nil
Central Butso	Emusanda Dispensary	Treatment of diseases, health education , immunization, referral of patients MCH	2 Clinical officers, 5 nurses, 1 pharmaceutical technologist, 1 medical laboratory, technologist, 1 CHEW, 1 counselor, 1 records officer, 2 support staff.	Treatment of diseases, Treatment of STIs, Health Education	Anti malarials, (AL), pain killers, i.e. anti biotics, anti-acids, anti-helminthes, flagyl,	Blood pressure, machine, astethoscope, thermometer	Nil
	Eshikhuyu Dispensary	Treatment of diseases, health education, immunization, referral of patients MCH	3 nurses, 1 public health officer 2 Medical laboratory technologists.	Treatment of disease, treatment of STI, health education., ante natal	Anti malarials, (AL), pain killers, i.e. anti biotics, anti-acids, anti-helminthes, flagyl,	Blood pressure, machine, astethoscope, thermometer	
	St. Anne Eshisiru	Treatment of diseases, health education, immunization, referral of patients MCH	1 Clinical officer, 1 nurse	Treatment of disease, treatment of STI, health education., ante natal	Anti malarials, (AL), pain killers, i.e. anti biotics, anti-acids, anti-helminthes, flagyl,	Blood pressure, machine, astethoscope, thermometer	
East Butso	Emukaba Dispansary	Treatment of diseases, health education, immunization, referral of patients MCH	1 Nurse 1 Public health officer 1 support staff	Treatment of disease, treatment of STI, health education.	Anti malarials, (AL), pain killers, i.e. anti biotics, anti-acids, anti-helminthes, flagyl,	Blood pressure, machine, astethoscope, thermometer	

4.5 Accessibility of Basic Healthcare Services to OVC

Asked whether basic health care services are accessed, 313 (81.3%) of those OVC who affirmed, identified friendly service providers 261 (83.4%), short distance to the health facility 116 (37.1%), no levies imposed on services provided 30 (9.6%) and others 20 (6.4%) cited varied reasons as the main motivating factors for them to easily access basic health services being provided (Table 4.6). Among those who stated to the contrary, 72 (18.7%) mostly complained about lack of information on basic health services 55 (76.4%), long distance to service provision site 54 (75.0%) and to others 17 (23.6%), it was due to stigma and discrimination while others 7 (9.7%) gave various reasons (Table 4.6). All OVC gave more than one response.

Table 4.6: Reasons for accessibility and inaccessibility to the basic health care services

Accessible (N=313)		Inaccessible (N=72)	
Reason*	n (%)	Reason*	n (%)
Friendly service providers	261 (83.4)	Lack of information on basic health care services	55 (76.4)
Short distances to the service provision sites	116 (37.1)	Long distances to the service provision sites	54 (75.0)
No levies imposed on services provided	30 (9.6)	Stigma and discrimination	17 (23.6)
Others	20 (6.4)	Others	7 (9.7)

*Multiple responses

When Key informants were asked to explain why OVC may not access basic health care services, they revealed that facilities that offered basic health care services were far. For example, a female Key informant stated that:

“Facilities that offer most of basic health care services are far. Some OVC travel for more than 10km to reach Kakamega Provincial General Hospital in search of services like VCT, nutrition foods for HIV and AIDS patients” (F2).

Another key informant stated:

“These children need transportation (in form of motorbikes or bicycles). Most OVC are poor. They cannot afford transport to Kakamega. The services are too costly for these children” (M3)

4.5.1 Distance to the nearest health care facility

Asked how far the nearest health facility (geographical accessibility) was from the respondent’s residence, (n=385), more than half 212 (55%) stated that they cover more than 5km, 91 (24%) stated 3-5km, 26 (6%) were within 1-2km and 56 (14%) covered less than 1 km (Figure 4.4).

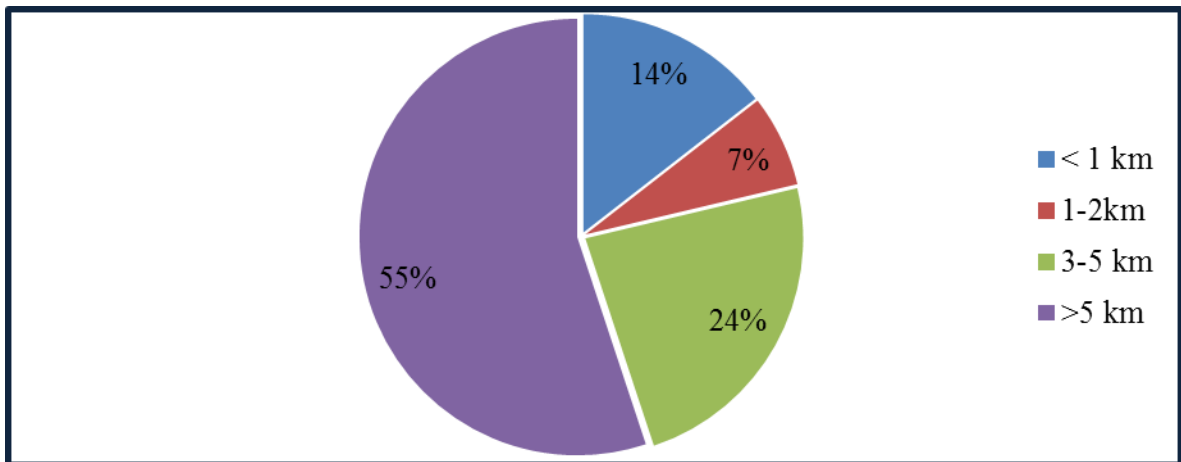


Figure 4.4: Distance to the nearest basic health facility in Lurambi Division, western Kenya September, 2010.

4.5.2 Difficulties faced by OVC in accessing basic health care services in the community

When OVC were asked what difficulties they faced in accessing basic health care services in the community, majority 302 (78.4%) indicated that the difficulties faced were inflexible system where OVC are not given special attention, 190 (49.4%) stated scarcity of services and 160 (41.6%) indicated service providers were prejudiced against them. Other difficulties included: lack of resources such as money, transport, information and communication (Figure 4.5).

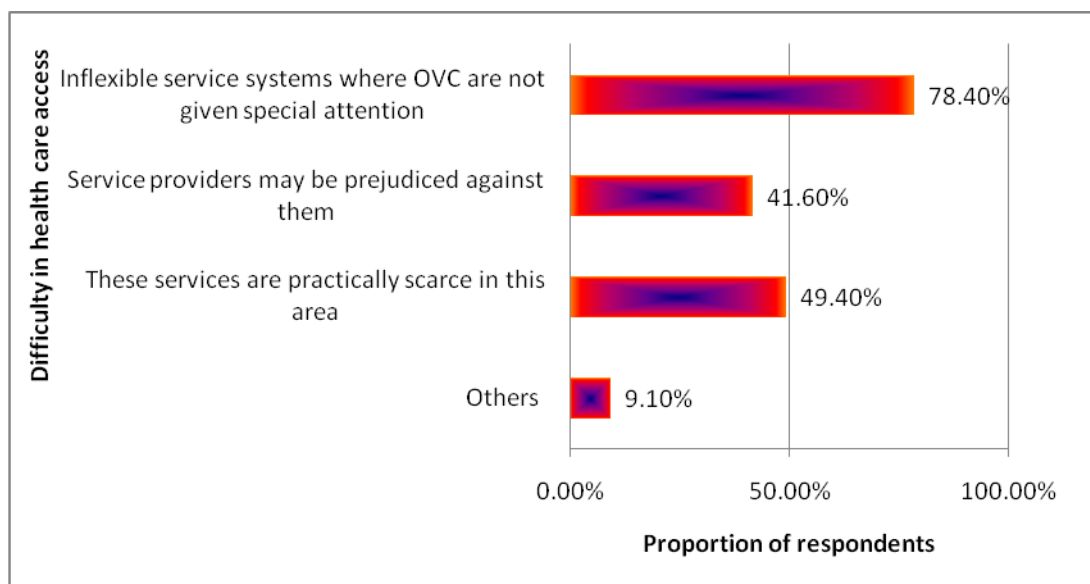


Figure 4.5: Difficulties faced by OVC in accessing basic health care services (N=385)

When key informants were asked to state the difficulties faced by OVC in the accessing the available basic health care services, the following was stated by a male key informant.

“Poverty and cost sharing levies for the services offered is a very big problem to OVC in this community. This makes OVC stay away from health services” (M1).

“OVC lack information on basic health care services, they are discriminated and isolated, these children suffer from stigma” (M4).

Other difficulties faced by OVC were reported *“corruption among service providers, inequality among children by guardians and sexual abuse” (F2).*

4.5.3 Suggestions given to assist OVC optimize access to basic health care services

When OVC were asked for suggestions on how they can be assisted to enable them optimize accessibility to basic health care services in the community, the majority 314 (81.6%) recommended being empowered with information on basic health care services, 260 (67.5%) stated moving basic health care services closer to them through outreach services, and 222 (57.7%) removal of levies on basic health care services for OVC (Figure 4.6).

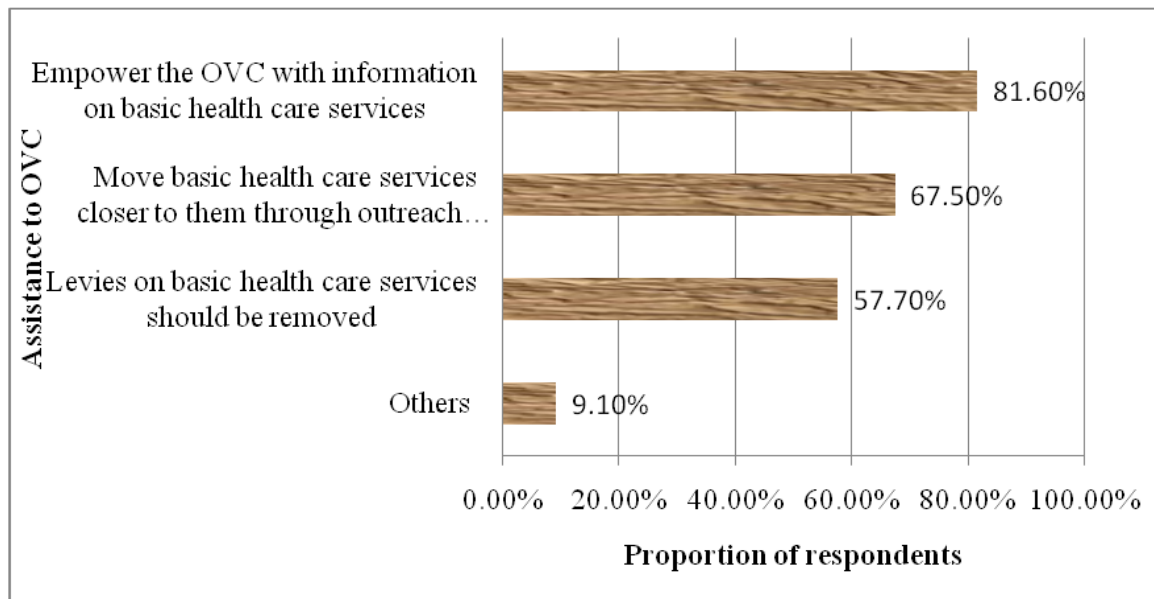


Figure 4.6: What can be done to assist OVC optimize access to basic health care services (N=385)

When key informants were asked on what can be done to assist OVC optimize access to basic health care services, the following suggestions were reported:

“.... OVC should be empowered with information about the basic health care services for them. They (OVC) don’t know these services” (M3).

Other suggestions reported by the key informants were: *“...OVC should be involved and participate in all issues affecting them” (F1).* *“Service providers should change their attitudes towards these OVC. ... let them (OVC) be given treatment whenever they come to hospital instead of being turned away due to non-payments” (M4).*

The informants further suggested that better mechanisms available in assisting OVC to ensure that they have increased access to the available basic health care services in the community were:

“... registration and keeping of records of OVC by village elders for easy identification because these are the community leaders who are on the ground” (M2).

“Let the OVC get free health care services through outreach services in the community just like VCT and counseling”. ... these children suffer from traumatic experiences in their lives... ” (M4).

The key informants further suggested the increase in number of service providers at provision sites to avoid understaffing:

“... the government should employ more nurses, clinical officers, public health officers. Kakamega MTC among other colleges in Kenya trains these officers. Every year, they graduate, why should we have shortages promoting long queues in hospitals?” (M3).

“...most health care services should be made available for the OVC within the community. Why should an OVC travel all the way (10km) to Kakamega in search of these health services?... ” (M4).

4.5.4 Socio-economic and Demographic Factors Affecting Accessibility

The study assessed the effect of gender, age, educational level, occupation and religion on accessibility to basic health services (Table 4.7).

The study revealed no significant association between socio-economic characteristics of OVC and accessibility to basic health services. However, there was borderline association between unemployed OVC with not being able to access to basic health care services compared employed (*i.e.*, child labour), [OR=3.7; 95% CI: (0.8-23.4); *P*=0.059]. This means that unemployed OVC were 3.7 times more likely to not access facilities, compared to those employed, suggesting that they could not afford to access the services due to costs involved. This also suggests the importance of targeting these services to those most economically deprived.

Table 4.7: Association of socio-economic and demographic factors on Accessibility to Basic Health Care

Characteristic		Accessible to basic health care services				Odds Ratio (95%CI)	p-value
		Yes		No			
		N	%	N	%		
Sex	Male	174	81.3	40	18.7	1.0 (0.6-1.7)	0.996
	Female	139	81.3	32	18.7		
Age	≤ 14 yrs	117	79.1	31	20.9	1.3 (0.7-7.2)	0.372
	> 14 yrs	196	82.7	41	17.3		
Education level	≤ primary	259	80.4	63	19.6	1.5 (0.7-3.4)	0.326
	> primary	54	81.3	9	14.3		
Employed	Yes	30	93.8	2	6.3	3.7 (0.8-23.4)	0.059
	No	283	80.2	70	19.8		
Birth place	Lurambi	290	81.0	68	19.0	1.3 (0.5-4.0)	.591
	Outside lurambi	23	85.2	4	14.8		
Religion	Christian	290	80.8	69	19.2	1.8 (0.5-7.9)	0.332
	Others	23	88.5	3	11.5		
TOTAL		313	81.3	72	18.7		

Most key informants reiterated that the occupation status of an OVC can influence his/her level of utilization of basic health care services in the community:

“... OVC can use their earnings to pay for most health care services. An OVC with an occupation becomes self-reliant and may even help support other OVC in the community” (M5).

“Most of the boys become cane cutters or herds boys while girls become house girls (maids) in order for them to make ends meet. This state of affairs promotes child labour which is contrary to the law”. “This is an abuse of the rights of a child...” (M1).

Key informants reported on some of the economic challenges that the OVC face which may influence the utilization of basic health care services:

“... high poverty levels, lack of income to pay for cost sharing levies and forced labour to earn a living (M3). “... social diseases (HIV and AIDS, herpes and trichomoniasis) and child abuse are common amongst the OVC. These children are sexually abused...” (F1).

The key informants also stated that the level of education of an OVC can influence his/her level of utilization of basic health care services in the community.

“...education makes an OVC to understand the importance of health services and therefore seek for them in order to remain healthy. This (education) makes OVC more self-reliant in all fields. Lack of education to OVC may lead to ignorance of utilization of health care services” (F2).

When the key informants were asked about their view on how age and gender of OVC can influence their utilization of basic health care services in the community:

“... tender/young OVC of up to about 14 years old may not know the importance of these health care services. Most of these children are only told what to do. They don't do everything on their own” (M2). “... isolation and discrimination along gender lines and sexual abuse to older OVC especially girls is common” (4).

The study also analyzed the association of the attitude of OVC towards basic health services and accessibility to these services (Table 4.8). The study found a significant association between attitude to basic health care services and accessibility (OR=4.8; 95% CI: [2.0-11.4]; P=000). The OVC with positive attitude towards basic health care services were 4.8 times likely to access these services. Similarly, the participants who viewed the health care workers as unfriendly did not access the basic health care services but those who viewed the service providers as friendly accessed the basic health care services.

This was also statistically significant (OR=4.2; 95% CI: [2.1-8.1]; $P=0.000$). The OVC who viewed service providers as friendly were 4.2 times likely to access these services (Table 4.8)

Table 4.8: Effects of attitude towards Accessibility to Basic Health Care

Characteristic		Accessible basic health care services				Odds Ratio (95% CI)	p-value
		Yes		No			
		N	%	N	%		
Attitude towards basic health care services	Positive	218	76.8	66	23.2	4.8 (2.0-11.4)	.000
	Negative	95	94.1	6	5.9		
Attitude towards Service providers	Friendly	170	73.6	60	26.1	4.2 (2.1-8.1)	.000
	Not friendly	143	92.3	12	7.7		
TOTAL		313	81.3	72	18.7		

4.6. Utilization of Basic Health Care Services by OVC

The study explored the proportion of OVC utilizing the available basic health care services in the study area. It was established that 228 (72.8%) of all OVC accessing available basic health care services were utilizing them, whereas 85 (27.2%) were not.

Asked which basic health care services are utilized, 160 (70.2%) stated treatment for ailments which was followed by safe water supply 126(55.3%), Reproductive health 52 (22.8%), family planning services 38(16.7%) and VCT 28 (12.3%) (Table 4.9).

Table 4.9: Basic Health Care Services utilized by the respondents

Utilization (N=228)	
Reason*	n (%)
Treatment for minor ailments	160 (70.2)
Safe water supply	126 (55.3)
Reproductive health	52 (22.8)
Family planning	38 (16.7)
VCT	28 (12.3)

When key informants were asked basic health care services utilized by OVC in the community, they reported them as follows:

“... OVC utilize the treatment of diseases, family planning, and VCT services” (F1)

“... Provision of shelter, supply of safe water, and health education are locally utilized by these disadvantaged children in the community” (M1)

Key informants further reported some of the services utilized by OVC, but they stated that they are far from them (OVC):

“.... Some basic health care services utilized by this age group like VCT and nutrition services are carried out at the Comprehensive Care Centre (CCC) for the OVC among other people living with AIDS and delivery services are sought in other facilities far away at Navakholo sub-district hospital and Provincial General Hospital, Kakamega” (F2)

4.6.1 Health Facility Specific Factors that hinder utilization

Reasons for non-utilization were identified as being categorized as OVC (stigma) topped the list 173 (76.0%), followed by health providers not providing information 160 (70.1%). Cost sharing levies accounted for 142 (62.4%) while 93 (40.8%) was due to discrimination and isolation by basic health care service providers and 60 (26.1%) was lack of privacy and confidentiality in service provision sites whereas other reasons were reported by 21 (9.1%) (Table 4.10).

Table 4.10: Factors that hinder utilization of basic health facilities

Factor	N=228	
	N	(%)
Being categorized as an OVC	173	(76.0)
Limited access to information and services	160	(70.1)
Cost sharing levies	142	(62.4)
Discrimination and isolation by basic health care service providers	93	(40.8)
Lack of privacy and confidentiality in service provision sites	60	(26.1)
Others	21	(9.1)

(*multiple responses)

The Key informants stated that hindrances to utilization of basic health care services by OVC included poverty, cost sharing levies, and discrimination and/or negative attitudes of service providers towards OVC:

“An OVC is usually expected to pay money for the services at the service provision site through cost-sharing like any other person. Cost sharing in hospitals is for everybody...” (F1).

“Lack of money is a big problem for an OVC to access the health facilities...” “Where do they get this money when they don’t have any source of income? ... most of these children are pupils” (M3).

Some key informants further reported that most of these facilities are under staffed leading to long queues that discourage would be clients:

“... Most of the health facilities especially dispensaries have either only one or two trained staff. You get one person prescribing, injecting, giving medicine dressing those with wounds” “.... Someone goes there and takes almost the whole day...”. “This is quite discouraging to most people who are seeking for services” (F2).

“The dispensaries sometimes don’t have enough drugs for treatment, making it ‘a waste of time’ to be visited. A sick person queues for a long time and after prescription, he/she is told to go to buy medicines from the nearby chemist (M1).

Most key informants reasoned that some services desired by the OVC such as reproductive health, VCT and nutrition are not offered in the local health facilities. *“ ... some crucial services like (antenatal services, VCT and nutrition for HIV and AIDS patients) are not available in these in our local dispensaries. They are offered at Navakholo sub district hospital or Kakamega provincial general hospital. These force OVC to cover long distances to be served (M3).*

4.6.2 Improvements needed to promote utilization of basic health care services by OVC

When asked for suggestions on how to improve access to basic health care services among the OVC, nearly three quarters 280 (72.7%), suggested exemption from charges like cost sharing, 254 (66%) suggested initiation of income generating activities, while 227 (59%) suggested constant monitoring of basic health care services being provided to enhance transparency and accountability (Table 4.11).

Other suggestions included Introduction of vocational and skills training and need for more outreach/mobile services to bring services closer to beneficiaries and need to involve OVC during planning (Table 4.11).

Table 4.11: Suggestions by respondents on how to enhance/maximize utilization

How to enhance utilization	N=385	
	N	(%)
OVC could be exempted from levy charges like cost sharing	280	(72.7)
Initiate income generating activities for them	254	(66.0)
Constant monitoring of basic health care services for them	227	(59)
Introduce vocational and skills training	212	(55.1)
Others	35	(9.1)

(*Multiple responses)

When key informants were asked for suggestions on how to enhance effective utilization of basic health care services by OVC, one suggestion was:

“Sensitizing the OVC on the importance of health care services, transparency and accountability by government officers/service providers is very important; and raising awareness on the importance of basic health care services by OVC should be encouraged” (M2).

4.6.3 Socio-economic and Demographic Factors Affecting utilization

Socio-economic and demographic factors were assessed on how they affect utilization of basic health care services in the community. The study revealed no significant association between socio-economic characteristics of OVC and utilization of basic health services (Table 4.12).

Table 4.12: Socio-economic and Demographic Factors Affecting Utilization of Basic Health Care Services

Characteristic		Utilization of basic health care services					
		Yes		No		Odds Ratio (95% CI)	p-value
		N	%	N	%		
Sex	Male	125	58.4	89	41.6	0.9 (0.6-1.4)	.718
	Female	103	60.2	68	39.8		
Age	≤14 yrs	92	62.2	56	37.8	1.2 (0.8-1.9)	.353
	> 14 yrs	136	57.4	101	42.6		
Birth place	Lurambi	213	59.5	145	40.5	1.2 (0.5-2.6)	.688
	Outside lurambi	15	55.6	12	44.4		
Religion	Christian	213	59.3	146	40.7	1.1 (0.5-2.4)	.870
	Others	15	57.7	11	42.3		
TOTAL		228	59.2	157	40.8		

Characteristic		Utilization of basic health care services					
		Yes		No		Odds Ratio (95%CI)	p-value
		N	%	N	%		
Education level	Primary and below	187	58.1	135	41.9	0.7 (0.4-1.3)	.301
	Secondary and above	41	65.1	22	34.9		
Occupation	Earners	17	53.1	15	46.9	0.8 (0.4-1.6)	.464
	Non earners	211	59.8	142	40.2		
TOTAL		228	59.2	157	40.8		

The study also analyzed the relationship between the attitude of OVC towards basic health services and utilization of these services (Table 4.13). The study found a significant association between attitude to basic health care services and accessibility

(OR=39; 95% CI: [5.4-54.4]; $P=000$). The OVC with positive attitude towards basic health care services were 39 times likely to utilize these services. Similarly, the participants who viewed the service providers as unfriendly did not utilize the basic health care services but those who viewed the service providers as friendly utilize the basic health care services. This was also statistically significant (OR=218; 95% CI: [95.2-501.2]; $P=000$). The OVC who viewed service providers as friendly were 218 times likely to utilize these services.

Table 4.13: Effects of attitude of OVC towards Utilization of Basic Health Care services

Characteristic		Utilization of basic health care services					
		Yes		No		Odds Ratio (95%CI)	p-value
		N	%	N	%		
Attitude towards basic health	Positive	227	79.9	57	20.1	39 (5.4-54.4)	.000
Care services	Negative	1	1.0	100	99.0		
Attitude towards Service providers	Friendly	217	94.3	13	5.7	218 (95.2-501.2)	.000
	Not friendly	11	7.1	144	92.9		
Total		228	59.2	157	40.8		

4.7 Results of Multiple Regression Analysis

This section presents multiple regression analysis findings. This is a parametric inferential statistical method that determines whether a group of variables taken together can identify predictors of a given dependent variable such accessibility or utilization of basic health care services (Jekel, *et al.*, 1996). The dependent variable was utilization while independent variables used in this study consisted of scaled continuous variables: gender, age, education and occupation. The analysis also determined that negative

attitude of OVC towards health care services has a strong negative relationship with accessibility and utilization of these basic health care services. This variable registered coefficient value of - 0.219. This finding implies that the more times the OVC has a positive attitude towards these basic health care services and service providers, the more he/she will access and utilize them.

In multiple regression analysis, an independent variable is said to be a significant predictor of the dependent variable if absolute t- value of the regression coefficient associated with that independent variable is greater than the absolute critical t- value. The analysis revealed that the main factors that affect accessibility and utilization are attitude towards basic health care services and service providers, occupation, education

Table 4.14: t- Static Coefficients for Multiple Regression Analysis

Model 1	Standardized Coefficient (β)	T	Significance
Occupation	0.085	-5.094	0.001
Attitude	-0.060	-0.219	-0.0051
Education	-0.058	-2.182	0.0060
Gender	0.51	-2.134	0.062
Age	0.046	-2.111	0.71

CHAPTER FIVE: DISCUSSION

5.1 Introduction

This chapter presents the discussion of the study that examined the accessibility and utilization of basic health care services by Orphans and Vulnerable Children in Lurambi division. It discusses the findings of the study, presents possible conclusions and recommendations. The study findings show that majority of OVC 332/385 (86.2%) knew what constitutes basic health care services are, 313/385 (81.3%) accessed the services, of which 228/313 (72.8%) utilized them. The attitude of OVC towards basic health care services and service providers was positive. Available basic health care services were immunization, maternal and child health, therapeutic nutrition, treatment of diseases, VCT, health education and safe water supply.

5.2 Socio-demographic characteristics of the OVC

In this study, the proportion of males (55.6%) was more than females (44.4%), suggesting that more females may have been forced into early marriage. This point to an overlapping of vulnerabilities in female gender, whose early marriage can be exacerbated by being also an OVC, as has been reported by the Kenyan Ministry of Planning (2003) and in Nigeria, where girl child OVC as young as 12 years were given out in marriage to old men (UNICEF and POLICY Project, 2004c). This was to either reduce the financial and social burden of the child on the caregivers, or to raise funds for other family commitments including payment of educational bills for other siblings, especially the male ones.

The percentage of those OVC aged below the mean age of 14.4 years was more than older OVC. This is due to the fact that older OVC get married and once married, cannot be called children as their status would have changed to wife and husband. This supports the report by Ministry of Planning (2003); UNICEF and POLICY Project (2004c and MoDP, 2013) which established that forced early marriages for OVC which act as a source of income for care takers, as well as more willing unions between these young people is prevalent in some parts of the world including Kenya.

On the type of OVC, the findings indicate that there were more (53.5%) paternal orphans than other groups of OVC who accounted for (46.5%). This concurs with UNICEF (2010) which estimated that out of 153.3million OVC globally, 66% were paternal orphans compared to maternal, double and vulnerable children. Even though this study did not assess causes for various types of OVC, many men in developing countries are known to engage in much risky behaviour such as multiple sexual partners with among those who earn more and involvement in civil strife (Daily Nation September 10th, 2013)

OVC predominantly stayed with their mothers, while double orphans (24.9%) were with their grandparents (grandmothers). Others (4.2%) stayed on their own with fellow siblings as heads of households. This break up of nuclear family leads to new living arrangements with different mindsets. This also concurs with World Bank, (2002a) report on education and HIV and AIDS which noted that in many cases, this disadvantaged group of children is taken care of by their grandparents, after the breakup of the nuclear family. Sometimes these new caregivers might be too old and some illiterate who may not value basic health care.

5.3 Socio-economic Characteristics that may Hinder the Utilization of Basic Health Care Services by OVC

Majority (74.4%) of the OVC stated to be attending primary school, hopefully utilizing the available free primary school opportunities in Kenya and given that education is considered a human right. Whether their education may be being interrupted due to some indirect costs may not be verified from this study. This level of education cannot enable one get permanent employment. These children end up being used by relatives as house helps especially girls while boys are used as herds' boys. This was well reflected in occupation of OVC by 80% of them being students being educated by either parent for partial Orphans and Vulnerable children or guardians for total Orphans. Three quarters (75.8%) of the respondents stated that being an OVC had hindered their utilization of basic health care services, while 55.3% felt that it had forced them get involved in child labour to make them earn a living. Child labour is contrary to the Constitution of Kenya (GoK, 2010) and The Children's Act number 8 (GoK, 2010). It was observed that

reduction in utilization of these basic health care services was mainly due to lack of resources to meet the levies at the service provision sites. This concurs with the study findings by Smart *et al.*, (2003) which established that in the face of reduced income and increased expenditure, money allocated for health expenses is also reduced.

Some OVC were assisted by well-wishers to enable them utilize basic health care services while others did casual work such as herding, house helps and small scale farming to enable them make ends meet and be able to utilize essential health services. Without such activities, these OVC who mostly leave below poverty line are unable to provide or get money needed for cost sharing services. This finding is in support of Funkquist *et al.*, (2007), who established that intermittent sources of income cannot enable or facilitate full utilization of basic health care services due to demand for cost sharing levies coupled with high level of poverty in the community.

Key informants also stated that the economic issues that OVC face influence their utilization of basic health care services. Among barriers to utilization of basic health care services include: high poverty levels, lack of income to pay for cost sharing levies and forced labour to earn a living.

“... high poverty levels, lack of income to pay for cost sharing levies and forced labour to earn a living.

Similar observations were made by UNICEF, (2004c) which established that a wide range of factors limits children’s access to and utilization of health care services, including poverty resulting from low resource base and lack of basic credit and employment facilities in most rural communities. The findings further supported UNICEF/IRC (2008) on AIDS public policy and child-wellbeing which observed that changes in health financing systems that dismantled free health care systems to privatization of health services have promoted the non-utilization of basic services. The study observed that out-of-pocket payments have risen sharply and increases in user fees (cost-sharing) correlate with decreased service utilization by the OVC. This is in agreement with the report by United Nations (2003; ECBO, 2011), which stated that many OVC today lack family, medical and community care, and bear responsibilities

beyond their ability and experience. Many are forced into high-risk labour, to support or to enable them access health care services.

There are many different models of orphan care, three of which are community-based, institutional residential care and self-care (Beard, 2005). The official policy in Kenya is that the extended family, caring the orphan within the community is the preferable form. However, the spatial dispersion of the extended family may mean migration and separation of siblings (Ansell and Young, 2004). Programmes also need to consider the effects of Hamilton rule, which states that closeness of biological ties governs altruistic behaviour. That is, the closer the guardian to an OVC is, the more likely the guardian will sacrifice in the best interest of the child (Case *et al.*, 2004).

The OVC in the study area thus felt that it is time the community and other partners assisted them access and utilize basic health care services not only through formal education, but also initiation of IGA and vocational skills that may be an important aspect in the orphan child's social development to enable them be financially self-reliant in terms of fees and other levies in health care services (Mann, 2000). Therefore more innovative measures to improve the economic situation of poor rural household caring for orphans are needed. Sherer *et al.*, (2004) reported on the village health bank initiative in Guatemala, Malawi and Thailand that improved the economic situation, nutrition status and school attendance amongst poor households. The fact that the Kenyan Government committed 7.2 billion Kenya shillings for OVC in 2014/2015 financial year is a move in the right direction (Daily Nation of 13th May, 2014, page 36)

The findings on socio economic characteristics are supported by key informants who stated:

“... OVC can use their earnings to pay for most health care services. An OVC with an occupation becomes self-reliant and may even help support other OVC in the community”.

5.4 Knowledge and the Attitudes of OVC towards Basic Health Care Services

Most of the OVC in this study, had knowledge on what basic health care services are. This is consistent with the Andersen (1995); knowledge has been identified as a determinant of accessibility and utilization of basic health care services. Knowledge is crucial in the accessibility to services and use thereof. The findings indicate that the respondents knew basic health care services to be either preventive and curative health services and or all hospital services. This finding concurs with the views of Government of Uganda), Ministry of Gender, Labour, and Social Development [GoU, MGLSD], (2008); International Federation of Red Cross Red Crescent Society [IFRCRC], (2008), Government of Rwanda [GoR], (2009) and United States Agency for International Development [USAID], (2009) that also held the same views.

OVC had knowledge of basic health care services as described by GoU, MGLSD, (2008), IFRCRC, (2008), GoR, (2009) and USAID, (2009). The importance of knowledge on accessibility and utilization had been originally proposed by Andersen in his health care utilization model. With knowledge on basic health care services, the respondents are able to make informed choice on accessing and utilizing them.

The findings were corroborated with those of key informants. They stated: "... basic health care services means preventive and curative health care services"

The respondents knew that being categorized as an OVC had an effect. The negative effects established included discrimination, increased stigmatization and isolation. Their awareness of negative or positive effects of being categorized as OVC influenced them to either access and utilize these important services or not. Those who hold that categorization has negative effects may shy off being identified with others in accessing health services. This concurs with the study findings of Hunter and Williamson (2000) in their report on the child on the brink: They noted that OVC encountered psychological traumas coupled with ostracism, discrimination and stigma as a result of their being categorized as OVC (Jones, 2008). These made them unhappy in communal environment (Funkquist *et al.*, 2007). This scenario may stem from the fact that OVC have knowledge

that they are grouped in a specific category in which they are identified in any given social set up.

These findings are also in consistent with UNAIDS (2002) and Boler and Carol (2003). They observed that some OVC knew that they are categorized alone in order for them to benefit in terms of provision of services and in order to track down their welfare. However they also noted that continued categorization of OVC may lead to increased stigmatization and discrimination. This was supported by key informants who stated: “OVC are often discriminated and isolated as a result of being identified as OVC

The attitude of OVC towards basic health care services and service providers was positive (73.8% and 59.7% respectively). This finding correlates with the level of utilization which was notably high (72.8%). Those who had negative attitudes (27.2%) did not utilize and attributed this mostly to limited access to information on basic health care services, cost sharing levies coupled with high level of poverty in the community. These findings were confirmed by the key informants who attributed negative attitude of OVC in utilization of basic health care services to high poverty levels in the community due to lack of information, discrimination by caretakers and negative attitude of the service providers. In addition to fore mentioned above, cost sharing levies at service provision sites also hinders utilization. The current study findings are similar to those of USAID, (2005) and a study in Malawi both of which established that utilization of basic health care services was globally low due to limited access to information and services coupled with unemployment and high levels of poverty (Funkquist *et al.*, 2007).

FHI (2005) and Pathfinder International, (2008), found that poverty hindered utilization of basic medical services which often became episodic and frequently occurred in emergency settings. This limited the provision of comprehensive longitudinal care to OVC as issues of day-to-day survival like security, lack of food, clothing and shelter often overrode other concerns like basic health care services that were purely preventive services. PATH (2004) in their studies in Zambia, El salvador, the United States and the United Kingdom established that underutilized resource for providing health information

and services to OVC hindered the utilization of health care services for poor families who include OVC. World Bank (2002a) found cost sharing levies to be a hindrance to utilization of basic health care services in developing countries. In Uganda, OVC services have been addressed. Services are more accessible, provided by friendly staff and are provided free of charge (Horizon, 2004).

5.5 Availability of Basic Health Care Services by OVC

Availability of services is crucial for their accessibility and utilization. The most basic health care services available in the community are immunization; maternal and child health services and treatment of common diseases. The finding is consistent with the Ministry of Devolution and Planning [MoDP], (2013). Services like immunization and maternal and child health services although available in the community, are unsuitable for OVC aged 10-18 except for those expectant OVC girl children and children aged below 5 years. The suitable services available for these disadvantaged children like therapeutic nutrition, VCT, and safe water supply are scarce and mostly in health facilities located in urban areas especially Kakamega and Navakholo towns. This concurs with Pathfinder International, (2008), who established that most health care facilities with quality services are located in urban centres where most of all suitable services are offered with scarcity in rural areas. The study findings were corroborated by key informants who stated: “Services such as Immunizations usually offered in every health centre here are not suitable for older OVC you are targeting (10-18 years). Immunizations are for smaller children aged below 5 years old or younger mothers”. “Nutrition program only supports targeted malnourished children or people living with HIV and AIDS registered in the Comprehensive Care Centre (CCC) at the Kakamega provincial hospital”. “Services that are suitable for the OVC include youth friendly clinics, reproductive health and treatments of illnesses, provision of shelter, clean water, maternal and child health care, VCT, Family Planning and health education”.

5.6 Accessibility of Basic Health Care Services by OVC

Geographical distribution of health services had affected access to health care services that in turn increased the use of these services by OVC. Health facilities were scarce in rural set ups (Funkquist *et al.*, 2007). It meant that longer distances are to be covered by OVC in search of the services. The long distances hindered the full access to these lifesaving services for OVC. This concurs with Bhatti (2005), who established that 3km was accessible distance to many community members but not all those people within this walking distance access the services and the health facility accessibility and utilization decreased as the distance increased to more than 5km by foot (Bhatti, 2005). This could be due to service providers who are prejudiced and or lack of resources such as money for cost sharing, transport, information and communication to these would be beneficiaries.

Lack of information on available basic health care services, coupled with stigma and discrimination also contributed to non-accessibility to the available basic health care services in the study area. These results were also in agreement with those of the key informants who had observed that OVC did not have access to basic health care services due to lack of information and illiteracy/ignorance of guardians coupled with poverty and cost sharing levies. These findings are also in agreement with other studies by Dias *et al.*, (2006); Family Health International [FHI], (2006) and Funkquist *et al.*, (2007) established that OVC could not access health care services compared to other children due to not only lack of information on these services, but also due to stigma and discrimination of being categorized as OVC.

OVC faced some difficulties in accessing basic health care services in the study area. Most of the respondents indicated that the difficulties faced were inflexible system where OVC are not given special attention, among services the available scarce facilities. This concurs with similar findings in other studies by Family Health International, (2006) and Pathfinder International, (2008). The finding was supported by key informants who stated: "Poverty and cost sharing levies for the services offered is a very big problem to OVC in this community, which makes OVC stay away from health services".

“OVC lack information on basic health care services, they are discriminated and isolated, these children suffer from stigma”.

Other difficulties faced by OVC were reported: “corruption among service providers, inequality among children by guardians and sexual abuse.

5.7 The Utilization of Basic Health Care Services by OVC

OVC mainly utilized services such as treatment of minor ailments, safe water supply, reproductive health, health education and VCT. The basic health care services available in the area to OVCs were mostly (72.8%) utilized this is because, the OVCs had positive attitude and availability of health services within the area. The findings further disagrees with Bhatt (2005), who observed that these disadvantaged group were discriminated and isolated by basic health care service providers since they were not able to pay for the services. For those 27.2% who do not utilize argued that some of the services like immunizations are not suitable for OVC aged 10-18 years old. Immunizations are suitable for children aged below 5 years and young expectant mothers. This forced OVC to travel far distance to get the services that were relatively cheap and suitable from government health facilities. The findings concur with similar findings by Bhatti (2005). Being categorized as an OVC had an effect on utilization of basic health care services. The negative effects established included discrimination, increased stigmatization and isolation. Their awareness of negative or positive effects of being categorized as OVC influenced them to either access and utilize these important services or not.

This concurs with the study findings of Hunter and Williamson (2000) in their report on the child on the brink: It has also been noted that OVC encounter psychological traumas coupled with ostracism, discrimination and stigma as a result of their being categorized as OVC (Jones, 2008). These make them unhappy in communal environment and often less likely to attend health care services (Funkquist *et al.*, 2007). The findings are also similar to those by Gilbon, *et al.*, (2001) on making a difference for children affected by AIDS in their baseline findings from operation research in Uganda who established the same for OVC aged between 13-18 years. The same study also showed that OVC were stigmatized

and discriminated against by service providers resulting in poor nutrition and lower utilization of basic health care services.

UNAIDS (2002) and Boler and Carol (2003) in addressing the educational needs of OVC in London, in the global HIV/AIDS epidemic and Orphans at Bangkok, Thailand respectively; argued that OVC should be categorized alone in terms of provision of services like basic health care services among others in order to track down their welfare. The same authors were of the view that categorization would lead to identification of their specific causes of vulnerability and orphanhood. However, they noted that continued categorization of OVC inadvertently may lead to increased stigmatization and discrimination, which in itself may be a barrier to utilization of basic health. The current study raises concerns of individualism, inadequate advocacy and social mobilization and lack of coordination and management at community level on issues affecting OVC. There is thus need for participatory awareness raising in communities with respect to OVC issues (Kidman *et al.*, 2007).

CHAPTER SIX: CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

Socio-economic and demographic characteristics of the study respondents

Most of the respondents stated that they were students either in primary or secondary school. Only a small minority (19.2%) had occupation as manual workers as a source of income.

Knowledge and the attitude of OVC towards basic health care services

Most OVC understood basic health care services to be preventive and curative health care services, and which also included all hospital services.

The attitude of the study participants towards basic health care services and healthcare service providers was positive. They considered basic health care services provided in the area as either useful or very useful; and regarded healthcare service providers as either friendly or very friendly. This positive attitude enabled them to access and utilizes the available basic health care services without feeling stigmatized, discriminated and isolated.

Availability of basic health care services

Most of the basic health care services available in the community were identified as immunization (84.9%); maternal and child health services (57.7%) and treatment of common diseases that provided serves to expectant OVC (girl children) and those aged below 5 years. Others suitable services for these disadvantaged children such as therapeutic nutrition, VCT, and safe water supply are scarce and mostly in health facilities located in urban areas especially Kakamega and Navakholo towns.

Accessibility to basic health care services

The study showed accessibility to basic health care services to be high (81.3%). Among the factors leading to high accessibility were friendly service providers and short distances to service provision sites coupled with positive attitudes towards basic health care services and service providers by OVC.

Utilization of basic health care services

Treatment for ailments, safe water supply, reproductive health, family planning services and VCT were the identified basic health care services utilized by OVC in the study area.

It was established that 85 of the 313 respondents who accessed basic health care services (27.2%) were not able to utilize the services provided, and this is of concern as it indicates missed opportunities.

6.2.1 Recommendations

The following recommendations are made to scale up the accessibility and utilization of basic health care services by OVC in the study area, and similar areas elsewhere.

1. Cost sharing levies on basic health care services should be removed by the Government should or introduce waiver system that can exempt OVC from levy charges as most respondents/OVC were either students and/or not in engaged in any meaning employment as only a few stated casual/manual workers.
2. Because of good knowledge and positive attitude towards basic health care services and health care providers, there is need to ensure continued availability of commodities always to motivate OVC to continue demand for the services.
3. While services for expectant OVC (girl children) and those aged below 5 years were found to be adequate, there is need for Ministry of health to ensure that other suitable services for these disadvantaged children such as therapeutic nutrition, VCT, and safe water supply are also in close proximity.
4. Because the noted high accessibility (81.3%), there is need for continued improvement to maintain this high level of accessibility or even raise it.
5. There is need to ensure most of the demanded basic health care services are available for utilization by OVC and as much as possible avoid missed opportunities for those who access health facilities.

6.2.2 Further Research

Further studies should be carried out to comprehensively address effect of OVC on education, food, clothing and other daily necessities, friends, love and care, labour and perceptions about the future, in order to inform/review policy.

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APPENDICES

APPENDIX I: Letter of Authorization



TEL: (057) 51622/51267/51110
FAX: (057) 51221/51153/51011

School of Public Health and
Community Development
Siriba Campus
Private Bag
MASENO,
KENYA

REF: MU/ESPUDEC/PG/MPH/002/04

03-06-2010

District Commissioner
Kakamega District

Dear Sir

RE: MR. BENEDICT MUYULA POMBO (PG/MPH/002/2004).

The above named person is an MPH student in the School of Public Health and Community Development who has successfully finished his course work and is now ready to collect his data for thesis writing.

His research is on the *“Access and Utilization of Basic Health Care Services by Orphans and Vulnerable Children in Lurambi Division, Kakamega District”*


The objective of Mr. Pombo’s study is to find out the challenges that orphans and vulnerable children face in accessing health care services and use thereof.

The study will be carried out in selected households in Lurambi Division
We Support this study because its findings and recommendations will be passed on to the relevant policy makers to help them put in place actions that can help in the improvement of health care provision for this group of children in Lurambi Division and other parts of the country with similar children.

I therefore, request you to support Mr. Pombo’s study and allow him to collect his data in the selected samples in Lurambi Division.

Yours sincerely


Prof. Rosebella O. Onyango
Chairman: Postgraduate Studies Committee
School of Public Health and Community Development.
Cc. Division of Public Health, Lurambi Division

Research Authorized

6/8/10

FOR: DISTRICT COMMISSIONER
KAKAMEGA CENTRAL

APPENDIX II: CONSENT FORM FOR PARTICIPANTS

Title: ACCESSIBILITY TO AND UTILIZATION OF BASIC HEALTH CARE SERVICES BY ORPHANS AND VULNERABLE CHILDREN IN LURAMBI DIVISION, KAKAMEGA DISTRICT MASENO UNIVERSITY SCHOOL OF PUBLIC HEALTH AND COMMUNITY DEVELOPMENT (ESPUDEC)

By: Benedict Muyula Pombo

Supervisors: Dr. Doreen A.M. Othero

Dr. Wycliffe H. Odiwuor

This questionnaire is for collecting information on access to and utilization of basic health care services by orphans and vulnerable children in lurambi division, kakamega district. You have been selected to participate in this study but your participation is on voluntary basis. You may decide to take part in the study or decline, and you may withdraw your consent at any stage of the interview on your own accord. If you are willing to participate, you will be interviewed about yourself and answers kept private and confidential.

If you have any questions related to this study, feel free to contact the researcher Benedict Muyula Pombo----- 0722447019 or the supervisors

Dr. Doreen A.M. Othero

Dr. Wycliffe H. Odiwuor

Are you willing to participate in this study? Yes () No ()

If willing to participate, Signature or Thumbprint of the respondent -----Date-----

Name of the Interviewer ----- Sign ----- Date-----

APPENDIX III: QUESTIONNAIRE

MASENO UNIVERSITY
SCHOOL OF PUBLIC HEALTH AND COMMUNITY DEVELOPMENT
MASTER OF PUBLIC HEALTH PROGRAMME

AN ASSESSMENT OF ACCESSIBILITY AND UTILIZATION OF BASIC
HEALTH CARE SERVICES BY ORPHANS AND VULNERABLE CHILDREN
IN LURAMBI DIVISION, KAKAMEGA DISTRICT

DATECODE NUMBER
Location..... SUB-LOC.....VILLAGE.....
NAME OF INTERVIEWER..... SIGN.....

ASSURANCE STATEMENT

Please note that this study is strictly for learning purposes. The information given will not be used for any other purpose and shall be treated with maximum confidentiality. Be free to respond to the questions.

Areas to be covered include:

1. Knowledge and the attitudes of OVC towards utilization of basic health care services
2. Availability and Accessibility of basic health care services by OVC
3. The level of utilization of basic health care services by OVC.
4. Socio-economic factors affecting utilization of basic health care services by OVC

SECTION 1: SOCIO-DEMOGRAPHIC INFORMATION

101. Sex of the respondent (observe) Male [] Female []
102. Age of respondent in years.....
103. Place of birth
- 1) Lurambi Division []
 - 2) Kakamega district but outside Lurambi Division []
 - 3) Outside Kakamega district []
104. Religious Affiliation
- 1) Catholic []
 - 2) Protestant []
 - 3) Muslim []
 - 9) Others (Specify)
105. Type of OVC
- 1) Maternal []
 - 2) Paternal []
 - 3) Total []
 - 4) Other OVC []
106. What is your relationship with the head of the household where you live?
- 1) Self []
 - 2) Parent []
 - 3) Sibling []
 - 4) Aunt/Uncle []
 - 5) Grandparent []
 - 6) Others (specify).....

SECTION 2: SOCIO-ECONOMIC FACTORS THAT MAY AFFECT UTILIZATION OF BASIC HEALTH CARE SERVICES BY OVC

- 201 Highest level of formal education reached by the respondent
- 1) None []
 - 2) Primary []
 - 3) Secondary []
 - 9) others (specify)
202. Current occupation
- 1) Work for pay []
 - 2) Student []
 - 3) Peasant []
 - 9) Others (Specify)

SECTION 3: KNOWLEDGE AND ATTITUDE OF OVC TOWARDS BASIC HEALTH CARE SERVICES

301. What do you understand by the term orphan and vulnerable children?
- 1) Children with increased vulnerabilities regardless of cause []
 - 2) Children who are orphans []
 - 3) Children whose parents are living with HIV and AIDS []
 - 9) Others (specify).....
302. What do you understand by the term Basic Health Care services?
- 1) Care and protection given to maintain health []
 - 2) Life saving health services []
 - 3) Curative and preventive health services []
 - 4) All hospital services []
303. Would there be any effect of one being categorized as an OVC?
- 1) Yes []
 - 2) No []
304. If yes, what is the effect?
- 1) It can help to track their welfare []
 - 2) Categorization can aid in directing OVC interventions to the rightful beneficiaries []
 - 3) Can lead to increased stigmatization and isolation []
 - 4) Can lead to finger pointing and discrimination []
 - 9) Others (specify).....

SECTION 4: ATTITUDE OF OVC TOWARDS BASIC HEALTH CARE SERVICES

401. The Views of OVC towards basic health care services in the community
- 1) Very useful []
 - 2) Useful []
 - 3) Not Sure []
 - 4) Fairly useful []
 - 5) Not useful []
402. The views of OVC towards basic health care service providers in the community
- 1) Very friendly []
 - 2) Friendly []
 - 3) Not Sure []
 - 4) Fairly Friendly []
 - 5) Not Friendly []

SECTION 5: AVAILABILITY OF BASIC HEALTH CARE SERVICES BY OVC

501. What basic health care services are available for you in this Division?

- 1) Family Planning []
- 2) Immunization []
- 3) Therapeutic nutrition []
- 9) Others (specify).....

Check list in Health facility assessment on availability of basic health services

Location	Health Facility	Health Service	Staffing pattern	Youth Friendly Service	Drugs mostly available	Basic Equipment	Policies for youth
North Butsotso							
South Butsotso							
Central Butsotso							
East Butsotso							

SECTION 6: ACCESSIBILITY TO BASIC HEALTH CARE SERVICES BY OVC

601. In your opinion do you have full access to the available basic health care services in this community?

- 1) Yes []
- 2) No []

602. If yes to question (601) above, what enables you have full to the available basic health care services in this community?

- 1) Short distances to the service provision sites []
- 2) Friendly service providers []
- 3) No levies imposed on services provided []
- 9) Others (specify).....

603. If no to question (601) above, why?

- 1) Long distances to the service provision sites []
- 2) Lack of information on basic health care services []
- 3) Stigma and discrimination []
- 4) Being categorized as OVC []
- 9) Others (specify).....

604. What is the approximate distance to the nearest Health Facility from where you stay?

- 1) Less than 1 km []
- 2) 1 km []
- 3) More than 1 km []
- 4). Don't know []
- 9) Others (specify)

605. What difficulties do the OVC face in accessing the available basic health care services?

- 1) Inflexible service systems where OVC are not given special attention []
- 2) Service providers may be prejudiced against them []
- 3) These services are practically scarce in this area []
- 9) Others (specify).....

606. What can be done to assist OVC optimize access to basic health care services in this community?

- 1) The OVC with the information on basic health care services []
- 2) Move basic health care services closer to them through out-reach Services []
- 3) Levies on basic health care services should be removed
- 9) Others (specify).....

SECTION 7: UTILIZATION OF BASIC HEALTH CARE SERVICES BY OVC

701. If you have full access to the available basic health care services in this community, do you utilize them?

- 1) Yes []
- 2) No []

702. If yes to question (701) above, which basic health care services have you benefited from in this community?

- 1) Treatment of minor ailments []
- 2) Reproductive Health []
- 3) Safe water supply []
- 4) VCT []
- 9) Others (specify).....

703. If No to question (701) above, what factors hinder the utilization of basic health care services?

- 1) Limited access to information and services []
- 2) Cost-sharing levies []
- 3) Discrimination and isolation by basic health care service providers []
- 4) Lack of privacy and confidentiality in service provision sites []
- 9) Others (specify).....

704. What do you suggest should be done to enhance/maximize utilization of basic health care services by OVC?

- 1) OVC should be exempted from levy charges like cost- sharing []
- 2) Constant monitoring of basic health care services for the OVC []
- 3) Initiate Income Generating Activities for them []
- 4) Payment of basic health care services for the OVC []
- 9) Others (specify).....

Thank you for your co-operation, patience and participation

APPENDIX IV: KEY INFORMANT INTERVIEW GUIDE
MASENO UNIVERSITY
SCHOOL OF PUBLIC HEALTH AND COMMUNITY DEVELOPMENT
(ESPUDEC)

ACCESSIBILITY AND UTILIZATION OF BASIC HEALTH CARE SERVICES
BY ORPHANS AND OTHER VULNERABLE CHILDREN IN LURAMBI
DIVISION, KAKAMEGA DISTRICT, KENYA
KEY INFORMANT INTERVIEW GUIDE

The Respondents were: A Chief, an Assistant Chief, A Village Elder, a Church Minister, a Head Teacher, a Public Health Officer, a nurse in charge of a Health Facility, and a Community Development Assistant)

Inclusion Criteria: The respondent must have stayed in the study area for at least six (6) months

CODE NUMBERDATE.....

LOCATION.....SESSION NUMBER.....

NAME OF INTERVIEWER.....SIGN.....

ASSURANCE STATEMENT

Please, note that this study is strictly for learning purposes. The information given will not be used for any other work. The information obtained from you shall be treated with maximum confidentiality.

Areas to be covered include:

1. The attitudes of OVC towards utilization of available basic health care services
2. The level of utilization of basic health care services by OVC.
3. Availability and Accessibility of basic health care services by OVC
4. Socio-economic factors affecting utilization of basic health care services by OVC.

Section 1. Socio-economic factors affecting utilization of basic health care services by OVC

101. What do you think could be socio-economic challenges facing OVC in this community related to basic health care services
102. What economic issues do the OVC face which may influence the utilization of basic health care services?
103. Do you think age and gender status of an OVC can influence his/her level of utilization of basic health care services in this community?
104. Do you think the level of education of an OVC can influence his/her level of utilization of basic health care services in this community?
105. Do you think the occupation status of an OVC can influence his/her level of utilization of basic health care services in this community?
106. What assistance do the OVC get to enable them access and utilize basic health care services in this community?
107. If any assistance is ever given, what are the eligibility criteria of selecting the beneficiaries?
108. What would you recommend to optimize the utilization of basic health care services by OVC in this community?

Section 2: The attitudes of OVC towards utilization of available basic health care services

- 201. How do OVC view the basic health care services in this Division?
- 202. What do you think should be done to correct the attitudes hindering effective utilization of basic health care services by the OVC?

Section 3. Availability and Accessibility of basic health care services for OVC

- 301. What do you understand by the phrase basic health care services?
- 302. What basic health care services are used by OVC in this Location?
- 303. What difficulties do the OVC face in accessing the available basic health care services?
- 304. What are your views concerning the OVC in relation to availability and utilization of basic health care services?
- 305. Do the OVC in this Division have access to basic health care services?
- 306. What factors do you think may influence the accessibility of basic health care services by OVC in this community?
- 307. What are the mechanisms available in assisting OVC to ensure that they have enhanced access to the available basic health care services in this community?
- 308. What are your recommendations concerning accessibility of basic health care services in this community by OVC?

Section 4: Utilization of basic health care services by OVC

- 401. Do you think all the OVC in this Division utilize the basic health care services?
- 402. What factors do you think influence the utilization of basic health care services by OVC in this community?
- 403. What are the mechanisms available in assisting OVC to ensure that they have enhanced utilization of basic health care services?

APPENDIX V: MAP OF THE STUDY AREA (KAKAMEGA CENTRAL DISTRICT)



Source: Kenya National Bureau of Statistics, 2013

APPENDIX VI: ADMINISTRATIVE BOUNDARIES KAKAMEGA CENTRAL DISTRICT



APPENDIX VII: HEALTH INDICATORS, KAKAMEGA DISTRICT, WESTERN KENYA, SEPTEMBER, 2010.

Indicator	
Number of health facilities	
Hospitals	2
Health Centres	2
Dispensaries	11
Private clinics	5
Nursing homes	6
Approximate distance to the nearest Health facility	
Rural facility	10.0 Km
Urban facility	0.5 Km
Top Ten prevalent Health problems	
Malaria	
Pneumonia	
Tuberculosis	
HIV/AIDs	
Acute respiratory diseases	
Diarrhoea	
Skin diseases	
Injuries	
Eye conditions	
Intestinal worms	
Some important demographic data	
HIV prevalence	7.0%
Doctor: Patient ratio	1:20,835
Nurse: Patient ratio	1:991
Crude birth rate	44/1000
Crude death rate	14.3/1000
Infant mortality	110.9/1000
Child mortality	62/1000
Life Expectancy	
Males	53.2 years
Females	58.7 years
Total fertility rate	5.7
Population growth	2.1%

(Source: MoH, 2007; CBS, 2009; MoDP, 2013).
 (www.christianalliancefororphans.org/orphanstats/).