COPING STRATEGIES OF OLDER PERSONS IN THE PROVISION OF CARE FOR ORPHANS AND VULNERABLE CHILDREN: A CASE OF MITHINI LOCATION, KITUI COUNTY

BY

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DECLARATION

I hereby declare that this project report is my original work and has not been submitted to any other University or Institution for any award.

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This Project report has been submitted for examination with my approval as the University Supervisor

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DEDICATION

I dedicate this work to my little Tatyana,

you are my inspiration.

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I would like to express my deepest appreciation to the following people who supported me during the process of this study.

First and most, I would like to thank God Almighty for guiding and supporting me in this study.

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TABLE OF CONTENTS

LIST OF TABLES

Table:

LIST OF FIGURES

ABBREVIATIONS AND ACRONYMS

AAC	Area Advisory Council
AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-Retroviral Therapy
AU	African Union
CBO	Community Based Organization
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CHW	Community Health Workers
CRA	Commission of Revenue Allocation
CRC	Convention on the Rights of the Child
CSO	Civil Society Organizations
CT-OVC	Cash Transfer for Orphans and Vulnerable Children
DfID	Department for International Development
DHS	Demographic & Health Survey
FBO	Faith Based Organization
GoK	Government of Kenya
HAI	HelpAge International
HIV	Human Immunodeficiency Virus
KDHS	Kenya Demographic & Health Survey
KI	Key Informants
LOC	Location Orphans & Vulnerable Children Committee
MOHA	Ministry of the Vice President & Home Affairs
NCCS	National Council of Children's Services

NGO	Non-Governmental Organization
OCG	Office of the Children's Guardian
OVC	Orphans and Vulnerable Children
PEPFAR	Presidents Emergency Plan for AIDS Relief
PLWAs	People Leaving with AIDS
SADC	Southern Africa Development Community
SGHs	Skipped Generation Household
SPF	Social Policy Framework
SPSS	Statistical Package for Social Statistics
UN	United Nations Specialized Agency for AIDSUNAIDS
UNGASS	UN General Assembly Special Session
UNICEF	United Nations Children's International Emergency Fund
USAID	United States Agency for International Development
WHO	World Health Organization

ABSTRACT

Older adults are increasingly playing the principal role in caring for orphaned grandchildren. In 2006 Kenya had HIV/AIDS national prevalence of 7.4 % with an estimated 1.1 million orphans under the care of older people. Not much has been documented on how older people cope with the management of OVC. it is for this reason that this study was conducted to explore and identify the strategies used by older persons in the provision of care to OVC.

Quantitative data were obtained through a questionnaire administered to selected sample of 49 older carers while qualitative data were obtained through key informant interviews with six community leaders. The Key Informants included a chief, Community Health Worker, two teachers, a children's officer and a member of community-based organization. Data analysis of the quantitative data was done using SPSS while the qualitative data analysis was done by categorization and coding against the set parameters of the research objectives.

The results showed that older male were more in the provision of care for OVC than older women carers, Older caregivers are also responsible for providing clothing, shelter, school fees, uniforms, books and other school requirements for children in their care, majority of the carers for the OVC did not have a good experience and did not enjoy taking care of OVC and many older carers experienced difficulties and stress in adapting to a new role of parenting at old age.

This study showed that older people are playing major caregiving roles amidst a multitude of challenges that included limited resources, knowledge, skills and social support related to patient care and rearing of OVC. This study recommends provision of financial support without limitation on the status of the OVC whether parent died of HIV related complications or not, advocacy for inclusion of social protection measures for older carers and OVC in national

HIV/Aids policies and strategic frameworks and child focused CSOs to mainstream support to older carers of OVC including facilitating older carers support groups and parenting skills training. It has also suggested further research on collection of comprehensive age disaggregated data on the needs and roles of older people providing care for OVC, design better HIV/Aids intervention that are inclusive of older people, additional information on the nature and composition of households affected by HIV/AIDS and details of who the primary caregivers and guardians for OVC are.

CHAPTER ONE

INTRODUCTION:

1.1 Background:

With a national prevalence of 7.4 %, HIV/AIDS is a major issue for Kenya resulting in 1.1 million orphans (UNAIDS, 2006).

> "The impact of the HIV/AIDS epidemic is most profoundly reflected in the lives of children, whose very survival and development are at stake." UNICEF, el at 2004).

Although only a portion of children affected by AIDS lose one or both parents, the impact on those who do can be severe. Under ordinary circumstances, the death of one young parent is not linked to the death of the other parent. But because HIV is sexually transmitted, the probability that both parents will die if one is infected is high. Moreover, many children are losing both parents in a relatively short period of time. By 2010, the number of children in sub-Saharan Africa who had lost both parents from AIDS was estimated to rise to 8 million, from 5.5 million in 2001(UNICEF, 2004).

The high prevalence rate has left many older people with the responsibility of caring for the orphaned and vulnerable children in their midst. Some surveys have shown that in sub-Saharan Africa approximately 40% of people living with HIV are being cared for by older people and much of the care of children affected by HIV is carried out by grandmothers (HelpAge 2009).This trend is causing a shift in household structure and responsibilities. A major impact of HIV and AIDS on older people is in their role as

caregivers to their children living with AIDS and grandchildren who have been left as orphans as a result of this pandemic.

> "At a time in their lives when many older people might have expected to be supported and cared for by their adult children, a growing number are taking on caring roles for orphaned and vulnerable children" (Samuels and Wells 2009).

The majority of these persons render care under conditions of extreme deprivation, and they are largely unprepared for this responsibility and are unsupported. Most of these elderly people are poor, and the older they get, the poorer the household may become as their ability to support the family declines. Children living with grandparents are therefore likely to be more susceptible to poverty and malnutrition, and are also much more likely to drop out of school early than children who live with both parents. This is possibly because it is assumed that they are infected with HIV and their illnesses are untreatable or possibly because of the lack of knowledge and resources needed to support them. In such situations, the infected are left to die or they don't get treatment until very late in life. This raises the questions regarding how best they can meet the needs of these children and how well informed they are about the children's needs hence, children who have been orphaned by HIV/AIDS may not receive the care needed.

HelpAge International (HAI) conducted a baseline survey amongst selected regions of 11 Sub-Saharan African countries. They found that older carers were providing on average 55 per cent of the care to children orphaned by AIDS and 44 per cent of the care of family members who were chronically ill or living with AIDS. Older people had taken on

the triple roles of carer, homemaker and income earner in many households. In the same baseline survey, HelpAge found that on average each older carer was caring for 3 orphaned children (HelpAge, 2006).The number of men becoming involved in this care was also growing. The studies showed that 80 per cent of older carers were female and 20 per cent were male.

HAI estimates that at least 40% of the approximately 12 million children orphaned by AIDS in Eastern and Southern Africa are being cared for by older caregivers, mainly older women carers. Decisive action is needed to strengthen and protect this emerging family structure. Older caregivers and the OVC in their care must be prioritized in national OVC, older person and children's policies, strategies and protocols. The national responses must effectively respond to the scale of the issue at hand. The existing vulnerabilities, lack of support for the older people generally, and the subsequent lack of support to aid them in fulfilling their additional caregiving responsibilities, in turn has the effect of heightening the vulnerability of the children who come into their care.

The UN (Malta, 2005) recommended that governments and civil society support older caregivers politically and economically, and mainstream them in HIV/AIDS policies and programmes. It called for

> "policy action that promotes intergenerational cohesion, targets the needs of infected and affected persons in all age groups simultaneously and comprehensively and provides support through cash transfers, income generation opportunities and micro-loans to households affected by HIV/AIDS, to enable the households to sustain their economic viability and the caregivers to cope".

The Kenyan government has responded by putting in place the National Plan of Action on OVC which helps to strengthen the capacity of families to protect and care for OVC, provide economic, psychosocial and other forms of social support, as well as mobilize and support community based responses to increase OVC access to essential services such as food and nutrition, education, health care, housing, water and sanitation despite not having accurate OVC figures. The Ministry of Gender, Children and Social Development in collaboration with the National Steering Committee on OVC developed the OVC Policy, a key aspect of which is the provision of a direct predictable and regular cash subsidy of Ksh 1,500 per month to households caring for OVC (UN Malta, 2005)

1.2 Statement of the Problem:

As HIV/AIDS rates continue to increase across the world, many parents are dying, leaving increasing numbers of orphaned and vulnerable children in the care of their grandparents and other older relatives. HIV/AIDS epidemic strikes at the heart of family and community support structures and therefore large numbers of older people are assuming responsibility for bringing up orphans and vulnerable children. Family structures are changing. Often the middle generation both men and women is completely absent, leaving the old and young to support each other. This means that families of older carers and orphans and vulnerable children are compelled to take on new roles. Therefore the impact of HIV/AIDS on older people, and the contribution older people are making to the care of orphans and other children made vulnerable by HIV/AIDS are enormous but not well documented. The enormous contribution of these older people to their families'

well-being, and the difficulties they face as a result of the HIV/AIDS epidemic, are rarely recognized. Without their help many children would have nobody to care for them.

Normally, the extended family in Africa is able to absorb a certain number of orphans, but the numbers are now so large that many communities can no longer cope (HAI). In some families a whole generation of young adults has died, leaving no aunts or uncles to care for orphans. In some cases the siblings of dying parents are no longer able or willing to accept responsibility for the care of their nephews and nieces, leaving more and more orphaned children to be cared for by their grandparents

Although many governments and programmes are trying to deal with the HIV/AIDS situation, the needs of older people and their ability to cope with the increasing demands made on them as a result of the HIV/AIDS epidemic are rarely taken into account. As a result, many older people have little or no access to health care and other services, nor to information or support programmes. Supporting their efforts could make them much more effective and greatly benefit the orphans and vulnerable children in their care, hence the focus of my study.

While some valuable research has been conducted on the strategies used by older persons in the provision of care to OVC in the context of the HIV epidemic in Kenya, significant gaps remain. The lack of vital strategic information is hindering policy makers and program leaders from making well-informed decisions about the way forward. However, with limited resources available to divide between programming and research, a

reasonable balance should be found to answer key questions without sacrificing support for critical services.

Therefore, the study will attempt to investigate and identify the strategies used by older persons in the provision of care to OVC. The study will make a valuable contribution to the existing body of knowledge about the role of older people in the provision of care to orphaned and vulnerable children. It is envisaged that the findings of this study would assist in policy development, programs that would build the capacity of older carers, their families and community members in order to deal with the obstacles these older people are facing as carers for orphaned and vulnerable children.

1.3 Purpose of the Study

The purpose of the study was to explore and identify the coping strategies used by older persons in the provision of care to OVC in Mithini Location, Kitui County.

1.4. Objectives:

1. To develop a profile of older people giving care to OVC
2. To identify circumstances leading to older people assuming the role of care givers to OVC
3. To document the experiences and coping strategies of older people in the provision of care to OVC
4. To identify obstacles experienced by older carers in the provision of care to OVC and their coping strategies

1.5 Research Questions:

The main research questions were:-

1. Who take care of the OVC?
2. What circumstances lead older people to assume the role of care giving to OVC?
3. What are the experiences and coping strategies of older people in the provision of care to OVC?
4. What are the obstacles experienced by older carers in the provision of care to OVC and how do they cope?

1.6 Justification of the study

Historically, the elders provided care to the children who in turn provided care to them in their old age, hence saying, "look after it and it will look after you". Nobody would starve when other members of the family had plenty. No children would live alone even if all the direct (or biological) members of their family died. The concept, "It takes a village to bring up a child", was applicable. This situation has significantly changed and older people are caring for the sick, the dying and the children orphaned or made vulnerable by the HIV/AIDS pandemic. Older people, mainly older women but also including a good proportion of older men, are providing economic, social and psychological care and support for a large number of family members. They are doing so with very few resources and no recognition or support.

GoK started a CT for older people in 2006 with a pilot programme in Thika and Nyando where each beneficiary is given $15 per month. This programme has not been rolled out

to other districts yet. Quoting information from Zimbabwe, Beales (2002) states that although it is often recognized that older people are primary carers, there is little support for the grandparents.

Therefore it is imperative for the governments, NGOs and society at large to recognize the fact that older people are caring for increasing numbers of children and must incorporate older people into their HIV/AIDS strategies. Failure to invest in older people will not only adversely affect the older generation, but also those they care for.

This study will help Kitui County to raise awareness of the needs of older people, and the actual and potential role they play as well as the need to recognize and acknowledge the enormous contribution they make in caring for their families and vulnerable children, as a first step in supporting them and reducing discrimination and encourage older carers to adopt healthy lifestyles.

Assembling the relevant available data on OVC under the care of elderly people in one place, and acknowledging the gaps that still exist in our knowledge, will assist policy makers and program implementers to make evidence-based decisions about how best to direct funding and program activities and maximize positive outcomes for children and their caretakers.

1.7 Scope and Limitation of the study

This study was conducted in Mithini Location in Kitui County. While this is a spatially/geographically limited area, the results do illuminate the plight of older cares providing care for OVC and can be extrapolated and generalized to the larger Kenyan society.

1.8 Assumptions

This study assumed that the target population was willing to be interviewed and was accessible. It also assumed that, the older people living with OVC were aware of the cause of death/challenge of the parents of the OVC.

1.9 Definitions of Key Concepts

i) Children

Although there are some differences in definitions at local and even national level, in Most international and national instruments, children are defined as boys and girls up to the age of 18 years old (Smart 2003:3). According to the Children's Act, 2001 it defines a child as any human being under the age of eighteen years. For the purpose of this study, the research adopted the definition by Children's Act.

ii) Orphaned and Vulnerable Children:

Maternal orphans are children under age 18 whose mothers, and perhaps fathers, have died (includes total orphans), paternal orphans are children under age 18 whose fathers, and perhaps mothers, have died (includes total orphans), while total orphans are children

under age 18 whose mothers and fathers have both died. The working definition of an orphan in this paper included all children under the age of eighteen who are maternal, paternal or total orphans.

iii) Vulnerability:

The concept of vulnerability is complex and local-context specific. Therefore, it is not easy to provide a universal definition. Smart (2003:6) provides an overview of children defined as vulnerable in some selected countries at national level. Based on her findings, for purposes of national policy and service provision, vulnerable children are best understood as children 'whose probability of suffering has been aggravated by unusual individual or societal circumstances (GoZ, 1992:61).Vulnerable children are those who belong to high-risk groups who lack access to basic social amenities or facilities, the main sources of vulnerability being considered to be HIV/AIDS.

iv)Older/Elderly carers:

The term "older/elderly carers" is used in this document to refer to older people caring for orphaned and vulnerable children. The United Nations defines older people as those aged 60 years and above, but there are huge issues around the definition of older people. The chronological definition alone presents immense problems in Africa because many older people do not know exactly when they were born and tend to use events to determine their ages. That leads to their ages being estimated. Different societies define their older people differently. In some cases, these definitions are based on what people have achieved in life, their wealth, the number of wives and children, the number of

grandchildren, the ability to give birth, etc. Physical features are sometimes used – colour of hair, the stoop while walking, wrinkled face and the knowledge that one has of important events, rituals and traditional processes. Retirement ages are also used to define older people. In Africa, these range from around 45 to 65 years.

For the purpose of this study, the United Nations definition of older people as those aged 60 years and above was adopted.

v) Care givers/giving

The terms 'older carers' 'grandparents raising their grandchildren', 'grandparent caregivers/caregiving', and 'grandparents-as-parents' are used interchangeably to specifically refer to families where grandparents provide full-time parental care of their grandchildren in the absence of the children's biological parents

CHAPTER TWO

LITERATURE REVIEW

2.1. Introduction;

This chapter reviewed the literature on the coping strategies of older persons as carers of orphaned and vulnerable children and the impact of that role in the context of the HIV epidemic. The theories upon which the study was premised is explained. It also includes a conceptual framework.

2.2 Emergence of OVC

As HIV and AIDS continue to impact on sub-Saharan Africa, the emerging picture indicates that the infection is producing social dislocation, one consequence of which is a breakdown in the basic infrastructure of life. In particular, the disease is cutting away the middle and the most productive generation of society. HIV and AIDS and other crises common to Sub-Saharan Africa disproportionately kill working-age adults. This results in what has become known as skipped generation households (SGHs). SGHs are defined by Samuels and Wells (2009) as

> "households where an older person, often a grandparent, becomes the primary caretaker for a child who has lost one or both parents, or whose parents are absent for a prolonged period of time".

Consequently, HIV and AIDS not only disproportionately kill working-age adults, but also impact on older people. Most children orphaned by AIDS live with their extended families, usually grandparents, and most often grandmothers.

In 2007, there were 2 million children under 15 years of age living with HIV – 8 times more than in 1990. 370,000 children under 15 years were newly infected with HIV, representing 17% of new infections (UNAIDS 2008). Sub-Saharan Africa remains the most affected region, with almost 90% of the world's children with HIV living in this region alone. Studies show that almost two-thirds of all young people (aged 15-24) with HIV live in sub-Saharan Africa.

> "In this region, approximately 75% of new infections among young people are among young women. In southern Africa the gender disparities in HIV infection are particularly striking – in Malawi, South Africa, Swaziland and Zimbabwe HIV prevalence in young men aged 15-24 was 2%,4%, 4%, and 6% respectively, among young women of the same age, the prevalence was 9%, 17%, 22% and 11% (Stirling et al, 2008; Piot, Mboup and Bekele, 2008).

In some populations in sub-Saharan Africa, a fifth of girls less than 18 years of age are infected with HIV.

In the same year of 2007 UNAIDS and WHO (2008) and Richter (2008) stated that nearly 12 million children under age 18 in sub-Saharan Africa were estimated to have lost one or both parents to HIV, representing about 37% of parental loss from all causes while UNAIDS (2008) reported that 24% of Zimbabwe's children (aged 0–17) had lost one or both parents to HIV. If the current inadequate pace of scale-up of access to antiretroviral therapy (ART) continues, the number of children under age 18 orphaned as a result of HIV is expected to grow to more than 14 million by 2015. Achieving universal treatment

access by 2010, however, was expected to reduce the number of orphans in 2015 by more than five million (UNAIDS & WHO, 2008)

An analysis of data from Demographic and Health Surveys (DHS) in Burkina Faso, Cameroon, Ethiopia, Ghana, Kenya, Malawi, Mozambique, Nigeria and Uganda found over 85% of orphans not living with the surviving parent were living with extended family. In addition, grandparents were more likely to be caretakers in high prevalence countries (in more than 50% of cases), whereas in low prevalence countries grandparents were identified as caretakers in 20-40% of cases (UNICEF, el at, 2006; Monasch and Boerma, 2004).

Ardington (2008) found that orphans in South Africa were still absorbed into extended families but single orphans were increasingly less likely to live with the surviving parent and there was an increasing reliance on grandparents as caregivers. In Thailand, grandparents were found to be the main caretakers for 55% of all orphans due to AIDS and 67% of double orphans due to AIDS, although siblings, especially sisters, also became caretakers for their HIV-infected brothers and sisters, as well as for their children (Knodel and Saengthienchai, 2005). A study (Hosegood et al, 2007) in Malawi, South Africa and the United Republic of Tanzania found that all but a small minority of orphaned children were being integrated into kinship, community and other support networks. There was no evidence of an increase in child-headed households in these countries.

2.3 The Role of Older persons as Carers of Orphaned and Vulnerable Children

The United Nations defines older people as those aged 60 years and above. The Organization of African Unity Policy Framework and Plan of Action on Ageing recommend Africa to use the UN definition to define its older people.

Older people have always been involved, to some extent, in the care of children. However, as a result of HIV/AIDS, the problem now is the increased extent of this care. The numbers of older people who are now taking full responsibility for the care and upbringing of orphaned children is alarming. As family structures change, the roles of older people and orphans and vulnerable children adjust to meet the impacts of the HIV/AIDS epidemic.

According to projections, the population of those aged 60 years and above, the world over is increasing rapidly.

> 'In 1950 it was 200 million, representing only 8% of the total world population, increasing by 75% to 350 million in 1975 and shooting to 630 million in 2002' (UN, 1991; UN Population Division, 1999; 2002).

In 2000, the proportion of older people was 10%. Projections are that older people will number 1.2 billion in 2025 and 2 billion in 2050, representing 21% of the world total. The population of older people is growing faster than the rest of the population at the rate of 2% per year, but will jump to a growth rate of 2.8% between 2025 and 2030. According to the United Nations (2003), Africa held 42 million older people, representing 5% of the world's population. Eight percent (8%) of these were over 80

years. By 2050, the projections are that the population of older people in Africa will shoot to 205 million.

Grandparents are emerging as the 'new' parents at a time when they themselves need care and support in old age. A survey of the scale of older-headed households revealed that this kind of household was becoming a dominant and typical family structure in sub-Saharan Africa. For example, a study in Kenya found that 40% of OVC lived with their grandparents (KDHS 2003), while in Namibia, Tanzania and Zimbabwe, 40-60% of orphaned children were cared for by grandmothers (UNICEF 2007). A study of 20,000 households in rural Tanzania found that virtually all orphans and foster children (those with one or both parents alive) were cared for by members of the 'extended family', often their maternal grandmothers (Urassa et al 1997). A WHO (2001) study in Zimbabwe documented that 71.8% of those giving care to orphans and the sick were over 60 years old, and in Tanzania, Dayton and Ainsworth (2002) encountered patterns similar to those found in Zimbabwe by the WHO.

HelpAge International (HAI, 2006) conducted a baseline survey amongst selected regions of 11 Sub-Saharan African countries. They found that older carers provided on average 55 per cent of the care to children orphaned by AIDS and 44 per cent of the care of family members who were chronically ill or living with AIDS. Older people had taken on the triple roles of carer, homemaker and income earner in many households. In the same baseline survey, HAI found that on average each older carer was caring for 3 orphaned children. The number of men becoming involved in this care was also growing. The studies showed that 80 per cent of older carers were female and 20 per cent were male. In a study carried out in six districts in Uganda, parents were most commonly cited as the

principal caregivers of AIDS patients (Ntozi, 2001) and another study established that in South Africa, Namibia and Zimbabwe 60% of the orphans are living with grandparents, while in Botswana, Malawi, Uganda, Ghana and Tanzania 50% of the orphans were said to be under the care of their grandparents (UNICEF 2003). In Uganda a HAI programme supporting older carers in Kampala found that 8 older people (aged 63-79) were caring for a total of 44 orphans between the ages of 2-16. Also during their work in Tete, Mozambique (2004) found that 4804 older people were caring for a total of 10 392 orphans. For the first time ever, UNAIDS, in its 4th global report, acknowledged the fact that a large number of orphaned and vulnerable children were being taken care of by older people. Studies undertaken in South Africa (HAI, 2003, Ferreira, 2002) indicated that the pension that older people were getting was proving to be important in providing support to family members and sustaining many households.

In many cases, older people shoulder the responsibility of caring for their children when they become ill providing physical, economic and social support. The greater the care needs, the less the time available for older people to participate in income generating opportunities. At the same time older people, according to Nhongo, 2002

> 'because of their ignorance about the disease, will run from one traditional healer to another trying to find a cure. They will sell all their wealth, possessions and strip themselves economically naked. At the end of all this, their reward is the burden they face in caring for the orphans - fending for them, providing food, clothing and school fees".

A number of studies have found that in sub-Saharan Africa the majority of orphans, whether orphaned as a result of HIV/AIDS or for other reasons, are cared for by older

persons, particularly older women. In South Africa and Uganda 40% of orphaned children are living with their grandparents and in Zimbabwe, up to 60%. In Zambia, Uganda and Tanzania, grandparents made up the single largest category of carers of orphans after the surviving parent with 38, 32 and 43% respectively. HAI (2000) found that older people had to shoulder the burden of caring for as large a number of orphans ranging from 12 to 17. In 1992, a survey conducted in Zimbabwe (Jazdowska, 1992) found that 90% of those caring for orphans were older people and most of them were women. In a study carried out in the same country in 1996 it was found that 143 out of 292 people caring for orphans were those aged 50 years and above. In fact, 125 of them were those aged 60 years and above (FACT, 1996). In the Cape Flats, South Africa, a study of older carers found 156 grandchildren below 19 years of age living with 43 older people. Of the children, 19 had AIDS (Ferreira, 2002). An analysis of Demographic and Health Survey Data from sub-Saharan Africa found that orphaned children are more likely than others to live in grandparent headed households (Bicego, forthcoming).

Research in Uganda (Williams and Tumwekwase, 1999) found that it was impossible to focus only on HIV/AIDS. In the village, 30 older people were looking after 58 grandchildren, of whom two-thirds were orphaned for reasons other than AIDS. The work of HAI in Tete, Mozambique found that 774 older people were caring for a total of 2,187 orphans. Of these, 95 were caring for children whose parents had died through war, domestic violence, road accidents and so on. In Kenya, 2002, K'Oyugi and Muita highlighted that older people were not only taking care of children orphaned by AIDS but orphans in general.

Research into the burden of orphan care in Africa is flourishing with studies reporting increases of anxiety (Ssengonzi, 2007), stress (Oburu & Palmerus, 2003, 2005) and financial hardship (Nyambedha et al., 2003b) faced by caregivers. The anxiety reported by elderly caregivers in Uganda was related to their inability to pay for school related expenses, full-time caregiving of younger orphans (below the age of 6 years) and care for children living with HIV/AIDS (Ssengonzi, 2007). This echoed the findings of another study in Uganda, which found elderly caregivers to face the hardship of accumulated costs, both related to time and money (Williams & Tumwekwase,2001).Oburu and Palmerus (2003, 2005) found limited instrumental support and perceptions of children's behavior, and the strategies used to discipline orphaned children, as stressful for elderly orphan caregivers. Also in Kenya, Nyambedha and colleagues (2003) discussed the 'new role' of elderly caregivers based on their finding that elderly caregivers struggle to meet the costs related to schooling, health care and food for orphaned children. They referred to the added responsibilities given to elderly people as a 'lost retirement'. A study commissioned by the Ministry of Gender, Labor and Social Development to analyze the available data in relation to the poor and vulnerable groups, found that 64% of older persons (60 years and above) fell below the poverty datum line. When these older people have to take on the role of providing care to the sick and the orphans, then the burden is really huge. The difficulties faced by older caregivers were articulated at the Madrid Conference on Ageing (2002) that,

> "they have little basic knowledge of HIV/AIDS and its prevention, they are exposed to HIV infection through their caregiving roles and responsibilities, they are often stigmatized as People Living with Aids (PLWAs) or as caregivers of children with AIDS, they

> are poor and lack economic support, they experience physical and emotional stress resulting from the increased level of violence in the family and community, they have difficulty adjusting to the physical and emotional changes associated with ageing in the context of a debilitating illness and older women caregivers tend to have a higher incidence of HIV than older men".

Distinct vulnerabilities of older people as identified by Samuels and Wells (2009) include the increased likelihood of their own compromised state of health – older caregivers are more likely to have chronic illnesses, sensory, physical and cognitive difficulties, the fact that older caregivers are at risk of abuse and neglect and a lack of understanding of the rights and entitlements of older persons. These findings support a study by Roe (1996) which found that,

> "apart from the burdens of care, older carers have special needs that require urgent attention in order to facilitate the performance of their new parenting roles".

UNICEF (2007) reported that older carers have the added strain of being constantly sick and weak as they go about their duties. Their frailty and compromised health creates the potential basis for the energy-sapping additional responsibilities brought about caring for younger children to precipitate the onset of illness. A study conducted by World Vision (2005) found that 37% of older carers succumbed to poor health once they had embarked on giving care.

> "Although many women have been provided with training and are by tradition equipped to provide home-based care, these elderly women are overworked to the point that it undermines their health" (Ankrah 1993; Caldwell et al 1993).

Thus, there is evidence to show that older people are playing important roles in taking care of the sick, the orphans and family members in general. Unfortunately, in the majority of countries in Africa, they perform all these tasks with no support at all and Kenya is not an exception.

2.4 Kitui County:

According to KNBS (2008) before Kitui district was declared a County and its jurisdiction extended, only 48 per cent of children of school going age lived with both parents, while seven per cent of these children were not living with one of their biological parent. Majority of the children who were not orphaned (34%) were living with only their mother although the father was alive. This could have been an indication of children born out of wedlock or increased divorce/separation rate. For those children who were orphaned, nine per cent of the children had lost one parent. The report also shows that children were less likely to live with their fathers if their mother was alive or dead. This implies that women were more likely to be caregivers for children who were orphaned or vulnerable. Overall, about eight per cent of the children were vulnerable in Kitui district. Orphaned and vulnerable children were found in 16% of the households in the district.

HIV/AIDS scourge has in the recent years slowly impeded development in Kitui County. The prevalence rate in the County is 14%, while hospital bed occupancy by such patients in hospitals stand at 40%. Currently, the number of HIV/AIDS orphans is 1450 while the total number of people who have tested positive for HIV is 1,690. Despite over 90 per cent awareness, the scourge continues to rise, and the effects are far reaching. The most

affected age group is between 15 and 49 who constitute the majority of the workforce. Prevalence of the scourge is highest in Kitui and Mutomo Townships because of their proximity to the Kitui-Kibwezi-Mombasa highway. Other urban centres that have high incidence rate include Mutitu, Kabati, Wikililye and Mutonguni (where Mithini belongs). The scourge has contributed significantly to high incidences of poverty. The greatest impact has been on the widows who are left with the heavy burden of caring for their households. This explains the increasing number of female-headed households in the county. The number of Aids orphans has also been on the increase, resulting in a rise in the number of families headed by orphans. Most of the orphans are forced to drop out of school due to lack of school fees. Others become street children as a coping mechanism. A large amount of family resources is used for medication and other forms of care to the infected (www.visitkitui.com).

2.5 Review of International Policies and Frameworks

At international level, there is explicit acknowledgment that the situation of older carers, particularly women, requires specific attention as part of the response to HIV and AIDS. UN member states have committed themselves in a number of documents to understand and address the needs of older people caring for OVC.

2.5.1. The Convention on the Rights of the Child (CRC)

The adoption of the CRC by the United Nations General Assembly in 1989 ushered in a new era for children in its promotion of their rights and well-being, and became an

international framework for guiding programmes for all the children of the world, including OVC.

> "It is underpinned by four cardinal principles: non-discrimination, the best interest of the child, the right to life, survival and development and respect for the views of the child" (UNICEF 1991).

The right to survival addresses the plight of millions of children worldwide who suffer from childhood diseases and HIV and AIDS. These illnesses should now be prevented or treated at low cost to improve child survival, and combined efforts must be made to reduce the child morbidity and mortality rate. The CRC adds that children should be protected not only from disease but all forms of violence and abuse as well. The right to development – physical, mental and emotional – requires that children attend school and perform well in order to reach their full potential. The CRC urges governments to increase educational opportunities for children, who, globally, have little or no access to basic education and literacy. The right to participation requires that all children participate in decision-making and in the processes of initiating and implementing programmes which target them as stakeholders and beneficiaries. Children must, in other words, be the focal point, the unifying concern, for all actions to be taken in their respective countries by national governments, NGOs and those working to address children's needs. Such entities must adopt the principle of 'first call for children' – a principle emphasizing that the essential needs of children be given high priority in resource allocation, irrespective of whether the times are good or bad. The CRC represents a key departure from the traditional welfare-based approach to children's

development and was adopted as the official international framework under which children should expect to enjoy their rights.

Society's role is to promote and respect these rights, while the family is recognized as having the primary responsibility for nurturing and protecting the child from infancy to adolescence.

2.5.2 The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)

CEDAW was adopted by the UN General Assembly in 1979 and ratified in 1981, it can be described as the 'International Bill of Rights for Women'.

> "CEDAW aims to improve women's position in society, and recognizes that discrimination is both widespread and often perpetuated by stereotypes, traditional cultures and religious beliefs detrimental to the development of women young and old."

Therefore the older carers of OVC should not be discriminated against whatsoever.

2.5.3 United Nations General Assembly Special Session (UNGASS 2001)

At a meeting of heads of state and government representatives in 2001, the United Nations General Assembly Special Session (UNGASS 2001) issued the Declaration of Commitment on HIV/AIDS in order to rally urgent global action that would change the course of the epidemic. Articles 65-68 of the declaration focus on children made vulnerable by HIV and AIDS, and UNGASS urged countries to commit themselves to

bringing OVC and older caregivers into the centre of the international, regional and national agendas. Recognizing that families headed by older caregivers needed to be included in policies, it called on world leaders, civil society and the private sector to give paramount attention this and AIDS and support for OVC and older caregivers.

At national level, the Declaration enjoined countries to

> 'ensure the development and implementation of multi-sectorial national strategies and financing plans for combating HIV/ADS' (Article 37).

Inter alia, these strategies were to

> "confront stigma, denial and silence, address gender and age-based dimensions of the epidemic and involve partnerships with civil society and the business sector and the full participation of people living with HIV/AIDS, those in vulnerable groups and people mostly at risk, particularly women and young people" (Article 37).

Articles 65-68 focus on OVC and they also elaborate on national obligations. Countries were to actualize policies and strategies for strengthening governmental, family and community capacity for building a supportive environment for OVC, which would include providing

> 'appropriate counseling and psychosocial support, ensuring their enrolment in school and access to shelter, good nutrition and health and social services on an equal basis with other children, they were also to be protected from 'abuse, violence, exploitation, discrimination, trafficking and loss of inheritance' (Article 65).

The theme of non-discrimination is taken up again in Article 66, but with emphasis lent to a visible policy of de-stigmatization of such children.

Article 68 reiterates the call for galvanized action on policy development, adjustment and implementation and requires the

> 'review of the social and economic impact of HIV/AIDS at all levels of society, especially on women and the elderly, particularly in their role as caregivers, and in families affected by HIV/AIDS, and the addressing of their special needs'.

Countries were to place older caregivers at the centre of their care and support strategies and ensure that adequate resources were available to them for the care of orphans in their households.

2.5.4 Madrid: Second World Assembly on Ageing, 8-12 April 2002

The Madrid World Assembly on Ageing served to further the UNGASS goals that fight HIV/AIDS through care and support of OVC who are under the wing of older carers. Noting that global data often do not reference the impact of HIV/AIDS on the older population, the Assembly set forth a list of the major challenges facing older carers. These challenges, it said, had to be tackled through clear policy guidelines and interventions that promoted the carers' health, enabled them to provide care and engage in development activities, and let them do this without their being discriminated against on the basis of old age.

2.6 Regional Policies and Frameworks

Regional bodies such as the African Union (AU) and Southern African Development Community (SADC) have worked to customize the international frameworks above to the African context, and findings indicate that they are increasingly demonstrating a commitment to the empowerment of children affected by HIV and AIDS. For example, the AU policy framework and plan of action on older people in Africa was drafted in Windhoek, Namibia, in 1999 and ratified at an assembly of heads of state in Durban, South Africa, in 2002, thereby making it binding on all member countries to develop policies for enhancing the quality of life of older carers and their OVC. In addition, in 2008 AU ministers in charge of social development adopted a Social Policy Framework for Africa that recommended the scaling-up of social protection, including income transfers that would mitigate the social and economic effects of HIV and AIDS on OVC. Similarly, SADC has finalized its Strategic Framework on OVC and youth, which provides a template for the development of a minimum package of social protection services that includes psychological support services and support to caregivers of OVC (UNICEF, et al, 2009).

2.7 National Policies and Frameworks

Only a limited number of the country's policies and strategic plans for OVC expressly recognize and seek to support 'older caregivers'. The concern is that if older caregivers are not included in policy and strategic plans in recognition of their key role in protecting and caring for orphaned children, the likelihood exists that they will be excluded from

national budgets as well as sectors where their participation and empowerment are vital to national growth.

Kenya has the National OVC Policy 2003 and National Plan of Action for OVC 2005-06, 2009-20.The policy and plan are located in the Ministry of the Vice President and Home Affairs (MOHA), and the development thereof was financed by UNICEF and USAID through Family Health International. Neither the policy nor the plan includes OVC in the households of older carers. It should be noted, however, that Kenya is one of the few countries so far to have initiated a National Cash Transfer Programme for OVC living in OCG-headed households. The programme targeted 12,500 households at the end of 2007 and was expected to expand to another 70,000 by the end of 2009.In addition to the Sexual Offences Act (2006), Kenya also has the Children's Act, operational since2002. It is said to be the region's most comprehensive legislation for children, and provides the necessary framework for the promotion and protection of child rights. During the development of the national programme guidelines on the Act, wide consultation took place but the participation of children is glaringly absent.

The National Child Labour Policy was expected to be ready in August 2007 (World Vision 2008). Its guidelines were developed under the National Council of Children's Services (NCCS) as well as Area Advisory Councils (AAC) in all districts. The Kenya National AIDS Strategic Plan 2009/10 – 2012/13 and Plan of Action includes several action points to support OVC and older caregivers, including the provision of social protection services to caregivers, conducting a participatory process to help communities

identify and design responses to the impact of HIV, including responses to the needs of the older persons and child-headed households, training at least one support group per community on care for caregivers, conducting at least two community outreach campaigns per year per community to sensitize guardians (which would include caregivers) on the rights of OVC, developing appropriate OVC care programmes and support programmes that reach the elderly and child-headed households, including using community support mechanisms.

2.8 Civil Society, International Aid Agencies and NGO interventions

These are some existing (and strategically advantageous) interventions that have been applied by civil society organizations in respect of the OVC.

2.8.1 The U.S. President's Emergency Plan for AIDS Relief (PEPFAR)

PEPFAR has guiding principles and sound practices that focus on OVC and the family. It emphasizes

> "the interest of the child and his or her family, believing that the needs and context of the children must guide interventions to prevent gender inequality, avoid further degradation of family structures, reduce stigma and avoid social marginalization".

Interventions should not generate jealousy and thereby create conflict in the lives of beneficiaries. It is concerned with the implementation of OVC programmes and prioritizes family/household care believing that the family is generally the optimal environment for the child's development, it supports family capacity, whether the head of

household be an ill or widowed parent, an elderly grandparent or a younger person. It bolsters families and communities on the grounds that both are involved in the raising of children. The emergency plan seeks to support interventions that strengthen the capacities of families and communities to make informed decisions about who needs care and how it should be provided. It strengthens networks and systems, and leverages reproductive health 'wrap-around' programmes and links together HIV/AIDS prevention, treatment, and care and support.

2.8.2 HelpAge International (HAI)

HelpAge works towards enhancing intergenerational relationships and communication between OVC and older caregivers. In collaboration with its partner organizations it develops programmes and advocates for regional and national policies and strategies which enhance intergenerational relationships such as social protection, social pensions and cash transfers, access to income generation schemes, home-based care (including psychosocial support), land inheritance rights for children and older carers, peer education, community support groups to older carers and children under their care, improved shelter and access to health care services.

2.8.3 Save the Children

Save the Children provides economic strengthening for OVC and the households and communities that care for them. It adopts a multispectral approach and ensures open dialogue in its programmes with various target groups, for example, OVC and caregivers. Save the Children provides social assistance, legal services, job creation and business

loans; it also purchases equipment for families affected by HIV and AIDS and encourages family savings designed around the needs and aspirations of OVC and caregivers.

2.9 Kenya Social Protection Review (2012)

Social protection in Kenya is defined as

> "policies and actions, including legislative measures, that enhance the capacity of and opportunities for the poor and vulnerable to improve and sustain their lives, livelihoods, and welfare, that enable income-earners and their dependants to maintain a reasonable level of income through decent work, and that ensure access to affordable healthcare, social security, and social assistance."

There is now broad consensus among policymakers that social protection is a powerful way to fight poverty and promote inclusive growth. This international consensus is most clearly articulated in the African Union's Social Policy Framework (SPF), which was endorsed by all African heads of state in 2009. The SPF explains that social protection includes

> "social security measures and furthering income security; and also the pursuit of an integrated policy approach that has a strong developmental focus, such as job creation..."

There is growing interest across Africa in safety nets as a means of providing predictable social assistance to poor and vulnerable populations. The most popular safety nets are amongst them social cash transfers and public works.

2.9.1 Cash Transfer Programme for Orphans and Vulnerable Children

The CT-OVC Programme is a government initiative supporting very poor households that take care of orphans and vulnerable children to enable them take care of those children and help them to grow up in a family setting. The main goal of the CT-OVC programme is to strengthen the capacity of poor households to protect and care for orphans and vulnerable children to ensure these OVC receive basic care within families and communities. Specifically, the Programme seeks to provide regular and predictable cash transfers to households living with OVC to encourage fostering and retention of the OVC within families, improve civil registration of guardians/caregivers and OVC, promote human capital development among OVC and enhance guardians' knowledge on appropriate care for OVC.

The population of OVC has steadily grown at an alarming rate in the recent past largely due to the HIV/AIDS pandemic. In 2004 the number of orphans in the country was estimated at 1.8 million. Since then the number has steadily grown to the current 2.4 million. Most of these children lack access to basic needs due to high levels of poverty. In view of 46% of Kenyans living below poverty line with children accounting for 19 %, the OVC are more prone to different forms of abuse and exploitation due to their vulnerable circumstances. Programme beneficiary households are identified and selected through an elaborate community-based selection process. To qualify for selection and enrolment, a household has to meet a selection criteria that includes being very poor, taking care of an orphan or vulnerable children under the age of 18 years and not receiving cash assistance from any other Programme. The process begins with the sensitization of the community on the nature, operational procedures and benefits of the Programme. The role of the

community in the selection of the beneficiaries is clearly articulated to enable community members participate effectively in the selection process and general delivery of the Programme. Community members in the selected geographical area are sensitized through chief's barazas, community sensitization meetings and chief's barazas (meetings).The programme is currently implemented in 60 districts supporting 102,000 households and benefiting 375,000 orphans and vulnerable children. It was envisaged that by 2012 the coverage will have grown to 150,000 households that will translate to benefiting 525,000 OVC.

The Programme implementation is coordinated by an OVC Secretariat housed in the Department of Children Services in the Ministry of Gender, Children and Social Development. The process is managed through a series of committees at the national, district and community levels and their roles are clearly defined in the Operational Manual that serves as the programme reference document. The Manual defines the structure of the Programme and procedures and processes to be followed in the implementation process. At the national level there is a national steering committee that provides policy guidelines while the district Area Advisory Committee (AAC) manages the community level implementation with the assistance of a location orphans and vulnerable committee (LOC) at the community level. The membership of the national steering committee comprises of policy makers drawn from other relevant line ministries and national offices of development partners. The LOC members are the regular agents of the Programme that the beneficiaries interact with.

The care givers and guardians are required to fulfill their roles and responsibilities to ensure effective programme delivery at the household level. The performance of these

roles and responsibilities ensures that the children enjoy the full benefits of the programme. These roles include ensuring OVC aged 0-5 years are taken for immunization and growth monitoring; OVC aged 6-17 regularly attend basic education; OVC acquire birth certificates; Care givers attend awareness sessions. Enrolled caregivers receive a cash payment of KSH. 1,500/= per month paid every two months through the Post Office and district treasury. The programme is financed by the Government of Kenya with support from development partners that include World Bank, UNICEF and DFID (IDA).

2.9.2 Cash Transfer Programme for Older Persons/Persons with Disabilities:

This is a programme started by the government of Kenya. The overall goal of the programme is to reduce poverty, vulnerability and deprivation, while promoting equity and social justice. According to GoK, 2008, it is to promote immediate relief to the vulnerable persons (Older Persons and Persons with Disabilities) from extreme poverty while enhancing their basic rights. The programme which was started in 2006 is fully GoK funded and the transfer rate is $15 per household per month. The pilot programme is implemented in 2 districts in Kenya, Thika and Nyando. The criteria of selection is for those above 70 years of age, those having a form of severe disability, extremely poor, those taking care of orphans (grandchildren), the HIV/ AIDS infected (severely ill) and other community indicators. The disbursement is done by the local chiefs to identified clients.

This programme has not been replicated to other areas thus the coverage is small with high demand due to the poverty level in the population.

2.10 THEORETICAL FRAMEWORK

There are several theories that can be used to explain coping strategies of older persons in the provision of care to OVC. Some of the theories instrumental in the study are Role Theory, Empowerment Theory and Developmental Approach Theory.

2.10.1 Role Theory

Role theory is a perspective in sociology and in social psychology that considers most of everyday activity to be the acting out of socially defined categories (e.g., mother, manager, teacher). Each social role is a set of rights, duties, expectations, norms and behaviors that a person has to face and fulfill. The model is based on the observation that people behave in a predictable way, and that an individual's behavior is context specific, based on social position and other factors.

The actors in this study are the caregivers and the OVC who when observed are likely to behave in a certain way. These are the names labeled on them according to their situations and hence they will play the roles as defined by their categories and by the society.

2.10.2Empowerment Theory

Empowerment refers to a process by which people are given power that enables them to be responsible and 'take charge' of their adverse conditions (Gray and van Rooyen, 2002). It can be defined as a process by which individuals, families, groups and communities are assisted in order to increase their personal, interpersonal, socio-

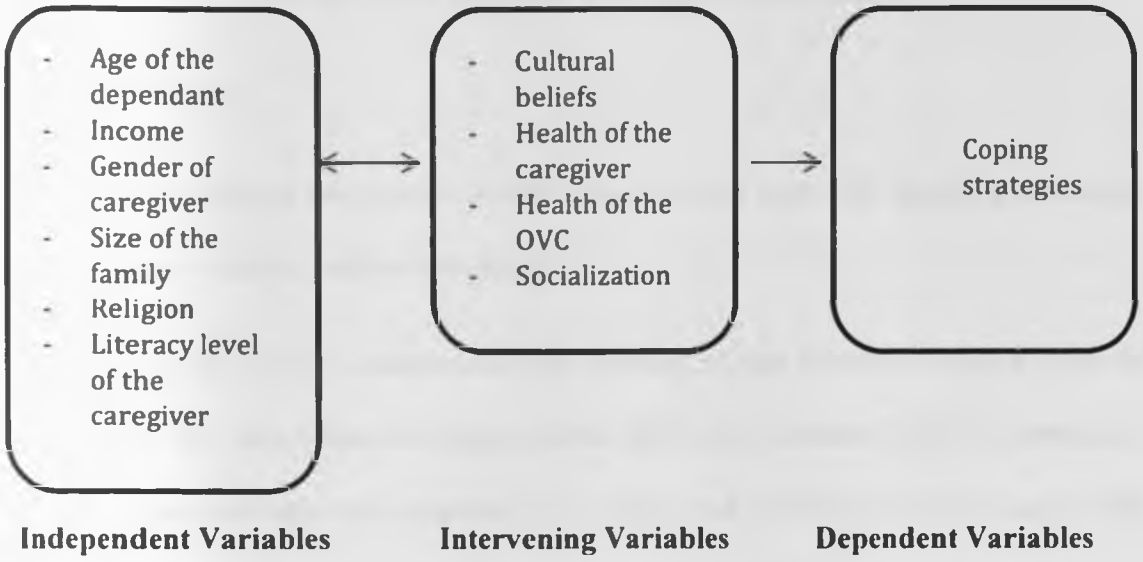
economic strength and enhance their capacity to improve their circumstances and to shape their destiny. For people to be empowered, their abilities, knowledge and skills must be expanded through capacity building. Gray (1997) is of the opinion that empowerment and capacity building are two components that are significant for professional intervention. These components are the main characteristics of developmental approach in the sense that people's potential is recognized and nurtured through empowerment and capacity building.

In this study, if the older carers are recognized by the society and the government amongst other stakeholders and given power through provision of resources for their survival then they could possibly take charge of their conditions.

2.11 Conceptual Framework

Conceptual framework (Mugenda & Mugenda, 2003) is defined as a set of broad ideas and principles taken from relevant fields of enquiry and used to structure a subsequent presentation. It is a hypothesized model identifying the module under study and the relationship between the dependent and independent variables. Such a framework is intended as a starting point of reflection about the research and its context. When the conceptual framework is clearly articulated, it has potential usefulness as a tool to support research and therefore assist the researcher to make meaning of subsequent findings.

FIGURE 1: CONCEPTUAL FRAMEWORK



2.12 Summary

This chapter has reviewed the literature on the strategies used by older persons in the provision of care to orphaned and vulnerable children. There is a lot of information about the numbers of OVC and their growth and the challenges they face. Though there is some review on older carers, little is available and especially within the Kenyan context, therefore little is said about their strategies. The chapter has also presented a conceptual framework to enable the study, exploration and identification of strategies employed by older carers in provision of care to orphaned and vulnerable children.

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

3.1 Introduction

This section explains the research design chosen for the study, the sampling techniques and the data collection methods employed.

Research design can be understood as the planning of any scientific research from the first to the last step (Bless & Higson-Smith 1995: 63). Mouton (2001:55) provides a closely related definition by comparing it to a house plan which explains how one intends to build the house from the first to the last step. Orodho (2003) defines it as a scheme, outline or plan that is used to generate answers to research questions.

In this study, both qualitative and quantitative approach were adopted. De Vos, Strydom, Fouche and Delport (2005: 268), explain qualitative research as a social interaction that allows the researcher to study the participants in detail thus interpreting the meanings they attach to their lives. By using a qualitative approach the researcher was able to collect information on how participants think, feel and act, as well as what they believe. Quantitative approach is conclusive in its purpose as it tries to quantify the problem and understand how prevalent it is by looking for projectable results to a larger population. In this research the researcher found out whether there was consensus in any particular issue. Therefore the design of this research was exploratory- descriptive. The study was firstly explorative because the researcher sought to gain insight into the role and coping strategies of older women as carers of orphaned and vulnerable children and the impact in the context of the HIV epidemic. De Vos et al. (2005) describe the aims of exploratory

research as establishing the facts, gathering new data and determining whether there are interesting patterns in the data. The advantage of using exploratory research was that it made initial work with the research data effective, while according to Bless and Higson-Smith (1995:154) the primary aim of descriptive research is to describe (rather than explain) a particular phenomenon. According to Orodho and Kombo (2002) descriptive research can be used when collecting information about people's attitudes, opinions, habits or any other variety of education or social issues.

While acknowledging the strengths and weaknesses of each approach, there was a further reason for choosing mixed-methods of qualitative and quantitative techniques for this study. They were chosen to benefit from the strengths of each other and to minimize the weaknesses inherent in applying them individually. Drawing on experiences in the field of poverty studies, Carvalho and White (1997) have argued that the quantitative approach to problem measurement and analysis typically uses random sample surveys and structured interviews for data collection (mainly, quantifiable data) and analyses it using statistical techniques. By contrast, the qualitative approach typically used purposive sampling and semi-structured or interactive interviews to collect data- mainly data relating to people's judgments, attitudes, preferences, priorities, and/or perceptions about a subject- and analyses it through sociological or anthropological research techniques.

In general terms, quantitative approaches are renowned for having breath, and qualitative approaches for having depth. The key was to combine the breath of one and the depth of another to gain from the strength of the synergy they create and to minimize their weaknesses through integrating the quantitative and qualitative data methodologies, examining, explaining, confirming, refuting, and/or enriching information from one

approach with that from the other and merging the findings from the two approaches into one set of recommendations (Carvalho and White, 1997)

3.2 Site Description

Kitui County is an administrative county in the Eastern Province of Kenya. The county has a population of 1,012,709 (2009 census) and an area of 20,402 km² with 10 administrative divisions, 57 locations and 187 sub locations. Kitui County has approximately 205,491 households, with a density of 33 persons per square kilometer (km²) and a poverty rate of 63.5% (CRA, 2011). The climate is semi-arid; it receives roughly 71 cm (28 inches) of rainfall which occurs practically only during the rainy seasons. The annual rainfall ranges between 500-1050mm with 40% reliability. The long rains come in April/May and short rains in November/December. The topography of the landscape influences the amount of rainfall received. The high land areas receive between 500-760mm of rainfall per year, hilly area receive 500-1050mm per year, while the drier eastern and southern areas receive less than 500mm.Kitui Town is hot, minimum mean annual temperature vary from 14 to 22°C and the maximum mean annual temperatures range from 26 to 34°C. The vast majority of the economy is based on subsistence farming, despite the fact that the agriculture is an extremely challenging endeavor giving the sporadic rainfall.

Kitui County has 606 Primary Schools scattered all over the vast county and resulting to long distances between schools. The teachers' pupil ratio is quite low at 1:40. The Primary school going population aged 6-13 years representing 27% of the total population. There is a very low transition from Primary to Secondary Schools. There are

some private secondary schools in the area. In addition there are several new schools for higher education: A branch of Nairobi University (SEUCO), Medical school (KMTC), Kitui Teachers Training College, Kenya Water Institute (KEWI) and the Kenyatta University has also established a campus (Kitui campus) in the town.

It has 92 health facilities most of which are found in central and Kabati divisions. Most of the facilities lack the necessary equipment and personnel to enable to provide quality service to the people. The average distance to the nearest facility is 5 Km. The most prevalent diseases are malaria, respiratory infections, diarrhea, skin diseases and eye infections. The doctor/patient ratio is 1:16,047. Life expectancy level in the county is 51 years, which is below the national average.

HIV/AIDS scourge has in the recent years slowly impeded development in the county. The prevalence rate in the county is 14%, while hospital bed occupancy by such patients in hospitals stands at 40%. Currently, the number of HIV/AIDS orphans is 1450 while the total number of people who have tested positive for HIV is 1,690. Despite over 90% awareness, the scourge continues to rise, and the effects are far reaching. The most affected age group is between 15 and 49 who constitute the majority of the workforce. Prevalence of the scourge is highest in Kitui and Mutomo Townships because of their proximity to the Kitui-Kibwezi-Mombasa highway. Other urban centres that have high incidence rate include Mutitu, Kabati, Wikililye and Mutonguni. The scourge has contributed significantly to high incidences of poverty. The greatest impact has been on the widows who are left with the heavy burden of caring for their households. The number of Aids orphans has also been on the increase, resulting in a rise in the number of families headed by orphans. Most of the orphans are forced to drop out of school due to

lack of school fees. Others become street children as a coping mechanism. A large amount of family resources is used for medication and other forms of care to the infected.

Mutonguni Location is one of the administrative areas in Kitui county situated at the western side of the county. It is in the hilly side and receives around 500-1050mm rainfall per year. It had a population of 34, 140 (2009 census) but it has since been subdivided into three smaller Locations in 2011, that is, Mithini Location, Musengo Location and Mutonguni Location. Mutonguni Location is served by three main hospitals and has several primary schools with an average distance of 5 km. HIV prevalence is high considering that it is along Mombasa-Kitui-Mwingi-Garissa highway.

According to Kenya National Bureau of Statistics (KNBS), the percentage distribution of the household population by age groups (KNBS, 2008) aged 60 years and above was 8% female and 6.7% male.

3.3 Unit of Observation

Older persons taking care of OVC were the unit of observation in this study.

3.4 Unit of Analysis

Schutt (1996) defines a unit of analysis of a study as the level of social life on which research questions focus. Singleton (1998) defines unit of analysis as the entity under study and could include people, social roles or positions and relations. The study was to look at the coping mechanisms of older persons taking care of OVC in Mithini Location of Kitui County.

3.5 Target Population

The study targeted older persons taking care of OVC. The older person were 60 years and above and the OVC in consideration were below 18 years. Older persons below 60 years were excluded from this study.

3.6 Sampling Procedure

3.6.1 Sampling Size and Sampling Criteria

A total of 50 household heads were selected to generate representative sample at the locational level and the sample selection aimed at ensuring that the spectrum of respondents were as representative of the population as possible. The sampling procedure was multi stage, that is, the sampling was done in stages.

(i) Stage I – Purposive Sampling

In the first stage Purposive Sampling was used. Purposive Sampling methods is based on some pre-determined characteristic where the researcher selects the sample subjectively based on this characteristic (Patton, 1990). In this study, the sampling unit was older persons aged above 60 years providing care to OVC. These were identified with the assistance of the chief, a member of a CBO and a CHW. The research was not able to attain the target of 50 through this process and therefore the researcher proceeded with the next step. Consequently, Snowball Sampling technique was used in order to reach our target sample of 50 older persons providing care to OVC.

(ii) Stage II – Snowball Sampling

The second stage involved snowball sampling. The identified sample with required characteristics identified with the help of the chief and the volunteer HIV/Aids care providers were requested to give names of others with similar attributes or characteristics. The researcher then endeavored to locate the households through the help of the village elder until the desired target sample of 50 respondents with required attributes was attained.

3.7 Data Collection

3.7.1 Methods and Tools of Data Collection

The methods of data collection used in the study included:

3.7.1.1 Secondary Data

Secondary data was collected by reading, analyzing, collating and recording data contained in readily prepared materials such as private and public statistical records, magazines, documents, books, newspapers and journal.

3.7.1.2 Survey

The research used questionnaire for data collection. According to Mugenda and Mugenda (1999) questionnaires have advantage as a tool of data collection since they are easy to analyze and can be structured in a way to collect the specific information. Questionnaires were used with both open ended and closed ended questions which were read out to the responded by the interviewer as the interviewer recorded responses. A total of 49 respondents were interviewed. One of the respondents was not willing to be interviewed.

3.7.1.3 Key Informants

The other method of data collection was key informants (KI). KI technique is a qualitative research method. KI are persons with knowledge, skills and experience and as a result of their personal skills or position within a society are able to provide more information and a deeper insight into what is going on around them. An advantage of the KI technique is the quality of data that can be obtained in a relatively short period of time compared to the same amount of information and insight from in-depth interviews with other members of a community which can be prohibitively time-consuming and expensive (Lincoln, 1985.). The KI were interviewed using KI guides. This study targeted6 KI in the community who were knowledgeable and held a position of authority in the community and included the chief, Community Health Worker, two teachers, a children's officer and a member of a community-based organization.

3.7.1.4 Direct observation method

Direct Observation method were used to provide information about actual behavior (Kombo and Tromp, 2006) as well as collecting data on general aspects such as the home condition and the physical presentation of the respondent. The researcher had an observation checklist which was filled in each visit to a respondent's household. The checklist is attached as an annex.

3.8 Data Processing and Analysis

Quantitative data were entered into a computer by use of Statistical Package for Social Scientists (SPSS). It was then presented in a form of tables for percentages, frequency

distribution and in form of descriptive statistics to make deductions and inferences. Qualitative data that included an in-depth interview / key informant data was summarized on the basis of major themes and patterns of responses that emerged across various respondents on each question. Data was then interpreted and a report written. The findings were merged with qualitative ones to form the final findings.

3.9 Ethical Considerations

It is of the outmost importance that one complies with professional ethics when conducting research. Strydom (2002: 24) defines ethics as a set of moral principles which is suggested by an individual or group, and is widely accepted and offers rules and behavior that is expected about the correct conduct towards the respondents. In this study informed consent, confidentiality and voluntary participation were adhered to.

3.9.1 Informed consent

Informed consent involves informing participants about the purpose of the study, risks and benefits that may be associated with participation in the study (Williams, Tutty, & Grinnell (1995: 30). Caregivers were informed of the purpose of the study and the possible benefits from the study like recommending on outcomes to the policy makers which could eventually influence policy making. Most respondents wanted to know whether this research would influence their support in any way may it be financial or material and the researcher clarified that. After ensuring clear understanding by the respondent they were given a consent form to sign after which the interview commenced.

Out of the 50 targeted respondents, 98% respondents participated in it while 2% of the respondents declined to participate.

3.9.2 Voluntary participation

Bless & Higson-Smith (1995:102) maintain that people should not be forced to participate in a research study and they have a right to refuse to participate. The right to privacy demands that direct consent for participation be obtained from people. In this study, the researchers explained to the respondents of their rights to either accept or not to accept being interviewed and were not obliged to answer any questions that they felt uncomfortable with. Consent for the participants' participation was obtained from the primary care giver or legal guardian (a consent form is attached as Appendix).

3.9.3 Confidentiality

The researcher assured the participants that whatever information given would be treated with confidentiality. That is, they were assured that the collected data would be only used for the stated purpose of the research study and that no other person would have access to the given information. Assuring the participants that information would be kept confidential resulted in the participants giving honest and complete information. In this study interviews were conducted at a place of care of the respondents' convenience. After the study was completed all transcripts were destroyed.

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION AND INTERPRETATION

4.1 Introduction

This section presents the analyzed information using Statistical Package for the Social Sciences (SPSS) as indicated in the methodology section. It gives the findings from the interview schedules and other observations that were encountered during the fieldwork.

4.2 Descriptive presentation of data

4.2.1 Care Providers Profile

4.2.1.1 Older Carers Gender

Although the target was 50, a total of 49 respondents were interviewed in this study from twelve administrative villages of Mithini Location namely Ithunzuni 12%, kitamwiki 4%, Kiatine 33%, Kololo 4%, Kyambolo 4%, Kyathumbi 12%, Mangeini 10%, Mithini 2%, Mtetembu 4%, Nguuni 2%, Utoo 2%, and Yenyaa 10%. These included 49% (n=24) female and 51% (n=25) male as indicated in table 4.1.

Table 4.1: Gender of Respondents

Sex	Frequency (n = 49)	Percent (%)
Male	25	51.0
Female	24	49.0
Total	**49**	**100.0**

4.2.1.2 Respondents' village

Table 4.2. indicates that the majority (32.7%) of the respondents came from Kiatine village, followed by 12.2% from Kyathumbi. The villages with least number of respondents were; Nguuni 2.0%, Utoo 2.0% and Mithini 2.0%. This shows that the carers are not evenly distributed. Kiatine is one of the villages near the local shopping centre which is along the busy Mombasa-Kitui-Mwingi-Garissa highway and this could have effect as it operates as a stopover hence could be a centre for HIV/Aids infections.

Table 4.2: Respondents' Village of residence

Village	Frequency (n = 49)	Percent (%)
Ithunzuni	6	12.2
Kitamwiki	2	4.1
Kiatine	16	32.7
Kololo	2	4.1
Kyambolo	2	4.1
Kyathumbi	6	12.2
Mangeini	5	10.2
Mithini	1	2.0
Mtelembu	2	4.1
Nguuni	1	2.0
Utoo	1	2.0
Yenyaa	5	10.2
Total	**49**	**100.0**

4.2.1.3 Marital status of the respondents

Table 4.3 revealed that the majority of the respondents (51.0%) were widowed; this was followed by those who were married (40.8%).Those who were single and those who were divorced accounted for 4.1% in each case. Despite the fact that a good percentage of the

respondents were married, the study indicates that the respondents' spouses may not have been contributing much to the household income.

Table 4.3: Marital status of the respondents

Sex	Frequency (n=49)	Percent (%)
Widowed	25	51.0
Married	20	40.8
Divorced	2	4.1
Single	2	4.1
Total	**49**	**100.0**

4.2.1.4 Religion of the respondents

People's ability to care for others are sometimes determined by their religious affiliations among other factors. All of the caregivers interviewed were members of a religious sect and theyfrequently acknowledged their belief and trust in God to improve their situation. The majority of the elderly carers were Christians (93.9%) as indicated in table 4.4. This may have contributed to the bringing out of clear understanding of the respondents source of inspiration as they take care of the OVC.

Table 4.4: Religion of the respondents

Sex	Frequency(n=49)	Percent (%)
Christian	46	93.9
Islam	3	6.1
Total	**49**	**100.0**

4.2.1.5 Education level of the respondents

Level of education is by all means the basis for choice of subsequent gainful economic activities in modern world. The study investigated the levels of education of the respondents in order to match the level of education with the application of skills acquired. The majority of the respondents (67.3%) were illiterate. The least were those who had completed college education (4.1%). The data in Table 4.5 revealed that the majority of the elderly carers living in Mithini Location were illiterate. On further enquiry from the KI, it was stated that during most of the older carers growing up time their parents never valued education and therefore never went to school and they did not embrace the adult education introduced by the goverment later in life possibly due to culture. This could be one of the reasons why their earning is too low.Their sources of income/businesses are not yielding much and therefore has not contributed to economic development of the area.

Table 4.5: Education level of the respondents

Sex	Frequency (n=49)	Percent (%)
Primary	11	22.4
Secondary	3	6.1
College	2	4.1
None	33	67.3
Total	**49**	**100.0**

4.2.1.6 Occupation of the respondents

Among the elderly OVC carers interviewed, farming was the principal activity for 87.8% (n=43) respondents out of the 49 respondents. This was followed by 2.0% of the respondents who were involved in formal employment and pensioners in each case . Otherwise 6.1% indicated that they had no occupation. This is represented as shown in

Table 4.6.The fact that only one person was a pensioner may indicate that respondents are less likely to have been involved in formal sector to receive a pension or access business opportunities.

Table 4.6: Occupation of the respondents

Sex	Frequency (n=49)	Percent (%)
Formal employment	1	2.0
Farmers	43	87.8
Pensioner	1	2.0
None	3	6.1
Other	1	2.0
Total	**49**	**100.0**

4.2.1.7 Monthly earnings from the main occupation

Table 4.7 indicates that most of the respondents were earning below 2,000 (59.2%) followed by those who had a monthly earning of Ksh 2,000 – 5,000 (24.5%). Only 8.2% were earning between 5,000 – 10,000. The remaining 2.0% indicated that they were earning above 10,000 shillings per month. This was a mean of KSh 2521.80 (SD 0.753). This implies that the earnings from the type of their occupations may not vary and hence the difference between their net earnings is very little. Large numbers of older people simply do not have the resources to cover the cost of bringing up several grandchildren and meeting their own needs. The low income is an indicator of the carers' restricted access to basic needs due to lack of economic means.

Table 4.7: Respondents' Monthly earnings from their main occupation

Sex	Frequency (n=49)	Percent (%)
Below 2,000	29	59.2
2.000 – 5,000	12	24.5
5,000 – 10,000	4	8.2
Above 10,000	1	2.0
None Response	3	6.1
Total	**49**	**100.0**

4.2.1.8 Alternative Sources of income

Table 4.8 revealed that most of the respondents were mainly dependant on only one source of income which in most case was farming. When asked about other income sources besides their main occupation, the majority (67.3%) of the respondents had no other alternative source of income. Only 32.7% of the respondents indicated that they had an alternative source of income. The fact that there were respondents with other alternative sources of income may be a coping strategyemployed by the old carers in order to supplement their income to meet the needs of the additional members of their households.

Table 4.8: Alternative Sources of income

Sex	Frequency(n=49)	Percent (%)
Yes	16	32.7
No	33	67.3
Total	**49**	**100.0**

4.2.1.9 Identified alternative Sources of income

Table 4.9 indicates that the majority of the respondents who had indicated that they had alternative sources of income (n=16) mentioned business as their alternative source (50.0%) followed by 37.4% who mentioned their children's remitances as their

alternative source. The least were those who mentioned that their children worked as casual labourers and those who mentioned that they got supprot from churches as their alternetive source (both at 6.3%).

Table 4.9: Identified alternative Sources of income

Sex	Frequency(n=16)	Percent (%)
Business	8	50.0
My children	6	37.4
Children work as casuals	1	6.3
Church	1	6.3
Total	**16**	**100**

4.2.1.10 Earnings from alternative Sources of income

According to this study as indicated in Table 4.10 those who earned from alternative sources,the majority of the respondents (75.0%) earned between ksh 2,000 – 5,000 followed by those who earned below 2,000 (25.0%). Otherwise the remaining 11.1% indicated that they earned between 5,000 – 10,000 with a mean of 3388.90 (S.D 0.532). That is, most of the respondents were earning an average of KES 3388.90. this compared to their needs was minimal and could hardly change their poverty status.

Table 4.10: Analysis of the earnings from alternative Sources of income

Amount earned	Frequency (n=16)	Percent (%)
Below 2,000	4	25.0
2,000 – 5,000	12	75.0
5,000 – 10,000	1	11.1
Total	**16**	**100.0**

4.2.1.11 Respondents running businesses

Business forms a good avenue for income as it brings the poor into the marketplace which is a criutical step on the path out of poverty by expanding people's opportunities to lead the kind of lives they value. Table 4.11 indicates that the majority (83.7%) of the repondents were not involved in businesses only 16.3% indicated that they had been running businesses.

Table 4.11: Respondents running businesses

Sex	Frequency (n=49)	Percent (%)
Yes	8	16.3
No	41	83.7
Total	**49**	**100.0**

4.2.1.12 The types of businesses run by the respondents

Of those who had indicated that they were running businesses , 42.9% indicated that they were shopkeepers, equal proportion wereinvolved in transport (Bodaboda/matatu). The remaining 14.2% were involved in business of buying and selling of cows as indicated in Table 4.12. One respondent did not respond to this question. On further enquiry, the researcher noted that, majority of the respondents (42.9%) earned between KES 5,000 – 10,000 per month. This could be a coping mechanism to meet the demands of the extra members of the family.

Table 4.12: The types of businesses run by the respondents

Amount earned	Frequency (n=7)	Percent (%)
Bodaboda/matatu	3	42.9
Buying and selling of cows	1	14.2
Shopkeeper	3	42.9
No response	1	14.2
Total	**7**	**100.0**

4.2.1.13 Asset Ownership

Ownership of assets is very vital in describing the basic livelihoods of a household. This can be used to establish the prevailing livelihood gaps/status of the households. In this particular study, this variable was used to identify the trends or livelihood standards of the respondents households.Table 4.13 indicates that the majority (85.7%) of the respondents owned assets. Those who indicated that they did not own any asset accounted for 12.2%. The remaining 2.0% (n=1) respondents did not respond to this question possibly because they were not ready to disclose their assets fearing that this would limit the kind of assistance they could get from the researcher which was a false perception. All the respondents (85.7%) owned land while others owned varied other items like cattle, bycycle, motorbike, matatu and a posho mill. This contradicted the observation by the researcher where most families had a few goats and chicken. It is possible that they did not consider this as assets. Ownership of assets is very vital in describing the basic livelihoods of a household. In this particular study, this variable was used to identify the trends or livelihood standards of the beneficiary households. This study shows that the households are generally asset poor.

Table 4.13: Respondents by asset ownership

Ownership of Assets	Frequency (n=49)	Percent (%)
Yes	42	85.7
No	6	12.2
No Response	1	2.0
Total	**49**	**100.0**

4.2.1.14 Earning income from the owned asset

Household assets are vital as they can be sold in case of emergency to mitigate against negative impact on the households livelihoods. Table 4.14 indicates that 35.7% of the respondents who had indicated that they owned asset got atleast some kind of income from the asset, most of them (46.7%) indicating that they earned between KES 2,000 – 5,000. The majority (54.8%) of the respondents indicated that they did not get any income from their assets. Four of the respondents did not answer this questions.

Table4.14: Respondents who get income from their assets

Earning from Assets	Frequency(n=42)	Percent (%)
Yes	15	35.7
No	23	54.8
No Response	4	9.5
Total	**42**	**100.0**

4.2.1.15 Respondents' Control over available income.

Common parameters used for establishing level of access to opportunities that may be used to determine the well being of a household range from sources of income to control of the available income. This study sought to establish whether the respondents were in control of their income. Table 4.15 indicates that the majority of the respondents (89.8%) had control over the income. Only 6.1% indicated that they had no control over

resources stating that their income was either controlled by their spouses or children. This collaborates the information from KI and observation by the researcher that some of the carers were too old to manage the OVC effectively. Two carers did not respond to this question.

Table 4.15:Respondents' control over available income

Control of income	Frequency(n=49)	Percent (%)
Yes	44	89.8
No	3	6.1
No Response	2	4.1
Total	**49**	**100.0**

4.2.1.16 Use of Income

Earning income is considered as important as how the income earned is utilized. The respondents were therefore asked to mention the uses to which they put most of their income . Table 4.16 indicates that all the respondents used their income to meet at least one basic need and at most four of which most used in buying clothes for themselves 63.2%. followed by buying food 59.2%. This implies that the greater share of the income is devoted to meeting the basic needs of the respondents which may be an indicator of high level of vulnerability of the household to food and nutritional insecurity. Here the respondents could give more than one answer.

Table 4.16: Respondents' Use of Income

Use	Frequency (n=49)	Percent (%)
Pay school fees	n=25	51.0
Buy clothes for myself	n=31	63.2
Buy clothes for the OVC	n=17	34.7
Buy food	n=29	59.2
Other	n=5	10.2

4.2.2 Circumstances that Lead to Older People to Assuming the Role of Care givers to OVC

4.2.2.1 OVC details

The 49 respondents' households had a total 165 OVC under their care who were all dependants with an average of 3.37 (std = 0.543) OVC per carer's household as shown in Table 4.17, that is, each household had an average of three OVC. This suggests that the income of old carers need to be huge to improve their livelihoods or dependents need to generate income from others.Education is the best inheritance a parent/guardian needs to give a child in modern world. The study delved to know whether the OVC were in school and their level of education. The majority of the OVC under the care of the respondents n=114 (69.1%) were in school while the remaining 30.9% were not in school. Out of those who were in school, majority (20.6%) were between class 2-4, followed by those who were between Form 1 - 4 at 12.7%, and the least the least were those OVC who were in colleges (5.5%). This indicates that most of the OVC were of young age and needed alot of attention and care from their carers which would translate to increased responsibility.

Table 4.17: OVC's level of education

Level	Frequency (n=165)	Percent (%)
Class 0-1	15	9.1
Class 2-4	34	20.6
Class 4 - 6	18	10.9
Class 7 - 8	18	10.9
Form 1 - 4	21	12.7
College	8	5.5
Out of school	51	30.9
Total	**165**	**100.0**

4.2.2.2 OVC Status

Table 4.18 indicates that the majority (46.9%)of the OVC under the old carers were total orphans (child lost both parents), followed by maternal orphans (child lost its mother) at 36.8%. The least were the social orphan (child vulnerable to poverty and parental illness) at 4.1%. Respondents were further asked about the cause of the OVC parents' death and they indicated that the majority of the parents died from HIV related sicknesses (75.5%). Other causes of death were natural death and accident related complications as indicated in Table 4.19. One respondent (2.0%) did not know what was the cause of the OVC parent's death as indicated in Table 4.26.

Table 4.18: OVC Status

Status	Frequency (n=165)	Percent (%)
Paternal orphan (child lost its father)	20	12.2
Total orphan (child lost both parents)	77	46.9
Social orphan (child vulnerable to poverty and parental illness)	8	4.1
Maternal orphan (child lost its mother)	60	36.8
Total	**165**	**100.0**

Table 4.19: Cause of death of OVC Parent(s)

Cause of death	Frequency (n=49)	Percent (%)
HIV	37	75.5
Accident	3	6.1
Natural	4	8.2
Others	4	8.2
No response	1	2.0
Total	**49**	**100.0**

4.2.2.3 Independent children contribution on their carers' upkeep

The study furthe investigated whether there were independent OVC and whether they contributed to their carer's upkeep.Table 4.20 reveals that only 16.3% (n=8) of the carers had atleast one independent OVC under their care. Out of the eight households who had an independent OVC, only 37.5% contributed to their upkeep while the remaining 62.5% did not contribute to their carers' upkeep. This could have been due to the indiscipline of OVC sighted by one of the KI. Among the respondents who indicated that the OVC contribute (n=3), majority (66.7%) indicated that they contributed in the buying of the family food while the remaining indicated that they helped in the farm. The contribution by OVC was a way of helping the household to cope with provision of food.

Table 4.20: Independent children contribution on their carers' upkeep

Contribution	Frequency (n=8)	Percent (%)
Yes	3	37.5
No	5	62.5
Total	**8**	**100.0**

4.2.2.4 Problems experienced by carers in the course of care provision

Asked whether they experienced any problems in the provision of care for OVC, most of the respondents (81.6%) indicated that they experienced problems and only a small number of the respondents (10.2%) indicated that they did not experience any problems as indicated in Table 4.21. on further investigation, majority of the respondents (55.7%) identified health as their main problem followed by indiscipline at 25.0%. Other problems included peer influence and lack of school fees. Four of the respondents (8.2%) chose not to answer this question echoing one of the KI responses that some of the carers

might fail to respond to some of the questions fearing they would appear as not loving the OVC under their care.

Table 4.21: Problems experienced by carers in the course of care provision

Any problem	Frequency (n=49)	Percent (%)
Yes	40	81.6
No	5	10.2
No Response	4	8.2
Total	**49**	**100.0**

4.2.2.5 Kind of health problems experienced by OVC

Health plays a major role in determining the welfare within a household. The study deliberately probed if any OVC taken care of by these respondents had any illnesses that interfered with their daily routines. Table 4.22 revealed that a significant percentage of the OVC (34.7%) experienced HIV related health problems possibly because most of the parents died of HIV related illnesses. This was followed by those who experienced malnutrition at 4.1% due to lack of food because of poverty as observed in most of the households and also stated by all the KI. The remaining respondents (26.5%) identified other types of illnesses such as Tuberclosis, Eye infections and Headache among other illnesses. However, out ot the 49 respondents, 30.6% (n=15)of the respondents were not confortable with this question and decided not to answer it. This could have been due to fear of stigmatization especially where some of the OVC had HIV related illnesses. However, when asked whether they sought medical treatment and what type of treatment, majority of them (83.9%) indicated that they sought medical attention and modern type of treatment (96.8%).

This is clear that despite the low income levels, majority of the respondent preferred modern treament to traditional treatment. This may be an indicator of high health awareness levels among this age group - it's significant to be noted. However, most of them (67.6%) accessed the treatment free of charge. Its important to note that majority of the respondents' medicare needs are sponsored possibly because most of them had HIV related illness which is subsidized by the governement. This may also be the reason why the majority of the respondents accessed modern treatment compared to those who acccessed traditional treatment.

Table 4.22: Kind of health problems experienced by OVC

Health Problem	Frequency (n=49)	Percent (%)
HIV	17	34.7
Malnutrition	2	4.1
Asthma	1	2.0
Other	13	26.5
All	1	2.0
No Response	15	30.6
Total	**49**	**100.0**

4.2.2.6 Effects of OVC illness on carers daily operations

Most of the respondents indicated that illness of OVC inhibited their daily operations as they had to take time to take them for medication or stay with them in the house to care for them (77.3%) , while others (18.2%) had to leave some household chores unattended to attend to the child because there was no one else to help the carer (Table 4.23). A few were not affected by the OVC illnesses.This may be the reason why high number of the respondent indicated that they did not enjoy caring for the OVC.

Table 4.23: How the carers' daily operations are inhibited by OVC illnesses

Inhibition	Frequency (n=22)	Percent (%)
I have to take the child to hospital	17	77.3
Other reasons	4	18.2
No Response	1	4.5
Total	**22**	**100.0**

4.2.3 Experiences and Coping Strategies of Older People in the Provision of Care to OVC

4.2.3.1 Respondents' experience in caring for OVC

Table 4.24 indicates that the majority of the respondents (73.5%) had a bad experience caring for the OVC , followed by 22.4% of those who had a good experience caring for the OVC. However 4.1% of the respondents did not answer this question. Respondents who had indicated that caring for the OVC was a good experience said that the OVC kept them company, felt that the OVC had given them another opportunity to be a parent, felt that the OVC's presence made the home lively among other reasons. Respondents who indicated that caring for the OVC was a bad experience stated that they did not have the energy to bring up the OVC , the OVC reminded them of the children they had lost and that made them feel sad, they did not have time to visit their friends and relatives and faced financial constraints.

Table 4.24: Respondents' experience in caring for OVC

Kind of Experience	Frequency(n=49)	Percent (%)
Good experience	11	22.4
Bad Experience	36	73.5
No Response	2	4.1
Total	**49**	**100.0**

4.2.3.2 Whether carers enjoy caring for OVC under their care

Table 4.25 indicates that, of the older carers taking care of the the OVC , 28.6% of them (n=14) enjoyed taking care of the OVC while 51% (n=25) did not enjoy taking care of the OVC. The remaining 20.4% of the respondents (n=10) did not respond to this question. Respondents who indicated that they enjoyed taking care of OVC were asked to give the reasons why they enjoyed taking care of the OVC . They indicated that they easily got long with the OVC , the OVC had accepted them in their lives as their carers and that they communicated well. For those who did not enjoy taking care of the OVC gave varied reasons. The responses indicated that the older carers did not get along well with the OVC , the OVC did not respect the carers and that the OVC had not adjusted to the change of their status and did not take the Old carer as their parent. This may be as a result of mental and physical exhausation as aresult of taking care of sibling rivalry, peer pressure and indiscipline cases among the OVC .

Table 4.25: Do carers enjoy caring for OVC under their care

Do they Enjoy	Frequency (n=49)	Percent (%)
Yes	14	28.6
No	25	51.0
No Response	10	20.4
Total	**49**	**100.0**

4.2.3.3 OVC school attendance

Table 4.26 indicates that the majority of the OVC (82.2%) attending school were in day school while the remaining 17.8% of OVC were in boarding school. Some of the respondents of school going age were not attending school. The respondents gave

different reasons such as they could not afford school fees, that the OVC had refused to go to school while others said that they could not afford to pay for the OVC school fees.

The reseacher sought to know who paid for the school fees of those in school and the study showed that the majority (53.1%) of the respondents paid for the OVC school fees, while others indicated that the school fees was paid by either sponsors, relatives or by the carers own children. Paying for the OVC school fees was a strain considering that the old carers did not have other sources of income and this increased their poverty level.

Table 4.26: OVC school type

School Type	Frequency (n=135)	Percent (%)
Boarding	24	17.8
Day	111	82.2
Total	**135**	**100.0**

4.2.3.4 OVC in day school bringing home school homework

According to Table 4.27 the majority of the respondents (68.2%) indicated that the children who were in day schools brought home homework but all of the respondents (100.0%) indicated that they did not help the OVC with the homework, the OVC either did on their own or were assisted by their siblings. This could be the case because majority of the carers were illitrate.

Table 4.27: OVC in day school bringing home school homework

Homework	Frequency (n=49)	Percent (%)
Yes	30	61.2
No	14	28.6
No Response	5	10.2
Total	**49**	**100.0**

4.2.3.5 Help with house chores

Human capital represents the skills, knowledge, ability to labour and good health that together enable people to pursue different strategies and achieve both their livelihood strategies and livelihood objectives. Human capital is required in order to make use of any of the four other types of assets. It is therefore necessary, though not on its own sufficient, for the achievement of positive livelihood outcomes. According to the study, 81.9 % of the respondents said that the OVC helped in house chores while theremaining 14.3% of the respondents said the OVC did not help in house chores. A significant proportion of the respondents (4.1%) were not willing to answer this question as shown in Table 4.28. Asked what kind of help the OVC gave, the carers indicated that the OVChelped in washing clothes, in the Shamba, washing younger siblings and washing dishes. The least were those who indicated that the OVC helped with the cooking. This may be an indicator that children were involved in early child labour to meet basic needs. However there were those who did not help in the house chores. Asked why the OVC did not help, a few (10%) of the carers indicated that they had house helps, other OVC were too young to help and others refused to help. Others indicated that they did not want the OVC to help them with the housechores may be as a result of fear that they may be seen as exploting the OVC under their care.

Table 4.28: Respondents helped by the OVC with house chores

Helped	Frequency (n=49)	Percent (%)
Yes	40	81.6
No	7	14.3
No Response	2	4.1
Total	**49**	**100.0**

4.2.3.6 Sibling rivalry

According to Table 4:29, majority of the respondents (81.6%) had not experienced sibling rivalry, while the remaining 4.8% had experienced sibling rivalry among the OVC . A significant proportion of the respondents (14.3%) did not answer this question.Those respondents who experienced sibling rivalry (n=2) employed different coping mechanisms like calling relatives to talk to the OVC others got professional help from counselors while a few were not specific on the tactics they use to deal with sibling rivalry a possibility that they did nothing about it hence aggrevating the situation.

Table 4.29: Sibling Rivalry among the OVC

Sibling Rivalry	Frequency (n=49)	Percent (%)
Yes	2	4.1
No	40	81.6
No Response	7	14.3
Total	**49**	**100.0**

4.2.3.7 Stigma

Stigma and discrimination by other children, the community, the neighbours, relatives and even teachers are common among the OVC . This study sought to find out whether the respondents had experienced any kind of stigma. Table 4.30 indicates that only 26.7% of the respondents had experienced some sort of stigma while 73.3% had not experienced any kind of stigma. A significant number of the respondent 8.2% did not respond to this question. The researcher sought to know what kind of stigam the carers faced. All the respondents (100%) identified isolation as the kind of stigma they experienced and the highest source of stigmatization was from the villagers, followed by the respondents' relatives and health providers. The lowest mentioned source of stigma

were the teachers. According to one of the KI, this was perceived stigma and really were old carers looked differently by the community due to their status. Asked how they dealt with stigma, most of the respondents indicated that they sought counselling services from CHWs, FBOs, relatives, friends and teachers especailly when in need while at times the CHW visited randomly to check on how they were coping.

Table 4.30: Proportion of respondents experiencing Stigma

Stigma	Frequency (n=49)	Percent (%)
Yes	12	24.5
No	33	67.3
No response	4	8.2
Total	**49**	**100.0**

4.2.3.8 Carers' Health

Vulnerabilities of older people as identified by Samuels and Wells (2009) include the increased likelihood of their own compromised state of health – older caregivers are more likely to have chronic illnesses, sensory, physical and cognitive difficulties. The study established that 25 (51.0%) of the respondents experienced ill health while 40.8% had not experienced any health related problem. Four respondents (8.2%) did not answer this question as shown in Table 4.31. The study revealed that most carers suffered from atleast one illness. Majority complained of general weakness of the body without being specific, others suffered from either blood pressure or diabetes or both while there were isolated cases of Asthma and Ulcers. Some of these diseases are associated with old age.

Table 4:31 Health

Health Issues	Frequency (n=49)	Percent(%)
Yes	25	51.0
No	20	40.8
No Response	4	8.2
Total	**49**	**100.0**

4.2.3.9 Respondents who sought medical treatments when ill

The respondents who indicated that they experienced health related problems (n=25) where asked whether they sought medical treatments for the illness. Table 4.32 indicates that the majority of the respondents 96.0% sought medical treatment while the remaining 4.0% did not seek medical treatments . The researcher intended to find out what type of treatment the carers sought and it was established that, majority (90.9%) of those who were ill sought modern treatment as opposed to traditional treatment.

Table 4.32: Respondents who sought medical treatments when ill

	Frequency (n=25)	Percent (%)
Yes	24	96.0
No	1	4.0
Total	**25**	**100.0**

4.2.3.10 Other challenges presented from OVC

The researcher wanted to find out whether there were other challenges faced by the older carers which were not yet documented so as to advise the study on the recommendations to be made. Table 4.33 shows that 57.1% of the respondents indicated that the OVC presented them with other challenges while 24.5% did not indicate any other challenges were presented by the OVC. A total of nine respondents (18.4%) did not respond to this

question and were not willing to discuss it. The challenges mentioned by the respondents included; difficulty in fending for the OVC, discipline related challenges as a result of peer pressure especially among the teenagers, lack of the OVC accepting the OVC state and therefore manifest it through throwing tantrums, the carers spending sleepless nights when the OVC are unwell among others..

Table 4:33 Other challenges from OVC

Other Challenges	Frequency (n=49)	Percent (%)
Yes	28	57.1
No	12	24.5
No Response	9	18.4
Total	**49**	**100.0**

4.2.4 Obstacles Experienced by the Older Persons Providing Care to OVC and their Coping Strategies

4.2.4.1 Other Supports Available for OVC and their Hosting Households

The study incisively delved into other support opportunities that could immediately be tapped in support of the OVC and their carers. Table 4.34 indicates that apart from income from the carers own sources, 57.1% of the respondents got support from other source to help them take care of the OVC. The remaining 36.7% had no support. Three respondents did not respond to this question. Extra support was got from sponsors, and relatives. At least one of the respondents was a pensioner. However, a high proportion of the respondents (82.1%) also mentioned various other sources of support including the church, friends, non-governmental organizations, provincial administrators among others.

Table 4.34: Respondents getting other support to care for the OVC

	Frequency (n=49)	Percent (%)
Yes	28	57.1
No	18	36.7
No Response	3	6.1
Total	**49**	**100.0**

4.2.4.2 Kind of support issued to the carers

According to Table 4.35, most common kind of support the respondents got from the other sources was in monetary form (50.8%) followed by the material support at 47.7%.This may also imply that the respondent value support in form of money and materials than other kinds of support to an extend that they may not regard other forms of support such as counseling as a sort of support. The respondents were allowed to give more than one response. This study delved in to the consistency of the support received to determine the level of reliability. A significant number of respondents got their support monthly, others got their support daily while the majority of the respondents got support when they are either bereaved, others after six weeks and others got support after two/ three months.

Table 4.35: Kind of support received by the respondents

Kind of Support	Frequency (n=65)	Percent (%)
Money	33	50.8
Material	31	47.7
Other	1	1.5
Total	**65**	**100.0**

4.2.4.3 Qualification for the support

Different reasons qualified the old carers to benefit from other kinds of support. Table 4.36 indicates that 35.7% qualified because of their old age, 3.6% because they were the administrators of the deceased property and majority (71.4%) because they were taking care of the OVC. The remaining 28.6% gave other reasons. The respondents were allowed to give more than one response.

The researcher investigated whether the respondents were aware of other kinds of support available for both OVC and the older people/carers which they were not benefiting from. The majority were aware of CT, Government bursaries, two NGOs working in the area, CDF, support groups and FBOs. Asked why they thought they were not accessing the support, 3.3% of those who knew about it identified the distance to the collection point while the majority (93.9%) gave other varied reasons including delayed decision to go for the support, stigmatization, favoritism by the administration and discrimination by some providers like religious organizations and especially if one was not a member of the church. The support was in form of money, material and psychological counseling

Table 4.36: Reasons given to justify the qualification for the support

Reasons	Frequency (n=28)	Percent (%)
Because of my age	N=10	35.7
Because I am the administrator of the deceased estate	N=1	3.6
Because I am taking care of the OVC	N=20	71.4
Other	N=8	28.6

4.2.4.4 Nutrition awareness levels among the older carers

Farming remains the major source of food for most households in Mithini location just like most other rural areas in Kenya. Despite the fact that farming is one of the major economic activity, the respondents indicated that they experienced various challenges when farming. Some of the challenges included lack of rains, lack of seedlings, others respondents lacked people to help in weeding and the least were those who indicated that they lacked enough land for farming. The study sought to know whether the respondents were aware of the type of food old people of their age are supposed to eat. According to Table 4.37 respondents (51.0%) indicated that they knew the types of food old people of their age are supposed to eat while the remaining 36.7% did not know.Of those who indicated that they knew the types of foods the old people are supposed to eat were asked whether they ate those types of foods. A significant propotion (56%) of the respondents said they ate the foods while the remaining 44.0% were not eating the type pf foods. Respondents who had indicated that they did not eat nutritious foods were asked why they did not eat them despite their knowledge. 81.8% of the respondents said that they did not have the money to buy the foods while the remaining 18.2% give different reasons like not able to go to the market and did not have any one to send to buy for them.

Table 4.37: Knowledge of the type of food requirements for the old

Knowledge of foods	Frequency (n=49)	Percent (%)
Yes	25	51.0
No	18	36.7
No Response	6	12.2
Total	**49**	**100.0**

4.2.4.5 Other sources of food utilised by the older carers and their households

Respondents who had indicated that they ate nutritious foods were asked regarding other sources of their food apart from the farming. Table 4.38 indicates that the majority (60%) mainly bought from the market. Only a handful (4.0%) mentioned being given food by their relatives. The finding is rather obvious because the households mainly depend on producing their own food for consumption. Food aid is mostly provided to PLHIV or during emergencies such as drought which are common in the area.

Table 4.38: Respondents other food sources

Food Source	Frequency (n=25)	Percent (%)
Buy from the market	15	60.0
Other	1	4.0
No response	9	36.0
Total	**25**	**100.0**

4.2.4.6 Respondents earnings against nutrition

Table 4.39 assesses the overall significance of the whole study where the significance of 0.347 is less than 0.05 hence the model is significant to the study.

Table 4.39: Respondents Earnings vs. Nutrition

ANOVA[b]

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	.685	1	.685	.928	.347[a]
	Residual	14.769	20	.738		
	Total	15.455	21			

a. Predictors: (Constant), NUTRITION

b. Dependent Variable: EARNING

4.2.4.7 Access to membership in community groupings

Membership in organizations as a social capital is a positive pointer towards group dynamics, capacity development and sharing.This study looked into membership of respondents in various groupings and committees including, village welfare, savings and loans groups, schools or churches and chamas. Table 4.40 indicates that the majority of the respondents (67.4%) were members of atleast one community group while the remaining 32.6% were not members of any community group. The community groupings included merry go rounds, community groups, support groups, business groups and bodaboda associations.Table 4.41 also reveals that more male 82.6% than female 52.2% were engaged in community groups. Benefits from the community groupings included financial, material benefits such as utencils, domestic animals,furniture at and those who indicated that they got counseling and moral support from the groups. Others got food stuff from the group. This was not frequent and it depended on the group one was in but the majority benefited if death occured in their family.

Table 4.40: Membership in community groups

Membership	Frequency (n=49)	Percent (%)
Yes	34	69.4
No	15	32.6
Total	**49**	**100.0**

Table 4.41 : Sex of the respondent vs their membership to community groups

SEX	GROUP		
	YES	NO	Total
MALE	19	4	23
% within group	82.6	17.4	100.0
% of the total	41.30	8.7	50.0
FEMALE	12	11	23
% within group	52.2	47.8	100.0
% of the total	26.1	23.9	50.0
Total	31	15	46
% of total	67.4	32.6	100.0

4.2.4.8 The reasons why carers did not belong to community groups

Respondents who had indicated that they did not belong to any community group were asked to give reasons for the same. 75.0% of them did not have money to contribute when needed while the rest (25.0%) gave other reasons like lack of time because they had to take care of the ailing OVC, family disagreements among others. Table 4.42 also indicates that a higher proportion of women 81.8% than men 60.0% were not members of community groups due to lack of money to contribute when needed. This could be because most of them did not have any source of income and those women who had possibly they did not control their income. It could also have been due to poverty as stipulated by the KIs.

Table 4.42: Gender vs. reasons of lack of group membership

SEX	REASON FOR NOT BEING IN COMMUNITY GROUPS		
	Do not have money to contribute when needed	Other reasons	Total
Male(n=5)	3	2	5
	60.0%	40.0%	100.0%
	18.8%	12.5%	31.3%
Female (n=11)	9	2	11
	56.3%	7.0%	68.7%
	81.8%	18.2%	100.0%
Total (n=16)	12	4	16
% of total	75.0	25.0	100.0

4.2.4.9 Carers monthly earning against group membership

Table 4.43 indicates that 100.0% of the respondents earning between 5,000 – 10,000 and those earning above 10,000 are members of community groups. This is followed by 70.0% of those who earn between 2,000 – 5,000. The least were those who earned below 2,000 at 65.5%. This implies that the higher the monthly earnings the higher the likelihood of being in groups. This may also imply that the groups have away of economically empowering the carers, thus a this could be a good coping mechanism for the caregivers.

Table 4.43: Carers monthly Earning vs group membership

Monthly Earning		GROUP MEMBERSHIP		
		Are members of community Groups	Not a member of community group	Total
Below 2,000		19	10	29
	% within Group	65.5	34.5	100.0
	% of Total	43.2	22.7	65.9
2,000 – 5,000		7	3	10
	% within Group	70.0	30.0	100.0
	% of Total	15.9	6.1	22.0
5,000 – 10,000		4	0	4
	% within Group	100.0	0	100.0
	% of Total	9.1	0	9.1
Above 10,000		1	0	1
	% within Group	100.0	0	100.0
	% of Total	2.3	0	2.3
Total		**31**	**13**	**44**
% of total		**70.5**	**29.5**	**100.0**

4.2.4.10 Earnings against group membership

Table 4.44 assesses the overall significance of the whole study where the significance of 0.167 is less than 0.05 hence the model is significant to the study.

Table 4.44: Earnings vs. group membership

ANOVA[b]

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	1.121	1	1.121	1.974	.167[a]
	Residual	23.856	42	.568		
	Total	24.977	43			

a. Predictors: (Constant), GROUP b. Dependent Variable: EARNING

4.2.4.11 The gender of the respondents and monthly earning

Table 4.45 indicates that more female carers (72.7%) compared to male carers (54.2%) earn below Ksh 2000 per month. It also revealed that more male carers (29.2%) earn between 2000 - 5000 compared to their female counterparts at 22.7%. It also indicates that more male carers (12.5%) earn between 5000 -10,000 compared to female carers at 4.5%. No female carer indicated that they earned above 10,000. This could have been because culture dictates that women are supposed to be at home caring for the OVC while the man is out fending for the family.

Table 4.45: Gender of the respondents vs monthly earning

		EARNING81				
SEX		Below 2,000	2,000 – 5,000	5,000 – 10,000	Above 10,000	Total
Male	Count	13	7	3	1	24
	% within Group	54.2	29.2	12.5	4.2	100.0
	% of Total	28.3	15.2	6.5	2.2	23.9
Female	Count	16	5	1	0	22
	% within Group	72.7	22.7	4.5	0	100.0
	% of Total	34.8	10.9	2.2	0	47.9
Total count		**29**	**12**	**4**	**1**	**46**
% Total		**63.0**	**26.1**	**8.7**	**2.2**	**100.0**

4.2.4.12 Attitude of different groups towards the OVC

The study sought to find out the attitude of different groups in the community towards the OVC. The attitude of the people around the OVC and their carers can determine their social status in the society. Table 4.46 indicated that the carers' relatives and neighbours were the most unfriendly people at 22.2% in each case, followed by the community at large at 20.0% and the teachers at 15.6%.The most friendly groups were identified to be the religious leaders at 97.7% followed by the Health Providers at 95.5%.

Table 4.46:The attitude of different people groups towards the OVC

Group		Friendly	Unfriendly	Total
Carers own children	Count	40	3	43
	% of Total	93.0	7.0	100.0
Teachers	Count	38	7	45
	% of Total	84.4	15.6	100.0
Religious leaders	Count	43	1	44
	% of Total	97.7	2.3	100.0
Carers Relatives	Count	35	10	45
	% of Total	77.8	22.2	100.0
Neighbours	Count	35	10	45
	% of Total	77.8	22.2	100.0
Health Providers	Count	42	2	44
	% of Total	95.5	4.5	100.0
The Community at large	Count	36	9	45
	% of Total	80.0	20.0	100.0

4.3 Summary

From the above results, it is clear that a number of OVC is under the care of older carers and this means that families of older carers and OVC are compelled to take on new roles. The study revealed that, the care of OVC strikes at the heart of the family and community support structures which causes strain to the older carers who themselves are illiterate and do not have a source of income, are aged and are in need of care.

CHAPTER FIVE

SUMMARY OF FINDINGS, DISCUSSIONS, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

Based on the results from 49 respondents, the coping strategies of older persons in the provision of care for orphans and vulnerable children have been considered. In the following section summary of the findings of this study is presented first. Secondly, the summaries of findings as per research objectives/questions are discussed. Thirdly, the conclusions of the results are conferred. Finally, the recommendations of this research are discussed and future researches proposed.

5.2 Summary of findings as per research objectives

In this section, the researcher discussed the results of the study as per the research objectives. The objectives of this study were: to develop a profile of older people giving care to OVC; to identify circumstances leading to older people assuming the role of care givers to OVC; to document the experiences of older people in the provision of care to OVC and to identify obstacles experienced by older carers in the provision of care to OVC. The key questions asked in this study were: who takes care of the OVC? What circumstances lead older people to assume the role of care giving to OVC? What are the experiences of older people in the provision of care to OVC? What are the obstacles experienced by older carers in the provision of care to OVC? The findings are herein presented for each of the objectives explored.

5.2.1 The profile of older people giving care to OVC

The study indicated that among the total population of 49 respondents, unlike the assumption of many, the majority of carers were men at 51.0% while 49.0% were women. Most of the respondents were widowed followed by those who were married, single and divorced in that order. Religion was an important source of emotional and spiritual strength for elderly caregivers hence a greater number were Christians and a few Muslims.

The study revealed that the majority of the respondents (67.3%) wereilliterate (had not attained any formal education). The study also revealed that the majority of the elderly carers were living in Kiatine Village and that those living in Mithini Location were the most illiterate . This could be one of the reasons why their earning was too low.Their sources of income/businesses were not yielding much and therefore could not contribute to economic development of the area. Further, the findings indicated that that the majority of the elderly carers were not in/ had never been into formal employment. Only 4.0% of the respondents indicated that they were either in formal employment or had been earning a pension as a result of being in formal employment. Although farming was the principle activity for the older carers as indicated by 87.8% of the respondents, most of the respondents produced for consumption other than as an economic activity. The common types of crops grown were maize, beans, green grams and sorghum. The analysis of the average earnings per month indicated a mean of KSh 2521.80 (SD 0.753) which most respondents depended on to meet their household basic needs.The fact that

the Standard Deviation for the monthly earning from the carers main occupation was much closer to the mean is a clear indication that almost all the carers had varies level of income depending ontheir level of vulnerability. Some carers however, had alternative sources of income to supplement on their earning. These included; owned business such as retail shops, *bodaboda*, matatu and selling and buying of cows as a coping strategy to supplement on their income to meet the needs of the additional members of their households. This level of income is too low for a family to survive on comfortably. Other carers got support from their families, well-wishers including neighbors and community organizations such as churches.

Ownership of assets is very vital in describing the basic livelihoods of a household. In this particular study, this variable was used to identify the trends or livelihood standards of the beneficiary households. The study also found out that all the carers owned at least an asset. The majority owned land (85.7%), but with a few (39.5%) earning income from the owned asset. Income generated from their activities was under the carers control with an exception of a few (6.4%) whose income was controlled by their own children or other parties. Older caregivers are also responsible for providing clothing, shelter, school fees, uniforms, books, and other school requirements for children in their care. They also ensure discipline and provide moral instruction. This implies that the greater share of the income is devoted to meeting the basic needs of the respondents which may be an indicator of high level of vulnerability of the household to food and nutritional insecurity. The study also revealed that the majority of the OVC were still dependent on the older carers (83.7%) and therefore did not contribute to their carers' upkeep. Only 16.3% of the

carers had atleast one independent OVC under their care who contibuted in the buying of the family food.

5.2.2 Circumstances leading to older people assuming the role of care givers to OVC

According to this study, the OVC under the respondents care were total, maternal, paternal and or social orphans of which 75.5% were due to HIV and Aids related illnesses. The ages of the OVC ranged from below one year to eighteen years of which majority of the OVC were school going and a few out of school and independent. It is clear from this study that the role played by older carers is very vital as they contribute significantly to the social capital needed to cope with the impact of HIV and AIDS and other life predicaments on children, families and communities. The reality, however, is that these responsibilities come at a time when older people might be expecting to receive support from their adult children and families, and instead they find themselves confronted with huge responsibilities of caring for the OVC.

5.2.3 The experiences and coping strategies of older people in the provision of care to OVC

The study showed that most of the carers (76.6%) had a bad experience caring for the OVC .The reason given was that they did not have the energy to care for the OVC (31.0%), and that the OVC did not respect them (61.9%).

Inability to meet the educational needs of children as a result of poverty was another major problem cited by the study respondents. Although primary school education is free in Kenya, older caregivers are unable to afford other requirements such as uniforms and

books. Moreover, secondary school is not free, so many OVC affected by poverty were forced to drop out of school at the primary level and others refuse to attend school all together. Those in secondary schools were mostly sponsored by either NGOs working in the area, churches or government bursaries but when this was not available, the carers struggled to keep them in school. School dropout seems to be as a result of both inability to afford school fees as well as peer pressure. The study revealed that many caregivers experience indiscipline among the OVC. This may be attributed to carers' lack of skills for disciplining children because they fear that the children may run away or become depressed.

The Study also noted that most households headed by older caregivers are poor. This includes some households that were well off prior to being affected by AIDS, but then depleted their resources to meet the health care expenses of household members infected with HIV. Inadequate nutrition, OVC illnesses, indiscipline cases and low income levels were identified by study respondents as the some of the problems experienced among older caregivers. Inadequate nutrition for the older carers was attributed to lack of income to purchase food, lack of rain, knowledge and skills in modern farming techniques, and cultivation of small portions of land that cannot yield enough food.

The study also indicates that most of the OVC helped in household chores (85.1%). However, the older carers' households experienced isolation and discrimination. This may be as a result of either stigma associated with the AIDS pandemic or fear that they may be burden to their neighbors and relatives.

In order to cope with the pressure associated with their role, slightly more carers (55.6%) sought counseling when there was need. However, CHWs visit the older carers randomly to offer the service. The findings of the study indicated that the majority of the respondents (51.0%) experienced varied health related problems with general weakness of the body being the leading followed by high blood pressure. Given the fact that most of the elderly do not go for regular check-ups, this complicated their health conditions and way of life. In addition to poverty, old age and ill health limit the elderly's capacity to perform their caregiving activities.

Inadequate shelter was found to be a problem among the very poor older caregivers, who lived in dilapidated houses that they said, leaked during the rainy season. Their compounds were unclean and their clothes looked tattered and or clipped indicating that they were rarely washed. The farms around them looked small and lacked care and on enquiry most indicated that was the only land they had.

5.2.4 Obstacles experienced by older carers in the provision of care to OVC and their coping strategies

A good proportion of the carers (57.1%) of the respondents indicated that apart from their own source of income they got support from other sources. These sources included the Cash Transfer for OVC, NGOs working in the community, church donations, relatives and their own children. This support was mainly in form of money and material in that order. which in most cases was not regular apart from the CT which was given after every two months at a rate of Kshs 1,500 per OVC. Most of the respondents had qualified for this support because of their age and the fact that they were taking care of the OVC.

However, those not benefiting from the CT were either not yet registered or because the OVC parents' death was not as a result of HIV which is a criteria for registration. The findings indicated that the majority of the respondents' nutritional intake was poor due to limited resources. While an evaluation of nutritional status is difficult with all age groups and particularly so with the elderly, this study asserts that nutritional status, physical health and degenerative effects of the aging process are inter-related and therefore is not always possible to separate the influences of the inadequate nutrition from changes resulting from physiological aging and degenerative diseases. The elderly hardly had enough to eat, as they were not physically able to farm and had limited sources for affording a good diet. Some elderly carers were not keen on diet as some had limited knowledge, they lacked the foods to buy or had no access and for those that could afford lacked someone to prepare the meal in the best way they would have liked. In Kitui County, there are no Nursing Home facilities like those in developed nations where professionals can address the dietary interests of the elderly. Given the elderly are a highly vulnerable population, there needs to be an instituted policy to take care of them either by training nutritionists health care givers or members of the family to provide the need nutritional care as none exists.

As a coping mechanism, most of the respondents belonged to community groups like merry go rounds where they benefited from financial support after a particular duration and moral and financial support in case one faced death in the family. Those who did not belong to the community groupings were not because they did not want to but because they lacked money

for contribution to these groups. Only 32.7% of the respondents indicated that they had an alternative source of income.

5.3 Discussion

According to literature reviewed, 80% of older carers were female and 20 per cent were male (HAI, 2006), but this research has shown that it is not only women who are the older carers of OVC, men are equally left with OVC to take care of OVC in case of death of their parents. This report showed men as the highest carers at 51% and women at 49%. Apart from OVC due to HIV related complications, the study has also established that there are other OVC because of parents' death caused by natural causes, accidents and at times the carers were not aware of what caused the death of the OVC parent. This may also imply that apart from the knowledge on the cause of the parents' death, the carers may as well be lacking essential documents to facilitate the inheritance process. The 49 respondent's households had a total of 165 OVC under their care who were all dependants with an average of 3.37 OVC per carers household. This confirmed the literature reviewed of a baseline survey conducted by HelpAge and found that on average each older carer was caring for 3 orphaned children (HelpAge, 2006).

The study confirmed that most of the carers did not have good experience and did not enjoy taking care of the OVC. The older carers indicated that parenting issues and lack of income and resources were the leading difficulties in fulfilling their role as caregivers. Other difficulties included physical and mental weakness, lack of social, community and family support and lack of agricultural input. A central issue for older carers caring for

OVC was the impact on their economic status, which also had multiple effects that influenced their emotional and physical health. There were both direct and indirect costs associated with providing care. Inability to meet the educational needs of children because of poverty was another major problem cited by study respondents. Although primary school education is free in Kenya, older caregivers often cannot afford other requirements such as uniforms and books. Moreover, secondary school is not free, so many children affected by povery are forced to drop out of school at the primary level. Therefore looking after OVC involved paying numerous additional expenses such as education fees and materials, clothing, healthcare, small cash allowances, and food. These costs tended to increase as the OVC grew older. Older carers experienced the loss of their own income through relinquishing or reducing work due to the time consuming demands of providing care. This agrees with a literature reviewed which underscores its contributions to the overall standard of living for these communities (HelpAge International, 2001). A number of older carers did not feel strong enough to work, and many did not benefit from social protection schemes. Indeed, the majority of older people lacked access to any form of financial allowance or pension. The absence of a regular, predictable source of income in their situation contributed to a series of responses with long-term consequences. This agrees with a literature reviewed which underscores its contributions to the overall standard of living for these communities (HAI, 2001).

Many older carers experience difficulties and stress in adapting to a new parenting role that sees their relationship with grandchildren become more authoritative. This is especially true as grandchildren enter adolescence, with a lack of understanding between grandchild and grandparent potentially straining relations. This agrees with the findings

of a study conducted by HelpAge International and UNIFEM which identified age gap and a challenge experienced by the carers (HAI, 2002).

Older carers who are busy caring for a young grandchild or sick adult child find that their workload interferes with their level of social interaction. Spare time is often used to search for food or earn money. Their ability to visit friends, important places such as the church or mosque, and attend community events is restricted, which accentuates feelings of isolation.

5.4 Conclusion

The study indicates that older carers are not a homogenous group and the impact varies greatly, depending on their level of vulnerability and the context in which they live. Older people are playing major caregiving roles amidst a multitude of challenges that include limited resources, knowledge, skills, and social support related to patient care and child rearing.

Children prefer to live with their grandparents after the death of their parents rather than other relatives. They feel that their grandparents provide more love and affection than other relatives. It is important for stakeholders among them the government, NGOs, CBO's to put measures in place to ensure necessary support is being provided to grandparents and children under their care to nurture and enhance this loving interpersonal relationship

5.5 Recommendations

Respondents were asked to suggest solutions to the identified problems of older caregivers in form of a last comment. The following suggestions to improve the situation of elderly caregivers have implications for government, specifically the health, social welfare, and agriculture sectors, and for nongovernmental organizations, churches, and community groups:

- Provide financial support to OVC without limitation on the status of the OVC – whether parent died of HIV related complications or not
- Help communities to identify their resources and how to use them
- Provide training to elderly caregivers in modern farming techniques, food security, and income generating activity startup and management
- Increase the knowledge and skills of elderly caregivers in child rearing and increase their access to caregiving supplies
- Develop mechanisms for providing support to households headed by the elderly for orphans to remain in school
- Train community health workers to assist elderly caregivers in managing OVC with HIV/Aids related illnesses at home
- Build houses for destitute caregivers or provide alternative shelter
- Provide psychosocial support for older caregivers, people living with HIV/AIDS, and orphans and vulnerable children.
- Link communities with organizations involved in HIV/AIDS care and support services

Policy and Programme Recommendations

Addressing income insecurity to alleviate impact on intergenerational relationships

- Advocate for inclusion of social protection measures for older carers and OVC in new regional and national HIV and AIDS polices and strategic frameworks
- Allocation of resources and implementation of programme action plans on social protection measures for older carers and OVC
- The government to consider rolling out the programme implementation of Cash Transfer programme for older persons/persons with disabilities countrywide
- Evaluate social protection/livelihood programmes supporting older carers and OVC implemented by CSOs and advocate for scale up in national and district development policies and programmes

Promoting community level support to older caregivers and their dependants to enhance intergenerational relationships

- Child-focused CSOs mainstream support to older carers of OVC including facilitating older carer support groups and parenting skills training
- Home-based care providers priorities PSS support to older carers and OVC
- Advocate for UNGASS indicators which assess the support to caregivers of children orphaned by AIDS

5.6 Suggestions for further research

Limitation and shortcoming of this study provided implications for future research. It would be necessary to the policy makers and implementers to undertake research and collect comprehensive age-disaggregated data on the needs and roles of older people and OVC, to design better HIV/AIDS interventions that are inclusive of older people. Additional information is required on the nature and composition of households affected by HIV/AIDS, details of who the primary caregivers and guardians of OVC are, and their coping strategies; the poverty impacts of HIV/AIDS, including asset depletion, and links to national and international poverty monitoring systems; the health needs and health-seeking behavior of older carers and OVC; the information needs of older people, and the effectiveness of formal and informal education for OVC; the effectiveness of older people as educators, and any impact on the understanding and behavior of OVC; the psychosocial impacts of HIV/AIDS on children and older people's wellbeing.

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APPENDIX 1

QUESTIONNAIRE FOR CARE GIVERS

SECTION A: PROVIDERS PROFILE

1. Sex of respondent
   1. Male [ ] 2. Female [ ]
2. Sub-location of residence _____
3. Village _____
4. Marital status
   1. Married [ ] 2. Widowed [ ] 3. Divorced [ ]
   4. Separated[ ] 5. Single [ ]
5. Is your spouse alive? 1. Yes [ ] 2. No [ ]
6. What is your religion? 1. Christian [ ] 2. Islam [ ] 3. Other [ ]
7. What is your highest level of education?
   1. Primary [ ] 2. Secondary [ ] 3. College [ ]
   4. None [ ] 5. Other (specify) [ ]
8. What is your main occupation?
   1. Formal employment [ ] 2.Farmer [ ] 3. Pensioner [ ]
   4. None [ ] 5. Other Specify [ ]
9. How much do you earn from your main occupation?

   _____
   1. below 2,000 [ ] 2. 2,000 – 5,000 [ ] 3. 5,000 – 10,000 [ ] 4. Above 10,000 [ ]
10. Do you have any other source of income? 1. Yes [ ] 2. No [ ]
11. If yes what other source (s)? _____
12. Approximately how much do you earn from the other source (s)?
    1. below 2,000 [ ] 2. 2,000 – 5,000 [ ] 3. 5,000 – 10,000 [ ] 4. Above 10,000 [ ]
13. Do you run any business? 1. Yes [ ] 2. No [ ]
14. If yes, what type of business? _____
15. Approximately how much do you earn per month in Kshs from the business?
    1. below 2,000 [ ] 2. 2,000 – 5,000 [ ] 3. 5,000 – 10,000 [ ] 4. Above 10,000 [ ]
16. Do you own any assets/property? 1. Yes[ ] 2. No [ ]
17. If yes, what kind of assets/property? _____
18. Do you get any kind of income from the assets/property? 1. Yes [ ] 2. No [ ]
19. If yes, how much do you earn from the assets in Kshs per month?
    1. below 2,000 [ ] 2. 2,000 – 5,000 [ ] 3. 5,000 – 10,000 [ ] 4. Above 10,000 [ ]
20. Are you in control of the income? 1. Yes [ ] 2. No [ ]
21. If no, who controls the income? 1. My children [ ] 2. A trustee [ ] 3. Other [ ]
Specify
22. If yes, how do you use this income? _____
    1. Pay school fees [ ] 2. Buy clothes for myself [ ] 3. Buy clothes for the OVC [ ]
    4. Buy food [ ] 5. Other [ ] Specify

SECTION B: CIRCUMSTANCES THAT LED TO THE OLDER PERSON ASSUMING THE ROLE OF CARE GIVER TO THE OVC

23. Do you have children? 1. Yes [ ] 2. No [ ]

24. If yes, please state the following

Age	Gender	Own child	Not own child	Dependent	Independent	OVC status (for not your own)

Key: OVC Status

1. Paternal orphan (child lost its father) **[P]**
2. Double orphan (child lost both parents) **[D]**
3. Social orphan (child vulnerable to poverty and parental illness) **[S]**
4. Maternal orphan (child lost its mother) **[M]**

25. If there are any children who are independent, do they contribute to your upkeep?
1. Yes[ ] 2. No [ ]

26. If yes, how do they contribute?
1. Pay school fees [ ] 2. Buy food [ ] 3. Help in the farm [ ] 4. Other [ ] Specify

27. If parent died, what caused their death?
1. HIV [ ] 2. Accident [ ] 3. Natural [ ] 4. Other Specify [ ]

28. Do you experience any kind of problems from the OVC when providing care to them?
1. Yes [ ] 2. No [ ]

29. If "yes" what kind of problems?
1. Health [ ] 2. Discipline [ ] 3. Provision of food [ ]
4. Provision of clothing [ ] 5. Provision of school fees [ ] 6. Other [ ] Specify

30. If health, what kind of illness?
1. HIV [ ] 2. Malnutrition [ ]3. Asthma [ ] 4. Other [ ] Specify

31. Do you often seek medical treatment for the illness? 1. Yes [ ] 2. No [ ]

32. If yes what type of treatment?
1. Modern [ ] 2. Traditional [ ] 3. Both [ ] 4. Other specify [ ]

33. Who pays for their treatment?
1. Myself [ ] 2. It is free [ ] 3. My own children [ ]4. Other [ ] Specify

34. Does the illness inhibit your daily operations? 1. Yes[ ] 2. No [ ]

35. If yes, how?
1. I have to take the child to hospital [ ]
2. I cannot attend my group meetings [ ]
3. There is no one to help in the household chores and I have to leave some unattended to attend to the child [ ]

36. If other and specified above, how do you deal with it? _____

SECTION C: EXPERIENCES OF THE OLDER PERSON PROVIDING CARE TO THE OVC

37. How do you find the experience of caring for OVC?

1. Good experience [ ] 2. Bad Experience [ ]

38. If good experience, why?

1. They keep me company [ ]
2. They have given me another opportunity to be a parent [ ]
3. Their presence makes the home lively [ ]
4. Other [ ] Specify

39. If bad experience, why?

1. I do not have the energy to bring them up [ ]
2. They remind me of the children I lost and this makes me feel sad [ ]
3. I no longer have time to visit my friends/relatives/friends [ ]
4. Other [ ] Specify

40. Do you enjoy caring for OVC under your care? 1. Yes[ ] 2. No [ ]

41. If Yes, why?

1. We easily get along [ ]
2. We communicate well [ ]
3. They have accepted me in their lives as their carer [ ]
4. Other [ ] Specify

42. If No, why?

1. We don't get along well [ ]
2. They don't respect me [ ]
3. They have not adjusted to the change of their status and do not take me as a parent [ ]
4. Other [ ] Specify

OVC Status

43. Please specify the following about the OVC under your care

Age	Attend school		Class	Out of school	Working	Other
	Boarding	Day				

44. If there are some who do not attend school, why?

1. I cannot afford to pay for their school fees [ ]
2. they have refused to go to school [ ]
3. Other [ ] Specify

45. If there are some who attend school, who pays for their school fees?

1. Self [ ] 2. Sponsor [ ] 3. Relative [ ] 4. My child [ ]5. Other [ ] specify

46. Do the ones in day school bring home school homework? 1. Yes[ ]2. No [ ]

47. If yes do you help in the homework? 1. Yes [ ] 2. No [ ]

48. If no who helps them with the homework?

1. No body [ ] 2. Elder sibling [ ]3. Does on their own [ ]

Social Responsibility:

49. Do the OVC help in house chores at home? 1. Yes [ ] 2. No [ ]
50. If yes, how?
    1. cooking [ ] 2. Washing clothes [ ] 3. Washing dishes [ ] 4. Helping in the shamba [ ]
    5. washing younger siblings [ ] 6. Other [ ] specify
51. If no, why?
    1. I don't let them help [ ] 2. I have a house help [ ] 3. They refuse to help [ ]
    4. Other [ ] Specify
52. Do you experience sibling rivalry? 1. Yes [ ] 2. No [ ]
53. If yes, how do you deal with it?
    1. talk to the children [ ]2. Call relatives to talk to them [ ] 3. Get professional counselors [ ]
    4. Other [ ] Specify

Psychological:

54. Do you face stigma/discrimination? 1. Yes [ ] 2. No [ ]
55. If yes, from whom?
    1. Teachers [ ] 2. Villagers [ ] 3. Relatives [ ] 4. Health providers [ ]
    5. other [ ] Specify
56. What kind of stigma/discrimination?_____
57. Do you get any counseling services? 1. Yes [ ] 2. No [ ]
58. From where/who? 1. Faith based [ ] 2. Organizations working in the area [ ]
    3. Community health workers [ ] 4. Other [ ] Specify
59. How often do you get the service? 1. Weekly [ ] 2. Monthly [ ] 3. When need arises [ ]
    4. Randomly [ ] 5. Other [ ] Specify

Health:

60. Do you suffer from any kind of illness? 1. Yes [ ] 2. No [ ]
61. If yes, what kind of illness?
    1. High blood pressure [ ] 2. Diabetes [ ] 3. Asthma [ ] 4. Ulcers [ ]
    5. Other [ ] specify
62. Do you often seek medical treatment for the illness? 1. Yes [ ] 2. No [ ]
63. If yes what type of treatment?
    1. Modern [ ] 2. Traditional [ ] 3. Both [ ] 4. Other [ ] specify
64. Do these children present you with any other challenges? 1.Yes [ ] 2. No [ ]
65. If yes, what are the challenges? _____

SECTION D: OBSTACLES EXPERIENCED BY THE OLD PERSON PROVIDING CARE TO THE OVC

Economic

66. Apart from income from your own sources, do you get support from any other source to help you take care of the OVC? 1. Yes [ ] 2. No [ ]
67. If yes, what is the source?
    1. Own children [ ] 2. Sponsors [ ] 3. Inheritance from the deceased parents of the OVC [ ]
    3. Pension [ ] 4. Relatives [ ] 5. Other [ ] Specify

68. What kind of support do you get?
1. Money [ ] 2. Material [ ] 3. Psychological (counseling) [ ] 4. Other [ ] Specify
69. How regular is the support?
1. Daily [ ] 2. Weekly [ ] 3. Monthly [ ] 4. Other [ ] Specify
70. How did you qualify for this kind of support?
1. Because of my age [ ] 2. Because I am the administrator of the deceased estate [ ]
3. Because I am taking care of the OVC [ ] 4. Other [ ] Specify
71. Are you aware of any other kind of support available to OVC and or older carers of OVC that you do not get?
1. Yes [ ] 2. No [ ]
72. If yes, from where/whom?
1. Cash transfer [ ] 2. CDF [ ] 3. LATF [ ] 4. Other [ ] Specify
73. What kind of support?
1. Money [ ] 2. Material [ ] 3. Psychological (counseling) [ ] 4. Other [ ] Specify
74. Why are you not able to get it?
1. I do not have the documents required [ ]
2. the point of collection is too far for me [ ]
3. I must be introduced by the chief and he has refused to introduce me [ ]
4. Other [ ] Specify

Nutrition:

75. Do you do farming? 1. Yes [ ] 2. No [ ]
76. If yes, please answer the following;

Type of crop	Quantity per harvest	For sale	For use at home	Both sale and use at home
Beans				
Maize				
Pigeon piece				
Cow piece				
Green grams				
Sorghum				
Millet				
Other (specify)				

77. Do you experience any kind of challenges when farming?
1. Yes [ ] 2. No [ ]
78. If yes, what type of challenges?
1. Lack of rains [ ] 2. Lack of seedlings [ ] 3. Lack of people to help in weeding [ ]
4. Lack of enough land [ ]
79. Are you aware of the type of food old people of your age are supposed to eat?
1. Yes [ ] 2. No [ ]
80. If yes what are the foods? _____
81. Do you eat these types of food? 1. Yes [ ] 2. No [ ]
82. If no, why?

1. I do not have money to buy [ ]
2. They are not available in the market [ ]
3. Other [ ] Specify

83. If yes and are not part of the what is grown, how do you get them?
1. Buy from the market [ ] 2. Supplied by my children [ ]
3. From good Samaritans [ ] 4. Other [ ]Specify

Socialization:

84. Are you in any community group? 1. Yes [ ] 2. No [ ]
85. If yes, which one (s)? _____
86. How do you benefit from the group (s)? _____
87 How often do you benefit? _____
88. If no, why?
1. I do not have money to contribute when needed [ ]
2. No one wants me in their group [ ]
3. they are far away and I cannot manage to attend [ ]
4. There are none in the community that I know of [ ]
5. Other [ ] Specify

Perception:

89. Rate the attitude of the following target groups towards the children under your care

Group	Friendly	Unfriendly	Not applicable
Your own children			
Teachers			
Religious leaders			
Relatives			
Neighbors			
Health Providers			
Community at large			

Comment:

90. Do you have any last comment on the provision of care to OVC?
1. Yes[ ] 2. No [ ]
91. If yes, comment _____

End of questionnaire, thank you.

APPENDIX II

INTERVIEW GUIDE FOR INFORMANTS:

1. Gender
2. What is your level of education?
3. What is your position in the community?
4. Are there any OVC in the community under the care of older persons?
5. According to your understanding, what circumstances led the OVC to be under the care of the older persons?
6. According to your understanding what are the experiences of older persons taking care of OVC?
7. What obstacles (if any) do the older carers experience?
8. What support is available for older carers of OVC?
9. What is the government doing about older persons taking care of OVC?
10. What support agencies are available and what type of support do they provide
11. How can support agencies best work to reinforce existing and latent coping skills in older persons carers of OVC and their communities?
12. How can you help as individual and community?
13. Are there any NGOs providing care and support for the old persons taking care of OVC and AID orphans?

APPENDIX III

OBSERVATION CHECKLIST

Check List	1	2	3
What is the state of the home compound			
Cleanliness			
Housing structures			
What is the state of the respondent			
Physical state e.g. frail, strong			
Physical presentation of the respondent e.g. cleanliness, cloths condition			
State of the housing			
If offered to go in to the house, how is the cleanliness of the house			
What is the state of the OVC ?			
Health – first impression			
Physical Cleanliness			
Clothing			

Key:

1 – Highest 2 – Moderate 3. Lowest

APPENDIX IV

REQUEST FOR AUTHORIZATION BY THE ADMINISTRATION (CHIEF)

Gladys Kalimi Martin
University of Nairobi
Department of Sociology & Social Work
Nairobi Campus
9th July 2012

To the Chief,
Mithini Location

Thro'
District Commissioner
Kauwi District
Kitui County

Dear Sir/ Madam

RE: REQUEST TO CONDUCT RESEARCH TO IDENTIFY STRATEGIES USED BY OLDER PERSONS IN THE PROVISION OF CARE TO OVC IN MITHINI LOCATION

I hereby request to be given permission to conduct my study **in Mithini Location to identify strategies used by older persons in the provision of care to OVC**, as a partial requirement to complete my MA studies in Medical Sociology. Below are details of the study and the role that will be played by the research participants.

Title of the research project: To **identify strategies used by older persons in the provision of care to OVC**.

The objectives of the study are:

- To develop a profile of older people providing care to OVC
- To identify circumstances leading to older people assuming the role of care givers to OVC
- To document the experiences and coping strategies of older people in the provision of care to OVC
- To identify obstacles experienced by older carers in the provision of care to OVCand their coping strategies

Based on the research findings, the study will draw conclusions and make recommendations on appropriate support services in order to encourage the older persons providing care to the OVC.

Old persons providing care to the OVC will participate voluntarily and all the information supplied above will be conveyed to them on the first day of the interviews. Each participant will be given a consent form that will be fully explained to them and this will be to ensure that the participant participates voluntarily. All the information provided during the interviews will be treated confidentially and will not be used for any other research study. After the study is completed the researcher will give the Local Administration a copy of the report and if given opportunity, share the report with the relevant authority.

Physical address of the researcher: Student at the University of Nairobi
: Department of Sociology & Social Work
: Admission No. C50/60831/2010
: Nairobi Main Campus
Contact number: Cell 0720 732 931

Your cooperation and that of the old person's providing care to OVC will be highly appreciated.

Yours faithfully

Gladys Kalimi Martin,

MA Research student

APPENDIX V

Research Participant Consent Form

Title of the research: **identify strategies used by older persons in the provision of care to OVC,**
Reference Number: **C50/60831/2010** (student number of the researcher)
Researcher: **Gladys Kalimi Martin**
: Student at the University of Nairobi
: Department of Sociology & Social Work
: Admission No. C50/60831/2010
: Nairobi Main Campus
Contact numbers: Cell **0720 732 931**

Declaration by the research participant:
I, the research participant was invited to participate in the above mentioned research project which is undertaken by Gladys Kalimi Martin of the Department of Sociology and Social Work, University of Nairobi, Kenya. The objective of the study is to explore and identify coping strategies of older people in the provision of care for OVC.

Based on the research findings, the study will draw conclusions and make recommendations on appropriate support services in order to encourage the older persons providing care to the OVC.

I understand that my participation is voluntary and that I have a right to withdraw from participating at any time without penalty. I understand that confidentiality will be maintained at all times. The person asking me questions will never tell anyone what I told her and my name will not be written down or recorded. My privacy will be maintained in all published and written data resulting from this study.

I know that if I have any questions or complaints about this study I can contact anonymously, the Head Department of Sociology and Social Work, University of Nairobi.

I voluntarily agree to participate in this study:

Signature (Participant): _____ Date:

Signature (Researcher): _____ Date: