

**A STUDY OF THE IMPACT OF HIV/AIDS ON AFFECTED
FAMILIES IN NAKURU MUNICIPALITY- KENYA**

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**A Project report Submitted to the Graduate School in partial fulfilment of the
requirement for the Degree of Masters in Guidance and Counselling of Egerton
University**



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JANUARY 2005

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DECLARATION

I declare that this research project is my original work and has not been presented for degree or diploma in any other university.

Sign  Date 25/4/05
Charles G. Mbugua

RECOMMENDATION

This research project has been submitted for examination with my approval as University Supervisor

Sign  Date 25/04/05
Dr. B.E.E. Omulema

DEDICATION

This project report is dedicated to my wife Agnes Wangari and sons: Mbugua, Thiga and Macharia whose patience, support and encouragement have helped and motivated me through this project.

ACKNOWLEDGMENTS

At the completion of my course I will take credit for the writing of this project report, however there are those who contributed significantly to the completion of the whole study. I therefore wish to express my sincere thanks to them for their contribution towards the completion of this document:

First, my deep appreciation is to my supervisor, Dr. B.E.E. Omulema who worked very hard and with unrelenting enthusiasm supervised this work. He guided me with constructive criticism and was available when I needed his consultation. Further, I wish to appreciate other lecturers, namely Dr. Kariuki, Dr. Chege Mungai, Dr Kamau, and Dr. Washanga who all showed interest in my research paper and read it. Their critique and moral support was so much needed to keep me going.

I have benefited from enormous support from staff of International Community for Relief of Starvation and Suffering (ICROSS) home based care programme for HIV/AIDS-affected families in Nakuru, without whose support data collection would not have been possible.

Members of FGCK in Elburgon and Nakuru I appreciate you for sponsoring my studies and project both financially, in kind and in prayers. I am thankful to Wanjiku and Carol for typing my work, which saved me on resources and made my work easier. Thanks to everyone who participated in responding to the questionnaires, which were the core of the research. Thanks to Mr. Mwai, Gicheru, Waweru, Oweke and Salome, all my classmates who provided support and companionship so much needed during the study.

Last but not least, I thank my wife Wangari, sons: Mbugua, Thiga and Macharia who endured long period of silence in our house and absence sometimes when they so much needed me but did acknowledge it was worth.

The lengthy list of others who merit explicit thanks, however for the sake of brevity and practicalities remain in head and heart. However, it is I alone who bear full responsibility of the shortcomings of the study

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ABSTRACT

In Kenya, households get devastated if any of their family members is infected with HIV/AIDS. Many families equate the presence of this scourge in their household to a death sentence. What really impacts HIV/AIDS affected families are psychological, social, and economic as well as priority material and counseling needs. The purpose of this study was to investigate the nature, the extent and manner in which family members have been impacted by HIV/AIDS in Nakuru Municipality. The researcher conveniently selected International Community for the Relief Of Starvation and Suffering (ICROSS), an organization that provides Home Based Care to HIV/AIDS-affected families in Nakuru Municipality. The target population was 200 HIV/AIDS-affected families who care for serious AIDS client by providing care or are sero positive themselves. Fifty three (53) HIV/AIDS-affected families and sixteen (16) HBC providers were purposefully (information rich subjects) and conveniently (alive, good state of health and willing men to participate), selected for data collection. Tools for data collection used were one self-formulated questionnaires for each group. These questionnaires had a reliability coefficient at alpha scale of 0.7547. By use of computer Statistical Package for Social Sciences (SPSS) data was compiled and coded into themes for analysis. The study findings revealed that HIV/AIDS-affected families were seriously impacted emotionally, socially, economically, and had needs of material things such as shelter, cloths, and medicine as well as for the counseling. Hence, the hope that the study will significantly enrich the advocacy towards alleviating suffering from HIV/AIDS-affected families, help point their psychological, social, economic as well as priority materials and therapy needs. The study recommended that the HIV/AIDS affected families in Nakuru Municipality be included in plans put in place to assist HIV/AIDS clients and this need be highlighted in creation of awareness and in prevention of HIV spread in this town. It is therefore important to note that these families also greatly suffer alongside their AIDS infected family members.

TABLE OF CONTENTS

DECLARATION.....	i
APPROVAL.....	ii
DEDICATION.....	iii
ACKNOWLEDGEMENT.....	iv
ABSTRACT.....	vi
TABLE OF CONTENTS.....	vii
LIST OF TABLES.....	ix
LIST OF FIGURES.....	x
ACRONYMS.....	xi
CHAPTER ONE: INTRODUCTION.	
1.1 Background Information.....	1
1.2 Statement of problem.....	1
1.3 Objectives of Problem.....	2
1.4 Research Questions.....	2
1.5 Significance of the study.....	3
1.6 Scope and Limitation of the Study.....	3
1.7 Limitations of the study.....	3
1.8 Assumptions.....	3
1.9 Definition of Terms.....	4
CHAPTER TWO: LITERATURE REVIEW.	
2.1 Introduction.....	5
2.2 Psychological Impact.....	7
2.3 Social Impact.....	9
2.4 Economic Impact.....	9
2.4 HIV/S and Orphans.....	12
2.5 Education and Health Care.....	13
2.6 Conceptual Framework.....	15
CHAPTER THREE: RESEARCH METHODOLOGY.	
3.1 Research Design.....	16
3.2 Location of Study.....	16
3.3 Study Population.....	16
3.4 Sampling Procedure and Sample Size.....	17
3.5 Instrumentation.....	17

3.6	Data Collection Procedures.....	17
3.7	Data Analysis.....	17

CHAPTER FOUR: RESULTS AND DISCUSSION

4.1	Introduction.....	18
4.2	The Psychological Impacts on HIV/AIDS affected families.....	20
4.3	The Social Impact on HIV/AIDS affected families.....	25
4.4	The Economical Impact on HIV/AIDS affected families.....	29
4.5	The Material needs on HIV/AIDS affected families.....	33
4.6	The counseling Needs on HIV/AIDS affected families.....	38

CHAPTER FIVE: SUMMARY, CONCLUSION AND RECOMMENDATIONS.

5.1	SUMMARY.....	41
5.2	CONCLUSION.....	41
5.3	RECOMMENDATION.....	42
5.4	SUGGESTION FOR FURTHER RESEARCH.....	43

	REFERENCES.....	44
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	APPENDIX A: QUESTIONNAIRE OF FAMILY MEMBERS.....	47
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	APPENDIX B: QUESTIONNAIRE FOR CARE GIVERS.....	51
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LIST OF TABLES

2.1	HIV/ AIDS Symptoms.....	6
2.2	Needs of PLWHAS.....	7
2.3	Categories of AIDS related Costs.....	11
2.1	Link between HIV/AIDS and Psychological, Social and Economic Effects	15
3.1	Distribution of the sample	16
4.1	Character of Research	19
4.2	Psychological Impacts on affected Families.....	21
4.3	Social Impacts of AIDS Affected Families.....	25
4.4	Social Impact by HBC Providers	26
4.5	Economic Impact on affected families.....	29
4.6	HBC Providers report on Economic Impacts.....	30
4.7	HBC Providers report on Material needs in affected families.....	33
4.8	Report of Material needs by HBC providers	37
4.9	Counseling Needs in affected families.....	38

LIST OF FIGURES

Figure 1. Conceptual Framework.....18

ACRONYMS

AIDS: Acquired Immune Deficiency

ICROSS: International Community for the Relief of Starvation and Suffering

HIV: Human Immunodeficiency Virus,

H.B.C: Home Based Care

PLWHAS: People/ persons Living With HIV/AIDS

UNAIDS: Joint United Nations Programme on HIV /AIDS.

USAID: United States Agency for International Development

UNICEF: United Nations Children's Fund

NASCOP: National AIDS and STDS control Programme

WHO: World Health Organization

CHAPTER ONE

INTRODUCTION

1.1 Background Information

AIDS (Acquired Immune Deficiency Syndrome) emerged in 1980's as a terrifying challenging epidemic of our modern times. The National AIDS and STDS control Programme (NAS COP 2000) recognizes that AIDS has become the Worlds biggest fatal disease and the largest cause of death in Africa. The sources further observe that the data collected to date depicts that the number of people suffering from HIV/AIDS and dying from virus has reached pandemic proportions. The scourge in its third decade has caused the most devastating epidemic in human history (UNAIDS 2002). It has continued to ravage families and communities in the World without relenting. It has so far caused 20 million deaths while 40 million people are now living with HIV/AIDS and are likely to die in the next 10 years or before. This pandemic is infecting 14,000 people daily with HIV and 95 percent of these new infections occur in Sub-Saharan Africa. There is no cure so far for AIDS, and the disease continues to threaten the psychological, social and economic well being of Nations of the World. In Kenya, Mohammed (2002) observed that one out of every eight adults is sero positive and that more than 1.5 million people have already developed AIDS since the beginning of the epidemic in 1984. Although, only about a small part of these have been recorded in the official health statistics. Yet the lives of those infected, and particularly their families, relatives, social set-ups and places of work are all devastated by this menace. NAS COP (2000) points out that most AIDS deaths occur in people between the ages 19-49 years. This makes up for the cream of the society in terms of productivity and energy. This depicts the devastation this pandemic causes to the affected families. It is on the basis of this background that the study undertakes to investigate the effects that this scourge exerts to the affected families in Nakuru Municipality.

1.2 Statement of the problem

After a person has been diagnosed with HIV virus from Voluntary and Counselling Testing (VCT) or from other health facilities, that sero positive person has two alternatives: Accept the status and disclose to the family or refuse to accept and live in self-denial in the same family. Whichever decision the People Living With AIDS (PLWHA) take, the family will have the responsibility of shouldering the burden of the pandemic as it provides care and

support to those family members. This pandemic is a terminal illness and requires a long period of management of opportunistic infections, which is done at home or in the hospital wards. This is an enormous impact, which devastates the family psychologically, socially, economically and spiritually. These impacts will affect families in different ways and for a long time. This study therefore aimed at investigating the impacts of HIV/AIDS-affected families in Nakuru Municipality where the scourge is prevalent.

1.3 Objectives of the Study

The Objectives of this study were:

- i. To determine the psychological impact of HIV/AIDS on affected families in Nakuru Municipality.
- ii. To investigate the social impact of HIV/AIDS on affected families.
- iii. To investigate the economic impact of HIV /AIDS on affected families.
- iv. To determine the priority needs of HIV /AIDS-affected families.
- v. To investigate the Counseling needs of HIV /AIDS-affected families.

1.4 Research Questions

The Research questions of this study were:

- i. What are the psychological impacts of HIV/AIDS on the affected families in Nakuru Municipality?
- ii. What are the social impacts of HIV/AIDS on the affected families?
- iii. What are the economic impacts of HIV/AIDS on affected families?
- iv. What are the material needs of HIV/AIDS-affected families?
- v. What are the counseling needs of HIV/AIDS-affected families?

1.5 Significance of the Problem

The study is important in that its results could be used to improve counselling among the HIV/AIDS-affected families as well as create awareness in the community on the pandemic. The information derived from the study could also assist the social workers, professional counsellors, employers, policy makers, and AIDS-workers to attend to the priority and counselling needs of these families. The Government of Kenya could also use the results to *enhance policies to reduce suffering among HIV/AIDS affected families.*

1.6 Scope of the Study.

The research was based in Nakuru Municipality. Nakuru town is the headquarter of Rift Valley Province in Kenya. This is a cosmopolitan and a fast growing town with an ever-growing number of PLWHAS (HIV/AIDS strategic plan 2003-2007). Families live here but under pressures of poverty, migration, economic hardships and AIDS scourge challenges. The study targeted 200 HIV/AIDS infected families that receive Home Based Care (HBC) from ICROSS. This is a Non-Governmental Organization (NGO) in Nakuru municipality that provide home-based care to terminally ill persons especially to AIDS sick persons in this town.

1.7 Limitation of the Study

There were some families of sero positive clients who could not volunteer information due to stigma, denial, disclosure, grief and shame that is associated with this scourge. Also, some of the people living with HIV/AIDS, were so ill with the opportunistic infections that they could not provide dependable information or had died of this scourge before collection of data.

1.8 Assumptions

It was assumed that this study had sincere and honest respondents who would objectively respond to the questionnaires. It was further hoped that psychological effects such as disclosure, stigmatisation, denial and shame, which are associated with this pandemic as well as the deaths of the client, did not negatively affect this research.

1.9 Definition of term

The following terms were operationally defined as follows:

ARV or Anti Retroviral Therapy: This is a combination of medicines, usually two or three or more medications, taken by HIV positive persons to slow down the growth of HIV in the Body. It helps to improve the immune system and helps the body to protect itself against AIDS related disease.

Affected family: This is the family where one of their own members or relative is a HIV positive or a AIDS client.

Home Based Care: The care of persons infected and affected by HIV/AIDS that is extended from the health facility to the patient's own home through family participation and Community involvement within available resources and in collaboration with health care.

Impact: This is force or effect with which a family is hit when one of their member contracts HIV/AIDS disease.

Opportunistic Infection: Diseases, which takes 'opportunity' of weakened immune response as a consequence of HIV infection to spread in the body of an HIV-positive individual

Sero positive: This is the testing positive for the HIV/AIDS virus. This means that there exist enough antibodies in the blood serum, which is detected by antibody based HIV test.

Pandemic: This term is used in reference to an epidemic, in which a great number of individuals affected are very high and over a large area.

Disclosure: This is failing to reveal or keeping secret ones HIV positive status to the other members of the family.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

AIDS as an epidemic is a disease that affects the greatest number of people in communities at a certain time and moving from place to place. Pandemic on the other hand is described by Willis (2002) as a wide spread epidemic. The spread of HIV/AIDS fits this description as it has swept around the world and in recent years, has centred in sub-Saharan African.. NASCOP (2000) reveal that AIDS is the World's biggest fatal disease and the largest cause of death in Africa and the greatest threat to African survival. This impact of HIV/AIDS is therefore a major concern for policy makers at all levels, be they families or Countries. The pandemic impacts are greatest because they affect the most economically active sections of the population more than any other. It is also fatal and widespread, affecting both the rich and the poor, rural and urban, educated and uneducated members of the society (Coleman and Wilkinson 1995). It is estimated by Mohammed (2000) that the gestation period between HIV and full-blown AIDS is at most ten years. This means that the impact spreads out over many years.

Many Kenyans are infected with HIV because Mohammed (2000) revealed that for every eight adults, one is infected. The same source concluded that out of a population of 28 million, 3.5 million are infected; most of the HIV infected clients do not know that they are infected. At the moment, Mohammed, (2001) asserts that more than 1.5 million people have already developed AIDS since the beginning of the epidemic in 1984). He further suggested that lives of those infected have affected their families, relatives, social set-ups and places of work, in one way or another. Most AIDS death occurs in people between the ages of 19 – 49years. This age makes up for the cream of the society in terms of productivity, energetic citizens and best brains in the community (Balint 1998). There is no cure for AIDS, and the disease continues to threaten the psychological, social and economic well being of this country.

The symptoms of this pandemic as outlined by Johnson, Schlerhount, Steinberg. Russel, Hall, and Morgan, (2002) identifies the HIV and AIDS Symptoms as indicated in **Table 2.1** These symptoms affect the family members who provide home basic care to these sero positive persons.

Table 2.1 HIV and AIDS Symptoms

Symptoms	% of 728 cases sampled
Weight Loss	89
Pain	87
Chronic cough	74
Difficult Breathing	56
Confusion (delirium)	52
Chronic Diarrhoea	52

Source: Johnson et al (2001)

The symptoms identified as the AIDS affected families had to deal with were weight loss 89 %, pain 87%, chronic cough 74%, difficult breathing 56%, confusion (delirium) 52% and chronic diarrhoea 52% (Johnson et al 2001).

However most families identify diarrhoea as the most disturbing symptom of all. This is expressed by constant washing of beddings and the client it requires. The family members become stressed and use a lot of time and money as they provide this kind of care to the client most of whom are adults.

Table 2.2 Need of help from the HIV affected families.

Activity	Independent	Needs help
Eating	328 (89%)	35(10%)
Moving in and out of bed	304 (83%)	59 (16%)
Personal care	317(86%)	46 (13%)
Going to toilet	301(82%)	62 (17%)
Washing	292(79%)	71 (19%)
Walking	286(79%)	76 (20%)
Dressing.	197(81%)	163 (44%)
Control bowel	298(81%)	59 (16%)
Control bladder	298(81%)	64 (17%)

Johnson, et al (2000) further observed almost half of 727 needed help in walking on uneven surfaces and help was needed for basic activities such as eating, dressing and toileting for between 10%-20% of the cases. This is shown in **Table 2.2** above. The affected family members, who are the primary care provider to the infected clients, are charged with duty of meeting the needs of their sero positive persons. These needs no doubt spent time and energy of family members as they cared for the sick.

2.2. Psychological Impact.

There are complex psychological and social issues that impact on family's ability to cope with HIV and AIDS infection. Individuals who participated in high-risk behaviour that lead to HIV infection may experience intense guilt, shame, and anger. Bassett and Mhloyi (1991) observe that these emotions may be intensified for women who transmit HIV infection to their children. Furthermore, the stigma related to HIV infection may lead to social isolation. Often, families do not disclose their HIV status to family members, including the infected

child, and their community for fear that they and their children will be mistreated. UNICEF (2001) asserts that this isolation prevents families from obtaining valuable social support during difficult times. It is important for members of the medical community to be aware of the fears that these families may have regarding disclosure, as women may not utilize services if they believe that their HIV status will be disclosed.

Chassin, Presson, Sherman and McConnel, (1995) suggest that HIV and AIDS infection is viewed as a multi-generational illness. Individuals may be overwhelmed by the loss of a number of family members, as well as coping with their own diagnosis. Illness and grief interfere with a parent's ability to provide consistent care for children. Due to illness or death of the parents, primary care responsibilities often fall to extended family members. Infact, grandmothers often become the primary care giver for multiple children. Loss of parents and changes in care givers interfere with mastery of developmental milestones and coping abilities of children and adolescents, (Peerman & Levy 1998). Parent's failure to develop a permanency plan further complicates this issue, particularly for children who are HIV infected. Development of a permanency plan and providing continuity of care are challenging tasks for parents with HIV and AIDS infection for numerous reasons (Kaleeb et al 2000).

These reasons include denial of the severity of illness, fear of disclosure, health status of parent and HIV infected child, lack of reliable adult to provide care, psychological adjustment of parents, and domestic violence in the home. Another complicating issue is that HIV and AIDS disproportionately affects children, adolescents, and women of poor city estates, especially where there are primarily minority communities. Chalfin (2000). These poor individuals from poor estates of the cities often struggle to cope with problems in their homes, schools, and neighbourhoods that increase their chances of participating in high-risk behaviours. Examples of such problems include; single parent families, domestic violence, physical abuse and neglect, substance abuse, and mental health diagnosis. All these reflect on the families they come from in negative ways.

O'Connor, (1997) reveals that the Central Nervous System (CNS) that sero positive persons suffer from, affects negatively the families they come from. The same sources assert that the progression of HIV infection to AIDS infection has been associated with CNS dysfunction. The signs and symptoms of HIV-related CNS infection include cognitive impairment, such as, short-term memory deficits and confusion. Other are changes in personality; psychotic

symptoms that are hallucinations and suspiciousness, and motor symptoms such as weakness. The effects of mental health illness, which lead to use of recreation drug, stress of living with a chronic or terminally ill, and nutritional deficiencies all contribute to serious effects to the HIV/AIDS-affected family members, (Chassin, et al 1995). The sero positive persons affect different members of family in variety of ways.

2.3 Social Impacts

Cohen, (1998) indicates that the sociological impact of HIV and AIDS infections in the family is devastating to children, adolescents, women, and their families. HIV and AIDS is a chronic or terminal illness that forces individuals and their families to cope with an uncertain progression of disease, complicated medical nutrition regimes, and the grief related to the loss of health and possibly, the loss of family members (Jackson, 2002). Unlike other chronic/terminal illnesses, HIV and AIDS infection is further complicated by the stigma related to the transmission of HIV infection. Due to disclosure fears and stigma associated with HIV and AIDS, many families isolate themselves from their extended family and communities to protect themselves and their children from maltreatment. Thus, they are cut off from valuable supports. In conjunction with coping with the psychological and emotional ramifications of being infected with or affected by HIV and AIDS, these individuals are forced to deal with a multitude of stressors with little support. NASCOP (2000) suggests that these factors place these individuals and their family members at risk for mental health disorders, developmental deficits, and behavioural problems such as drug or alcohol use, school failure, inability to maintain a job, and criminal behaviour. These issues complicate the HIV and AIDS infected children, adolescents, and women's ability to access medical care and comply with complicated medication regimens. These reveal the psychological and social issues, which impact on families who live with HIV and AIDS clients.

2.4 Economic Impact

Mann & Tarantola, (1996) observe that the impact of the HIV/AIDS crisis on African economies is worsening. It further asserts that rising health care and funeral costs, combined with lost income and savings, are devastating to families. Productivity losses, increased absenteeism, and rising insurance and training costs are hurting economies and businesses. Without preventive measures, this pattern could repeat itself in Asia and Latin America. The source further indicates that very little data is available about the macroeconomic impact of AIDS. However, the World Bank (1997) and others have predicted an annual reduction in per

capita income growth of 0.1 to 0.41 percent in Africa, depending on variables such as productivity and viral incubation periods.

A study by the World Bank (1997) found that South Africa's Gross Domestic Product would be 17 percent lower in 2010 than it would have been without AIDS, costing the economy \$22 billion. A recent Harvard study postulates that these predictions are low because they do not take into account the negative feedback effects of AIDS, including falling worker productivity, declining savings and investment, and rising business costs. More studies are needed on the economic impact on African, Asian, and Caribbean nations.

Although the full brunt of the epidemic has not yet been felt because adults generally take seven to ten years to die from AIDS, the effects on business can be measured. Direct costs to companies include sick leave, health benefits, death and disability benefits, and pension liability. Metropolitan Life, one of the major insurance providers in South Africa, has developed a model to project the scope and effects of the epidemic (Johnson et al 2002). The model estimates that the cost of life insurance as a proportion of salary will increase between 1997 and 2007, and pension benefit costs will nearly double. Table 3 below indicates the related costs.

Table 2.3 Categories of AIDS-Related Costs

Categories of AIDS related Costs	Percentages
HIV Absenteeism	35
AIDS Absenteeism	15
Health Care Costs	12
Recruitment Costs	10
Burial Costs	10
Training Costs	7
Labor Turnover	5
Funeral Attendance	3
Productivity Loss after Training	1

Source: Whitesand and Sunter (200)

Whitesand and Sunter (2000) cite a multi country study that indicated the following direct labour costs attributed to HIV/AIDS. They included absenteeism from HIV 35%, absenteeism from AIDS 15%, health care costs 12%, recruitment costs 10% and burial costs 10% (**Table 2.3**). While these costs may be small for individual employees, when multiplied by the number of affected workers, they are significant. Employers will have to either decrease benefits proportionately or increase the price of their product to cover the extra cost. In addition, studies in Kenya and South Africa have shown that indirect costs—absenteeism, time off for care and funerals, lost productivity, recruitment and training of replacement employees -comprise more than two-thirds of the total cost to businesses. When combined with intangible costs, such as the loss of institutional knowledge and disruption in work patterns, the toll on business balloons. Companies must also account for the devastating impact that AIDS deaths could have on their capacity to continue production. The International Labor Organization for example, estimates that Zimbabwe, Botswana, and

Namibia could each lose 29-35 percent of their labor force by 2020, and Metropolitan Life in South Africa predicts the number of South African workers sick or dying from AIDS will multiply in the next decade.

2.5 HIV/AIDS and Orphans.

United Nations Children Education Fund or UNICEF (2000) suggests that the psychological and emotional aspects of the epidemic are seriously affecting growing numbers of children. Data are not kept on affected families. However, well over four million women have died of AIDS since the beginning of the epidemic and well over 12 million more are infected with HIV virus. Little work has been done on the psychological and emotional impact of the epidemic on children, (UNAIDS, 2000). Abandoned boys are considered to be too great an economic liability and are left to fend for themselves. This helps to indicate to us the glimpses of not only psycho-social impact of the epidemic on individual children or families of children, but also how whole communities and societies of children are beginning to be affected in ways we are barely beginning to understand.

Muraah and Kiarie (2001) concluded that the psychosocial effects of conflict on children might be relevant. These individual children may regress to an earlier developmental stage. Children of early school age can have these features too and be overtly unhappy, nervous, restless, irritable, and fearful. There may be self-stimulation such as rocking or head banging. They may not want to eat, or they may have physical complaints - headache, dizziness, and abdominal pains - with a psychosomatic basis. The sources further reveals that children can regress too to behaviour appropriate to a much younger child, in some cases to prolonged muteness or to bed bound incontinence as if they were babies. They frequently have particular fears: of being left alone in a room or sleeping alone, or of situations, which carry some reminder of the traumatic events they have witnessed. UNICEF (2000) observe that the social behaviour of traumatized children can be markedly affected, some becoming extremely withdrawn and mistrustful, others loud and aggressive. They may have learning problems. The source further reveals that war can have an all-pervading impact on child development, on the experience of human relations, moral norms, and basic attitudes to life. So too can the HIV epidemic. The source further observes that children are seriously affected in communities by HIV pandemic and are experiencing the terror of its unpredictable, relentless and accumulating death toll. However feeling of its social demoralization and paralysis are experienced silently by quiet characteristics of its advance (UNICEF, 2000).

Most of them know that one of their parents brought the virus into their family through behaviour that is often socially unacceptable and religiously forbidden.

This can cause strong emotional reactions and can have an adverse effect on the children's sexual and social development. Many children in these families are placing themselves in, or being forced into, situations where they too might become infected. The National AIDS Secretariat of Malawi estimates that one in five primary school children will contract HIV in the next five years. Mann & Tarantola (1996) indicate that eighty per cent of these will be girls. In one study of rural adolescent girls in this country, 55 per cent said they are often forced to have sex. Increasingly, children are heading families, a phenomenon unknown until now. In the past, wars or illness mostly wiped out only one adult or else took the whole family. Those few families left without adults to guide and care for them in the past could be absorbed into the extended family or the community.

AIDS is not the only cause of orphans, but it creates the highest percentage. There are approximately 1 million AIDS orphans. According to UNAIDS (2000) an AIDS-orphan is defined as a child under the age of 15 who has lost her/his mother to AIDS.

The children are exposed to bleak futures in terms of education, good health and other necessities that are required during these formative years. There has been an increase in AIDS-orphans becoming street children. This and the need to help them have created increased pressure on the society that has to look for ways to deal with them. Included in the social burdens is the issue of homes, orphanages, education and health care facilities. On the family scene many grandparents, who are not in a position to fully take care of them, are left to feed the children. In some worse cases, there are families that are headed by very young children who take care of their siblings (Baggaley & Needham, (1997).

2.6 Education and Healthy care

The impact of HIV/AIDS is already being felt in the education arena. Many children infected at birth do not survive to enrol in formal education. There are those who have been forced by circumstances to quit school so as to take care of the other infected members of their families. Others have no source of income to meet their education needs due to the loss of the breadwinners. At the same time the teacher population is being affected. They are getting infected and also dying. Others have to relinquish their jobs to take care of the infected family members. In some cases children drop out of school so that the cost of medical bills

can be met using the school fees rations. According to a World Bank (1997), the cohort size of primary-aged children in Tanzania would shrink by 22% and for secondary aged children by 14% relative to a no-AIDS scenario by the year 2020. By 2010 Tanzania will have lost 14,460 teachers to AIDS and by 2020 some 27,000 teachers will have died of the disease. Training replacement teachers will cost about \$37.8 million in recurrent costs.

KENCO (2000) states that AIDS has no cure and there is no known vaccine against it. There will be increased need for hospitalisation facilities and medical attention. The drugs available in the market are not to cure the disease but to make the lives of the infected more bearable. The cost of medication and all related health issues takes a large portion of income both on household, institutional as well as national level. The cost of anti-retroviral drugs and viral load are still not affordable for most people. Though the costs of the drugs are being reduced, the price is still way above the affordability of the majority of people considering that these are life-prolonging drugs and the patients have to constantly take them the rest of their lives. This excludes the charges on doctor's fee, counselling, information, education and communication.

Muraah and Kiarie, (2001) reveal that another problem an individual has to contend with is the treatment of opportunistic infections such as tuberculosis, pneumonia and thrush. This high figure does not also take into consideration the expenses incurred on utilisation. For people suffering with HIV/AIDS, there are times when they will suffer from uncomfortable symptoms such as diarrhoea, nausea, headaches, fever and coughs and will need palliative (sedating) care to deal with them. NASCOP (2000) reveals that the figure is way above what even an average Kenyan can afford. In all cases, good dietary observance is critical with carefully monitored well-balanced foods being consumed. Yet all these are essentials in the care and treatment of the disease. In some cases, the breadwinners have to quit their source of income to take care of the ailing ones and thus reducing the source of finances for medical attention. The source further comments that the issue arises for the medical fraternity on how to take maximum care of the HIV/AIDS patients without neglecting those who are negative yet need medical attention. They also need to educate them about the HIV virus and this deadly disease. Poverty in some cases has forced the health providers and patients to opt for lower doses of prescribed medication or choose less effective alternatives in order to save money,

2.7 Conceptual Framework

According to **Fig 2.1** below, AIDS in the family has fatal consequences that leaves surviving spouse either a widow or a widower and siblings become orphans. This is further complicated by impacts as shown in fig 1 below. The model of law of effects is at play here where the cause of emotion, social, economic and material and counselling is the HIV/AIDS scourge.

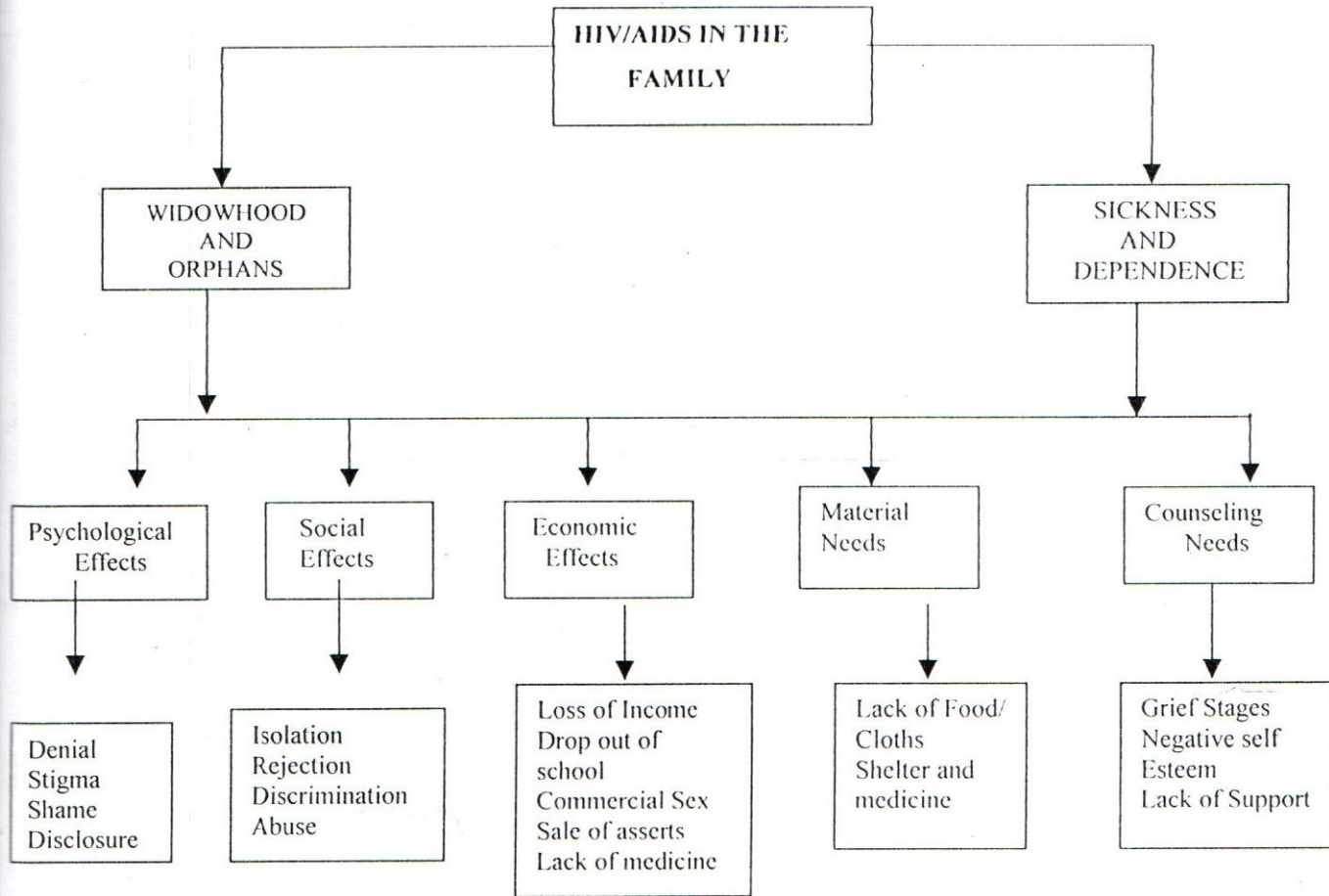


Fig 2.1 Link Between HIV/AIDS and its Psychological, Social and Economic effects.

The result of this scourge is that clients become so ill or so affected with opportunistic infections such that they require help from family members. These consequences of death or illness will no doubt trigger serious effects on affected family members. These effects comprise of psychological, social and economical impact, which the researcher is out to investigate in this work. The researcher found out that each of the impact affected AIDS-affected families in variety of ways. This result indicated need for intervention to elevate the suffering caused by this scourge in the families.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Research Design

The research design adopted in this study was Ex Post Facto, which examines an event after it has happened. The researcher looked at variables in their natural settings and in their historical occurrence that had happened prior to the data collection stage.

3.2 Location of the study

This research was carried out in Nakuru Municipality in the Estates of Kaptembwa, Bondeni and Free Area in Nakuru District, Rift Valley Province. This town has an estimated 45,587 of HIV/AIDS cases, prevalence of 25 and amongst five top districts with highest number of HIV/AIDS in Kenya (Ministry of Health, Kenya 2001).

3.3 Population

The research targeted 200 AIDS affected families who live in Nakuru Municipality amongst 45,587 of HIV cases in this urban area. Each of these families has at least one member who is a sero positive client and one or more family members who responded to the questionnaire. These were the affected families who receive home-based care from ICROSS in Nakuru. The numbers of HBC providers who serve in these estates were 60. They personally responded to their respective questionnaires at researchers supervision.

Table 3.1 Distribution of the sample

Sampled Category	Population	Sample size
AIDS-affected families	200	53
HBC Providers	60	16
TOTALS	260	69

The size of sample was 69 of the target-estimated population of 260

3.4 Sample and sampling procedure:

The researcher purposefully and conveniently sampled 53 sero positive affected families because the area of study is one associated with combination and complication of illnesses that cause emotional feelings of shame, stigmatisation, denial and therefore not all respondents filled the questionnaires. This comprised of the HIV and AIDS-affected families whose family member was receiving home based care services from ICROSS, an NGO that works amongst these families in Nakuru municipality. The researcher also offered to work with these clients and their families to familiarize him with their needs and experiences as well as create a rapport with them (Kathuru & Pals 1993).

3.5. Instrumentation

Instrument in this research was a tool that was used to collect data. The researcher formulated and used two questionnaires for data collection in this research. One questionnaire was administered to the affected family members while the other was administered to home base care providers who work with these sero positive affected families.

3.6. Validity and Reliability of the Instrument

To validate the instrument, the researcher sought expert advice from his supervisor and other research experts. To ascertain the reliability, the researcher subjected the instrument to a pilot test and Cronbach Coefficient Alpha formula was calculated at 0.7547 , which determined the internal consistency.

3.7 Data collection

After obtaining authority to carry out this research from ICROSS management, and from the Government of Kenya, the researcher personally administered one questionnaire to HIV/AIDS affected families and the other to Home Based Care Providers who worked with ICROSS in Nakuru Municipality.

3.8 Data Analysis

Data collected through questionnaire was analysed using disruptive statistics with the help of SPSS, software that summarises and analyses data with ease and makes it ready for interpretation and discussion.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 Introduction

In to investigate the impact of HIV/AIDS on affected family members, data on psychological, social, economic impacts as well as on the counseling and material needs that faced these families. The analysis made revealed the following finding as indicated in **Table 5** below which reflected the characters of the research respondents. The findings found out that females (62.5%) supported and provided Home Based Care to the AIDS-affected persons as compared to males (37.7%). in this town. This was in agreement with the earlier mentioned sources that in most communities, women and girls provided most care for the most terminally sick people home and especially in AIDS pandemic. This gender is naturally endowed and is culturally prepared to carry out such tasks both at home and in community. Most men and boys on the other hand are not so prepared to care for the sick. The data also revealed the age bracket of people who provide HBC to most AIDS clientele as between 20-30 years old (56.3%) as compared to 30-40 years old who handled only 30.2 %. This concurs with earlier cited sources that reported that the age-bracket most devastated by HIV/AIDS is 19-49 years old. This therefore means that most of the family members who support their sick relatives will be of their own age group as indicated by the findings.

The education level of most AIDS affected family members interviewed were of primary and secondary education level, 41.5% respectfully. However 17% of them had College or University education level. This reveals that most AIDS affected family members are not adequately educated and therefore the provision of care and support would be inadequate. It also indicates that they need training to help them cope with scourge and handle the pandemic issues wisely. The HBC providers on the other handle were educated, which means that they adequately administered services without getting themselves infected with HIV virus.

In the **Table 4.1** below, some respondent's characteristics are indicated to help understand and be able to relate them with other sources.

Table 4.1 Characters of Research Respondents

Character Respondents	of	HBC Providers		Family members	
		Frequency	Percentage	Frequency	Percentage
Gender	Male	6	37.5	16	30.8
	Female	10	62.5	36	69.2
Age bracket-	less than 18yrs	0		7	13.2
	20-30 yrs	9	56.3	16	30.2
	30-40	5	31.3	16	30.2
	More than 40 yrs	2	12.5	14	26.4
Education Level –	Primary	3	18	22	41.5
	Secondary	6	35	22	41.5
	College/University	7	41	9	7
Discovery of Status	C/Observation	2	12	15	28.3
	VCT	12	75.6	21	39.6
	Self- Disclosure	1	6.3	16	30.2
Family's life	less than 1yr.	13	24.5		
	4yrs	30	56.6		
	5-8yrs	9	17.0		
	Over 10yrs	1	1.9		
HBC worked with ICROSS	less than 1yr	4	25		
	1-4yrs	11	68.8		
	5-8yrs	1	6.3		

Most HBC providers had College or University educational level (41%), secondary 35% and 18% of them had primary level. This indicated that informed and educated people did home care provision in ICROSS.

It also follows that most investigations of HIV status were done in VCT centers. HBC providers reported that 75% of AIDS affected families were screened in VCT centers, 12% of them were clinically observed while 6.3% were self disclosed. This discovery indicated that VCT services were effective and significant in this town.

The data also indicated that 68.8% of the respondents had received HBC services from ICROSS for 1-4 years, 25% had it for less than 1 year and 6.3% of them had it for 5-8 years. This information pointed out that this organization had experienced HBC providers who were skilled and informed in their work with HIV/AIDS-affected families. The research findings also revealed that 56.6% of affected families had lived with the AIDS -sick person for 1-4 years while 24.5% had lived with them for less than one year. These findings indicated that operations of ICROSS had good effects in the community

4.2 Psychological Impacts of AIDS-affected families

The research findings revealed that AIDS-affected families were impacted psychologically. **Table 5** below indicate the specific areas and extent of impact as follows: Shame 94.3%, fear 94.5%, stress 86.8%, anger 86.8%, stigma 83.0%, denial 79.2% and behavior problems 71.7%. Home Based care providers agreed with family members on the same emotional impacts and for comparison reason,

Table 4.2 below is posted to indicate the manner in which families were affected. These two reports helped to point out the devastation experienced by the HIV/AIDS-affected families. Home Based Care providers further reported that family members had behavior problems as a result of HIV/AIDS in the family. This report further supported the finding of this research that agreed with the family member's report as well as other reviewed literature.

Table 4.2 Psychological impacts on affected families In Nakuru Municipality.

This table, indicate the psychological aspects that impacted the AIDS-affected families. They include stigma, shame denial, fear stress and behaviour problems.

Table 4.2 Psychological impacts on affected families

Psychological Impact		Frequency	Percentage
Stigma	Yes	44	83.0
	No.	8	15.1
	Not sure	1	1.9
	Total	53	100
Shame	Yes	50	94.3
	No	3	5.7
	Total	53	100
Denial	Yes	42	79.2
	No/sure	11	20.8
	Total	53	100
Fear	Yes	56	94.3
	No	7	13.2
	Total	53	100
Stress	Yes	47	88.7
	No	6	11.3
	Total	53	100
Behavior Problem	Yes	38	71.7
	No	13	24.5
	N/ Sure	2	3.8
	Total	53	100

Table 4.2 indicated the psychological aspects that impacted the AIDS-affected families. Almost 80% of the families were impacted by emotions of stigma, shame, stress, fear, and denial behaviour problem, as shown in above.

The scourge of HIV/AIDS is a life-threatening disease and therefore people are scared of contracting it or have a member of their family contract it. Most of them take it as a death sentence, which increases anxiety in their lives. The disease is also associated with behaviours such as sex between men, a practice that is not socially acceptable in this community. Substance abuse such as drug pushing is also another antisocial behaviour, which many sources relate with HIV/AIDS and which conflict clients psychologically. This practice does add emotional feelings to already stigmatised societies. The other factor that contributes to this is that people living with HIV/AIDS are often thought of as being responsible for becoming infected as well as religious or moral beliefs that lead some people to believe that having HIV/AIDS is the result of moral fault such as promiscuity or 'deviant sex' that deserves to be punished.

Other people attribute these psychological impacts to cultural curse. This scourge leaves individuals in such a high degree of distress such that it is only the psychotherapy that can help reduce suffering among the HIV affected persons. The intervention best befitting for AIDS affected people includes: exercise i.e., training to help client improve their physical fitness, overall health, and psychological well being, appraisal training to help clients make adaptive appraisals as well as coping training to help clients learn and practice positive coping skills. The other aspects are social support training to help clients obtain the social support that suits their needs and also self-sufficiency training to help clients maintain an attitude of active involvement and mastery. The psychological issues that impact on HIV affected families shows similar psychological impacts earlier sited, that stigma could lead to social isolation and mistreatment (Besset & Mloyi 1991). This isolation causes conflict, which does not allow the family member to socialize well with others in community or at work. This further leads to economic difficulties to all the affected member of family and may withdraw from work. Stigma eliminates any sharing of this burden and also prohibits pro-activity in learning and also documentation of any information about HIV/AIDS.

The UNAIDS (2000) quotes a HIV positive man in India as stating that:

"Nobody will come near me, eat with me in the canteen, nobody will want to work with me, I am an outcast here."

The source further observes that stigma discourages seeking of care of an early stage of this scourge. This therefore contributes to negative impacts on family members because of delay to seek for help, which includes therapy. The disclosure caused by stigma could also threaten life especially when it prevents the sufferers from going to seek for therapy.

Denial is failing to admit that the respondents have been affected by HIV/AIDS in family while in essence they have been. Those who have been impacted by denial fail to disclose that their family members have been infected by HIV/AIDS and this reveals negative behaviours, which robs the affected family members normal functions. Some people do not believe that they have HIV/AIDS even when a social or medical worker tells them they will die of it. Denial can be dangerous for a person with HIV/AIDS and for other members of the family. This state of denial therefore, does not encourage HIV/AIDS afflicted family members to work, socialize and engage in meaningful relationships.

Fear is an emotional feeling that results from being left alone or isolated by the rest of the community who tend to withdraw from a HIV/AIDS-affected family, thus causing them to fear. Fear is very debilitating feeling as it a primary appraisal of actual peril or danger. It is characterized by the urge to avoid this fear provoking experience. This does not fit with the situation of having an AIDS infected person in the family. It also robs them motivation to work productively in the community. Those who are in learning institutions are also so negatively affected that they sometimes discontinue with education. Those that are in business or employment are also immobilized by fear to a point where their business decline. These psychological feelings of fear and worry can make the AIDS patient or family lose their will to live. This is also true to the implicated members of household whose fear has taken toll in their lives. There arises suicidal tendency and is the most likely thing among those who want to free from their fears and misery. This emphasizes that fear and anxiety in AIDS-affected family members can be very serious. This further causes worry over effects of treatments and medication, isolation through rejection because of the fears of others

concerning infection and anticipating the family's inability to cope with situation. The fear of being infected is also a significant cause of fear.

Members of HIV/AIDS-affected family feeling betrayed in their relationships or being abandoned by members of community because a person they love has contracted HIV/AIDS cause anger. The anger may get worse as the sero positive person becomes ill and they may not have the ability to provide medical care to the sick. Anger is a strong feeling of displeasure and usually of antagonism. Most AIDS affected members become frustrated by anger as they try to understand the HIV/AIDS infection in their family. They often place blame on the sick person and also neglect him by concluding that he was not careful. This will therefore make them withdraw from the infected person, thus depriving him the most needed support and care that he so desperately needs. The sero positive person will also anger the family members by losing his job that probably supported them at home.

Stress is psychological feeling that disturbs the peace of an AIDS affected family and could reduce its ability to cope. The HIV/ AIDS pandemic interferes with the affected family to a point where they no longer live a normal life. This results in stress that is a many-sided phenomenon and can have serious harmful effects on these families.

4.3 The Social impact of AIDS-affected family

The findings revealed that AIDS-affected families were socially impacted by being isolated, rejected and were discriminated against in the community.

Table 4.3 Social Impacts on affected families

Social impact Variables		Frequency	Percentage
Community Isolation	Yes	43	81.1
	No	10	18.9
	Total	53	100.0
Community Rejection	Yes	43	81.1
	No	8	15.1
	Not Sure	2	3.8
	Total	53	100.0
Criminal Behavior	Yes	17	32.1
	No	29	54.7
	Not Sure	7	13.2
	Total	53	100.0
School Discrimination	Yes	31	58.5
	No	20	37.7
	Not sure	2	3.8
	Total	53	100.00

The extent in which AIDS-affected families were affected is indicated in **Table 4.3** above and was as follow: 81.1% of families were isolated and rejected in Nakuru Municipality. Over half (58.5%) of their children were discrimination against in schools. However over half (54.7%) denied that they experienced criminal behaviours in community while a few of the families (32.1%) admitted that they experienced it in the their families.

The home based care providers agreed with findings of families except in the area of discrimination in school. Those who reported that they were school discrimination and those who said that there were none 37.5% while those who were not sure were 25%.

Table 4.4 Social Impact by HBC Providers

Social Variables	Impact	Frequency	Percentage
Community Isolation	Yes	11	68.8
	No	3	18.8
	N/S	2	12.2
	Total	16	100
Rejection	Yes	11	68.8
	No	4	25
	N/S	1	6.3
	Total	16	100
Criminal Behavior	Yes	3	18
	No	8	50
	N/S	5	31
	Total	16	100
School Discrimination	Yes	6	37.5
	No	6	37.5
	N/S	4	25
	Total	16	100

Table 4.4 above compared the findings of AIDS-affected with those of HBC providers as follows: community isolation 60%, rejection 68.8% and criminal behaviours 50%.

The reasons why social impact devastated AIDS-affected families are that the population of the study is in Sub-Saharan area which in general comprises of people who are destitute, homeless, families who cannot care for their people due to poverty. This therefore is made worse by the pandemic and at this age of AIDS the families are driven deeper into poverty as breadwinners get sick and die, a psychologically stressed, orphaned children increase and elderly and disabled also increase in number without support. All these factors further complicate social impacts on these HIV/AIDS affected families in Nakuru Municipality.

Isolation is being excluded by the community from social contacts such as, not being visited, not being invited to a gathering such as wedding or birth-day party on the context that family is HIV/AIDS affected. When this happens to a family, it leaves them more devastated and unable to cope with such a serious epidemic as this. This will then mean that their functions will be hampered and limited. This may go as far as being sacked from a job and therefore suffer from economic problems as well as lose necessary social contacts. When this happens, it means that social support will become very necessary for such a family.

Collins (1988) admits that community isolation is a reality among HIV/AIDS affected people and goes on to suggest a remedy; social support. Thus support for HIV isolated families; is not given by many people and several of them are afraid of virus. Some of the community members think that living near someone with HIV virus will infect them with virus and therefore some family members may be tempted to abandon their own HIV/AIDS client and leave them without support. It is apparent that co-workers in the farm or factory do not want to work with an infected person and that some countries encourage employers to segregate employees who are HIV positive. Some countries even go as far as ordering arrest for all people who are HIV patients with an aim of arresting HIV spread. All these efforts contribute towards stigmatisation and isolation of the HIV/AIDS client and their families. The community isolation is closely related to rejection. The Rejection is being avoided or excluded by the community or the person that have a HIV/AIDS person in the family. Such community behavior of isolation and hence rejection limits a HIV/AIDS client from functions and operations in the community. If for example a teacher in a school suffers rejection as a result of HIV, his services will not be well received in his institution and the entire community. People who are sero positive persons seen as a shameful group and

therefore rejected by the community. These clients are also the first ones to be rejected and blamed for contracting HIV/AIDS.

After news of HIV is released to the clients they think of hurting themselves or other people. The care providers, most of who is HIV positive are the ones to shoulder the burden of AIDS infected person. The immediate reaction of this care provider is to experience shock after realizing that their partner is HIV/Positive. This is followed by anger, a state in which criminal behaviour is likely to take place. This is further followed by shame; helplessness and low self-esteem and this could make HIV sufferers be involved in criminal activity to solve some economic problems. Criminal activities among HIV/AIDS-affected families on the contrary are not caused by stigmatization, disclosure and denial issues. For example shame does not encourage one to be involved in such activities neither does some bodily weakness that some family members may have.

Discrimination that students in schools experience includes being teased, ridiculed and being abused. When this happens, to any student, he will not be able to concentrate in learning and could even abscond learning and run out to the city to be street children. Some even marry early thus creating a future community problems. People with HIV have been denied access to services or exclusion from all sorts of social and community events. They have to endure stigma, rejection and isolation in addition to the agony of facing a life threatening disease. The school has not been spared either from these feelings that lead to discriminatory behaviours in schools to both students and teachers who suffer from HIV/AIDS.

4.4 The Economic Impact On HIV/AIDS-affected families

Economic impact was examined in light of variable family items sold to pay health care. Findings revealed that most families did not sell their variable assets.

Table 4.5 Economic Impact on affected Family

Economic Variables sold		Frequency	Percentage
House	Yes	6	11.3
	No	46	86.8
	Total	53	100.0
Plot	Yes	7	13.2
	No	46	86.8
	Total	53	100.0
Shares	Yes	9	17.0
	No	44	83.0
	Total	53	100.0
Business	Yes	10	18.9
	No	43	81.1
	Total	53	100
Farm	Yes	8	15.1
	No	45	84.9
	Total	53	100
Animals	Yes	25	47.2
	No	28	52.8
	Total	53	100

Over 80% of AIDS affected families said that they did not sell their farm, house, business or shares. However 47.2% of the families said that they sold their animals to pay for the Health care of the sick person.

Table 4.6 HBC report on Economic Impact on affected Family

Economic Variable sold		Percentage	Frequency
Family House	Yes	4	25
	No	12	75
	Total	16	100
Plot	Yes	2	12.5
	No	14	87.5
	Total	16	100
Shares	Yes	4	25
	No	12	75
	Total	16	100
Business	Yes	16	100
	No	0	0
	Total	16	100
Farm	Yes	6	37.5
	No	10	62.5
	Total	16	100
Animals	Yes	4	25
	No	12	75
	Total	16	100

The HBC providers' responses agreed with that of family members in observing that families did not sold their house 75% against 25%.

They further said that the families did not sell their plot 87.5%. While others reported HBC providers agreed with family members response in reporting that the family shares were not sold to buy medicine 75% against 25%. They however disagreed with family members in saying 100% of them sold their businesses. HBC providers differed with family members in reporting that they did not sell animals to pay for health care, 75% against 25%. This difference is attributed to the shortness of time HBC providers who had served these families, they met them when they were already devastated by the pandemic and therefore did not have any business nor animals to sell.

The researcher set out to investigate which economic challenges faced the HIV/AIDS-affected families in Nakuru Municipality. This was approached from point of view of whether some family assets such as house, plot, business, shares, farm or animals had been sold to pay for healthy care. **Table 4.6** indicates the result of data analysis. This resulted from the fact that most AIDS sufferers are virtually poor people and did not own any house, farm, business, plot or shares. They therefore had no assets to sell. It could also mean that the amount needed by the HIV/AIDS affected family did not require a lot of money at a go and so they could not sell their assets. Also most families realized that death from AIDS was soon coming and they did not want to sell their children's inheritance. The sale of animals was possible as this attracted many buyers and involved a small amount of money as compared to other assets. The findings of the study pointed out that that HIV/AIDS affected families have been grossly devastated by pandemic in the households. The findings also said that the scourge affected the economy by causing illness and death, which increased absenteeism from work, which in turn caused reduction in overall productivity and increased health costs. At a household level, HIV/AIDS caused even greater economic devastation, through greater health costs and also loss of income as family members become less productive through sickness and psychological traumatization.

UNAIDS and UNICEF (1999) concur with this study finding and further outlines economic impacts that affect household as: loss of income, remittances or productive labour leading to increased poverty and poorer nutrition as well as increased expenditure on health care transport and funerals.

Reduced expenditure on food, clothing school and other costs are some of the other economic challenges on the HIV/AIDS-affected families. Children, especially girls are also usually drawn out of school due to depleted drawing of savings and sale of assets.

This results in increased workload on women and children, which are another economic challenges. The reasons for negative economic impacts on AIDS-affected families are that most households are conflicted by absenteeism from work due to sick leave, bereavement and funerals as well as leave to care for their AIDS dependant clients. This greatly reduces their income and therefore reduced performance in factories businesses and farms due to HIV/AIDS sickness all of which complicates issues either directly or indirectly. Other factors that affect family economy include replacement of workers, reduced productivity, family pensions and cost of medical treatment.

In countries like Ethiopia AIDS affected households were found to work 11-16 hours as compared to 33 hrs per week for non-AIDS- affected households. In South Africa, falling income forced about 6% of households to reduce the amount they spend on food and almost half of households reported having insufficient food at times. The scale of HIV/AIDS infection in sub-Saharan Africa has economic implications at the levels of households, national budgets, and businesses. This is demonstrated by the decline of economic growth in the Third World where at the household level the effects of HIV infection are obvious; the cost of medical care and related areas increases while the ability for a family to earn income or undertake productive and domestic work decreased; if the infected person is an adult, then the production and income of the household reduces.

4.5 Material Needs For HIV/AIDS affected families in Nakuru Municipality

The researcher set out to investigate the needs that HIV /AIDS inflicted families had in Nakuru Municipality. The outlined needs included health care, counselling needs; cloths shelter medicine and home-based care.

Table 4.7 Material needs in HIV/AIDS affected families

Priority Needs		Frequency	Percentage
Health Care	Yes	51	96.2
	No	2	3.8
	Total	53	100
Counseling Needs	Yes	47	88.7
	No	6	11.3
	Total	53	100
Cloths	Yes	40	75.5
	No	11	20.8
	N/Sure	2	3.8
	Total	53	100
Shelter	Yes	35	66.0
	No	16	32.1
	Total	53	100
Medicine	Yes	52	98.1
	No	1	1.9
	Total	53	100
Home Based Care	Yes	47	88.7
	No	5	9.4
	N/Sure	1	1.9
	Total	53	100

The data analysis pointed out that 96.2% of the respondents indicated need of health care while 98.15% needed medicine. The study revealed other needs as counseling (88.7 %) against 11.3%, cloths 75.5 % against 20.8%, shelter 66% against 32% and home based care 88.7% against 9.4%.

These findings result from sheer poverty that AIDS-affected families are in. As have been mentioned above, the loss of jobs, absenteeism from work, impact of psychological and socio-economic and long illness that sometimes lead to death, all combined devastate AIDS affected families.

The health care and medicine needs are interrelated and they include nursing care or hospitalization and provision of drugs. Care can be in hospitals, nursing homes or the patients own homes. Good health care usually requires several individual with different skills e.g. Doctors, nurses, family members and counselors. Adequate knowledge on HIV/AIDS and on opportunistic infections allows significant human contact that is required to provide good treatment and care without risking infection to the caregiver. And since 60% of hospital beds are occupied by HIV/AIDS-patients, the relatives of sero positive person have to pick up drugs from hospital and be treated at home so that beds could be occupied by patients with other disease. However, care must be exercised in handling blood and other bodily fluids of HIV/AID patients to protect both patient and the caregiver.

To avoid stigmatization it is advisable not to isolate HIV/AIDS patients except in cases of opportunistic infections like tuberculosis and typhoid. Drugs or medicine on the other hand are the pharmaceutical products that prolong life in HIV/AIDS clients or treat other opportunistic infections. The drug that prolongs life is known as anti- retroviral or ART. These ART are too costly especially in sub – Saharan Africa and very few people can afford them. Secondly there are efforts to develop ART, which will be cheaper for Africa countries and which will be accessible and affordable to most. African countries. This idea will in no doubt bring these drugs into the hands of most families which desperately need them and who can benefit from such discoveries.

Therapy or post –test counseling is very vital if the HIV positive client will positively adapt to a near normal life. If counseling is not provided, even after client has tested positive, then varied disastrous reaction could take place. It is predicted that suicidal tendencies could result from the HIV positive person complications or the client could run away never to seek

therapy again. This would mean that the client will spread the virus and family members will fail to discharge their duties as expected.

The AIDS scourge has psychological implications as it is incurable and causes ultimately fatal disease. Anxiety, depression and intense feeling of hopelessness and helplessness usually accompany it. Thoughts of suicide are common and report of friends who have died from AIDS related diseases intensify emotional feelings. All these psychological feelings necessitate therapy to alleviate such conflicts and help HIV/AIDS affected families cope with situations. Promiscuity, use of drugs and sexual behaviours inflict guilty feeling to both the client and family members, thus causing them intense problems. Another thing that most HIV/AIDS-affected families experience are isolation, alienation and loss of their social contacts. These sufferers are often affected by losing their self-esteem. These issues help to point out the necessity for therapy with a view of encouraging, educating and helping to focus on the future of the HIV/AIDS affected family members.

The need for cloths indicates the presence of economical needs whereby all funds go to pay for medical care. These expenses drain all the funds such that family members go without cloths. In South Africa for example, poor households coping with AIDS sick members were reducing basic necessities and the most likely cut costs were cloths, and electricity and even food expenses were reduced in order to pay for hospital bills and is contradicted by fall of incomes in these HIV/AIDS affected families, AIDS affected families are suffering from reduced expenditure on food, cloths, school and other things.

The need for housing among AIDS-affected families in Nakuru Municipality helps emphasize the need for shelter. These findings indicate that AIDS affected families lack housing, or cannot afford house rent in Nakuru Municipality. House rents may be too high such that their economical status cannot meet it. AIDS affected families need for housing, can be through social welfare organizations such as churches, and NGOs. However, the provision of Health care and home based care is best done at AIDS affected families residents as the scourge is a long term sickness.

This home-based care involves providing basic support by simply showing concern and spending time with the sick person. These simple care roles help to improve morale and reduce loneliness and feelings of rejection and can allow AIDS client to have a break. This home-based care is best done at home to ease congestion of HIV/AIDS patients in the health

institutions. The care that families or friend provides to the HIV/AIDS client most often extends to nursing care as well as counseling the sick. The inability of family to pay for the hospital bills and overstretched National health care system have necessitated the home based care service. This service also reduces significantly the travel expenses to and from hospitals. These service providers of home based care, should be given basic training in counseling and nursing to avoid risks associated with this pandemic. These service providers also need support to strengthen them in their work and to break from their caring roles to protect them from other psychological conflicts.

Most care providers are women and young girls who also do other household chores, farming and other employments. They also look after other members of family as well as the AIDS-sick persons in the family. Most women caring for the sick husbands or babies will have HIV themselves and their own health may deteriorate. These tasks will no doubt reduce their ability to care for the sick in the family. They therefore need to be supported and equipped to reduce this pandemic's burden on families. Support group would be beneficial in that they strengthen service of care providers. To reduce this burden on women men and boys who are not culturally prepared for the lack should be encouraged and trained for the work. People who have HIV/AIDS can also be trained to take care of themselves rather than be left helpless, in low self-esteem and depressed. They should be encouraged to join HIV support groups. In such groups they can be helped to adapt to and learn to live with HIV virus as well as deal with opportunistic infections.

Comparatively AIDS affected families responses agreed with those of HBC providers. The areas they agreed on included need for HBC 100%, medicine 100%, therapy 100% and healthy care 100%. However the HBC providers emphasized these needs than the family members did. On the issues of cloths (56,3%) and shelter (56,3%), they said that AIDS affected people did not need them as shown on **Table 4.8** below. This is attributed to the fact that HBC providers prioritized their needs. They concluded that HBC, medicine, counseling and health care are the most necessary needs of these families as compared to cloths and shelter.

Table 4.8 Report of Material Needs by HBC providers

Material need valuables		Percentage	Frequency
Health Care	Yes	16	100
	No	0	0
	Total	16	100
Counseling Needs	Yes	16	100
	No	0	0
	Total	16	100
Cloths	Yes	7	43.8
	No	9	56.3
	Total	16	100
Shelter	Yes	7	43.8
	No	9	56.3
	Total	16	100
Medicine	Yes	16	100
	No	0	100
	Total	16	100
Home Based Care	Yes	16	100
	No	0	100
	Total	16	100

4.6 Counseling needs for HIV/AIDS affected families in Nakuru Municipality

Table 4.9 Counseling needs for HIV/AIDS affected families

Counseling variables		Frequency	Percentag
Is counseling necessary	Yes	51	96.2
	No	1	1.9
	Not sure	1	1.9
Disclosure	Yes	48	90.6
	No	5	9.4
	Not sure	0	0.0
Stigma	Yes	45	84.9
	No	8	15.1
	Not sure	0	0.0
Shame	Yes	47	88.0
	No	6	11.0
	Not sure	0	0.0
Coping skills	Yes	52	98.1
	No	1	1.9
	Not sure	0	0.0
Behavior problems	Yes	37	69.8
	Not	16	30.2
	Not sure	0	0.0
Mental disorders	Yes	31	58.0
	No	22	41.5
	Not sure	0	0.0
Total		53	100.0

The HIV/AIDS affected families desperately required counseling (96.2%) as shown on **Table 4.9** The emotional needs that respondents rated as needing great deal of counseling were disclosure 90% against 10%, stigma 84% against 16%. The other areas that respondents indicated moderate counseling needs were behavior problems (69 %) and mental disorders (58%). Generally the need for counseling in HIV/AIDS affected families is high.

If any AIDS affected member have engaged in behavior that can transmit HIV, it is very important that you consider counseling and testing. The following checklist helps assess their needs and degree of risk.

There is evidence that HIV, the virus that causes AIDS, has been around since 1978. The following are known risk factors for HIV infection. If any of these questions affects them then they should definitely seek counseling and testing. They may be at increased risk of infection if any of the following apply to them:

- i Have they shared needles or syringes to inject drugs or steroids?
- ii If they are a males, have you had unprotected sex with other males?
- iii Have they had unprotected sex with someone who they know or suspect was infected with HIV?
- v Have they had sexually transmitted disease (STD)?
- vi Have they received a blood transfusion or clotting factor since 1978?
- vii Have they had unprotected sex with someone who they suspect has HIV Virus?

If AIDS affected family members have had sex with someone and they didn't know their risk behavior, or they have had many sex partners, then they have increased the chances of contracting HIV/AIDS. If they on the other hand plan to become pregnant, counseling and testing is even more important. Without treatment, HIV-infected women have about a one-in-four chance of infecting their baby during pregnancy or delivery. Medical treatment can reduce this to about a 1 in 12 chance.

Knowing your result, even if you are infected or have positive test result, one may be less stressed for some people, than the anxiety of thinking you might be infected but not knowing. If your result indicates you are not infected (negative), you can take action to be sure you don't become infected in the future

The HIV/AIDS affected families need counseling to alleviate counseling as per **Table 4.9** Nelson - Jones (2000) defines counseling as a process whose aim is to help client to make better choice, to choose and make helpful relationship which is aimed at changing specific aspects of their lives. The pandemic of HIV/AIDS in a family causes devastation of serious psychological issues as indicated above and which requires therapy to help the counselee cope in life. The findings indicate a serious need in this area of counseling. Whenever a HIV affected family is receives therapy, they become less depressed and better adjusted. When they use positive coping skills and also become less devastated when they are given social supports, which are part of therapy. Psychotherapy is a necessity for HIV affected persons, which are left in such a high degree of distress and devastation. The intervention best befitting for these clients as outlined by Chesney & Folkman (1994) include:

- i Exercise that is training to help client improve their physical fitness, overall health, and psychological well-being.
- ii Appraisal training to help clients make adaptive appraisals.
- iii Coping training to help clients learn and practice positive coping skills such as problem solving, self-revelation and humour.
- iv Social support training to help clients obtain the social support that suits their needs.
- v Self - efficiency training to help clients maintain an attitude of active involvement and mastery

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Summary

The research findings revealed that HIV/AIDS-affected families in Nakuru Municipality have been severely devastated by psychological, social, economic impacts and had lack of material as well as counseling need. The extent in which emotional feelings impacted the families was about 80%. This included: shame, fear, stress, anger, stigma, denial and behavior problems. The social impacts that affected the families were community isolation 81.1%, and rejection 81.1% against 18.9% respectively. It was also evident that over half of their children reported school discrimination as opposed to 37.7% who reported no discrimination in school. However a few families admitted that they experienced criminal behavior.

Under economic impacts, most families said that they did not sell their dear assets. Over 80% of them said that they did not sell their farm, house, business or shares against over 10% who reported sales. However, 47.2% of them said they sold their animals to pay for the Health care of the sick person. On the priority needs, respondents reported that they lacked health care 96.2%, medicine 98.15%, counseling 88.7 %, cloths 75.5 %, shelter 66% and home based care 88.7%. The report on

5.2 Conclusions

The study was carried out in Nakuru Municipality in Rift Valley Province of Kenya. The purpose was to investigate and to understand the Impact of HIV/AIDS that devastate the families that live in this place. The data was collected, analyzed and the findings revealed that:

- i. Between 70% and 90% of AIDS affected families in Nakuru were psychologically devastated by Stigma, shame, denial, fear, stress, and behavior problems.
- ii. The social impacts experienced by families living with sero positive clients were isolated (81.1%), rejected (81.1%) and discriminated against (58.5%). However, 32.1% of them did not report criminal behavior.

- iii. Economically, over 80% the families did not sell their dear assets such as house plot, business shares and far to pay for their health care. They however sold animal (47.2%) to meet some of their household expenses.
- iv. Material needs of between 60% to 90% impacted AIDS affected families and they included: health care, therapy, cloths shelter, medicine, and home based care.
- v. 96.2% of AIDS affected families admitted that they needed therapy while over 60% of them reported specific needs in areas of disclosure, shame, stigma, coping skills and behavior problems. Slightly over half of them said they needed help in mental disorders.

5.3 Recommendations

Based on research findings, a number of recommendations can be made which if implemented, would go along way in improving HIV/AIDS affected families in Nakuru Municipality. These include the following

- i The Ministry of Health and Social Services to review their HIV/AIDS programmes and integrates the entire families of the suffering persons.
- ii Therapy programs for the clients should be comprehensive and expanded to meet the psychological needs of entire family members.
- iii The donor community wishing to put a hand of help in this pandemic should aim at the entire family and not to the sick person only.
- iv Programmes such as the counseling, meeting the physical needs, training more social workers and initiatives of poverty reduction should be improved and expended.
- v The training of husbands, wives, siblings in schools and community on how to provide: home based care, nursing care to their sero positive family members without getting infected, preparation of meals that is nutritious and beneficial to the clients, group counseling and basic exercises for HIV/AIDS clients should be put in place.

5.4 **Suggestions for further research.**

Following research areas were recommended:

- i A study on stress level of HIV/AIDS conflicted families.
- ii Assessment of counseling needs of HIV/AIDS affected families
- iii A study on effectiveness of counselors in helping the terminally ill.
- iv A study to evaluate the cost of material needs of HIV/AIDS affected families.
- v A research on poverty reduction in HIV/AIDS affected families is necessary.
- vi A comparative study on effectiveness of different organizations that work with HIV/AIDS in Nakuru Municipality.

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12. Stress a) Yes () b) No () c) Not sure ()

13. Behaviour problems a) Yes () b) No () c) Not sure ()

14. Are there children in school from this HIV/AIDS affected family?

a) Yes () b) No () c) Not Sure ()

15. Are children in school learning well without interruptions from HIV/AIDS

sickness in the family? a) Yes () b) No () c) Not sure ()

16. Who provides for Home Based Care in your family?

a) ICROSS () b) Love and Hope () c) Provincial Hospital ()

d) Other organizations ()

17. If a donor was to provide assistance, which needs would your HIV/AIDS affected family require?

Health Care a) Yes () b) No () c) Not sure ()

Food a) Yes () b) No () c) Not sure ()

Cloths a) Yes () b) No () c) Not sure ()

Shelter a) Yes () b) No () c) Not sure ()

Therapy a) Yes () b) No () c) Not sure ()

Medicine a) Yes () b) No () c) Not sure ()

Home based Care a) Yes () b) No () c) Not sure ()

18. Do your HIV/AIDS affected family experience the following sociological impacts?

a) Community isolation a) Yes () b) No () c) Not sure ()

b) Rejection a) Yes () b) No () c) Not sure ()

c) Criminal behaviour a) Yes () b) No () c) Not sure ()

d) School discriminations a) Yes () b) No () c) Not sure ()

19. Is counselling necessary in your family to alleviate or reduce suffering?

a) Yes () b) No () c) Not sure ()

20. In which areas do your family need counselling?

Denial a) Yes () b) No ()

Disclosure a) Yes () b) No ()

Stigma a) Yes () b) No ()

Shame a) Yes () b) No ()

Coping Skills a) Yes () b) No ()

Behaviour problem a) Yes () b) No ()

Mental Disorders a) Yes () b) No ()

21. Is your HIV/AIDS affected family impacted by the following economical impacts?

Lack of Health Care a) Yes () b) No ()

Lack of Food a) Yes () b) No ()

Lack of Cloths a) Yes () b) No ()

Lack of Shelter a) Yes () b) No ()

Sale of assets a) Yes () b) No ()

Loss of income a) Yes () b) No ()

22. Who provides for the Health care this family needs?

a) The family () b) Relatives () c) Well-wishers ()

23. Which family assets have you sold to pay for the HIV/AIDS Health Care?

Family House a) Yes () b) No ()

Family Plot a) Yes () b) No ()

Shares a) Yes () b) No ()

Family business, a) Yes () b) No ()

Family Farm a) Yes () b) No ()

Animals a) Yes () b) No ()

APPENDIX B

THE IMPACT OF HIV/AIDS ON AFFECTED FAMILY IN NAKURU MUNICIPALITY

QUESTIONNAIRE FOR HIV/AIDS CARE PROVIDERS

Kindly answer the following Questions by ticking the most appropriate response. The accurate answers you give will assist researcher complete his studies towards the award of a master's degree in Guidance and Counseling of Egerton University.

1. My Gender is: a) Male () b) Female ()
2. My Age bracket is: a) Below 18 years () b) 20 – 30 years ()
c) 30 – 40 years () d) Above 40 years ()
3. Highest education level attained is. a) None () b) Primary School ()
c) Secondary school () d) College/University ()
4. How long have you worked with the ICROSS ?
Less than 1yr. () b) 1-4 yrs () c) 5-8 yrs () c) More than 10 yrs ()
5. Did you come to know the HIV/AIDS status of the people you care for?
a) Observation of clinical symptoms () b) VCT () c) elf disclosure ()
d) Am not sure () e) Through ICROSS ()
6. Do this HIV/AIDS affected families experience the following psychological impacts?

Stigma	a) Yes ()	b) No ()	c) Not sure ()
Shame	a) Yes ()	b) No ()	c) Not sure ()
Denial	a) Yes ()	b) No ()	c) Not sure ()
Anger	a) Yes ()	b) No ()	c) Not sure ()
Disclosure	a) Yes ()	b) No ()	c) Not sure ()

Fear a) Yes () b) No () c) Not sure ()

Stress a) Yes () b) No () c) Not sure ()

Behavior problem a) Yes () b) No () c) Not sure ()

7. Are the members of this family stressed by having to live with HIV/AIDS in the family? a) Yes () b) No () c) Not sure ()

8. Do children who go to school from this family learn well without interruptions?

a) Yes () b) No () c) Not sure ()

9. Who provides for the Home Based Care for this family?

a) ICROSS () b) Love and Hope ()

c) Provincial Hospital () d) Other organizations ()

10. If a donor was to provide assistance, which needs would you recommend for this HIV/AIDS affected family?

a) Health Care () b) Cloths () c) Shelter () d) Food ()

e) Therapy/ () f) Medicine () g) Home based Care ()

11. Does this HIV/AIDS affected families experience the following sociological effects?

a) Community isolation a) Yes () b) No () c) Not sure ()

b) Rejection a) Yes () b) No () c) Not sure ()

c) Criminal behavior a) Yes () b) No () c) Not sure ()

d) School discriminations a) Yes () b) No () c) Not sure ()

12. Which areas do this HIV/AIDS affected family need counseling in?

Grief a) Yes () b) No () c) Not sure ()

Disclosure a) Yes () b) No () c) Not sure ()

Stigma a) Yes () b) No () c) Not sure ()

Shame a) Yes () b) No () c) Not sure ()

Coping Skills a) Yes () b) No () c) Not sure ()

Behavior problem a) Yes () b) No () c) Not sure ()

13 Is this families affected by the following economical impacts as a result of HIV/AIDS?

Lack of Health Care a) Yes () b) () c) Not sure ()

Lack of Food a) Yes () b) () c) Not sure ()

Lack of Cloths a) Yes () b) () c) Not sure ()

Lack of Shelter a) Yes () b) () c) Not sure ()

Sale of assets a) Yes () b) () c) Not sure ()

Loss of income a) Yes () b) () c) Not sure ()

14. Have the family sold any of the following assets to pay for the HIV/AIDS Health Care?

Family House a) Yes () b) No ()

Family Plot a) Yes () b) No ()

Family Shares a) Yes () b) No ()

Family business, a) Yes () b) No ()

Family Farm a) Yes () b) No ()

Animals a) Yes () b) No ()

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