The Socio-Demographic Characteristics and Their Effects on the Adaptation Levels of Family Caregivers of PILWHA in Thika District, Kenya

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Abstract
This paper sought to investigate the socio-demographic characteristics of family caregivers (FCGs) of PLWHA in Thika District. A total of 177 primary FCGs of PLHWA, drawn through proportionate stratified random sampling from three divisions in the study area were used. Data was collected using interview schedules and Focus Group Discussion (FGDs). The collected data was analyzed quantitatively and qualitatively. Quantitative data was analyzed with the use of Statistical Package for Social Sciences (SPSS) where descriptive statistics and inferential statistics were computed in order to understand the patterns and nature of relationships. Qualitative data was analyzed by use of content analysis, where labels were assigned to various categories and themes of the data. In addition, the data was presented, where possible, using verbatim quotation. The FCGs: were mostly found in rural areas (46.7%); the majority was female (70.1%); the majority were found to be between 20 and 59 years of age, with the highest age group being made up of 30 to 39-year olds (25.4%); the majority (52.5%) were married; 62.1% had had no schooling and/or primary education; a majority (over 38.1%) had no jobs; 59.3% of the families were male-headed; incomes ranged from KShs. 200 to 35,000 with 61.6% spending Kshs. 100-200 daily. The study recommended that: The Kenyan government to put in place strategies that will ensure equitable distribution of resources to all FCGs and specific interventions by government and non-governmental agencies focusing on FCGs of PLWHA should pay attention to gender considerations with customized approaches or strategies for both males and females.

Keywords: care recipient, coping, family caregiver, PLWHA.

INTRODUCTION
The 2007 Kenya AIDS Indicator Survey showed that more than 1.4 million Kenyans are living with HIV/AIDS. This represents 7.4 percent of Kenyan adults aged 15-64 years (NASCOP/MoH, 2008). Death rates from HIV in Kenya, are at about 80,000 per year. As observed, even with the scale up of treatment death rates in Kenya are likely to continue to rise because of the large number of people who were infected in the 1990s (NASCOP/MoH, 2005). Over two decades since the first AIDS case was diagnosed, in Kenya, HIV/AIDS remains a huge challenge for the country in its efforts for social and economic development. Responses to the pandemic have evolved over time as people became aware of this new disease, as they experienced illness and death among family members, and as services have developed to confront this epidemic (MoH, 2005).

According to the National Aids Control Council (2000), Thika District has been a region of high HIV prevalence with rates of 20-29 percent for the 15-49 year olds. It is estimated that 55,335 had been infected in the District (MoH, 2001). However, the district has had a steady decline in HIV prevalence from 39 percent in 1994 to 31 percent, 11 percent and 8 percent in 1998, 2001 and 2004 respectively (NASCOP/MoH, 2005). Based on the same report, it seems to have been stabilizing since 2003. In 2006, Thika district had the highest number of HIV infected people and AIDS deaths amongst the seven districts in Central province. It had 17,541 HIV infected persons and 1,968 AIDS deaths (NACC/NASCOP, 2007).

Nonetheless, though there has been a HIV prevalence decline, the number of those already infected is high due to the previously high prevalence rates. At one point in their lives these persons infected with HIV will need care and/or assistance and this will most probably be given by their relatives in the homes.

STATEMENT OF THE PROBLEM
HIV/AIDS care support programmes usually tend to concentrate on the care of PLWHA and not on the caregivers especially the family members. As Limanonda (2004) observes not much attention has been paid to the needs of family members who act as caregivers, most of whom are women. Yet, these caregivers are in a vulnerable position since they
have to carry out other household chores in addition to providing care for PLWHA. There is a gap in knowledge regarding the situation of FCGs of PLWHA with a view of providing the necessary recommendations to improve their welfare and strengthen their capacity. The factors that influence the plight of the FCGs, ways of reducing their vulnerability and strategies of improving their welfare need to be understood.

**RESEARCH OBJECTIVES**

One goal of this study was to investigate the socio-demographic characteristics of family caregivers of PLWHA in Thika District. This paper sought to investigate and describe these factors and suggest ways to enhance their efficacy and welfare so that they can provide better and quality care to PLWHA.

**SIGNIFICANCE OF THE STUDY**

The information generated from this study will be valuable to governmental and non-governmental organizations, private sector as well as development agencies working in the field of HIV/AIDS. These agencies can have a better understanding of what programmes will better meet the needs of these caregivers. Hence, they can develop programmes aimed at enhancing the caregiver’s welfare and efficacy the result of which will be improved wellbeing of PLWHA since they are likely to get better care. It will equally be useful to policy and program developers who have interest in better understanding the advantage of including FCGs in their strategies to manage the effects of HIV/AIDS. An application of which would be the development of policies and programmes that would empower and enhance the efficacy of the FCGs as key assets in the care of PLWHA as well as strengthen community support to the FCGs.

The study findings are anticipated to stimulate further research in the area of family care giving. In addition, the information generated will also contribute in bridging the information gaps in family care giving for PLWHA in Kenya. Lastly, it is envisaged that from the findings of the study, a framework for support for FCGs will be developed by the researcher and this will be designed to improve their care giving.

**SCOPE AND LIMITATIONS OF THE STUDY**

The study focused on selected FCGs of PLWHA in Thika district only and, therefore, generalizations of results to other non-familial caregivers or other areas should be done with caution. Owing to the difficulty in identifying and accessing the FCGs and the sensitive nature of the subject of study, the sample was comprised of caregivers identified through community health workers organizations in Thika district.

**HIV in Thika**

In Thika, the first recorded case of HIV/AIDS was in 1986 (Kinyanjui, 2007). The district has been an area of high prevalence as shown by the prevalence rate among pregnant women visiting antenatal clinic at the surveillance site (NACC/NASCOP, 2007).

Thika has had a vibrant industrial sector, made up of agro-processing, chemical and textile industries, since the 1920s. Consequently, it has a highly mobile population as migrants come to seek for employment. According to Barnett & Whiteside (2002), migration and mobility, leading to concentration of large numbers of unaccompanied spouses in certain parts of the district, created patterns of sexual behaviour and mixing which are perfect for the spread of STDs. Generally, Thika district attracts a large number of unskilled and casual labourers and those who do not find employment end up offering sexual services (RoK, 1994). Moreover, findings of the KDHS (2003) showed that prevalence was higher among men who slept away from home (9 percent) than those who did not (3 percent).

Kinyanjui (2007) reports that men who were isolated from their spouses and solicited sex from CSWs in Thika were often aware of the risks they were exposing themselves to but this did not stop them from doing so. He also observes that the collapse of the agricultural sector in the neighbouring districts from the mid-1980s pushed many women to the towns to make a living. The high turnover of sexual partners in Thika drawn from different social groups increased the risk of contracting and passing on the virus (Kiellmann, 1997; Baylies & Bujra, 1999).

**HIV/AIDS, Poverty and Family Care Giving**

The word caregiver applies to anyone who tends to someone s/he loves, regardless of that persons relationship or age or duration and amount of care (Johnson & Rejins, 1998). Caregivers may be family members, volunteers, or health and social workers. There are relatively few health workers per person in many African countries healthcare facilities, making the home the likely location of HIV and AIDS care (Leake, 2009). Leake (2009) also asserts that the diminished capacity of many countries’ health sectors makes the prospect of having people with HIV treated at home all the more attractive to governments.

Home Based Care (HBC) has increasingly become an appropriate strategy as a response to the increasing prevalence of HIV/AIDS. This has led to the adoption of the HBC strategy as an option for caring for PLWHA. HBC is the care of persons infected and affected by HIV/AIDS that is extended from the health facility to the patients’ home through family participation and community involvement within available resources and in collaboration with health care workers (NASCOP/MoH, 2002). In Kenya, the
governments developed a National Curriculum for training those involved in care giving. According to the NASCOP/MoH (2002), using the national curriculum on training home-based caregivers to care for people living with HIV/AIDS at home, volunteers are trained to provide a wide range of services in the home and community, encompassing the four main components of HBC (clinical care, nursing care, counseling and psycho-spiritual care and social support).

About 56 percent of the population in Kenya lives below the poverty line, subsisting on less than one dollar per person per day. HIV and AIDS can push affected households deeper into poverty. The complex relationship between HIV/AIDS and poverty is bi-directional in that poverty is one of the key factors in transmission and HIV/AIDS can impoverish people in such a way as to intensify the epidemic itself (Drimie, 2002). Generally, AIDS causes a reduction in the size and experience of the labour force, increases health care expenditure, raises the cost of labour and reduces savings and investment. Moreover, it is different from most other diseases because it strikes people in the most productive age groups.

The prediction was that the economic effects of AIDS will first be felt by individuals and their families and then will ripple outwards to firms, businesses and the micro-economy (MoH, 2001). With regard to care giving, a process of impoverishment develops, with increased household costs and diminished capacity to meet them, because of the loss of productive labour both of the sick person and the caregivers (Jackson, 2002). This is essentially because PLWHA and their families face huge medical bills and other expenses at the same time their ability to earn an income is greatly reduced (RoK/MoH, 2002). Moreover, the work of care giving, which usually falls on women, can take other adults away from other productive responsibilities, adding to families’ financial stress (Schietinger, 1998). Poor people infected with HIV are considerably more likely to become sick and die faster than the non-poor people since they are likely to be malnourished, in poor health and lacking in health attention and medications. The experience of HIV/AIDS by poor individuals, households and communities is likely to lead to intensification of poverty, push some non-poor into poverty and some of the very poor into destitution (Drimie, 2002).

RESEARCH METHODOLOGY

Research Design

A survey design was used for this study. The survey design was used because of its convenience in collecting extensive data from a large sample of respondents within a short time. Also, the survey research was the most appropriate for this study since according to Mugenda & Mugenda (2008), it seeks to obtain information that describes existing phenomena by asking individuals about their perceptions, attitudes, behaviours or values.

Variables

The study considered two major variables; the dependent and independent. The independent variables included: socio-demographic characteristics (residence, sex, age, marital status, level of education, occupation, household type and income, knowledge, training), caregiver roles (daily living, health, psycho-social), challenges of caregivers, coping strategies, support structures and the caregivers’ perceptions of HIV/AIDS, care recipient and care giving roles. The dependent variable was the adaptation levels.

Study Area and Target Population

This study was carried out in Thika district. It is one of the seven districts of Central Province in Kenya. Its main economic activities are agriculture and industries. It has six administrative divisions namely Thika Municipality, Gatanga, Kakuzi, Ruiru, Gatundu North and Gatundu South (Thika District Poverty Reduction Strategy Paper, 2001-2004). According to the 1999 Population and Housing census, its population stood at 645,713. The district is divided into 2 zones along the Thika-Nairobi highway with the higher agriculturally potential areas lying to the East while the lower potential ones lying to the West. Higher zones cover Gatundu South and North divisions, Gatanga and upper zones of Ruiru and Thika Municipality divisions. Lower Zones include Kakuzi, Lower Ruiru and Thika Municipality divisions.

Thika district, according to the NACC (2000), has been a region of high HIV prevalence with rates of 20-29 percent for the 15-49 year olds. It is estimated that 55,335 people had been infected in the District by 2000 (MoH, 2001). However, the district has had a steady decline in HIV prevalence from 39 percent in 1994 to 5 percent in 2006 (NACC/NASCOP, 2007). According to the same report, in 2006 Thika district had the highest number of HIV infected people and AIDS deaths in amongst the seven district in Central province.

This enquiry focused on the rural, peri-urban and urban areas of this district in order to capture the diversity of the settings. The target population included all primary family caregivers of PLWHA working with registered groups in Thika District.

Sampling Techniques

Thika district was purposively selected for the study. Purposive sampling is where the sample is arbitrarily selected because characteristics, which they possess, are deemed important for the research (Sproul, 1988). This is because the district is grouped among the
areas which have had the highest HIV prevalence rates in the country (NACC, 2000). The study sample was drawn from three divisions: Thika Municipality, representing urban population; Ruiru, representing peri-urban population, and Kamwangi, representing rural population. These divisions were also purposively chosen because Ruiru is the largest division in the district and has the largest number of organizations of CHWs while Thika municipality boasts of being the largest town (urban area) as well as industrial area and is central point for jobseekers in the District and Kamwangi for it rural orientation and, according to NACC/NASCOP (2007), it had the highest HIV prevalence in 2000 in the district. In addition, the divisions lie on the higher lower potential areas of the district and this was deemed to offer varied characteristics especially with regard to socio-economic backgrounds. Through the District office of Social Services (D.S.S.O), a list of organizations working with families of PLWHA at the community level was obtained. From the list, five organizations were chosen for the study. These organizations included three Community Based Organizations (CBOs), one women’s self-help group and one Faith Based organizations (FBOs). The individual respondents were randomly selected from a list provided by each of the five organizations. The selection of the respondents was done with the aid of a random table. The respondents were selected using a proportionate stratified random sampling as is presented in Table 1.

Table 1: Sampling Procedure

<table>
<thead>
<tr>
<th>ORGANISATION</th>
<th>DIVISION</th>
<th>CATEGORY</th>
<th>POPULATION</th>
<th>ELIGIBLE FCGs</th>
<th>PERCENT</th>
<th>NUMBER SAMPLED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ruira AIDS Awareness Group (R.A.A.G)</td>
<td>Ruira</td>
<td>CBO</td>
<td>380</td>
<td>60</td>
<td>17.09</td>
<td>32</td>
</tr>
<tr>
<td>Mugutha</td>
<td>Ruira</td>
<td>SELF-HELP</td>
<td>92</td>
<td>57</td>
<td>16.4</td>
<td>30</td>
</tr>
<tr>
<td>Baptist</td>
<td>Ruira</td>
<td>FBO</td>
<td>114</td>
<td>45</td>
<td>12.81</td>
<td>23</td>
</tr>
<tr>
<td>Speak &amp; Act</td>
<td>Thika</td>
<td>CBO</td>
<td>115</td>
<td>81</td>
<td>23.2</td>
<td>42</td>
</tr>
<tr>
<td>IAP</td>
<td>Kamwangi</td>
<td>CBO</td>
<td>315</td>
<td>107</td>
<td>30.5</td>
<td>56</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td></td>
<td><strong>1016</strong></td>
<td><strong>350</strong></td>
<td><strong>100</strong></td>
<td><strong>183</strong></td>
</tr>
</tbody>
</table>

After the respondents were selected, the CHWs under whose jurisdiction the FCGs fell were enlisted to introduce and accompany the researcher to the homes of the selected FCGs. Two visits were scheduled to each FCGs home. The first visit to the home was to seek consent of the participant, explain the objectives and the procedure and requirements of the study and to book an appointment for the interview date. The subsequent visit was to ensure informed consent and to carry out the interview. However, some of the FCGs participated in the interviews on the first visit. This enabled the researcher to reach almost all of the 183 sampled FCGs. Six caregiver’s were not able to be interviewed since they were committed elsewhere even on subsequent visits. Because of the time constraints, it was not possible to get replacements and the return level of 177 respondents was considered relatively high at 97 percent.

**Inclusion and Exclusion Criteria**

The study sample comprised of primary FCGs of PLHWA. These were the primary respondents. The primary caregivers were chosen because once a person develops AIDS or starts falling ill even before developing full blown AIDS s/he requires intense care and hence the care giving at this stage is quite tasking. Only caregivers who had given care for more than 6 months were included. They were considered to be in a position to give a valid account of their situation since they had provided care for a substantial amount of time. Of the sampled FCGs, the willing and available ones were interviewed.

**Sample size**

A sampling frame of 350 FCGs was drawn from the selected organizations in study. A sample frame is the set of people that has a chance to be selected given the sampling approach that is chosen (Fowler, 1993). The sample size was determined by use of Fisher et al. (1995) formula for sample size determination symbolized by the following function.

\[
n = \frac{Z^2 \cdot p \cdot q \cdot D}{d^2}
\]

Where:
- \( n \) = Sample size
- \( Z \) = Standard score at 95 percent level of significance (1.96)
- \( p \) = The proportion of occurrence of the variable of focus (which is 0.5 where the figure is not known)
- \( q \) = The proportion of non-occurrence of the variable of focus (which is 1-p= 0.5)
- \( D \) = Design effect (Which is 1 for a homogenous population)
- \( d \) = Probability of error for 95 percent level of significance (which is 0.05)

Substituting for the formula:
Data Collection Procedures and Instruments

Data was collected using interview schedules and Focus Group Discussions (FGDs) with the assistance of two research assistants. Interview schedule was the main data collection tool targeting the FCGs. Interview schedule was chosen because it enables the researcher to obtain in-depth data from the respondents since it allows for probing, high response rate and personal interaction. Additionally, it allows for clarifications of questions to the respondents and thus gives room for flexibility without changing the meaning of questions. The questions for the interview schedule were both open (for qualitative data) and closed ended (for quantitative data). According to Roberts (2004), blending of quantitative and qualitative approaches allows greater depth of understanding and insight than what is possible with just one approach. It also helps to overcome biases contained in each method. The interviews were administered in either English or Kiswahili, depending on the respondent’s preference. The interviews lasted between one and a half hours to two hours and the responses were recorded through note taking.

The FGDs were conducted with the CHWs in order to obtain additional information to verify and triangulate those from the FCGs. FGDs allow respondents to react to and to build upon responses of other group members. This synergistic effect of the group setting may result in production of data or ideas that might not be uncovered in individual interviews (Stewart & Shamdasani, 1990). There were five FGDs with 8 CHWs each. The FGD sessions lasted for two hours on average. The researcher facilitated the FGDs with the assistance of a research assistant who took notes during the sessions.

Study Variables

The study considered a number of variables for the research objectives. The variables presented in Table 2 indicate the anticipated predictors of adaptation levels and the selected statistical tests of analysis that were used.

Table 2: Measurement of study variables

<table>
<thead>
<tr>
<th>VARIABLES</th>
<th>STATISTICAL TESTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent Variable</td>
<td>Dependent Variable</td>
</tr>
<tr>
<td>Socio-demographic characteristics (Residence, sex, age, marital status, level of education, occupation, household type and income, knowledge, training).</td>
<td>Adaptation levels</td>
</tr>
</tbody>
</table>

DATA ANALYSIS

Data was analyzed both quantitatively and qualitatively using Statistical Package for Social Sciences (SPSS). Descriptive and inferential statistics were used. Descriptive statistics utilize numerical and graphical methods to look for patterns in a data set, to summarize the information revealed in a data set and to present that information in a convenient way (McClave & Sincich, 2000). Frequencies and percentages were used to summarize the data. Inferential statistics utilizes sample data to make estimates, decisions, predictions or other generalizations about a larger set of data (ibid). For this study, chi-square and regression were also used. Chi-square test of significance at a probability of error of 0.05 was used to determine relationships between independent and dependent variables. The Chi-Square test was preferred since both the dependent and independent variables used in the study were measured at nominal and categorical levels of measurement. Since the Chi-Square tests do not give the quantity of relationships, the study used the Contingency Coefficient measure of association which measures the relative strength of an association between two variables with values ranging from zero (representing lack of association) to one (representing strong association).

Qualitative analysis was done to enable the researcher to analyze the respondents’ perceptions, views and opinions in a meaningful and useful way. Qualitative data was transcribed to enable the researcher to capture fully all the information gathered. Due to the massive amounts of qualitative information collected there was need to code and assign labels to various categories and themes so as to draw conclusions and conduct content analysis. Coding was used because it...
reduces information gathered through narrations to something useful.

RESULTS

Residence

The caregivers were mostly from the rural areas (46.7%), followed by the peri-urban areas (29.9%) and urban areas (23.2%) respectively. This is consistent with KAIS (2007) which indicated that since 75% of Kenyans live in rural areas, the greatest burden of HIV infection is in rural areas.

Caregivers’ Sex

124 (70.1%) of the caregivers interviewed were females and the rest (29.9%) were males. This finding concurs with the observation that women account for two thirds of all caregivers for people living with HIV in Africa (UNAIDS, 2008). In one South African study, over two thirds (68%) of FCGs in households affected by HIV and AIDS were women or girls (Steinberg et al., 2002). The finding could be explained from the African traditional standpoint that men are not expected to undertake basic care roles and responsibilities, leaving women as the nurturers and caregivers in families. The FCGs also reported that those who assist them in daily care giving roles are mainly female members of the family. This finding is in agreement with Jackson (2002) that that the work of home care falls on women in the family.

In the study, men’s participation in care giving was mostly financial in nature by availing money for transport to hospital or for buying medication. According to UNAIDS/UNIFEM (2008) what is clear is that traditional gender norms which result in more women and girls providing care, also create the social barriers to men and boys becoming caregivers, exacerbating the burden for women and girls. The female CHWs, despite having male colleagues among them, generalized about why few men care giving:

“They (men) do not have the roho (heart) to provide care; they are not huruma (pitiful) like the women…..so they just give money.” (FGD session with CHWs).

Caregivers’ Age

The study results showed that the sampled caregivers were aged from below 20 years to above 60 years, with the oldest interviewed caregiver being 85 years. The study revealed that all the ages (below 20 -60 and above) participate in care giving. In total the main age cluster providing care is 20-59 years (76.8%). The largest proportion of caregivers were in the age bracket 30-39 years (25.4%) followed by 20-29 years (20.9%), 60 and above years (21.5%), 40-49 years (19.8%), 50-59 years (10.7%) and below 19 years (1.7%). It is significant to note is that those aged 50 years and above accounted for 32% of the caregivers.

Caregivers’ Marital Status and Family type

The study further established that over half (52.5%) of the caregivers were married, 33.3 percent were single while the rest 14.2 percent were widowed or separated. Over half (58.4%) of the caregivers were from nuclear families while polygamous and extended families were represented by 7.3 percent and 14.6 percent respectively.

Education

Over a third (40.1%) of the caregivers had primary level of education, 30.5 percent had secondary education and 22.0 percent had no schooling while 7.3 percent had tertiary/college education. Thus a large proportion (62.1%) of the caregivers had no schooling and primary education. Therefore, many of the caregivers had low formal education qualifications implying that the explanation of the treatment regimes should be simplified in an understandable language to them.

Caregivers’ Occupation

Just over a third (38.4%) of the caregivers reported having no jobs, while nearly a quarter 24.9 percent engaged in self-employment comprising mainly of small business ventures like vegetable kiosks. Casual laborers and salaried/professionals were 18.6 percent and 18.1 percent of the sample respectively. This finding portrays the picture that those family members with no occupation are likely to take up the care giving role of PLWHA in the home. This is because those who are not working are likely to spend most of the time at home.

Caregivers’ Household type

Almost three fifths (59.3%) of the caregivers families were male headed while 40.7 percent were female headed. Yet, most (70.1%) caregivers are women. This may be an indication of a double work for the female-headed households who may be required to be FCGs as well as breadwinners.

Caregivers’ Income

The study further investigated the income levels of the caregivers and that of their households per month. The caregivers average monthly income ranged from as little as Kshs. 200 to Kshs. 35,000. On the other hand the daily expenditure in the caregivers’ households ranged between less than Kshs. 100 to Kshs. 200 daily. However, the study did not establish how much of the income specifically goes towards meeting the care recipients’ needs because most of the caregivers were not able to give estimates of this. Nevertheless, they admitted that a substantial amount went into meeting care recipients’ needs. This indicates that most of these
caregivers usually spend beyond their income and hence are more likely to seek other means to make a living. Catering for the PLWHA needs especially those related to provision of a healthy diet tended to be a major issue. Similar findings were documented in India where research in New Delhi, found that average monthly expenditures exceeded income among families of people living with HIV, partly because of a doubling in purchases of medicines (UNAIDS, 2006). Most of those who were unable to estimate their income and/or expenditure were from the rural areas. This was mainly because they claimed to depend heavily on farm produce and thus estimating their income and/or expenditure was difficult.

Table 3: Demographic Predictors of Caregiver Adaptation levels

<table>
<thead>
<tr>
<th>Demographic variables</th>
<th>-2 Log Likelihood of Reduced Model</th>
<th>Chi-Square</th>
<th>Df</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercept</td>
<td>100.691(a)</td>
<td>.000</td>
<td>0</td>
<td>.000</td>
</tr>
<tr>
<td>Knowledge</td>
<td>104.699</td>
<td>4.008</td>
<td>1</td>
<td>.045</td>
</tr>
<tr>
<td>Residence</td>
<td>101.748</td>
<td>1.057</td>
<td>2</td>
<td>.590</td>
</tr>
<tr>
<td>Sex</td>
<td>101.214</td>
<td>.523</td>
<td>1</td>
<td>.469</td>
</tr>
<tr>
<td>Occupation</td>
<td>103.912</td>
<td>3.221</td>
<td>3</td>
<td>.359</td>
</tr>
<tr>
<td>Income level</td>
<td>108.808</td>
<td>8.117</td>
<td>3</td>
<td>.044</td>
</tr>
</tbody>
</table>

**DISCUSSION**

Immediate family members (parents, siblings, spouse) are the main caregivers of PLWHA in Thika with most caregivers providing care to their children, siblings, spouses, grandchildren and parents in that order. Notably, there were more female caregivers accounting for more than two thirds of the FCGs. The adaptation levels of FCGs varied by residence, occupation, sex and incomes. FCGs who lived in urban areas scored better on adaptation as did those who had higher incomes and in salaried employment. It was therefore not surprising that males score higher than females on the adaptation scale since they often have a higher chance of securing salaried employment and, thus, higher incomes. Notably, such factors as level of education, marital status, household type and age did not significantly influence the adaptation levels despite their mentioning in a number of cases as key determinants of human wellbeing.

**CONCLUSIONS**

The study concludes that FCGs play an important part in the provision of care to PLWHA in the Thika district. It is however clear that the burden of care for PLWHA falls disproportionately more on female members of the family more than on their male counterparts. This added role to the daily duties of the female members of the households may subsequently have negative implications on the family wellbeing and particularly of the female caregiver. The study therefore concludes that addressing gender inequality is crucial in improving the adaptation levels of FCGs. Generally, important as it is, access to economic resources will need to be complemented with strategies for management of stress, stigma elimination and training of FCGs prior to embarking on provision of care to PLWHA.

**RECOMMENDATIONS**

The Kenyan government should put in place strategies that will ensure equitable distribution of resources to all FCGs. This is mainly by economically empowering them with sustainable livelihoods. This may require equipping the FCGs with skills for economic empowerment such as entrepreneurial skills, financial management, marketing and record keeping. Specific interventions by government and non-governmental agencies focusing on FCGs of PLWHA should pay attention to gender considerations with customized approaches or strategies for both males and females. This will require sensitization of the community members on gender differentials and care giving roles to PLWHA.

**REFERENCES**


