PSYCHOSOCIAL IMPACT OF HIV/AIDS CAREGIVING AMONG THE
PRIMARY CAREGIVERS IN MOMBASA COUNTY, KENYA

BY

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DECLARATION
This Research Project is my original work and has not been presented for a degree in any other university or for any other award.

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This research Project has been submitted for review with my approval as the University Supervisor

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DEDICATION

This work is dedicated to my nuclear and extended family for their continued support and prayers when the journey seemed tiring.
ACKNOWLEDGEMENTS
Thanks to Almighty father for giving me the knowledge and opportunity to take the study and keep me free from diseases. I thank Kenyatta University giving a chance to take my studies in the university and utilize their facilities optimally. Not forgetting my colleagues whom we discussed with and gave insights in to the study.
ABSTRACT

HIVAIDS has been noted to be spreading rapidly especially in developing countries in a wide variety of literature. Review of such literature has revealed that there is few data examining what primary care givers go through as they are caring for HIV/AIDS patients. The current study sought to find out the psychosocial impact of HIV/AIDS care giving among the primary care givers in Mombasa County, Kenya. It was guided by the social constructionism theory that observes caregiving and HIV/AIDS as both a reality and social constructs. In this context of study, social constructs within the society determines the perception of the people about primary caregivers in Mombasa. The study used descriptive research design. The target population composed of the primary care givers aged between 25-45 years in Mombasa County. Convenience sampling approach was used to select the suitable sample size whose data was collected using both questionnaires and interview guide. Female were found to be dominant caregivers at 75.61% although with improvement on male involvement. Majority of the caregivers were in the age bracket of 25-30 years (75.6%) and were already married (58.5%). It was found that the caregivers suffered from stress and stigma that affected them psychologically and socially. However, the respondents had identified the most suitable coping mechanism among the alternatives as medication. Also the experience was found to be involving and tiring. The findings will be shared with the relevant stake holders in the ministry of Health at National and County levels and National Aids and Control Council. However, the study recommends for a quantitative study with a wider coverage of three leading counties in terms of HIV/AIDS prevalence.
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<td>AIDS: Acquired Immune Deficiency Syndrome</td>
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<td>ARV: Anti Retro Viral</td>
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<td>HBC: Home Based Care</td>
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<tr>
<td>HIV: Human Immunodeficiency Virus</td>
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<td>KU: Kenyatta University</td>
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<td>NACC: National Aids Control Council</td>
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<td>NACOSTI: National Council of Science and Technology</td>
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<td>NASCOP: National AIDS and STIs Control Programme</td>
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<td>NGO: Non Governmental Organization</td>
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<td>PLWHA: People living With HIV/AIDS</td>
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<td>UK: United Kingdom</td>
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<td>UNAIDS: United Nations Programme on HIV/AIDS</td>
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<td>USAID: United States Agency for International Development</td>
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<td>WHO: World Health Organization</td>
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DEFINITION OF TERMS

Burnout: This refers to physical and emotional exhaustion suffered by HIV and AIDS primary caregivers which may lead to reduced energy

Debriefing: Refers to a process through which HIV and AIDS primary caregivers can be able to verbalize their fears, pain and problems to a professional psychologist who will in turn help them to get treatment

Stress: A state of mental or emotional strain or tension resulting from adverse or very demanding circumstances

Primary caregiver: Someone who takes primary responsibility for someone who cannot carefully for themselves.

Home based care givers: This refers to families, professionals, community health workers, volunteers and church groups who provide health care to people in their home environment.

Social impact: It is the effect caused by environmental factors on individuals social aspects.

Psychological impact: It is the effect caused by environmental factors on individual psychological aspects.

Support: Give assistance to someone
CHAPTER ONE

INTRODUCTION
This section will describe the background of the study. The chapter will address the following subtopics; statement of the problem, purpose of the study, research questions, justification and significance, scope and limitation, and assumption of the study.

1.1 Background of study
Since the beginning of the HIV/AIDS epidemic, informal caregiving (defined for this study as unpaid helpers including family, friends and volunteers) has emerged as a critical component of the health delivery system for HIV-positive clients (London, et al., 2001). However, despite the the success of antiretroviral medications the need for primary HIV/AIDS caregiving continues to exist. Different studies have been done on its transmission and prevention but very few studies have looked at the primary caregivers who end up caring for those who are infected and what they go through psychologically and socially (Kimemia, 2016). This research aims at looking at the psychosocial impact of HIVAIDS on the primary caregivers.

In the fourth decade of the HIV/AIDS epidemic, health care system all over the world still grapples with a disease that may exist for generations or even centuries. Globally, countries have responded to the HIV/AIDS pandemic by investing millions of dollars to help fight the disease, but the impact of HIV/AIDS is even greater in developing countries (Department of Health, 2017). Although, the impact can be felt the role of primary caregivers who are always closer to the PLWHA cannot be undermined.

Providing care to a patient suffering from HIVAIDS requires a lot of time as indicated in a study that was carried in America. The study revealed that caregivers spent 8.5 hours a day performing personal care and household tasks for individuals with HIV/AIDS. The unpaid
care cost for each person living with HIV/AIDS is USD 25,858. This goes to show that a lot of time is used with no compensation hence these people end up lacking finances to cater for themselves and sick resulting to stress and burnout which can lead to depression (UNAIDS, 2012).

National Caregiving Alliance (2015) carried a study in America on Hispanic/Latino caregivers emphasizes spirituality as a coping mechanism. Sheidow (2014) discusses caregiver stress as one aspect of social stress in an intra-ethnic study of elderly Hispanic/Latinos who were Mexican, Cuban, and Puerto Rican. A multivariate analysis reveals that marital status and income affected the level of caregiver stress, leaving no significant differences for either race or gender.

In addressing the problem of time spent by primary caregivers, it is important to quantify the time and calculate the cost. As indicated by a study done in 2016 in New Zealand involving individuals with HIV/AIDS, the caregivers had the cost measured and a value assigned. The private direct costs rose as the illness progressed with a value of US$ 100 per month for asymptomatic HIV/AIDS infected individuals and US $ 400 per month for those with symptomatic HIV/AIDS (WHO, 2016).

In Africa, very little has been done when calculating the cost of care giving (Phaladze, 2003). This is because the culture sees it as a responsibility for women and girls; it’s their duty to provide the care without any form of compensation. Any form of support to the caregivers is often ignored. As HIV/AIDS infection rates continue to increase globally (CDC, 2004), statistics indicate that sub-Saharan Africa was the worst hit with 28.1% adults and children living with HIV/AIDS. The UNAIDS (2001) report further noted that by the year 2001, about 11.5 million people in sub-Saharan Africa had died from AIDS.
A review of the literature indicates that substantial research exists on the effects of HIV/AIDS on the infected individuals. Hanson (2002) observed that in Africa not much of the existing research specifically addressed the issues of AIDS caregivers. In addition, the little research that exists has mostly been conducted in the developing world (D’cruz, 2004). Many African countries lack adequate resources to provide care for those infected with HIV/AIDS and the inadequate health care system cannot deliver even basic care (Freeman, 2004).

Governments in Africa have been pushing for home based care to ease the burden on medical facilities (Ramanathan et.al, 2012: UNAIDS, 2011). However, the home based caregivers have not been equipped with the necessary skills and knowledge to match those efforts. There is little understanding about the kind of psychological intervention that can enhance HIV/AIDS care (Vollmer & Valadez, 2009). The situation creates the need to refocus on training and educating caregivers on the necessary skills for handling the HIV/AIDS victims.

With the increasing numbers of HIV/AIDS infected people especially in Africa it is necessary to address what the primary caregivers go through psychologically and socially on daily basis. Vollmer and Valadez (2009) noted that Africa had many family members caring for the sick individuals. They noted the increased need for psychological care and support services for persons living with HIV/AIDS and their families. There is great need to address the psychosocial implications of care giving especially since Majority of researches have focussed on medical aspects of HIV and strategies for fostering behaviour change in HIV prevention while ignoring the psychosocial implications of the disease (Freeman, 2004).

In mid 1990s there was chaos in Uganda which was social, economic and political. This chaos ended up creating an ideal situation for HIV/AIDS to be spread (Mameli, 2013). For those families that were affected with HIV/AIDS, it increased stress especially on the primary
caregivers. Some had to abandon their formal jobs so as to take care of the sick and others had to take care of the orphaned children and cater for the increased medical costs of those infected.

The number of PLWHA is estimated to have increased from about 1.4 million in 2009 to 1.6 million in 2013. Women constitute about 57% of the PLWHA, while men account for 43%. According to the Kenyan report on Global AIDS Response Progress Report (2013) indicators, about 80% to 90% of the PLWHA are adults.

In June 2011, Kenya’s President-Mwai Kibaki-joined other Heads of State and Government to review progress achieved in realizing the 2001 Declaration of Commitment on HIV/AIDS. This High Level Meeting approved the UNAIDS Strategy - ‘Getting to Zero 2011-2015’. The leaders expressed concern regarding the inability of majority of low- and middle-income countries to meet universal access to HIV treatment targets despite the major achievement of expansion in providing access to anti-retroviral treatment.

A concern was also expressed that the number of new HIV infections was outpacing the number of people starting HIV treatment by a factor of two to one. The leaders committed themselves to redouble their efforts to achieve universal access to HIV prevention, treatment, care and support as a critical step towards ending the global HIV epidemic, with a view to achieving Millennium Development Goal 6, and in particular to halt and begin to reverse the spread of HIV by 2015. Although some strides were made the journey remains far away from achieving it (WHO, 2017).

In Kenya very few studies have been done on primary caregivers and majority have concentrated on transmission of HIV/AIDS and areas that have been highly affected by the disease. In literature this problem has remained unresolved due to the inconsistencies found in different studies. Therefore, there is need for a comprehensive study on the psychological
impact of primary care givers of PLWHA in Kenya and particularly in Coast where HIV/AIDS prevalence is high.

Despite many strategies to curb HIV/AIDS transmission it has remained a threat to the country and the world at large. Lack of cure makes it even harder to deal with the increasing number of infected individuals. According to a survey done in the Coast province, there has been an upward trajectory in the HIV/AIDS infection. The district health officer in Mombasa Dr Anissa Omar noted that HIV/AIDS is a reality since the prevalence rate is greater than 20% of the adult population. In Addition she attributed this high rate to factors such as drug abuse and sex businesses. She further urged for support by family members, not to discriminate and stigmatize the victims (Van der Elst et al., 2013).

The findings of this study will help in identifying the possible strategies that may be used to address the challenge of psychosocial impact of HIV/AIDS care giving on primary care givers.

1.2 Statement of the problem

The best place to take care of PLWHA is at home as opposed to the already resource constrained hospitals. Hence, primary caregivers have a critical role to play and which they will continue to the infected. However, although the primary care giving comes with numerous advantages, the burden of care giving finds many primary caregivers having not adequately prepared in terms of resources and support.

Care support programmes available concentrate more on the PLWHA neglecting the primary caregivers who play an important support role. As research points out, little attention has been paid to primary caregivers’ psychological impact with most emphasis on the economic effect of HIV/AIDS. It remains evidently clear that the caregivers remain in a vulnerable position because they have to carry their household chores on top of providing care to
PLWHA. More so, the caregivers are at times to forego their daily bread winning activities to concentrate on the infected person. The welfare of caregivers translates into the welfare of the person receiving the care-PLWHA. In line with the discussed problems, the current study aims to fill the existing knowledge gap by looking at the psychosocial impact of HIV/AIDS care giving among primary caregivers in Mombasa County.

1.3 Purpose of the study

The purpose of the study was to establish the psychosocial impact of HIV/AIDS care giving among the primary caregivers in Mombasa County, Kenya. This is with an aim of developing ways of assisting in preventive and curative intervention.

1.4 Objectives of the study

This study was guided by the following objectives

1. To determine the impact of stress on primary caregivers of HIV/AIDS patients.

2. To determine the impact of stigma on primary caregivers of HIV/AIDS patients.

3. To explore the experiences of HIV and AIDS caregivers in Mombasa County, Kenya.

4. To identify possible strategies that might be used to address the psychological and social impact of HIV/AIDS on primary caregivers.

1.5 Research questions

The research sought to answer the following questions

1. What is the impact of stress on caregivers of HIV/AIDS patients?

2. What is the impact of stigma on caregivers of HIV/AIDS patients?

3. What is the experience of HIV/AIDS caregivers in Mombasa County?
4. What are the study recommendations on addressing psychological and social impact of HIV/AIDS on primary caregivers?

1.6 Justification and significance of the study

This study will help the affected society gain insight into what primary caregivers go through as they are providing care for the HIV/AIDS patients. This will help people who stay with primary caregivers make necessary changes to address the issues they go through in their lives especially psychological and social.

The study has been necessitated by the increasing number of HIV/AIDS patients in Mombasa County and lack of curative medicine. It is hoped that this study will add on to the body of knowledge on primary caregivers well being in Kenya. Further, the study will inform the policy makers as well as the society with evidence on psychosocial impact of HIV/AIDS care giving in Mombasa County. Based on the findings, recommendations on the interventions will then be made.

1.7 Scope and limitation

The study was carried out in Mombasa County, Kenya. It focused on primary caregivers of HIV/AIDS persons and HIV/AIDS infected persons who collected their ARVs drugs from the Coast General Hospital-Mombasa. In obtaining the sample population, convenience sampling was used since the caregivers are not evenly distributed and the best place to target them was in the facilities when collecting the medicines.

As the research dealt with sensitive issues, there could have been some difficulty in getting information from the primary caregivers. However, this limitation especially in regard to the collection of data, the participants were assured of anonymity as well as confidentiality by the researcher. Again, self-reported questionnaires allowed for privacy as the participants responded to the questions.
The study faced financial constraints necessitating the use of self-administered questionnaires to obtain information from primary caregivers. Efforts were made to reduce any dishonesty from the respondents by informing them that the information will be confidential and for academic purpose only. The participants were also assured of anonymity. However, it was important to note that dishonesty may not have been completely eliminated. The self-administered questionnaires are fast to fill requiring minimal time.

1.8 Assumption of the study

The basic assumptions of this study were

i. Primary caregivers can communicate either in Swahili or English.

ii. Primary caregivers have different psychosocial challenges.

iii. There are negative and positive effects of caring for the HIV/AIDS patients.

iv. The primary caregivers will be willing to discuss their experiences in HIV/AIDS care giving by participating actively in this research thus helping in resolving the related problems.

v. Care giving of HIV/AIDS patients can have a psychosocial effect on the primary caregiver.
CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

In this chapter the researcher describes the theoretical framework that was used to guide the study as well as the review of the literature on psychosocial impact of HIV/AIDS care giving on primary caregivers. The researcher started with theoretical grounding before proceeding to review related literature.

2.2 Theoretical framework

2.2.1 General systems theory

It was proposed in the 1940s by biologist Ludwig von Bertalanfy (Heylighen & Joslyn, 1992). It can be defined generally as elements that are in exchange and are also bounded. The elements can be anything and in this research the elements were primary caregivers. Exchanges were relationships that exist between the elements. Boundaries were things that are seen, heard, sensed and separate the system from the environment (Gregory, 2011). These boundaries could either be open or closed (Gregory, 2011). A system must be open to changes in its environment if it is to stay relevant and active. Changes in the environment result in the system changing so as to adapt to the new realities (Covington, 1998).

In this context of study, primary caregivers in Mombasa urban could be seen as a system existing within the larger context of the HIV/AIDS pandemic. The open system permits working relationships amongst caregivers and patients of HIV/AIDS and it were characterized by an exchange of behaviour and emotions. The community’s involvement in their work could ensure a sense of belonging. The primary care givers relations with the external structures they are in contact with such as hospitals need to be noted.
The psychosocial wellbeing of the primary caregivers was therefore affected by their relations with their patients and broader systems in which they exist. Based on the above discussion of general systems theory it was clear that primary caregivers in the HIV/AIDS context should not be viewed as an isolated condition. However, the theory is not directly applicable in the context of the study hence the need to review another more relevant theory.

2.2.2 Social Constructionism Theory

Since HIV/AIDS erupted on the world scene in 1981, societies have grappled with the implications of a deadly disease that has killed millions (Agyemang & Otoo, 2013). In this context of social disruption, consideration of informal HIV/AIDS caregiving requires a theoretical framework that emphasizes a critical view of widely accepted assumptions of homosexuality and other controversies. The researcher grounded this study in social constructionism and used relevant aspects of related theories which highlight the constructs of emotional and social impacts. These theories directly relate to the study’s research questions of the HIV/AIDS caregiving psychological impacts on caregivers.

Social constructionism definition differs among disciplines making it hard have a come to a common meaning. Hackings (1999) deconstructs the social constructionism by questioning the status quo on the reality of concepts such as race and gender. He argued that constructs like racism are based on reality but are still affected by changing societal definitions of this form of discrimination and prejudice. On that note, the common-sense approach to social constructionism remains relevant to the current study since illness like HIV/AIDS has both physical and social aspects. Health as a construct varies with culture encompassing feeling well, integration of physical/mental/spiritual, social, and independence.

Applying the modified version of social constructionism, HIV/AIDS and informal caregiving are both realities and social constructs. The name “HIV/AIDS” is a social construct, since the
original names were “Gay Related Immune Disorder” and “Gay Pneumonia” until medical researchers realized the broad scope of this medical phenomenon (Fajardo-Ortiz et al., 2017). The parallels with leprosy are striking, especially because both diseases are communicable and evoke fear (Oaten, Stevenson & Case, 2011). Sontag (1990) explores the metaphors related to the social construct of AIDS, including the militaristic tone of some statements that added to the stigma. By considering AIDS as an alien invader in our society, people unconsciously shift these negative perceptions onto the HIV-positive person. “What makes the viral assault so terrifying is that contamination, and therefore vulnerability, is understood as permanent” (Sontag, 1990, p. 108), besides the slowness of the syndrome’s progression. This aspect of HIV/AIDS is relevant to this research because fear may affect the person’s decision to become a caregiver and the social reactions to this decision.

The second construct, “informal caregiving,” is important to this research but is harder to define. This researcher considers caregiving to be a social construct because the term itself did not become widely used in research literature until the 1980s, yet family members and others have cared for ill or disabled people in their homes for centuries. Researchers could have placed “caregiving” as an ancillary to the broader constructs of “marriage” or “family,” but instead chose to consider “caregiving” as a separate construct (Kimemia, 2016).

Researchers have also created the constructs of caregiver burden and primary caregivers. The construct of caregiver burden is defined as the “practical difficulties and mental pain” on both the objective and subjective levels (Schwartz & Gidron, 2002, p. 145). Fatigue and sleep difficulties, for instances, are common among Alzheimer’s caregivers (Song et al., 2017). One study (Northouse, Katapodi, Schafenacker & Weiss, 2012) describes six aspects of caregiver burden: financial, health, schedule, lack of family support, the amount of the caregiver’s responsibility, and social reactions. In a conceptual overview of the caregiver
experience, another study divides the caregiver’s stressors into three categories: primary (e.g., exhaustion), secondary (e.g., social isolation) and intrapsychic (Wittenberg-Lyles, Demiris, Oliver, Washington, Burt & Shaunfield, 2012).

Gender differences in perceptions of caregiver burden are possible factor in this research, since women may feel more obligated to help than men. Gerstel (2013) explores the differences between male and female caregivers, stating that women are more likely to take their work for granted and not think of complaining. Previous studies supported the idea that the primary caregiver is usually female (Cancian & Oliker, 1999; Briggs, 1998). However, there is evidence to the contrary regarding the increasing number of male caregivers (Tolliler, 2015; Sharma, Chakrabarti & Grover, 2016).

In current caregiving research, the focus is on these specific elements (i.e., caregiver burden, primary caregivers) instead of on the broader question of what could be the social construct of an informal caregiver. This study considered an informal caregiver as someone (either family or non-family) who actively constructs his/her role instead of passively accepting his/her fate. The primary caregiver had perceived the potential problems and benefits when assuming the role.

2.3 Review of related studies

This section dealt with reviewing literature of the studies done before and those related to primary caregivers and HIV/AIDS caregiving. Literature was reviewed according to the objectives.

2.3.1 Stress as a psychological impact of HIV/AIDS on primary caregivers.

The physical and psychosocial impacts of care giving on primary caregivers’ wellbeing were rarely acknowledged as primary caregivers often ignore their own health concerns (UNAIDS
2008). In addition, many caregivers were living with HIV themselves. As a result of the complex demands associated with care giving in the HIV/AIDS field, the emotional stress on caregivers of all ages and gender was very significant.

Globally, African American female caregivers too suffer the same problem as their counterparts in Africa world. In an exploratory study done in America (2001) as cited by Tolliler (2015) found out that their lives were marked by stress and change they used a variety of strategies to cope in their HIV/AIDS caregiving role. They expressed having a strong sense of spiritual faith and need for support both formally and informally.

African primary caregivers suffer the same problem as their counterparts in the Western World. A study done in South Africa to investigate the lived experiences experienced by the HIV/AIDS caregivers of orphans focused on stress. The study used phenomenological research approach and the results of the study were identified in themes. The first emerging theme was poverty which was seen as a cause of psychological distress. The second theme was the overwhelming nature of the work. The third was being in need of support structures and lastly coping and psychological wellbeing of the caregiver (Kefilwe, 2012).

Much of the stress experienced by caregivers in the field of HIV/AIDS is related to the nature of the work itself (Armstrong, 2000). This is according to his study done in South Africa which highlighted on how HIV/AIDS caregivers are confronted with an incurable condition that kills largely young people causes terrible suffering and is heavily stigmatized. However, stress may also be caused by organizational factors, which include the way a care program is designed and managed. The most commonly reported causes of stress among caregivers working with AIDS program me include: financial hardship; oppressive workloads; over-involvement with people with HIV or AIDS and their families; personal identification with the suffering of people with AIDS; the unmet needs of children; lack of an effective voice in
decisions that affect them and their work; inadequate support, supervision and recognition of their work; inadequate training, skills and preparation for the work; lack of clarity about what the caregiver is expected to do; lack of referral mechanisms; and lack of medication and health care materials (Guqa 2012).

Like other countries in the World, Elizabeth (2012) did a study on stress associated with caregiving among Kenyan Luo elders and revealed the following findings; that cultural context is important in examining the impact of caregiving on stress. The next finding was that caregiving stress is a function of gender and differential appraisal within a cultural context. The researcher used longitudinal study in order to come up with the following findings.

In Kenya, Muchiri (2012) carried out a study on the association between parenting stress and adjustment difficulties exhibited by children raised by their caregivers. The study came up with the following findings; that fulltime caregivers reported elevated levels of stress more than biological mothers. Another finding was that there was a significant negative association between child maladjustment and caregiving stress. Lastly caregivers experienced stress that was linked to advanced age and new adoptive roles (Muchiri, 2012).

With the above literature on stress amongst caregivers, it was important to find out the situation in Mombasa County. The above literature has not exhaustively depicted the situation of stress in primary caregivers and among the important area left out is on how this stress impacts on them.

2.3.2 Stigma as social impact of HIV/AIDS caregiving on primary caregivers

Primary caregivers of PLWHA are associated with spoilt identity arising from the people they serve. The concept is a social constructionism that arises from societal determination. They are seen as contaminated by coming into contact with PLWHA which is a contagious
disease. Hence, primary caregivers may lack the necessary support and resources including gloves, essential drugs and food to offer care to the infected person.

Wu, Wu, Jia, Lieber and Lu (2008) conducted a study to examine the impact of HIV-related stigma on families living with HIV/AIDS in China. HIV/AIDS stigma was reported to have major impacts on family identity and interactions. The small sample size of 45 participants used by Li et al. (2008) given the population of China, demonstrated the hard task of getting respondents for such a sensitive research area.

Mitchell and Knowlton (2009) also examined relationships amongst caregivers on stigma, disclosure, and depressive symptoms in a cross-sectional sample of 207 informal caregivers of PLWHA. Results indicated that among caregivers, HIV care giving-related stigma was associated with more depressive symptoms, while disclosure of care giving status was associated with fewer symptoms. They concluded that these results suggest that there is need for interventions to address high levels of depressive symptoms among informal HIV caregivers.

Home based care programmes were started in North America and Europe when it was found that many families had difficulty coping on their own with the demands of caring for those PLWHA (Uys, 2003). This type of service was introduced in Africa in late 1980s and early 1990s. A qualitative study was done in India looked at care givers experiences of informal support in the context of HIV/AIDS (Cruz, 2012). It found out that caregivers were not satisfied with the informal support networks and the little support coming was not spontaneous. It informs the study on the part of establishing what these primary caregivers are actually going through.

In Africa, the situation is not any different from other parts of the World. A descriptive study on stigma and discrimination was also done in 2010 in Nigeria. It found out that stigma is a
barrier to all essential components that make up a good prevention program. This informs the study on what the primary caregivers are going through and how it affects them (Olalekan, Akintunde & Olatunji, 2014).

Again in Ghana, the situation is the same. A qualitative study done in 2013, that looked at strengthening the rights of people living with HIV/AIDS (Adjei, 2013). Although the constitution protects people living with HIV/AIDS on discrimination within the healthcare system, it’s difficult to enforce it outside of public health facilities. To overcome these obstacles, a web-based reporting mechanism was launched. As a result by 2015, 32 cases of discrimination had been recorded and addressed.

Makori and Onyango (2008) did a descriptive study in western Kenya on community attitudes towards male caregivers. 92% agreed that men should be involved in care giving, over 50% said that it is a taboo for men to cook or fetch water and that care giving is for women and men who participate in housework are considered weak or bewitched. Male involvement in home based care variables were negatively correlated with social cultural variables.

Bukusi and Onono (2010) did a longitudinal study on pregnant women attending nine rural ANC clinics in Nyanza Province that aimed at examining the effects of HIV/AIDS stigma on pregnant women’s use of health facilities. The results indicated refusal by some women to participate in the study as 3.3 per cent. It showed high levels of anticipated stigma on disclosure of HIV-positive status and perceived community stigma.

With the high rate of HIV infection in African and especially Kenya, hospitals are unable to accommodate the resulting large number of sick people, discharging patients for home care has become one way to cope. Many people in Africa and in particular Kenya believe that a person discharged for home-based care has been sent home to die which sometimes it’s not
true and some individuals do become better and even return to work. The mixed findings from literature on society perception of stigma beg for more evidence through research on this area to clarify the psychological and social impact of HIV/AIDS on primary caregivers especially in Africa.

2.3.3 Experiences of primary caregivers in caring for HIV/AIDS patients

Little research has been conducted on caregivers of PLWHA. This is particularly needed with regard to primary caregivers since these people spend most of the time with the HIV sufferers. According to Mullan (1998), caregivers experience a lot of difficulties that have to do with patients’ comfort; especially when patients are acutely ill. Secondary to that is interpersonal strain resulting from imbalances within the relationship when dealing with issues of autonomy, independence or reciprocity (Mullan, 1998).

There are a number of studies that have been done on experiences of primary caregivers for HIV/AIDS caregivers. Globally, a qualitative study done in USA in 2015 on informal HIV/AIDS caregivers on their experiences and decision making made the following findings (Tshoboeng, 2015). First the findings of this study indicated that the less action the caregivers receive, the more tasks the caregiver performed. Next the caregiver with a disability reported devoting time than non-family members.

The research further yielded some unexpected findings including the magnitude of caregiving both in number of hours and number tasks. Feelings of loss do not only occur during the death of the care recipient. It is noted that chronic illnesses also give rise to longer periods of uncertainty resulting in what is termed anticipatory grief (Holley, 2009). This is according to a study done in the USA on caregivers experience with HIV/AIDS. Anticipatory grief is associated with behaviors such as discussing the possibility of death, thinking what the future would be like without that person, discussing death with the person, adapting to role change,
changing assumptions, finding a balance for staying separate from and yet involved with the person, and experiencing feelings of sadness and depression (Holley, 2009; Tshoboeng, 2015).

Another qualitative study was also done on experiences in caring for HIV/AIDS patients among Muslim family caregivers in Terengganu Malaysia (Lua, Mustapha, Abdullah & Rahman, 2014). The researchers used a qualitative study design and it was chosen as it was deemed to be the most appropriate method to generate in-depth knowledge about caregiving for PLWHA. Results of this study indicated that majority of the participants had attended either primary or secondary school. Majority identified themselves as self-employed and was related to the PLWHA as either mothers or wives. Themes that came up from that study were challenges of caregiving which was sub categorized as ensuring medication adherence, treatment misconception and coping with caring. The other theme was financial issues where they had to work harder in order to sustain their family household income, especially when loss of income originated from patients themselves who were the main family breadwinner. The other theme was stigma and discrimination which was further explained as reaction to illness and response to relatives reactions.

Mashau and Davhana-Maselesele (2009) conducted a qualitative study on experiences of HIV/AIDS home based caregivers in Vhembe District of the Limpopo Province. The researcher used explorative, descriptive and contextual research design. The findings of this study were categorized into themes; the first theme was caregiver’s expression of pain and despair when providing care to HIV/AIDS patients at their homes. The second theme was on problems related to stigma and lastly lacks of basic resources since majority of the patients were living in extreme poverty. The study recommends building of a working relationship between the home-based caregivers, community and the family.
Closer home is a qualitative study done on the experiences of health and illness in children living with HIV/AIDS, in Gulu District Northern Uganda (Constantine, 2014). The research design used was exploratory ethnography. The emerging themes from the analyzed data were on family breakdown after the death of a loved one by HIV/AIDS, especially women who were deprived of their properties. The second theme was on belief in the antiretroviral therapy and how its efficient and lastly social stigma (Constantine, 2014). The themes were crucial in caregiver’s perception of caring to the affected family members and children.

Caregivers in Kenya also experience feelings of poor self esteem, stress, low morale, fatigue, anxiety and hopelessness about the future. Past psychiatric status, personality, social support networks, and the relationship of the caregiver and recipient, together with the nature of the illness and the degree of impairment, all are factors that aggravate the emotional experiences of caregivers (Kamau et al., 2017).

2.3.4 Intervention Mechanisms

In 2012, half of all people living with HIV in Thailand were starting treatment very late and had CD4 counts under 100 cells per cubic millimeter. In response to these findings, the Ministry of Public Health in collaboration with the civil society and international partners developed initiatives to sensitize healthcare workers in both clinical and non-clinical settings.

Palattiyal (2010) did a study on intervention mechanisms in HIV/AIDS care across two contexts of development, Scotland in U.K and Kerala in India. Findings indicated that respondents from Scotland used a larger number of coping strategies than respondents from India. The difference was reflected in the way the carers narrated their experiences. Carers in both communities mentioned experiences of stigmatization and discrimination but they were
more severe in Kerala. These differences may reflect the disparity in resources available to the family carers in the two settings.

The informal caregivers are not the only group that experience challenges while caring for HIV/AIDS patients, the formal caregivers like nurses also experience as shown in the following study. Fako, Wilson, Linn and Forcheh (2013) conducted a survey in Botswana on coping strategies and work environmental stress among nurses and came up with the following findings. The results of this study indicated that there are factors associated with stress. The factors included education attainment and coping behaviour. In overall all the participants experienced high levels of role demand, job control and shift work stress. All this findings from this study indicate a greater need for specific interventions. The study suggested the probable benefit from. In-service education modules on positive stress management, healthy lifestyles, regular exercises and appropriate nutrition and optimally follow up counselling by professionals on all of these issues (Fako et al., 2013).

Another quantitative and qualitative study was done in 2014 in Thika District, Kenya on challenges faced by family caregivers in dealing with people living with HIV/AIDS and their coping strategies. The results of this study indicated challenges in food in food provision, stress and stigma. There coping strategies included increasing their resource base through getting loans, positive living, prayers and improving their knowledge of the disease (Kathuri-Ogola, Mugenda, & Kerere, 2014).

Kimemia (2016) carried out a qualitative study in Nairobi, Kenya on female primary caregivers of HIV/AIDS family member and their coping mechanisms. The results of the study identified significant coping response factors such as social support, hope, acceptance, planning and disposition. Various caregiver and care recipient characteristics indicated a significant relationship between the caregiver’s age and caregiver burden, and education level
and caregiver burden. An increase in age correlated with a decrease in caregiver burden. An increase in education level correlated with reduced caregiver burden.

If the above studies is anything to go by and the continued reality of HIV/AIDS spread, then there is need for more distinct intervention plans on control and prevention strategies that can cater for the challenge of HIV/AIDS caregivers who experience the psychological and social impact.

2.4 Summary of literature review & theoretical framework

This chapter has reviewed literature concerning the psychosocial impact of HIV/AIDS on primary caregivers. Social constructionism framework will be adopted in order to explore the lived experiences of the primary caregivers. Social constructionism theory sees HIV/AIDS and caregiving as both realities and social constructs that have a psychological impact on the caregiver.

Caregivers need to find ways to cope in order to maintain sound physical, mental, and emotional well-being, experiences of caregivers, psycho social support and society expectations. It is finally captured in the conceptual framework below.

2.5 Conceptual framework

The conceptual framework indicates the relationship of the variables under the study.
From Figure 3.1 above, Caregiver characteristics refer to the demographic such as gender, age, relationship, ethnicity and social economic status of the caregiver which are critical in determining the kind of services offered to the patient.

Objective impacts are the observable concrete costs incurred by the family as a result of mental illness like disruption of everyday life in the household, financial constraints, limited personal activities, and social interactions.

Subjective impacts in this study refer to personal appraisal of the situation and the extent the caregiver perceives to carry the burden of care. They result from care giving experience including emotions, attitudes, and feelings. They will be predicted using the caregiver characteristics.
CHAPTER THREE
RESEARCH METHODOLOGY

3.1 Introduction

This section describes the research methodology used in the study on the psychosocial impact of HIV/AIDS on primary caregivers in Mombasa County. The chapter addresses the methodology under the following sub topics; research design, study variables, site of the study, target population, sampling techniques and sample size, validity reliability, pilot study, data collection procedures, data analysis and presentation, data management and ethical considerations.

3.2 Research design

The research design for this study was a descriptive survey design. The descriptive survey design is a method of collecting information by interviewing or administering a questionnaire to a sample of individuals (Orodho, 2003). Descriptive survey design was suitable for this study since the research was intensive with rapid data collection and ability to understand a population from part of it. Primary care givers were many but through survey design part of them were interviewed as a representation of the whole group. The design was used to collect information about primary care givers experiences while caring for HIV/AIDS patients.

3.3 Study variables

The study variables were psychological impact of HIV/AIDS care giving and primary caregivers. The psychological impact of HIV/AIDS care giving were the dependent variable and it was conceptualized in terms of feelings, attitudes, and emotions (stress). Objective impact was the independent variable and it was conceptualized in financial problems,
disrupted household activities, and decreased social interaction with coping skills and social support as the intermediating variables.

### 3.4 Site of the Study

The study was conducted in Mombasa County. The national Aids Control Council database (2015) statistics suggested that Mombasa County recorded 1600 new annual HIV infections. According to the strategic plan, 54,670 people currently live with HIV in the county. When it comes to sub-counties, the HIV prevalence rate was higher in Likoni at 9.8 per cent; followed by Changamwe at 7.4 per cent. Both of these sub counties are adjusted to Coast general Hospital which is the biggest Public Hospital in Mombasa County. Therefore there was need to understand the psychosocial impact of HIV/AIDS care giving among primary caregivers.

### 3.5 Target population

The research targeted the 550 primary caregivers between the ages of 25-45 with two to four years in care giving within Mombasa County in Kenya. The primary caregivers did not require any form of training on how to care for HIV/AIDS patients. The primary caregivers were mainly women but few men were also included. According to UNAIDS (2008), although the majority of caregivers are women there is still a significant number of men who also are providing primary care in the homes, thus including a male participant in the study helped the researcher to have access to underlying perceptions of both male and female primary caregivers in the context of caring for HIV/AIDS patients,

### 3.6 Sampling techniques and sample size

Convenience sampling was used to select the sample size used in the study (Mugenda & Mugenda, 1999). Primary caregivers aged between 25 and 45 were selected because they were informative and they possessed the required information giving a sample size of 50 respondents.
3.7 Pilot Study

A pilot study was conducted with the purpose of pretesting the study processes and tools. A pilot sample of eight caregivers was obtained from Nyali constituency in Mombasa County through convenience sampling. However, the sample was excluded from the final sample to avoid contamination of the results. The questionnaires were personally issued to the participants by the researcher and the research assistants and collected immediately upon completion. The interview was also conducted by the researcher and assistants only. The illiterate were assisted by the researcher and research assistants while for the literate it was self-administered. The feedback and results from the pilot study helped to eliminate the vague and unclear questions which assisted in enhancing reliability of the instruments.

3.8 Research instruments

The research instruments that were used were questionnaires and interview guide. Selection of the tools was guided by the nature of the data to be collected, time available and the study objectives. The choice of a questionnaire was made considering the sensitivity of the issues being investigated, which is HIVAIDS and primary care giving. It was also noted that the questionnaires allowed the respondent to individually and privately respond to it.

The tools used were constructed by the researcher. The researcher was mainly concerned with views, opinions, feelings and attitudes, where such information was best collected through use of questionnaire and interview techniques (Bell, 1993; Touliatos & Campton, 1988). The questionnaire was divided into four sections. Section one was collecting social demographic information of participants while section two was seeking information on impact of stress among the caregivers, section three dealt with impact of stigma on caregivers. Sections four addressed the caretakers experience and the coping mechanisms available. Both unstructured
and structured questions were used in the design of the questionnaire. Unstructured questions allowed greater indepths of response while structured questions were easier to analyse.

According to Kothari, (1990), the interview method of collecting data involves presentation of oral-verbal stimuli and reply in terms of oral-verbal responses. Interviews allowed the researcher to obtain information that cannot be directly observed and also gain control over the line of questioning. The interview was used to capture the meaning beyond the words from the targeted group which also assisted when analysing the feelings and experiences of the group and also attaining historical information.

3.9 Validity and reliability

Efforts were made to build in validity. Firstly to enhance construct validity the researcher ensured the two constructs under study (namely psychological and social) were operationalized in line with their definitions in existing theory and literature. Secondly, efforts were made to ensure that the items in the questionnaires were relevant to the construct as defined in the study. Thirdly efforts were made to enhance content validity by ensuring that the items of the two tools had comprehensively covered the various dimensions of the two constructs as defined in the study. In addition expert opinion was sought to judge on the appropriateness of the content of the instrument considering the objectives of the study and feedback was given on the areas that need modification so as to enhance the validity of the instrument.

To enhance the reliability of the instrument test retest procedure was used. The researcher administered the questionnaire to 8 similar participants to the ones in the sample but who will be exempted from the final study. After two weeks, the researcher administered the same questionnaire to the same group of people under the same conditions. The total score for each
group was then computed and checked against each other. Pearson’s correlation coefficient index of 0.7 was considered appropriate as recommended by Rosner, (1995).

3.10 Data collection procedures

The data collection started with the researcher getting approval from Kenyatta University and a research permit from the National Commission for Science Technology and Innovation (NACOSTI), after which the researcher proceeded to the field. The researcher conducted an induction to the research assistants on how to facilitate the data collection. Three research assistants were trained and used after undergoing a process of induction on the important elements of research and ethics, where English and Kiswahili language were used for interview. A group of 10 participants were selected by the researcher to conduct an interview in order to try and cover areas which needed more explanation. . The Researcher with the assistance of research assistants administered the questionnaires using drops and pick method.

3.11 Data Analysis and presentation

Data was both qualitative and quantitative. In data analysis the researcher used descriptive statistics that is percentages so as to analyze data from questionnaires on psychosocial impact of HIVAIDS care giving among the respondents. The analysed data was presented using charts, graphs and tables.

The researcher who is also fluent in both English and Swahili proof read the transcripts to a certain validity of information while comparing with the original documents. Editing of data was done to identify and eliminate any errors made by the researcher especially during the interview. Coding of data was then conducted to translate question responses into specific categories. Qualitative data was analysed using content analysis.
3.12 Data Management and Ethical Considerations

As already noted, the researcher received authority to conduct research from Kenyatta University (KU) Graduate School, and a research permit from National Commission for Science and Technology and Innovation (NACOSTI), prior to conducting the study. Considering the nature of the phenomena under investigation, ethical considerations were pertinent. Kumar (2005) noted that informed consent is one of the common methods used in medical and social research and it implies that the participants have been made aware of the nature of the study, why the information is needed and how it will be used. In line with this the researcher informed the participants of the nature of the study so as to allow them to freely choose to be part of it or not. Those who were willing to participate were required to sign consent form.

Secondly, Privacy and confidentiality were ensured by the researcher asking participants not to write down their names on the questionnaires to ensure anonymity. A statement on confidentiality was included on the questionnaires and also emphasized during the administration of the questionnaires.

As this research dealt with sensitive issues, debriefing was done in case there was any unwanted psychological effects by a professional counsellor.
CHAPTER FOUR

FINDINGS

4.1. Introduction

This chapter discusses the presentation and interpretation of the findings obtained from the field. The chapter presents the background information of the respondents, findings of the analysis based on the findings of the study. Descriptive statistics and content analysis were used to discuss the study findings.

4.2. Response Rate

The study sample comprised of primary caregivers aged between 25 and 45 years of age both male and female with over two years rendering the services. After the administration of the questionnaires, 41 out of the 50 respondents completely filled and returned them and hence, giving 82% response rate. All the 10 interview schedules were fully answered and completed appropriately. However, the interview schedule replicated information on the questionnaire and they had little impact on the outcome. For generalization when using questionnaires Mugenda and Mugenda (2003) made the conclusion represented in the table below.

Table 4.1: Response rate conclusions

<table>
<thead>
<tr>
<th>Response Rate</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>50%</td>
<td>Adequate</td>
</tr>
<tr>
<td>60%</td>
<td>Good</td>
</tr>
<tr>
<td>70% and over</td>
<td>Excellent</td>
</tr>
</tbody>
</table>


From the Table 4.1 above, based on the assertion, the response rate of the study was excellent.
4.3. Social Demographic Information

This section covers the demographic information of the study respondents. The information captured includes; respondents age, gender, marital status, education level, and the source of income. The importance of capturing this information was to provide understanding of the study informants and hence it provided a good foundation for detailed discussion of the findings based on the specific objectives of the study. Also, UNAIDS (2008) underlines the importance of including both genders in the study.

4.3.1 Distribution by gender

Male caregivers were minimal from the previous studies with only 10 percent involved in care giving among PLWHA. From the study, 75.61 percent of the respondents were females indicating a significant increase in the number of male care givers who accounted for 24.39 percent as shown in Figure 4.1 below.

Figure 4.1: Respondents’ gender
4.3.2 Distribution by age

Majority of the respondents fell in the 25-30 years age bracket (75.6 percent) same case with the interviewed. They were followed by 30-35 years at 22 percent with only 2.4 percent for age bracket 40-45 years as indicated in Table 4.2 below.

Table 4.2: Demographic Data

<table>
<thead>
<tr>
<th>Variables</th>
<th>Category</th>
<th>Frequency</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Male</td>
<td>10</td>
<td>24.4</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>31</td>
<td>75.6</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>41</strong></td>
<td><strong>100.0</strong></td>
</tr>
<tr>
<td>Age</td>
<td>25-30 Years</td>
<td>31</td>
<td>75.6</td>
</tr>
<tr>
<td></td>
<td>30-35 Years</td>
<td>9</td>
<td>22.0</td>
</tr>
<tr>
<td></td>
<td>40-45 Years</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>41</strong></td>
<td><strong>100.0</strong></td>
</tr>
<tr>
<td>Marital status</td>
<td>Married</td>
<td>24</td>
<td>58.5</td>
</tr>
<tr>
<td></td>
<td>Divorced</td>
<td>5</td>
<td>12.2</td>
</tr>
<tr>
<td></td>
<td>Not Married</td>
<td>12</td>
<td>29.3</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>41</strong></td>
<td><strong>100.0</strong></td>
</tr>
<tr>
<td>Level of Education</td>
<td>Completed Primary</td>
<td>10</td>
<td>24.4</td>
</tr>
<tr>
<td></td>
<td>Completed Secondary</td>
<td>21</td>
<td>51.2</td>
</tr>
<tr>
<td></td>
<td>Completed Tertiary level</td>
<td>10</td>
<td>24.4</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>41</strong></td>
<td><strong>100.0</strong></td>
</tr>
<tr>
<td>Source of Income</td>
<td>Casual labourer</td>
<td>10</td>
<td>24.4</td>
</tr>
<tr>
<td></td>
<td>Salaried employment</td>
<td>13</td>
<td>31.7</td>
</tr>
<tr>
<td></td>
<td>Self employed</td>
<td>13</td>
<td>31.7</td>
</tr>
<tr>
<td></td>
<td>Student</td>
<td>2</td>
<td>4.9</td>
</tr>
<tr>
<td></td>
<td>Unemployed</td>
<td>3</td>
<td>7.3</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>41</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
4.3.3 Marital Status Distribution

According to Table 4.1, the results of marital status shows that 58.5 percent of the primary caregivers were married, 29.3 percent not married and 12.2 percent divorced. This indicated the burden that great burden fell among married partners in caring for their spouses.

4.3.4 Distribution by Level of Education

Regarding education level, most of the respondents (51.2 percent) had completed secondary school. The trend may be attributed to increase literacy levels in the country. Both those who had competed primary school and tertiary level stood at 24.4 percent each.

4.3.5 Distribution by Source of Income

Most of the participants were in self employment and salaried employment as indicated by 31.7 percent each in Table 4.1 above. Casual laborers represented 24.4 percent, unemployed stood at 7.3 percent with students at 4.9 percent. The result indicates that most of the respondents had a reliable source of income to cater for their care giving needs.

4.3.6 Number of dependants

From Figure 4.2 below, majority of the households had two or three dependants as represented by 24.39 percent. It was followed by 4 dependants at 17.07 percent, zero, one and 5 dependants at 9.756 percent and extreme cases of 7 and 10 dependants of only one family for each case at 2.439 percent. The trend can be associated with the family planning sensitization education and the need to provide a quality family life.
4.4. Sign of Stress

The first objective was to determine the impact of stress on primary caregivers of HIV/AIDS patients. The respondents indicated that they experienced both physical and emotional problems as indicated in Table 4.3 below.

**Table 4.3: Signs of stress**

<table>
<thead>
<tr>
<th>Physical Problems</th>
<th>Frequency</th>
<th>Percent</th>
<th>Emotional Difficulties</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headache and pains</td>
<td>15</td>
<td>36.6</td>
<td>Marked Sadness</td>
<td>7</td>
<td>17.1</td>
</tr>
<tr>
<td>Exhaustion</td>
<td>13</td>
<td>31.7</td>
<td>Discouragement</td>
<td>21</td>
<td>51.2</td>
</tr>
<tr>
<td>Sleeping difficulty</td>
<td>3</td>
<td>7.3</td>
<td>No</td>
<td>13</td>
<td>31.7</td>
</tr>
<tr>
<td>No</td>
<td>10</td>
<td>24.4</td>
<td>Total</td>
<td>41</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>100.0</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Physical problems were marked by headache and pains with a majority supporting it at 36.6 percent, followed by exhaustion at 31.7 percent and sleeping difficulty at 7.3 percent. 24.4
percent indicated not to experience such problems. Emotional difficulties were marked by sadness and discouragement. Majority indicated discouragement as a leading at 51.2 percent followed by marked sadness at 17.1 percent with 31.7 percent not experiencing emotional difficulties. The same was supported by interview conducted with 63.64 percent indicating that they experienced stress related signs like headache and fatigue and only 36.36 percent not experiencing such signs.

The physical and emotional problems symptoms were indicated to occur less often in many of the respondents represented by 46.3 percent. 29.3 percent indicated to experience the symptoms often with 24.4 percent not experiencing such at all. For those who experienced the symptoms, majority at 41.5 percent opted to relax to relieve the stress, 17.1 percent sought medication, 9.8 percent shared with friends, 7.3 percent involved themselves in physical exercises, and 24.4 percent did nothing about it. However, the problems never affect their care giving duty as indicated by 58.54 percent with only 41.46 percent indicating negative impact as shown in Figure 4.3 below.

![Figure 4.3: Whether affected by stress signs.](image)
4.5 Stigma in caring for HIV/AIDS Patients

As indicated in Figure 4.4 below, majority of the participants indicated not to experience stigma with 46.34 percent experiencing stigma. The efforts by the government and non-governmental institutions to help sensitize people on HIV/AIDS have bared fruits in the area of study. The National AIDS Control Council (NACC) in 2016 reported an increase in HIV/AIDS awareness and a reduction in stigma although not all that significantly.

Figure 4.4: Experienced stigma or not

Those who experienced stigma indicated that it had effect on their social and economic life. 39 percent experienced isolation and discrimination with 7.3 suffering from normal day’s duties disruption. Those interviewed gave the following responses;

*I suffer from loneliness as I have few friends nowadays –Female respondent*

*It lowers my self esteem since people treat me with a lot of suspicion* –Female respondent

To manage the stigma, majority opted to seek spiritual guidance from the religious leaders and consulting the holy books 19.5 percent. 14.6 percent opted to avoid stressors by turning a
blind eye on the stigmatizing factors and conditions. 12.2 percent preferred sharing with fellow care givers whom they entrusted with their information with 4.9 percent sharing with their friends and relatives. 48.8 percent represented those who never experienced stigma.

Table 4.4: Stigma management

<table>
<thead>
<tr>
<th>Stigma Management</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sharing with other caregivers</td>
<td>5</td>
<td>12.2</td>
</tr>
<tr>
<td>Turn a blind eye</td>
<td>8</td>
<td>19.5</td>
</tr>
<tr>
<td>Involve in spiritual activities like reading the bible</td>
<td>6</td>
<td>14.6</td>
</tr>
<tr>
<td>Sharing with friends and relatives</td>
<td>2</td>
<td>4.9</td>
</tr>
<tr>
<td>Not applicable</td>
<td>20</td>
<td>48.8</td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>100.0</td>
</tr>
</tbody>
</table>

4.6 Experiences of primary care givers in caring for HIV/AIDS patients

Figure 4.5 below indicates the feelings of the caregivers. Majority at 53.66 percent found the activity to be involving, 31.71 percent tiring and 14.63 percent termed it boring. The findings support Mullan (1998) work that care giving comes with a lot of difficulties especially when critically ill. Respondents’ statements;

*It is very involving and tiring since I also have other family duties and responsibilities requiring my attention* - Female Respondent
To further explore the theme, the participants were provided with statements on a nominal scale of yes or no in the questionnaires. Table 4.5 below shows the nine statements presented to the respondents and their responses as per statement.

Figure 4.5: Experiences of feelings for HIV/AIDS caring
Table 4.5: Difficulties experienced when caring for HIV/AIDS patients

<table>
<thead>
<tr>
<th>Statement</th>
<th>YES frequency</th>
<th>YES %</th>
<th>NO frequency</th>
<th>NO %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial problems</td>
<td>31</td>
<td>75.6%</td>
<td>10</td>
<td>24.4%</td>
</tr>
<tr>
<td>Taking care of yourself (meeting your personal needs)</td>
<td>19</td>
<td>46.3%</td>
<td>22</td>
<td>53.7%</td>
</tr>
<tr>
<td>Asking help when you need it</td>
<td>24</td>
<td>58.5%</td>
<td>17</td>
<td>41.5%</td>
</tr>
<tr>
<td>Discrimination</td>
<td>18</td>
<td>43.9%</td>
<td>23</td>
<td>56.1%</td>
</tr>
<tr>
<td>Difficulty in thinking or concentration</td>
<td>14</td>
<td>34.1%</td>
<td>27</td>
<td>65.9%</td>
</tr>
<tr>
<td>Difficulty in sleeping/oversleeping</td>
<td>18</td>
<td>43.9%</td>
<td>23</td>
<td>56.1%</td>
</tr>
<tr>
<td>Change in appetite or weight</td>
<td>29</td>
<td>70.7%</td>
<td>12</td>
<td>29.3%</td>
</tr>
<tr>
<td>Lose weight or pleasure in activities that you once enjoyed</td>
<td>26</td>
<td>63.4%</td>
<td>14</td>
<td>34.1%</td>
</tr>
<tr>
<td>Turn to Alcohol or drugs to relieve your feelings</td>
<td>15</td>
<td>36.6%</td>
<td>26</td>
<td>63.4%</td>
</tr>
</tbody>
</table>

Most of the respondents agreed with the statements; financial problems, asking help when you need it, change in appetite or weight, and lose weight or pleasure in activities that you once enjoyed. Conversely, they disagreed with the statements on the problems of; taking care of myself, discrimination, difficulty in thinking, difficulty in sleeping or oversleeping, and turn to alcohol or drug abuse to relieve your feelings. The findings support Lua et al. (2014) study which came up with four themes based on difficulties; challenges of care giving, financial problems, and stigma and discrimination.

4.7. Interventions for primary care givers

Intervention plans remain crucial to care givers to help them cope up with the associated challenges of their day to day duty. A range of coping mechanisms exist that the care givers are assumed to adopt. To record their most preferred mechanisms, the participants were presented with seven mechanisms to give their views on a likert scale of 3; not helpful, slightly helpful, and helpful as shown in table 4.6 below
Table 4.6: Coping mechanism

<table>
<thead>
<tr>
<th>Coping Mechanism</th>
<th>Not Helpful</th>
<th>Slightly Helpful</th>
<th>Helpful</th>
<th>Mean</th>
<th>Implication</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>%</td>
<td>F</td>
<td>%</td>
<td>F</td>
</tr>
<tr>
<td>Talking with friends</td>
<td>7</td>
<td>17.1</td>
<td>12</td>
<td>29.3</td>
<td>22</td>
</tr>
<tr>
<td>Talking with family members</td>
<td>19</td>
<td>46.3</td>
<td>4</td>
<td>9.8</td>
<td>18</td>
</tr>
<tr>
<td>Shopping</td>
<td>28</td>
<td>68.3</td>
<td>9</td>
<td>22.0</td>
<td>4</td>
</tr>
<tr>
<td>Medication</td>
<td>2</td>
<td>4.9</td>
<td>10</td>
<td>24.4</td>
<td>29</td>
</tr>
<tr>
<td>Exercise</td>
<td>10</td>
<td>24.4</td>
<td>21</td>
<td>51.2</td>
<td>10</td>
</tr>
<tr>
<td>Counseling</td>
<td>4</td>
<td>9.8</td>
<td>16</td>
<td>39.0</td>
<td>21</td>
</tr>
</tbody>
</table>

The mechanisms of talking with friends and medication were found to be helpful. Talking with family members and exercise were slightly helpful. While shopping as an activity was not found to be helpful. Apart from the coping mechanisms indicated, participants indicated spiritual nourishment through reading holy books and singing, beer and drug use, and others indicated not to participate in anything else as show in Table 4.7 below.

Table 4.7: Useful Extra activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spiritual nourishment</td>
<td>20</td>
<td>48.7</td>
</tr>
<tr>
<td>Beer and drug use</td>
<td>12</td>
<td>29.3</td>
</tr>
<tr>
<td>Nothing else</td>
<td>9</td>
<td>22.0</td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>100.0</td>
</tr>
</tbody>
</table>

When asked to pinpoint their most useful coping mechanism, the respondent answers revolved around social activities, physical exercise, counselling, and spiritual nourishment. The results are shown in the Figure 4.6 below.
On the people who assisted the care givers to access the coping mechanism, the care givers gave the following responses as indicated in Table 4.8 below.

**Table 4.8: Assistant in accessing the mechanism**

<table>
<thead>
<tr>
<th>Assistant</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Close friends and relatives</td>
<td>26</td>
<td>63.4</td>
</tr>
<tr>
<td>Spiritual leaders</td>
<td>4</td>
<td>9.8</td>
</tr>
<tr>
<td>Professional counsellors</td>
<td>5</td>
<td>12.2</td>
</tr>
<tr>
<td>Fellow caregivers</td>
<td>2</td>
<td>4.9</td>
</tr>
<tr>
<td>Internet</td>
<td>4</td>
<td>9.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>41</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

From Table 4.8, close friends and relatives played a crucial role in helping the care givers access the mechanisms as indicated by 63.4 percent. They were followed by professional counsellors at 12.2 percent, spiritual leaders and internet at 9.8 percent each, with minority at 4.9 percent indicating internet.
4.8. Summary of Findings

The following is a summary of results from the data analysis. In terms of sex differences, there were more female caregivers than their male counterparts. With respect to age demographics, 75.6% of the sample was in the 25-30 years age bracket. 58.5 percent of the sample was married underlying the role of female care giving, 12.2 percent divorced and 29.3 percent not married. Most of the respondent had acquired secondary level of education at 51.2 percent. In terms of income source, only 12.1 percent was unemployed or were students indicating the burden of multitasking required among the caregivers.

Regarding signs of stress, physical difficulties were mostly marked with headache and pains at 36.6 percent with only 24.4 percents indicating no physical problems. Emotional difficulties were marked by sadness in majority at 51.2 percent. To overcome the problems the respondents opted to take a break, seek medication, share with friends, take physical exercise, or do nothing in that order. However, the problems never affected the care giving duty significantly with only 41.46 percent indicating their caregiving duty to have been affected.

In terms of stigma towards caregivers, government and other agencies sensitization efforts on HIV/AIDS have had tremendous effect with only 46.34 percent experiencing the stigma. However, for those who were affected by stigma it had detrimental effect on their economic and social life. As a way of managing the stigma majority opted to seek professional guidance and spiritual nourishment. Majority at 53.66 percent termed the caregiving as involving resulting into challenges.

Regarding intervention mechanisms which are critical for caregivers to cope up with associated challenges, sharing with friends and seeking medication were found to be the most effective. On top respondents reiterated the need for spiritual nourishment with others opting
for beer and drug use. Close friends and relatives, professional counsellors, spiritual leaders and internet sources were found useful to access and come up with intervention mechanisms.
CHAPTER FIVE
DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction
The purpose of the study was to establish the psychosocial impact of HIV/AIDS care giving among primary caregivers in Mombasa County. The chapter covers an account of the study findings, discussion as well as the conclusions drawn from the findings. In line with the study findings and conclusion, the chapter also covers recommendations and areas for further research.

5.2 Discussion
The discussion will be guided by the study’s research objectives.

5.2.1 Impact of stress on primary caregivers of HIV/AIDS patients
The first objective of this study was to determine the impact of stress on primary caregivers of HIV/AIDS patients. Care giving is characterised by unending demands from the recipient. This ends up creating financial, social and emotional stress on the care givers regardless of age and gender.

From the results obtained, primary care givers experienced stress related conditions both physical and emotional less often. This was marked by headache and pains, exhaustion and sleeplessness for physical problems. Discouragement and marked sadness were the most common emotional problems. The results confirm Bezuidenhoudt et al. (2006) study that termed the condition as physiological and psychological disorders among the affected (caregivers). The conditions emanates from financial hardships, care giving work demands, inadequate support if any, and undefined roles of caregivers.
To counter the symptoms, the caregivers mostly opt to relax which may even mean withdrawal from the duty. Others will seek medication which exerts more financial stress that many suffer from already. Very few recognize the need for physical exercise as a way of relieving the stresses. The findings confirms UNAIDS (2000) and Valjee and Van Dyk (2014) study findings that pointed out that stress are inherent in HIV/AIDS patient care giving role and recommended ways of coping with the stress. They include religious guide, anticipation of stress and planning ahead, avoiding talks on HIV/AIDS when at home, and seeking advice from professional counsellors.

5.2.2 Impact of stigma on primary caregivers of HIV/AIDS patients

The second objective was to determine the impact of stigma on primary caregivers of HIV/AIDS patients. Caregivers face stigmatization from friends and relatives who feel that they must also be HIV affected when taking care of the infected. This creates a situation of wants but nobody or very few are willing to extend a helping hand.

The researcher found that stigmatization among the respondents was minimal. This is a credit to the ongoing sensitization campaigns all over the world. Those who underwent stigmatization experienced isolation and discrimination from friends and relatives. Their daily chores were affected due to the demand care duties. Agyemang and Otoo (2013) findings are in line with the study that stigmatization is not only among the infected but also on the affected-caregivers. Hence, it can be argued that stigmatization extend to a wide group of people.

In terms of managing the stigma caregivers mostly sought guidance from religious leaders, ignored the naysayers, shared with close friends and relatives and shared with other caregivers. The result confirms Uckokis (2007) findings that stigma is a social burden among
the caregivers. To avoid instances, the caregiver must consider when and to whom to disclose the HIV status of the patient and that of themselves.

**5.2.3 Experiences of HIV/AIDS patients caregivers**

The third objective was to explore the experiences of HIV and AIDS caregivers in Mombasa County, Kenya. Care giving calls for sacrifice from the primary caregiver. The duty attracts no material gain only psychological returns when the infected gets better.

From the findings, the respondents indicated the responsibility as involving, tiring and boring. The duty never caters for other family needs and hence the carer has to toil the whole day trying to cater for family needs. In terms of difficulties, the researcher found the subjects were undergoing through issues like financial problems, getting help when needed, physiological changes, and attitudinal change. However, they were comfortable in sustaining themselves, sleeping pattern, problem solving and avoided drug and substance abuse. The findings reiterate Mashau and Davhana-Maselesele (2009) study findings of pain and despair among home-based caregivers creating the need for creating a working relationship among all stakeholders.

**5.2.4 Possible strategies to address the psychological and social impact of HIV/AIDS on primary caregivers**

Last objective of the research was to identify possible strategies that might be used to address the psychological and social impact of HIV/AIDS on primary caregivers. Care giving comes with stress and stigma which directly impact on carers psychologically and socially. Hence, there is need for a coping mechanism.

According to the findings, the participants found sharing with friend and seeking medication as most useful. Slightly helpful were talking with family members and taking exercise with
shopping classified as not helpful. However, participants preference of coping mechanism was involvement in social activities, physical exercise, counseling and spiritual nourishment. The results confirms Folkman (1997) study that identified positive reappraisal, goal-directed, problem-focused coping, spiritual beliefs and practices and the infusion of ordinary events as coping mechanisms associated with positive psychological and social states. The mechanisms are identifiable with the participants’ options.

5.3 Conclusions

The care giving process placed considerable demands on caregivers at household level, negatively impacting on their mental health. Insufficient support, lack of stable income and poverty experienced by most respondents, and the added responsibilities of caring for other household members exacerbated the psychosocial impact. The lack of support that the household caregiver received was as debilitating as the caring process. Respondents identified the types of support that were most useful to them and linked this support to improved health status. This has important implications for policy and programme development and implementation. The valuable work undertaken by household caregivers was unrecognized. Women formed the bulk of caregivers and their supporters were also most likely to be other women or girls, and this has important gender implications. These issues need urgent attention at policy and programme levels.

5.4 Recommendations

Based on the study findings, the researcher makes the following recommendations;

i. Primary caregivers need to be psychologically prepared on the tasks awaiting them and the inherent stress associated with the duty. This will help reduce instances of psychological and social stress.
ii. More sensitization is required in order to bridge the gender gap that exists among the primary caregivers. Although records indicate that men participation has increased, there is still a deficit on their involvement.

iii. Future research needs to explore the caring demands of patients on the primary caregivers to create more understanding among the caregivers and necessary intervention measures. The study needs to be carried out in three leading counties in HIV/AIDS prevalence adopting a quantitative approach.
REFERENCES


Hendrick, J. (2000). The impact of HIV on caregivers. PHASE: Canadian


APPENDICES

Appendix 1: Introduction Letter and Consent Form for the Primary caregivers

My name is Peninah Muthoni. I am a master student at Kenyatta University. I am conducting a study on Psychosocial impact of HIVAIDS care giving among the Primary care givers in Mombasa County, Kenya. The information will only be used for the above named study.

Procedures to be followed

Participation in this study will require you to answer a questionnaire that will be provided. The information will only be used for the intended research purposes and will bear no identifying information. You have the right to refuse participation in this study. Please remember participation in this study is voluntary. You may ask questions related to the study at any time.

You may refuse to respond to any questions and may stop responding at any time, You may also stop being in the study at any time without any consequences.

Discomforts and Risks

The study involves no known risk to you and contains no deception. However if any of the questions make you uncomfortable, you may refuse to answer these questions if so you choose.

Benefits

Participation in this study is voluntary and if you choose to participate, you will help us learn the psychosocial impact of HIVAIDS care giving among primary caregivers. In case of any counselling needs, the services will be offered.

Rewards

There will be snacks that will be provided, to the participants of this study.
Confidentiality

Privacy and confidentiality will be ensured. You are not required to write your names on the questionnaire to ensure anonymity. The questionnaires will be kept in a private office in order to ensure privacy.

Contact information

If you have any questions you may contact the Kenyatta University Review Committee Secretariat on chairman.kuerc@ku.ac.ke, secretary.kuerc@ku.ac.ke or ercku2008@gmail.com.

Investigators Statement

I, the undersigned have explained to the volunteer in a language that he/she understands, the procedures to be followed in the study and the risks and benefits involved.

Name of the investigator............................................................

Investigators signature............................... Date.........................
Appendix 2: Assent form for Primary care givers

The information regarding my participation in the study on psychosocial impact of HIV/AIDS care giving among primary care givers in Mombasa County is clear to me. I have been given a chance to ask questions and my questions have been answered to my satisfaction. My participation in this study is entirely voluntary. I understand that my record will be kept private.

_________________________  ______________
Signature                                      Date
Appendix 3: Interview schedule for the primary care givers

1. Are you in 20-25 years, 26-40 years, 41-45 years age bracket?

2. Is primary care giving good or bad?

3. Why is it good or bad?

4. Do you experience signs that are related to stress like headache and fatigue while caring for HIV/AIDS patients?

5. Do you experience any form of stigma from the society?

6. How does stigma affect you and how do you manage it?

7. Where do you get your income from?

8. How is your social life now that you are caring for a patient with HIV/AIDS?

9. Does caring for people with HIV/AIDS place considerable emotional demands on you?

10. How do practical daily demands of the caring process impact on you as the primary care givers?

11. How do you manage the practical daily demands of the caring process?

12. Do you experience any support from health services or NGO?
Appendix 4: Questionnaire for primary caregivers

Section A: Demographic information

Tick (✓) or answer what applies to you

1. Indicate your Age
   - 25-30 years □
   - 30-35 years □
   - 36-40 years □
   - 40-45 years □

2. Gender; Male □ Female □

3. Marital status; Married □ Divorced □ Not Married □

4. Level of education; Completed Primary □ Completed Secondary □ Completed University (Degree/Diploma) □

5. How many dependents do you have in the household? ..............

6. What do you do for a living; Casual labourer □ salaried-employment □
   - Self-employed □
   - student □
   - unemployed □

Section B: Signs of stress

7. Do you experience any physical problems (such as headache and pains, exhaustion, difficult sleeping) and emotional difficulties (such as marked sadness, discouragement) as a result of your work? .................................................................................................................................
   ........................................................................................................................................
   ........................................................................................................................................

8. Are the above physical and emotional symptoms occurring often or less often?
   ........................................................................................................................................

9. What do you do when you experience the above symptoms often?
   ........................................................................................................................................

59
10. Does this affect your caregiving role responsibilities in any way?

Section C: Stigma in caring for HIVAIDS patients

11. Do you experience any form of stigma from the society?

12. How does stigma affect you?

13. How do you manage stigma?

Section D: Experiences of primary care givers in caring for HIVAIDS patients

14. What are your experiences or feelings when caring for HIVAIDS?
15. Do you experience difficulties of the following situations when caring for HIV/AIDS patient?

<table>
<thead>
<tr>
<th>S/NO</th>
<th>Difficult Situations</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Financial problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Taking care of yourself (meeting your personal needs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Asking help when you need it.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Discrimination</td>
<td></td>
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<tr>
<td>5</td>
<td>Difficulty in thinking or concentrating</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Difficulty in sleeping/ oversleeping</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Change in appetite or weight</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Lose interest or pleasure in activities that you once enjoyed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Turn to alcohol or drugs to relieve your feelings</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Section E: Interventions for primary care givers

16. Please indicate whether you do any of the following to address or solve the difficulties faced above?

<table>
<thead>
<tr>
<th>NO</th>
<th>Coping Mechanism</th>
<th>Not helpful at all</th>
<th>Slightly helpful</th>
<th>Helpful</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Talking with friends</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Talking with family members</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Shopping</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Medication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Exercise</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Counselling</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
17. Which other activities do you do to address the above mentioned difficulties?

18. What is the most useful way of coping?

19. Who assisted you to access the coping mechanism?
Appendix5: Proposed Budget

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COST (Kshs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 rims of foolscaps</td>
<td>1,750</td>
</tr>
<tr>
<td>Writing pens, pencils &amp; Erasers</td>
<td>350</td>
</tr>
<tr>
<td>Typing &amp; printing of report</td>
<td>5,000</td>
</tr>
<tr>
<td>Typing &amp; printing of questionnaires</td>
<td>3,000</td>
</tr>
<tr>
<td>Travelling for search of literature</td>
<td>5,000</td>
</tr>
<tr>
<td>Meals &amp; Drinks (Researcher &amp; Assistants)</td>
<td>50,000</td>
</tr>
<tr>
<td>Internet services</td>
<td>5,000</td>
</tr>
<tr>
<td>Binding of report 3 copies</td>
<td>900</td>
</tr>
<tr>
<td><strong>Total cost</strong></td>
<td><strong>71,000</strong></td>
</tr>
</tbody>
</table>

The source of these funds shall be the researcher's own savings.
## Progress Track

<table>
<thead>
<tr>
<th>NAME</th>
<th>DATE CHECKED</th>
<th>SIGN</th>
</tr>
</thead>
<tbody>
<tr>
<td>PENINAH MUTHONI</td>
<td>7/1/2014</td>
<td>PENINAH</td>
</tr>
<tr>
<td>DR OLALY</td>
<td>28/2/2014</td>
<td>DR OLALY</td>
</tr>
<tr>
<td>PENINAH MUTHONI</td>
<td>1/4/2014</td>
<td>PENINAH</td>
</tr>
<tr>
<td>DR OLALY</td>
<td>2/5/2014</td>
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<td>DR. OLALY</td>
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FROM: Dean, Graduate School

TO: Peninah Mathoni Gatamba
C/o Psychology Dept.

SUBJECT: APPROVAL OF RESEARCH PROJECT PROPOSAL

This is to inform you that Graduate School Board at its meeting of 2nd November, 2016 approved your Research Project Proposal for the M.A Degree Entitled, "Psychosocial Impact of HIV/AIDS Caregiving Among The Primary Caregivers in Mombasa County, Kenya".

You may now proceed with your Data Collection, Subject to Clearance with Director General, National Commission for Science, Technology and Innovation.

As you embark on your data collection, please note that you will be required to submit to Graduate School completed Supervision Tracking Forms per semester. The form has been developed to replace the Progress Report forms. The Supervision Tracking Forms are available at the University's Website under Graduate School webpage downloads.

Thank you.

JACKSON LUVUSI
FOR: DEAN, GRADUATE SCHOOL

cc. Chairman, Psychology Department.

Supervisors:

1. Dr. Wilfrida Olany
C/o Department of Counseling Psychology
Kenyatta University
MOMBASA COUNTY GOVERNMENT

Ref. No. ERC-CGH/MSc/VOL.I/23

Date: 10TH MAY, 2017

Gatama Peninah Muthoni, B. ED
MOMBASA.

Re: Psychosocial Impact of HIV AIDS Caregiving Among the Primary Caregivers in Mombasa County, Kenya.

Reference is made to your letter dated 1st February, 2017. The Ethics Review Committee acknowledges receipt of your protocol.

This is to inform you that the Ethics Review Committee reviewed the document submitted and is satisfied that the issues raised at the meeting of Ethics Review Committee on 26th April, 2017 have been adequately addressed.

The study is granted approval for implementation effective from the date of this letter. Please note that authorization to conduct this study will automatically expire on the 26th April, 2018. If you plan to continue with data collection and analysis beyond this date, please submit an application for continuing approval to the ethical Review Committee-Coast General Hospital in appropriate time.

Any unanticipated problem resulting from the implementation of this protocol should be brought to the attention of the ERC-CGH. You are also required to submit any changes to this protocol to the ERC-CGH.

The ERC-CGH looks forward to receiving a summary of the research findings upon completion of the study to be part of the database to be consulted when processing related researches to minimize duplication.

DR. M. A. OCHOLA
SECRETAIRE ERC-CGH