

Socio-Economic Challenges and Coping Mechanisms of Home Based Caregivers for People Living With HIV/AIDS in NJORO Sub-County, Kenya

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Abstract: *AIDS scourge has put to test the capacity of Kenya's health delivery system to meet the ever-increasing number and needs of AIDS related illnesses and complications for equitable and humane treatment. This has led the government to rely on home-based care to fill the gap. Home-based care giving is well-recognized as the majority of care work due to illness takes place in the homes for a number of reasons, including the lack of a coordinated public policy addressing care needs, limited health infrastructure and human resources, and the preference of patients. The purpose of the study was to determine the socio-economic challenges of home based caregivers for people living with HIV/AIDS in Njoro Sub-county. The specific objectives were; to examine the types of support provided by home based caregivers for people living with HIV/AIDS; to determine the social challenges faced by home based caregivers for people living with HIV/AIDS; The study employed descriptive survey research design which sought to obtain information that describes existing phenomena by asking individuals about their perceptions, attitudes, behavior or values. Purposive sampling was used to identify 420 home based caregivers who were registered with the local administration to receive relief of which Simple random sampling was used to obtain a study sample of 103 from a population of 420 who are registered. A questionnaire was used to collect data and the Statistical Package for Social Science (SPSS) version 22.0 aided in the analysis.*

Keywords: *Socio-Economic, Challenges, Coping Mechanism, Home Based Caregivers, People Living with HIV/AIDS.*

I. Introduction

HIV/AIDS is a global pandemic that affects individuals, families, and entire communities around the world and has profound social and economic implications. In 2012, the pandemic killed an estimated 3 million people, and an additional 40 million were living with the infection (UNAIDS, 2012). The epidemic primarily affects the world's poorest people in countries with the greatest gender inequities, disparities in income, and access to productive resources (World Health Organization, 2012). HIV/AIDS is primarily a heterosexual epidemic in developing countries, yet sex between men remains a critical aspect of the epidemic in middle and high-income countries (Akintola, 2004). Internationally, an estimated 33.3 million people are living with HIV (NASCOP, 2012). The burden of the epidemic continues to lie disproportionately heavily within lower- and middle-income contexts. Approximately 15 million people living with HIV who need treatment are in these contexts, and of these, only a third (5.2 million) have access to the necessary facilities and resources (WHO,2012). Sub-Saharan Africa remains the region most severely affected by the epidemic: Approximately 68% of all people currently living with HIV, 69% of new infections and 72% of AIDS-related deaths occur in sub-Saharan Africa (WHO,2012). Furthermore, HIV has been recognised as a major humanitarian crisis in this context, as well as a significant threat to socio-economic development (UNAIDS, 2012).

Community Home Based Care programs have the potential to bring about important health and social benefits for the patients, families, and communities involved, a strategy that transfers some of the responsibilities of care from the health facilities to families and the communities in which patients live. CHBC programs have the potential to bring about an attempt to provide a quick and easy solution to relieving overburdened hospitals and clinics, without a real commitment to strengthening the services provided to those deeply affected by HIV/AIDS. Home-care programmes were started in North America and Europe when it was found that families had difficulty coping on their own with the demands of caring for people living with HIV/AIDS (PLWHA) (Molefe, 2009). During the late 1980s and early 1990s this type of service was introduced in a number of African countries (Sardiwalla, 2004).

Community-based care organizations have been designed to take care of those that are homecare workers, and the expansion of home care technology has increased the care giving responsibilities of families (Steinberg, 2011). Family caregivers are being asked to shoulder greater burdens for longer periods of time. In

addition to more complex care, conflicting demands of jobs and family, increasing economic pressure, and the physical and emotional demands of long-term care giving can result in major health impacts on caregivers (Shebi,2006). Home based caregivers who experience the greatest emotional stress tend to be female. They are at risk for high levels of stress, frustration, anxiety, exhaustion and anger, depression, increased use of alcohol or other substances, reduced immune response, poor physical health and more chronic conditions, neglecting their own care and have higher mortality rates compared to non-caregivers (Tarimo.etal, 2009). Home-based care has emerged as an effective method of providing cost-effective and compassionate care to people infected with HIV and AIDS. Many governments have acknowledged the need and value of caring for people living with HIV and AIDS in their homes. In South Africa, this was recognized by the government in 2004 as being an effective care measure when the government called for the establishment of 600 home-based care programmes by 2005 (Ehlers, 2006). In 2002, the World Health Organization published a framework for establishing community and home-based care programmes in poorer nations in response to the growing realization of their valuable role in dealing with the epidemic (WHO, 2002).

The inability of health systems to care for all people living with HIV and are in need of services has led many governments to rely on home-based care to fill the gap. In order to provide appropriate care and support for people with HIV and AIDS, especially in less developed countries with minimal resources and health budgets, a comprehensive integrated approach that addresses the medical, psychosocial, spiritual and emotional needs, is necessary. In Kenya a formal system of community based care (CHBC) has not yet be implemented by ministry of health (UNAIDS, 2007). However, there are a number of NGOs, religious organizations and donor agencies engaged in the provision of home based care throughout Kenya. The HIV pandemic is overwhelming public hospital capacities. In Njoro Sub-county due to the cosmopolitan in nature and establishment of various agri-business industries for example flower farms, processing industries and institution of higher learning, the prevalence of HIV and AIDS in the Sub-county has increased among the community living.

In Njoro Sub-County District Hospital due to high prevalence of HIV/AIDS the pandemic places enormous burden on healthcare services, as a result patients are forced to be discharged prematurely due to low bed capacity in the hospital. This has led to HIV/AIDS patients to seek care at their homes which includes physical, psychosocial, palliative and spiritual interventions. In Njoro Sub-county home based care is done at homes for a number of reasons, including, limited health infrastructure and human resources, and the preference of patients. A serious consequence of this being that other patients care is compromised due to premature discharges from hospitals. The increased demands placed on medical budgets, combined with the prolonging of patients' lives through antiretroviral therapy treatment, has led to vast majority of care costs and burdens are borne, therefore, by households and individuals. The purpose of the study was to investigate social-economic challenges faced by home based caregivers for people living with HIV/AIDS in Njoro Sub-county.

II. Literature Review

2.1 HIV/AIDS Situation in Africa and Kenya

The global AIDS epidemic has caused vast suffering throughout Sub-Saharan Africa. This region has the highest HIV prevalence rates in the world, accounting for 32% of all HIV infections (UNAIDS, 2012). The number of people living with HIV in the world was estimated at 33.3 million in 2009, out of which 2.6 million were newly infected. In the same year, 1.8 million people died of AIDS. The Sub-Saharan region, although it contains little more than ten per cent of the world's population, remains most severely affected by HIV. It accounts for over two-thirds of all HIV cases, and some of 75 per cent of deaths. The virus disproportionately affects women and prime-age adults who are at their productive and reproductive peak (UNAIDS, 2009).

Four southern African countries Botswana, Lesotho, Swaziland, and Zimbabwe had national adult HIV prevalence rates exceeding 20% (UNAIDS, 2012). The mounting morbidity and mortality of the epidemic has placed increasing pressure on these countries' public health sectors. The care of HIV/AIDS patients has created demand for healthcare beyond the capacity of hospitals and clinics, forcing states to look for alternatives. In response, several Sub-Saharan African countries have initiated CHBC programs, a strategy viewed as more affordable and attainable than hospital care. CHBC programs have the potential to bring about important health and social benefits for the patients, families, and communities involved, but many studies have questioned their effectiveness (World Health Organization, 2012).

As of December 2011, 1.6 million people in Kenya were living with HIV (UNAIDS, 2012). Kenya projects that the number of people living with HIV will continue to grow, placing continuing demands on health and social service systems. A comprehensive update of the HIV/AIDS epidemic in Kenya summarizes progress achieved over the last decade as; the rate of new HIV infections has fallen by 40%, 69% of HIV-positive pregnant women received drug prophylaxis to prevent transmission to their infants in 2011, and antiretroviral therapy reached 83% of all adults who were medically eligible (NASCO, 2012). Kenya has a severe, generalized HIV epidemic, but in recent years, the country has experienced a notable decline in HIV prevalence, attributed in part to significant behavioral change and increased access to ART.

2.2 The Concept of Home Based Care

Home based care programmes started in North America and Europe when it became clear that hospital care was too expensive, and that family and other caregivers found it difficult to cope on their own with the demanding nature of caring for people living with HIV/AIDS (PLWA) (Naidu, 2005). In the USA, the Committee on a National Strategy for AIDS (1986:101) concluded that: "If the care of these patients is to be both comprehensive and cost effective, it must be conducted as much as possible in the community, with hospitalization only when necessary. The various requirements for the care of patients with asymptomatic HIV infection, ARC or AIDS (i.e. community-based care, outpatient care, and hospitalization) should be carefully coordinated (Mabude, 2008).

In most African countries, there are now well developed home based care programmes and systems, although access to these programmes is still not universal (Uys and Cameron, 2013). The impact of this on health services, families and communities is placing an overwhelming burden on society at large. In an attempt to deal with this impact, it is common practice for health care facilities to rationalise services to people with HIV, and shift the bulk of the burden of care onto the shoulders of home based caregivers' households and communities. No wonder that in South Africa, home based care has become a national policy priority (Steinberg, 2011). increased demand for preventive and curative services to respond to the epidemiological and clinical impacts of the pandemic (UNAIDS, 2012). These effects include increased burden of disease, increased service needs associated with caring for these illnesses and for HIV/AIDS itself, and the inadequate and diminishing capacity to respond to these needs, central to which is the limited human resource capacity. Its effects on Kenya's health delivery systems is devastating and has led to unprecedented pressure on the health delivery system as cases of AIDS illnesses are increasing on a daily basis (Onyango, 2009).

Home-based care programs have been muted in an endeavor to prop up the health delivery system whose inadequacies have been severely exposed by the AIDS scourge (Makoae et al., 2008). The care of terminally ill AIDS patients has also morally and financially burdened family caregivers as a result of an increase in family members who are falling victim to the life-limiting disease. It is on this contention therefore that voluntary euthanasia can be morally justified in an attempt to lessen the burden on both the health delivery system and the home-based caregivers. The concept of home-based care, itself, promotes discrimination and segregation against terminally ill AIDS patients. It shows that the medical profession has resigned the life of AIDS patients to fate. When hospital staff tells a terminally ill AIDS patient to go home and be cared there, obviously, he will feel discriminated against. He will feel that he has been treated like an inferior being and this is emotionally and psychologically disturbing on the part of the patient (Held and Brann, 2007).

2.3 Social Challenges Faced by Home Based Caregivers

HBCGs are faced by many challenges emanating from caring for PALHIV. Caring for PALHIV is associated with high levels of stress, burnout, anxiety, and financial burden, and can be very draining—physically, emotionally and psychologically as well as socially (Homan et al., 2005). Both caregivers and PALHIV are faced with challenges such as continuous physical and psychological deterioration, their own mortality and the fear of contagion and death. This can challenge a caregiver's ability to cope. If they do not learn how to care for themselves, they will not survive the on slaughter of the HIV pandemic (Akintola, 2004; Van Dyk, 2001). Despite this challenges, the CHBC programs in Kenya, as currently being implemented, have faced several challenges therefore there was need to evaluate whether in Njoro Sub-county HBCs faced the same challenges.

Family members, including those with HIV, are involved in many different roles, from parent to child to caregiver. As an international public health issue, HIV/AIDS is proving severely disruptive to families, entire communities, and social structures worldwide. AIDS affects the entire household, with family members losing their most productive years, resulting in permanent poverty as the illness reduces the ability to work, and increases medical costs, as well as funeral expenses (UNAIDS (2012). Young people continue to be at the growing center of the pandemic. For example, in Africa, nearly one million African students are deprived of a teacher annually because of the impact of HIV/AIDS (Grindel, 1999). Worldwide, there is insufficient programming and support services for family members/caregivers and orphans. Children orphaned due to AIDS-related deaths of parents or caregivers face an unpredictable future that is often compounded by the same stigma, discrimination, and social isolation faced by their parents/caregivers (Greene, 2008).

Children infected and affected by AIDS will face similar problems to other children in difficult circumstances. It was estimated that by the year 2010 in sub-Saharan Africa alone, more than 18 million children more than all the children in the United Kingdom will have lost at least one parent to AIDS (Ehlers, 2006). The loss of parents can have profound emotional, economic, and developmental consequences for any child, especially in poor households. In Africa, AIDS has produced the phenomenon of child-headed households, where the older children have to care for their siblings in the absence of adults (France, 2008). This situation will be worse in cases where some of the children may also have HIV/AIDS and are in need of medical

care. Child caregivers and other orphans in poor households may have to earn a living off the streets or in poorly paid work where they are even further at risk from hunger, disease, or sexual exploitation and consequent risk of HIV infection (Homan et al., 2005).

2.4 Economic Challenges of Home Based Caregivers

The global estimated value of unremunerated work by women is 11 trillion dollars (Bharat and Mahendra, 2007). At the societal level, economic growth in many nations is lagging because so many skilled and experienced workers have died of AIDS. High unemployment and high rates of infection among skilled workers bode ill for countries' ability to keep social supports intact (Avert, 2010). Long term caregiving has significant financial consequences for caregivers, particularly for women. Caregivers face the loss of income of the care recipient, loss of their own income if they reduce their work hours or leave their jobs, shrinking of savings to pay caregiving costs (Wringe *et al.*, 2010). In a study by France (2007), finance was one of the challenges experienced by HBCGs as their stipend included transport to see a doctor, and transporting patients to hospital, for example. Some therefore leave caregiving after having received training, as they often do not receive any stipend or it is not sufficient to cover their needs and those of their patients. This challenge can be categorized as secondary stressors (economic hardships), which may include loss of employment and income (Aldwin, 2007). When it comes to the financial costs, caregiving may negatively impact working daughters more than sons, both in terms of their ability to work and the hours they log at work. More than one-third of caregivers end up leaving the workforce or reducing their work hours, and women are more likely to leave their jobs once they begin caring for a parent than to reduce the hours they work (Demmer, 2004). This study focused on establishing whether HBCGs in Njoro Sub county experienced the challenge of lack of finances when dealing with PALHIV.

III. Methodology

The study used descriptive survey design which sought to obtain information that describes existing phenomena by asking individuals about their perceptions, attitudes, behavior or values. The study was carried out in Njoro Sub-county in Nakuru County. The Sub-county was selected because HIV/AIDS pandemic places enormous burden on healthcare services in Njoro Sub-County District Hospital, as a result patients are forced to be discharged prematurely due to low bed capacity in the hospital. Simple random sampling was used to sample 103 individual home based caregivers from 420 who are registered in the local administration for relief of people living with HIV/AIDS in Njoro Sub-county. The study used questionnaires which were administered to the home based caregivers. The data was then analyzed using descriptive statistic. Data was presented using frequency distribution tables.

IV. Results

4.1 Socio-demographic Data

This section dealt with socio-demographic data of respondents. This data included information on respondents' ages, gender, number of dependants and employment status. From the findings the characteristics of the respondents in the study area were as follows. Most respondents across the study area were females 73.8% while 26.2% were males. Female headed households were 76.7% while 23.3% were female headed households. On average 13.6% of the respondent's ages ranged between 25 years and below, 33.3 % ranged 26-35 years, while 35.0% were aged 36-45 years while 18.4% had 45 years and above. This is an indication of engagement of both young and old in home based care-giving hence a great variation in household age data. In the sub-county, 55% of the respondents had between 3-6 dependents, while 30.8% of the respondents had 7-9 and 14.2% of the respondent had 10-12 dependants. The household size of most respondents ranged between 3-6 persons. The number of dependants in a household could have some influence on financial and social burden to the caregiver. From the data 50.5% of the respondents were self employed, 19.4% were housewives, 17.5% were government employees while 9.7% were students and 2.9% were unemployed. There was a relatively high level of unemployment (including housewife) amongst home based caregivers (32%) in the study.

Table 4.1: Socio-demographic Data

Variable	Frequency	Percentage
Gender		
Male	76	73.8%
Female	27	26.2%
Age		
25years and below	14	13.6%
26-35%	34	33.3%
36-45%	36	35.0%
Above 45 years	19	18.4%
Employment status		
Self employment	52	50.5%
House wife	20	19.4%
Government	18	17.5%
Students	10	9.7%
Unemployment	3	2.9%

Field Survey, 2013

The home based caregivers consisted of both men and women; their care recipients were also men and women. The most salient finding that emerged is that majority of the caregivers consisted of women, with only very few men being caregivers. A conclusion drawn on this fact is that care-giving seems to attract more women than men. Most of the caregivers were between 25years and 45years. These are the ages during which most people are economically active, married, or are involved in stable relationships, have children to raise and are expected to be socially and sexually active. The age of the home based caregiver may also have had an influence on the interaction and coping mechanism on the challenges as it could influence emotional and psychological support being offered to the people living with HIV. From the results majority of caregivers (50.5%) were self employed and this could have some effects on their productivity on their work, as more time was used in provision of care than on productive work. Employment of caregiver influenced availability of resources necessary for provision of care for people living with HIV. The income obtained could also be used to provide quality palliative and physical care. Some of the caregivers were not working since some were housewife's, others students and they depended on pension funds/social grants, causing an adverse financial impact.

The reason for having both male and female caregivers is that though in the past caregiving was associated with women, ever since the recognition of HIV/AIDS it was found that men do also become caregivers (Shebi,2006). It was also noted that, in the past, women were perceived to be more emotional in comparison to men, and consequently were perceived to be unable to cope with certain challenges. But the most salient finding that emerged is that majority of the caregivers consisted of women, with only very few men being caregivers. A conclusion drawn on this fact is that care-giving seems to attract more women than men a view that authors such as Leake (2009), Homan et al. (2005), as well as Bharat and Mahendra (2007) support in their studies. This scenario could be because of the fact that more women than men work in or around homesteads.

4.2 Social Challenges Experienced by Home Based Caregivers

With regard to identifying challenges faced mainly by caregivers due to their caregiving services, respondents indicated their ranking of the listed challenges in terms of major challenge, minor challenge, not a challenge or do not know (cannot tell). The major challenges of home based caregivers in the area were stigma and discrimination at 87 % while stress and burnout when dealing with people living with HIV was suggested by 76% of the respondents. The financial effect was suggested by 69% of the respondents. Risk of contracting the disease was suggested by 63% while physical effects were suggested by 61% of the respondents.

Table 4.2: Social Challenges Faced by Home Based Caregivers

Challenge	Severe challenge	Minor challenge	Not a challenge	Do not know	Total
	%	%	%	%	%
Stress and burnout	76	17	7	0	100
Physical effects	61	31	6	2	100
Financial effect	69	21	9	1	100
Stigma and discrimination	87	10	3	0	100
Risk of contracting the disease	63	24	10	3	100
Confidentiality and autonomy	54	21	11	14	100

Field Survey, 2013

From the results on the Table 4.2 on the issue of the major challenges of caregivers in the study area, it can be stated that the four major challenges in the area were reported by the respondents in order of highest percentage as “major cause” were stigma and discrimination (87%), stress and burnout (76%), financial effect

(69%), risk of contracting the disease (63%) and physical effect (61%). In all relationships personal or professional discrimination counteracts trust, as mentioned by Molefe (2009). Stigmatization is still a major challenge since it prevents open statements about HIV status. Universal tolerance of HIV/AIDS needs to be advocated for, through awareness programmes in an attempt to reduce stigmatization and discrimination. caregivers 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 (Ehlers, 2006). According to Bharat and Mahendra (2007) caregivers experience feelings of helplessness, denial and despair, and that this happens more often when the sufferer does not want to eat or respond to the services being rendered to him/her. These conditions might bring feelings of uncertainty that in turn will exacerbate feelings of stress and low self-esteem among the caregivers. It is also noted that poverty increases the worries of caregivers, as they might not have enough money for a balanced diet and regular medical check-ups, especially when the person is bedridden as there is a need for transportation to medical facilities (Dieleman et al.2007).

4.2.1 Fear of contagion

A clear majority of the HBCGs (63%) expressed fear of contagion. Fear of contagion is one of the major concerns among HBCGs working in the field of HIV/AIDS. This is confirmed by studies such as Primo's (2007:56), where some of the home based caregivers feared that wearing gloves may not provide sufficient protection to prevent infection by HIV/AIDS. Despite the knowledge that HBCGs may have about HIV transmission, they still have fear of contagion which can compromise the quality of care that PALHIV might need, and which explains why a HBCG can think of using disinfectant when taking a bath after caring for a PALHIV. This is confirmed by a study of Akintola (2004), that the fear of contracting the disease has been noted as a concern among HBCGs and many regard working in the field of HIV/AIDS as a high risk occupation. This fear is further exacerbated by difficulties experienced in maintaining consistent and appropriate infection control precautions. Despite the well-documented fact that the AIDS virus can only be transmitted through bodily fluids, there are still health care workers who harbour irrational fears of contagion taking place through casual contact, or touching the patient's clothes, bedding, eating utensils or bathing facilities (Demmer, 2004). This fear may result in physical or empathetic withdrawal from persons with HIV/AIDS, resulting in clients being deprived of physical and emotional contact, a most valued intervention, which could make them feel unclean and contaminated. These factors can cause considerable stress, anxiety and discomfort for the client as well as the person working with the AIDS patient.

4.3 Economic Challenges Faced by Caregivers

The third research objective focused on economic challenges faced by home based care givers. The economic challenges experienced by the caregivers when taking care of HIV/AIDS victims were listed by the respondents as in the Table 4.3 below:

Table 4.3: Economic Challenges Faced by Caregivers

Socio-economic challenge	Frequency	Percentage
Lack of finances	94	91.3
Poor nutrition	86	83.5
Reduced time for skill building and time for engaging in leisure activities	81	78.6
Unemployment	77	74.8
Rising number of orphans and vulnerable children	69	67.0
Poverty	63	61.2
Shortage of basic necessities such as gloves, soap, disinfectants	55	53.4
More people requiring care	41	39.8
Lack of skills	37	35.9

Field Survey, 2013

As indicated in Table 4.3, 91.3% of the caregivers reported that lack of finances was one of the major challenges faced when taking care of HIV/AIDS victims. This is because majority of caregivers were not in a position of securing job or even engaging in activities that were income generating. Poor nutritional status was the other challenge among the infected and affected person's which deteriorated their health status as reported by 83.5% of the respondents. Moreover, 78.6% of the caregivers stated that they have limited time for skill building and engaging in leisure activities. This makes them feel isolated in social groups and hence develop a negative attitude of self denial. Other economic challenges experienced included; unemployment, poverty, rising number of orphans and vulnerable children. Income generation by HBCG was hindered due to the fact that they had to provide care before operating their business. This implies that economic challenges pose great challenges to the caregivers. In line with the findings, Lever *et al.*, (2002) asserted that strengthening the family structure is

important because of the tremendous stress that HIV puts on family systems. Besides caring for ill relatives and for orphans, families are often beset by economic and social problems as well as the grief that accompanies the loss of family and friends. Furthermore, Tarimo *et al.*, (2009) argued that the increased financial costs related to caring for the sick ranges from costs incurred to provide immediate care such as gloves to financial outlays for medicines and user fees for accessing health care services, transportation costs involved with attending clinics, rising food costs and others.

4.3.1. Lack of Finances and Poverty of Caregivers

Lack of finances was reported as a major challenge by 91.3% of the respondents as well as poverty by 61.2% and unemployment by 74.8%. Coupled with limited time to work due to the demand of caregiving, poor finances become a big limitation in giving good care. Income generating activities would go a long way in improving the financial status of the caregivers. There are also companies that come and sponsor the income generating activities like home gardens, e.g. Compassionate International gave patients, milk goats, seeds and farming training to enhance food security and reduce malnutrition cases. Financial support, whether formal or informal, is an important buffer for the caregivers. This concur with studies by Ntsuntswana (2006), that poverty remains one of the main challenges faced by HBCGs when they provide care to PALHIV and unless it is reduced there will be little progress in achieving more in caring for PALHIV as the quality of the care given to PALHIV will be compromised for they would not be able to afford basic essentials including food, which they need to be able to take their medication.

V. Conclusions

It can be noted that financial constrain and poverty increases the worries of caregivers, as they had not enough money for a balanced diet and regular medical check-ups, especially when the person is bedridden as there is a need for transportation to medical facilities. The results suggest that caring for an HIV positive individual can be emotionally and physically draining, but later can be fit into one's daily lifestyle. It can lead to prejudice and stigma from those that could potentially offer support to the PLWHA as well as the caregiver, causing strain. The study further reveals that participants experienced little emotive and financial support from family, society, and the community health workers who were visiting PLWHA at home. This led them to feel more helpless, leading to the use of poor coping mechanisms.

VI. Recommendations

Policies on home based caregivers should be developed to accommodate the challenges faced by this group which provide alternative health care at home that ease pressure on health care facilities. The social workers in collaboration with home based caregivers to work together in identifying difficulties and the resources that impact in the individual experiences of caregiving, both in the families themselves as well as in the larger socio-economic context.

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