CHRONIC POVERTY AND HIV/AIDS HOME BASED CARE: A CASE STUDY OF UKWALA, SIAYA DISTRICT

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DECLARATION

I declare that this thesis is my own original work and has not been presented for a degree in any other university or any other award.

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DEDICATION

To my late mother Mary Ogoma, my husband Musa Otieno Ng'ayo, my two handsome boys Nadra Ng'ayo and Naji Muganda and my beautiful baby girl Naila Ogoma who gave me the inspiration and ceaselessly encouraged me to accomplish this study.

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LIST OF ABBREVIATIONS

AIDS : Acquired Immune Deficiency Syndrome

HBC : Home Based Care

HIV : Human Immune Virus

NASCOP : National AIDS and STI Control Program

NGO : Non Governmental Organization

OVC : Orphans and Vulnerable Children

PLWHA : People Living With HIV/AIDS

TASO : The AIDS Support Organization

ABSTRACT

Strong links between HIV/AIDS and poverty have been demonstrated, with AIDS deepening poverty in the affected household. Chronic ill health creates immense stress, even among the financially secure. However, stress levels escalate sharply when chronic illness is combined with chronic poverty or entry into poverty. In Kenya the declaration of HIV/AIDS as a national disaster was followed by development of home based care by NASCOP as the best approach of taking care of the infected at home. This approach has been seen as impacting negatively on the care givers because of the multiple expenses that are involved in it.

This study explored the roles played by care givers in HBC and the implication of these roles on their poverty situation. The study surveyed households in Ukwala Siaya District Nyanza province which has the highest poverty rate and HIV/AIDS prevalence. The study also looked at coping mechanisms employed by the families affected and infected. The study involved the use of both primary and secondary sources of data. The data collection was accomplished using open and closed ended questionnaire, focused group discussion and observation check list.

The study found out that caregivers played myriad of roles which affected their livelihood. Majority of the respondents resorted to selling their properties when faced with hard situation in order to survive. The study also established that most of the care givers have not had basic training on HBC which is a very vital tool for people taking care of people infected with HIV/AIDS.

Finally the study makes recommendation and suggestion on policy implication. Efforts to alleviate poverty should have clear guidelines on how to assist those affected and infected with HIV/AIDS in terms of general awareness on HIV/AIDS, prevention and care.

In conclusion the study emphasizes the importance of supporting the care givers both materially and morally. This is already being done by some NGOs and CBO. The question however is what about those who are not near such organizations? The study recommends that the government should step in and not only play coordination role but also take active role in areas where there are no NGOs and CBOs.

CHAPTER ONE

1.0 Introduction

World health organization considers poverty to be the world's most ruthless killer and a great cause of suffering (WHO, 1995). Indeed, poverty is the main reason why babies are not vaccinated, clean water and sanitation are not provided, curative drugs and other treatments are unavailable, and why mothers die at childbirth. Poverty conspires with the most deadly and painful diseases to bring a wretched existence to those who suffer it (WHO, 1995). Kenya's economic performance has been dwindling leading to high poverty rates. Welfare Monitoring Surveys (WMS, 2003) shows that poverty incidences in Kenya have increased from 34 percent in 1994, 51 in 1997, and 56 percent in 2000. This implies that at least one in every two Kenyans is poor. The WMS report also indicates that three quarters of the poor live in rural areas while the majority of the urban poor live in informal settlements. These trends show poverty that is extended in duration. Those trapped in poverty also suffer from multi dimensional and long-term deprivation which makes them incapable of meeting their basic needs. These trends and others could be used to justify the fact that some proportion of Kenyan population could be trapped in chronic poverty.

According to Chronic Poverty Research Centre (CPRC 2004), chronic poverty refers to multidimensional, long term and severe deprivation which leads to inability to meet basic needs. This definition covers all the three competing notions (multidimensionality, long duration and severity) which bring about debate on how best to define chronic poverty. Chronically poor persons usually live below poverty line which is defined in

terms of money indicators (consumption and income) (Hulme *et al.,* 2001). Degree of chronic poverty varies from one society to another.

The children, elderly persons, women, widows, refugees, HIV/AIDS sufferers and those taking care of them, the homeless and the disabled, among others, are more vulnerable to chronic poverty. Key drivers of chronic poverty identified by (UNIFEM,2006 and CPRC, 2004) include; spatial location, low skill level, low level of education, HIV/AIDS, low asset status, social exclusion, lack of social net works and vulnerability to shocks among other factors. Of all the drivers of chronic poverty, HIV/AIDS has been of great concern to both scholars and policy makers. This is due to the synergistic relationship that exists between HIV/AIDS and chronic poverty (Barrett and Whiteside, 2002; Marzo, 2004). The double causality relationship has been shown between chronic poverty and HIV/AIDS, with poverty fostering the spread of the illness on one hand and the illness increasing poverty of the affected and the infected on the other hand and even exposing them to chronic poverty (Barrett and Whiteside, 2002; Marzo, 2004).

HIV/AIDS deaths have continued to rise unabated ever since the scourge was first diagnosed in Kenya in 1984 and declared a national disaster as it poses major obstacles for the country in its efforts for social and economic development (UNDP, 2006). The government and the various stakeholders have over time initiated various intervention measures, targeting development of vaccines, awareness creation and sexual behavior change. However, results have varied from one geographical place to another. In some places such as Siaya District, reporting HIV prevalence rate of about 38.4 percent and

being the highest prevalence in Nyanza Province, only marginal success has been recorded, especially in adoption of safer sexual practices (IPAR, 2004; National Coordination Agency for Population and Development Ministry of Planning and National Development, 2005). Consequently those infected and affected by HIV/AIDS have continued to increase in number leading to high incidences of chronic poverty. The onset of AIDS in a household frequently triggers the slide into poverty or, for those already poor, the slide into destitution. The cost of treating the disease and caring for the sick diverts household resources away from productive activities that might provide the means by which households can make positive exits from poverty. HIV/AIDS also contributes to the intergenerational transmission of poverty. It strikes down the economically active population and leaves the young with little hope of equipping themselves with the skills and capacity to find their own way out of poverty (Slater, 2008).

Over 95 percent of People Living with HIV/AIDS (PLWHA) lives in lower-income or developing countries. Nearly two-thirds of PLWHA globally live in sub-Saharan Africa, and Asia is catching up at an alarming pace (UNAIDS/WHO, 2004). As the number of people living with HIV/AIDS (PLWHA) increases, health care services continue to become overburdened and are not able to meet the needs of those who are sick. Relying on the strengths of family and community networks, Home-Based Care (HBC) has emerged as a way to provide effective and compassionate care to those infected and affected by HIV/AIDS. HBC is not a replacement for hospital care; it is the care and support of PLWHA within their own homes and communities to help the infected live healthier and positive lives. It is part of a comprehensive continuum of prevention, care,

treatment, and support services. It includes the family, the community, and health care providers. HBC also contributes to prevention efforts in the community. It brings issues surrounding HIV/AIDS into the open, helps to clarify myths, reduces stigma, empowers those infected and affected, and influences people's willingness to know their HIV status (Colton *et al.*, 2006).

WHO, (2000) reported that between 70 percent and 90 percent of illness takes place within the home. Studies have also shown that most people would rather be cared for at home and that effective home care improves the quality of life for ill people and their family caregivers. What is not clear is the impact of this caring role on the caregivers. HBC is the best way for most people to be cared for and to die. Throughout the world, most caregivers are family members (usually women and young girls), and these caregivers are valued as the main source of care for ill people (WHO, 2002). The first requirement for care is to ensure that the basic needs which include shelter, food, safe water, sanitation, and clothing are provided. Providing effective HBC therefore becomes difficult if there is difficulty in providing basic needs as a result of scarcity/poverty.

Caregivers in the HBC settings experience poverty, social isolation, stigma, psychological distress, and lack basic care giving education (Lindsy et al, 2003; Mohammad and Gikonyo 2005). Receiving preparatory information, continued training and support from the health workers might be important components influencing coping and provision of quality care among home care providers. Furthermore, different levels of health information may be associated with different coping strategies and quality care

(Ndaba-Mbata and Seloilwe, 2000). In Ukwala division, Siaya district the impact of HBC on poverty situation of those affected and infected by HIV/AIDS is not clear. If HBC is leading to impoverishment of those caring for those affected and infected by HIV/AIDS, then it is adding to more problems in society. There is a need therefore to study the implications of HIV/AIDS home based care for chronic poverty situation of the affected and infected households in Ukwala.

1.1 Problem statement

HIV/AIDS is reshaping the landscape of development by undermining most of the progress barely achieved during the last century in the developing world. AIDS epidemic in Kenya has devastated many populations, generated millions of orphans, and continues to contribute to the erosion of civil order and economic growth (Forsythe and Rau 1996; NASCOP, 2007). The disease is now recognized as one of the leading challenges to socio-economic well being of the developing countries, of which Kenya is among the most affected nations. This is because more than one half of the reported HIV/AIDS cases occur among the economically active and productive segment of the population, viz. 5-55 years. This is the age bracket in which investments in education and training begin to pay off and families are established and natured. HIV/AIDS prevalence is high among the productive age group (15-49). It is estimated to be in the range of 38.4% and is the highest in Nyanza Province having increased from 36.9% in 1997. About 60% of beds are occupied by patients with AIDs related illnesses while Sexually Transmitted Diseases (STDs) stands at 27% among all patients and is 12.4% among pregnant women attending Ante Natal Clinics. With over 60% of hospital beds occupied by patients with AIDs related ailments, it means that more resources are now spent on treating and managing the disease at the expense of other preventable health care services. Some of the factors that have led to the rise in HIV infection rate along the shores of Lake Victoria include poverty, retrogressive cultural beliefs etc. The impact is mainly felt at the village level due to the increasing number of orphans who are in and out of school; increasing number of female headed and child headed households, the high drop-out rates in

schools, rising cases of child labor, depression and increasing crime rates in the urban as well as rural settings, among other problems (IPAR, 2004; National Coordination Agency for Population and Development Ministry of Planning and National Development, 2005).

It is generally accepted that HBC for HIV/AIDS demands not only significant financial resource but also time (UNAIDS, 2004). It is estimated that HBC may cost between 50 to 500 US dollars per month to provide HBC to a person infected by HIV/AIDS (Kihumbi, 2003). Though there are many development initiatives in rural areas, poverty is still a major challenge. Most families live on less than a dollar a day.

There are reports that show that poverty has not always been a problem in rural areas (www.bushdrums.com, accessed in, 2009). The historical evidence indicate that rural community had had times when there was plenty of milk and food, cattle herds were big and used their manure as fertilizers to replenish soil fertile. New migrants in towns used to get their food from rural areas as they search for employment. The emerging trends of poverty that has been on the rise in the past twenty years in most rural areas can be attributed to high population growth, changing land use patterns, and the shift of ownership from common to individual. These factors have led to a growing pressure on natural resources such as trees (for firewood and building), water and marginal land. As a result there has been widespread deforestation leading to erosion and desertification and subsequently a decrease in soil fertility. The rainfall patterns have also been erratic causing rivers and streams to dry up. The reduced soil infertility and other causes have led to low crop production and lower animal production and thus increasing the proportion of households living below poverty line amidst an increase in the cost of education and healthcare in Kenya (www.bushdrums.com, accessed in, 2009).

Poverty challenge in rural areas with majority of the households living below poverty line implies that home based care of HIV/AIDS is likely to put a lot of pressure on already scarce resources particularly the limited household assets. The situation is compounded by the fact that majority of persons in rural areas, who are the HIV/AIDS care givers generally lack productive assets and regular source of income yet these are very essential for HBC. The high cost of management of the disease is likely to make those who are poor; chronically poor at the same time it is likely to make those who are not poor to become poor. The overall implication of home based care of HIV/AIDS for families is an issue to be studied. This study therefore tries to fill this gap by looking at HIV/AIDS home based care in Ukwala Division of Siaya District, Kenya.

1.2 Research Questions

This study investigates one overall and four specific questions. The overall question is: what is the implication of HIV/AIDS home based care to the asset base of those involved in providing HBC? The following specific questions are addressed in this study.

a) What is the poverty situation of the caregivers' households?
b) What is the nature of home based care roles undertaken by the care givers?
c) How does home based care affect the poverty situation of the care givers households?
d) What are the household coping mechanisms?

1.3 Objectives of the Research

The general objective of this study is to asses the implication of home based care to the poverty situation of care givers households. The specific objectives are;

a) To examine the poverty situation of the caregivers household

b) To examine nature and scope of home based care roles the care givers are involved in.

c) To assess how HBC roles affect their poverty situation.

d) To determine households coping mechanisms.

1.4 Justification for the study

HIV/AIDS has been declared a national disaster as it poses major obstacles for the country in its efforts for social and economic development. The infection with HIV/AIDS in a household frequently triggers the slide into poverty or, for those already poor, the slide into chronic poverty. It has been shown that cost of treating and managing HIV/AIDS and caring for the sick diverts household resources away from productive activities that might provide the means by which households can make positive exits from poverty (Slater, 2008).

This study is important because it tries to explain in part the reason why several strategies and interventions by the government, donors, NGOs' and other development agencies have not bear fruit. It also explains why over 50 percent of Kenya's population still languishes in poverty. No studies have been done in Ukwala showing implication of HBC of HIV/AIDS to poverty situation of the affected households yet Ukwala is among the hardest hit divisions with HIV/AID in Siaya District. This study therefore seeks to deepen our understanding on the reason why the HIV/AIDS care givers are predisposed to being chronically poor in this era of HIV/AIDS and shed light on actions/policies that could be put in place to change the situation.

1.5 Research methodology

This section presents the research methods used in the study. Specifically, it presents the details of the study sites, sampling methods, data collection methods and data analysis procedures.

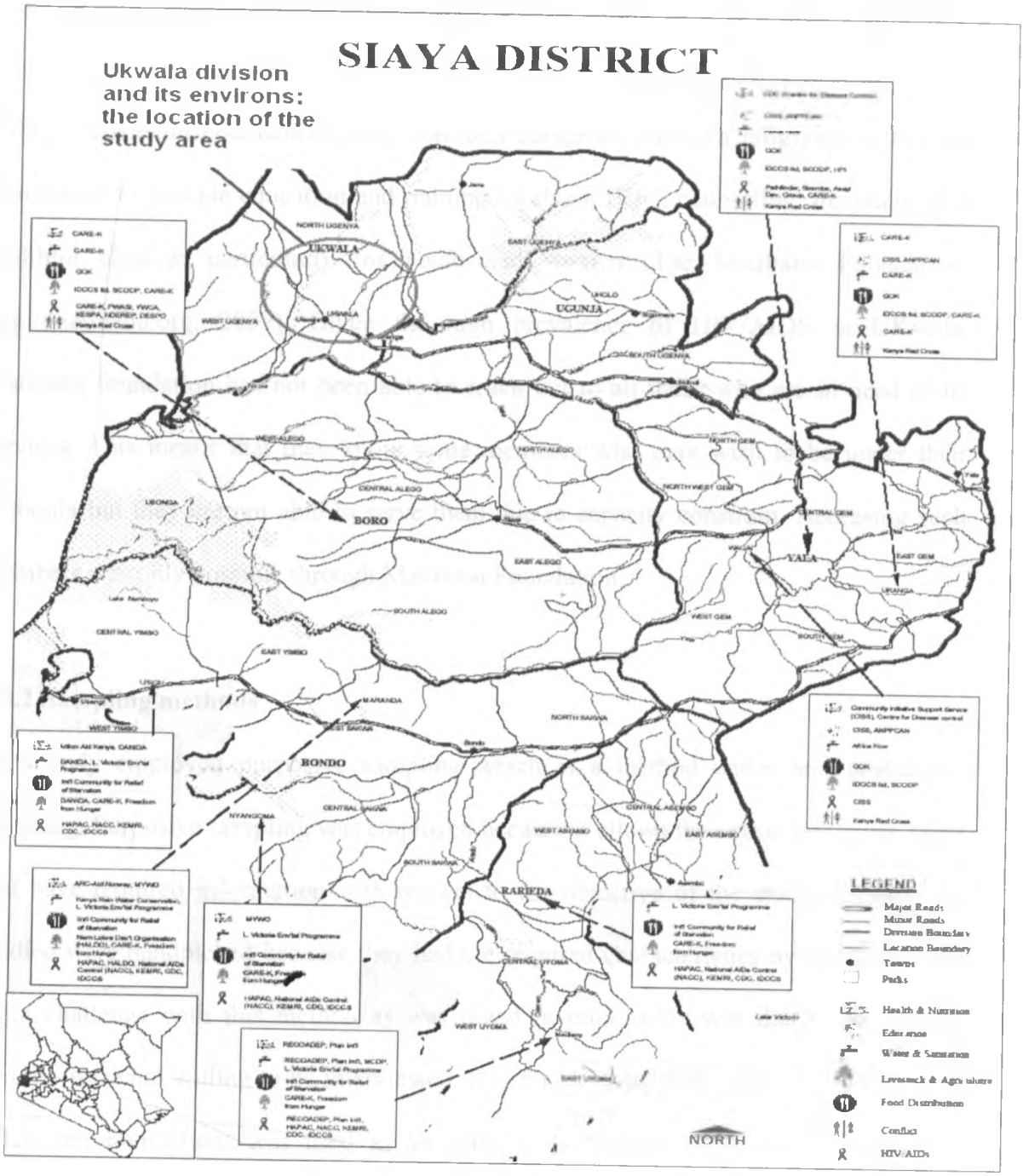
1.5.1 Study site

The study was carried out in selected households in Ukwala, Siaya district Nyanza province of Kenya. The existence of an NGO (Matibabu Foundation) tackling HIV/AIDS related issues and high prevalence rate of HIV/AIDS influenced the choice of the location of the study. Matibabu Foundation facilitated access to potential respondents given the stigma, fear and suspicion that is still attached to HIV/AIDS. The area is also hardest hit by poverty with majority of the residents living below one US Dollar a day. Further more no study has been done in the area to establish if HBC of HIV/AIDS worsens poverty situation of the care givers.

Siaya district is divided into seven administrative divisions namely, Yala, Wagai, Karemo, Ugunja, Boro, Uranga and Ukwala divisions respectively. Ukwala division is the largest division covering an area of 319.5 sq km, while Boro division is the smallest covering an area of 180.1sq km (see figure 1.1). The population settlement patterns in the district follow the agro-ecological patterns with high potential areas having large populations and population density. The high potential areas with reliable rainfall of Ukwala, Yala and Ugunja have high population size and higher densities (National Coordination Agency for Population and Development Ministry of Planning and National Development, 2005).

The estimated projected population for Siaya district in 2002 was 493,326 comprising of 227,044 males and 266,282 females. The estimated population growth rate is 0.9 percent per annum; life expectancy for both males and females is 52.6 years. Infant mortality rate in the district stood at 102/1000 while under five mortality was 113/1000 in the same year. The total fertility rate in the district is 4.3 children per woman. The most densely populated division is Yala with 410 persons per km2. The very low population growth rate (0.9 percent) is mainly due to the rising HIV/AIDS prevalence which has led to a high mortality rate (National Coordination Agency for Population and Development Ministry of Planning and National Development, 2005).

Figure 1.1: Map of Ukwala location and its environs



The Matibabu Foundation is one of the many NGOs in Ukwala that provides medical care, training and equipping residents of Ukwala with life time skills. Matibabu Foundation is actively involved in HIV/AIDS advocacy for prevention and support. In addition Matibabu Foundation clinic conducts numerous outreach programs within the community to provide education and training locals on HBC, counseling, treatment, and healthful choices, particularly for youth and women (The Matibabu Foundation, http://matibabu.org, 2009). Given the high prevalence of HIV/AIDS in UKwala, Matibabu foundation has not been able to reach out to all those who are in need of its services. This means that they know some members who may wish to be under their umbrella but they are not able to serve them due to capacity constrain. Accessing such members was only possible through Matibabu Foundation.

1.5.2 Sampling methods

This study employed purposive sampling which is a method under non probability sampling. Purposive sampling was employed because it allows the researcher to use cases that have required information with respect to the objective of the study. Cases to be studied were handpicked because they had the required characteristics by the study. The main challenge with this method as was noted in pilot study was that people in the vicinity were not willing to be interviewed. It is for this reason that the NGO in the area (Matibabu foundation) was used as an entry point to help identify cases that have relevant/ required information.

The study used qualitative approaches in drawing the study sample. The unit of analysis for this study was individual members and heads of households. The target population was the care givers of affected and infected, that is, those who are HIV positive and HIV/AIDS orphans. Head of households were interviewed in instances where care givers were not the heads of household. The respondents were identified through purposive sampling. Only those individuals who meet the above stated target group requirements were identified and selected for the study. Matibabu Foundation officer was consulted to assist in identifying the first case which was to introduce the researcher to subsequent cases. A total sample size of 45 respondents was purposively selected for the study. A further seven respondents were selected for focused group discussion. The information obtained complemented data generated from the 45 respondents.

1.5.3 Data collection methods

The study relied on books, journals, maps, magazines, newspapers, internet, observation, focused group discussion and interviews to generate both primary and secondary data required for the study. The use of multiplicity of approaches was adopted mainly to neutralize possible bias inherent in particular data source, method and investigation.

1.5.3.1 Survey

Survey was used in collecting descriptive and exploratory data since it the excellent vehicle for measuring attitudes, orientation and public opinion. The method was used to obtain primary data from the 45 respondents using both structured and unstructured questionnaire (appendix 1). The questionnaires were administered to the respondents on a face to face format by the researcher. The questionnaires assisted in maintaining focus on

the study objectives and in probing on the points of interest. During the survey, the poverty situation of the households interviewed was observed. Information obtained included: the roles that the care givers play in home based care, poverty situation of the affected households, source of finance and the impact of the roles on their asset base, coping mechanisms employed by the respondents among others.

Survey studies can also be inflexible in the sense that the survey typically requires that an initial study design remain unchanged throughout. It is for this reason that focused group discussion was conducted to compliment survey.

1.5.3.2 Focused Group Discussion

Since poverty varies from one society to another, focused group discussion was conducted with one chief, one assistant chief, one programme officer from Matibabu Foundation and seven respondents from the main study sample in order to get insights on the locals' definition of poverty and to discuss emerging issues from the main interview. This discussion generated key indicators of poverty among some other issues. It was conducted with the aid of interview guide (appendix 2). This came in handy in regulating and guiding the discussion. Through FGD emotions were covered and in-depth information on the study topic obtained.

The major challenge in FGD was the difficulty in gathering respondents together for the discussion given the fact that some of them were the care givers of those bedridden and had to be by their side throughout. Another challenge was coming up with a central place for meeting given the group members were from dispersed location. To overcome these

challenges the group members selected venue for the discussion and appropriate times and days that suited them. This had the repercussion of the discussion taking longer than was expected. Those coming far from the venue of discussion used bicycle (boda boda) which was paid for by the researcher.

1.5.3.3 Secondary data

Secondary data was used to provide background information to the study focusing on HBC of HIV/AIDS and chronic poverty. This was derived mainly from books, documents, journals, maps, magazines, newspapers and the internet. This information was used to augment primary data and to enrich the study findings.

1.5.4 Data analysis

The quantitative data was analyzed using statistical package for social sciences (SPSS). The data was then represented in the form of frequency tables, graphs and charts which represent the most elementary way of summarizing and displaying data as well as being the most effective. Various qualitative study findings from interviews and focused group discussion were analyzed thematically in relation to study objectives and research questions. The key themes that guided the analysis were poverty situation in Ukwala, HBC roles and chronic poverty, implication of HBC on business/work and coping mechanism and chronic poverty. This exploration was meant to bring out the relationship between chronic poverty and HBC of HIV/AIDS and to identify specific issues relevant to future planning for intervention.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

The introductory chapter identified HBC of HIV/AIDS as a factor that is most likely to push the affected and infected families into chronic poverty. The chapter further identified one overall and three specific questions to guide the study. The overall question was: what is the implication of HIV/AIDS home based care to the asset base of those involved in providing HBC? The specific questions were: a) what is the poverty situation of the caregivers' households? b) What is the nature of home based care roles undertaken by the care givers? c) What are the household coping mechanisms? Chapter two will therefore look at literature review and then go a head to identify a frame work which the study will use to explain how the variables interact.

2.1 HIV/AIDS in Siaya District

The HIV/AIDS epidemic in Kenya has devastated many populations, generated millions of orphans, and continues to contribute to the erosion of civil order and economic growth (Forsythe and Rau, 1996; NASCOP, 2007). The disease is now recognized as one of the leading challenges to socio-economic well being of the developing countries, of which Kenya is among the most affected nations. This is because more than one half of the reported HIV/AIDS cases occur among the economically active and productive segment of the population that is 15-55 years. This is the age bracket in which investments in education and training begin to pay off and families are established and natured. Some of the factors that have led to the rise in HIV infection rate in Siaya District include poverty,

retrogressive cultural practices like wife custodianship among other factors. The impact is mainly felt at the village level due to the increasing number of orphans who are in and out of school; increasing number of female headed and child headed households, the high drop-out rates in schools, rising cases of child labor, depression and increasing crime rates in the urban as well as rural settings, among other problems (IPAR, 2004; National Coordination Agency for Population and Development Ministry of Planning and National Development, 2005).

2.2 HIV/AIDS and HBC

Home based care in Kenya was developed by National AIDS/STD Control Program (NASCOP) drawing examples from Uganda and Zimbabwe where the approach had been in operation as a way of controlling HIV/AIDS. The increasing number of AIDS patients, 12000 new cases every year and hospital bed occupancy by HIV/AIDS patients standing at 51 percent in 2000 necessitated the adoption of home based care. This approach was viewed as having the potential of not only decongesting hospital beds only but also the hospital personnel and reducing stigma (GOK, 2002). Home-based care has a variety of typologies, each representing a different delivery scheme, mix of services, staff and reach. Some of the more identified types include facility-based, community-based and integrated. The emphasis of each type tends to differ. For example, facility-based programs often focus on medical aspects of care involving teams including health professionals who can provide higher levels of care. Community home based care programs emphasize psycho-social support to people living with HIV/AIDS and their families and deliver their services primarily through volunteer networks in the

community together with program staff, not specifically health professionals but also involves community and family members (GOK, 2002).

As the number of people living with HIV/AIDS increases, the gap continues to widen between the demand for, and the availability of health care services. Relying mainly on the family and community as caregivers, community home-based care (CHBC), has become a significant contributor in the treatment, care and support of those infected and affected by HIV/AIDS. Home-based care is seen as a holistic, collaborative effort by the hospital, the family of the patient, and the community to enhance the quality of life of people living with HIV/AIDS and their families. In fact, in Africa the family still remains the greatest strength of the people in the rural areas particularly in Kenya. Effective home based care rely on communities and individuals adopting new attitudes and behaviors towards people living with HIV/AIDS (PLWHA) and people affected by HIV/AIDS and the provision of quality care, treatment and support services in the home environment.

Home based care is an approach to care provision to those affected and infected by HIV/AIDS. Its components are clinical services, nursing care and social support. It is a continuation of care from hospital to community and family and back again of the individuals affected and infected by HIV/AIDS. Those infected have to be taken to hospitals for check up and medication and that is why home based care is viewed as continuum of care from home to hospital and hospital to home.

GOK, 2002 defines Home-based care as the care of persons infected and affected by HIV/AIDS that is extended from the health facility to the patient's home through family participation and community involvement within available resources and in collaboration with health care workers.

The emergence of home based care can be traced to different initiatives and approaches. One is TASO of Uganda which originated from within the community and later developed hospital and other care centres. Others began as collaborative efforts between hospitals, clinic, community groups and NGO agencies for instance Kariba AIDS network in Zimbabwe (Jackson and Mhambi, 1994).

The needs of people living with HIV/AIDS are categorized into four broad categories namely: clinical care, nursing care, counseling/psycho spiritual care and social support. These categories includes need for drugs to treat opportunistic infections, clinical care which includes medication and regular check-ups, shelter, balanced diet meals that is locally available, clothing, attention to toilet, care of wounds, personal and oral hygiene, physical therapy, exercise and massage, counseling, information and up to date accurate information on HIV/AIDS among others. The care in home based care does not end when a person infected with HIV/AIDS dies, but it extends to the survivors especially children (GOK, 2006).

The care givers in family setting also have needs which must be met in order for them to provide quality care to those infected with HIV/AIDS. The needs include; proper

education on HIV/AIDS and training on the care that they are expected to provide, help with household chores in order to have ample time to care for the bed ridden, financial support to be able to meet the expenses associated with home based care, acceptance by the community among others. Partnership among family members, health care workers, local communities, CBOs, NGOs and people living with HIV/AIDS has been necessitated by the increasing number of people developing AIDS. The main objective of this partnership has been to provide care to both infected and affected.

Players in home based care include health facility, home care team, family care givers, community members, people living with HIV/AIDS and the government. Each and every player has a role to fulfill in home based care. Home care team and the government recruits and trains members of the community to provide the primary care at family level. This study concentrates on the household because members of a household are the primary care giver. The role of family members in home based care includes diagnosis, nursing care, material aid, counseling and pastoral care among others (GOK, 2006).

Resource is very vital in home based care. The three types of resources required in home based care are; material, man/woman power and moments also known as the three Ms of home based care. Material is the finances used to purchase food, drugs, clothing, and soap among other material needs that the infected might have. Man/woman power is the energy displayed by care takers when performing tasks like cooking, bathing, changing clothes and bedding of the sick to ensure that they are comfortable. Moments on the other

hand is spending quality time with the infected counseling them or even feeding them. Sources of these resources are derived from the players in home based care.

2.2.1 Advantages of home base care

Home based care has the potential of changing people's attitudes towards persons living with HIV/AIDS and people's attitudes towards the disease itself (GOK, 2002). In so doing it reduces the stigma attached to the disease. The fact that home based care involves family members, neighbors and the whole community not only increases care access to the infected but also enables those involved in care giving to be cautious and take control of their lives.

Home based care represents a partnership approach that has advantage for those infected, the affected and the health care system. To the community, home based care provides awareness of HIV/AIDS, example to motivate behavior change and reduce the stigma attached to the disease. To the infected it enables them to maintain their roles in the family and community at large. To the health care system it frees up hospital beds and health personnel.

Home based care can have negative impacts on the care givers if not checked. Most of the care givers are already poor and this new role can easily push them to being chronically poor. This may be as a result of multiple expenses in HBC which include health care expenses, food, transport and burial among others other expenses associated with home based care. Care givers may also risk being isolated from the community and

its activities since they lack time to interact and engage in community affairs. This is particularly true for those taking care of the bed ridden.

2.3 The poverty situation in Ukwala, Siaya District

The overall poverty level in the district stands at 58.02 percent of the district's population having increased from 41 percent in 1994. This means that more than half of the population is in some state of poverty. This level of poverty has implications on the district's efforts in development initiatives since no meaningful development can take place with over half population still unable to meet their basic needs. The district's contribution to National Poverty is about 1.3 percent. Absolute poverty accounts for about 57.9 percent while those without food accounts for 52.6 percent of the district's population (National Coordination Agency for Population and Development Ministry of Planning and National Development, 2005).

The causes of poverty are diverse and include; poor soil leading to low yields; over reliance on traditional methods of agriculture; unpredictable rainfall patterns; high rate of deaths due to HIV/AIDs; collapse of the main cash crops in the district; lack of industries and cultural beliefs and practices. The trend in poverty indicate a possible increase in the levels of both overall and poor food production in the district unless urgent measures both short term and long term are put in place (National Coordination Agency for Population and Development Ministry of Planning and National Development, 2005).

2.4 Poverty and chronic poverty

The Chronic Poverty Report, the (CPRC 2004) estimates that between 300 and 420 million people are trapped in poverty. Those trapped in poverty experience deprivation over many years or even over their entire lives, and sometimes pass poverty on to their children (Moore, 2004). Many chronically poor people die prematurely from health problems that are easily preventable. For them, poverty is about deprivation in many dimensions ranging from hunger and under nutrition, dirty drinking water, illiteracy, a lack of access to health services, social isolation and exploitation to low income and assets. Such deprivation exists in a world that has the knowledge and resources to eradicate it (Moore, 2004). The chronically poor are not a distinct group, but usually are those who are discriminated against, stigmatized or 'invisible': socially-marginalized ethnic, religious, indigenous, nomadic and caste groups; migrants and bonded laborers; refugees and internally displaced; people with impairments and some illnesses (especially HIV/AIDS). In many contexts, poor women and girls, children and older people (especially widows) are more likely to be trapped in poverty. While chronically poor people are found in all parts of the world, the largest numbers live in South Asia and Sub Saharan Africa (134 to 188 million) (Baulch and McKay, 2003, Moore, 2004).

The poor are those who experience real basic needs deprivation. Basic need has been expanded to encompass not only food, shelter and clothing but also access to other assets such as education, health, participation, security and dignity. Narayan *et al* (1999) observed that there are categories of the poor as used by the poor themselves. These categories are based on the various causes of poverty and the duration. The two broad

categories are the hungry poor and the resource poor. Based on the aspect of duration that is for how long one has been poor and under this category we get new categories; the new poor, always poor, and the temporary poor.

Those experiencing resource and food poverty are most likely to be chronically poor. Chronic poverty is poverty that is multidimensional, extended in duration and severe. Multidimensionality, severity and duration are the three characteristic of chronic poverty which are highly contested. Duration aspect for instance distinguishes the temporary and the always poor. The big question that comes with the duration aspect is; how long should one be poor in order to be considered chronically poor? Even though (CPRC 2004) studies suggest duration of 5years, this duration may also depend on available data. Using available data which may have been gathered at an interval of two or three years, one may be able to identify chronically poor groups.

Severity aspect looks at those people whose average incomes are well below the poverty line while dimensionality looks at poverty that is manifested in several ways for instance households experiencing food insecurity with children experiencing poor health and not going to school. Duration and severity aspect combines together to exclude those who are fluctuating around poverty line. This group of persons experience seasonal poverty and are not necessarily considered to be chronically poor since they move in and out of poverty (CPRC2004)

2.4.1 Drivers of chronic poverty

Chronic poor are heterogeneous group whose deprivation stems from various factor and experience overlapping vulnerabilities. Not all chronic poor are born chronically poor. They may slide into chronic poverty after a shock or series of shocks. Drivers to chronic poverty are the same as the drivers to general poverty. The drivers include ill health, injury, environmental shocks, violence, market and economic collapse and old age among other factors (Bird *et al.,* 2003).

The shocks which are also the drivers to chronic poverty affects households differently thus some households may recover from the shocks and escape poverty while others are not able to recover and sinks into chronic poverty. The big question then is; why do some households recover while others are pushed into chronic poverty?

Factors that determine the ability of a household to recover or not to recover include the level of assets that a household has access to, the depth and sequence of shocks and the nature of institutional context which caters for the social protection and the provision of basic services. Maintainers of chronic poverty also make poverty situation worse by hindering recovery from the shocks. The maintainers includes narrowly based economic growth, social exclusion and adverse incorporation, logjams of geographical, agro-ecological, socio-economic and political disadvantages, high capability deprivation especially during childhood among others.

Lack of human and technical skills to exploit available income generating and life improving opportunities are both a cause and symptom of poverty. With the bulk of Kenya's population in the subsistence sector utilizing unskilled labor, it is essential that for growth to be pro-poor it should focus on labor-intensive techniques. But labor intensive production of goods and services in today's competitive world requires that the abundant labor be abundant in skills. Inability to access and process information about available income generating and life improving opportunities is a major constraint to poverty reduction.

Lack of affordable comprehensive insurance mechanisms to enable people to ward off economic, health and other related shocks, can lead to slippage into poverty at the occurrence of any such shocks. Vulnerability to shocks can therefore be a cause or symptom of poverty. In Kenya there are no effective state operated safety nets as mechanisms for mitigating risks of natural and man-made disasters. Furthermore, vulnerability and poverty per se can be exacerbated and perpetuated by insecurity of life and property.

The AIDS scourge can result in disproportionate reallocation of household resources away from consumption to health. In some cases households may have to liquidate their assets to finance the health care of those infected by HIV/AIDS. In sections of the society where collective support is given to community members, such social capital becomes overstretched. As a consequent of all this, the production base of households and communities is eroded, resulting in a decline in welfare for a long period of time.

2.5 Impacts of HIV/AIDS on chronic poverty

HIV/AIDS is both a cause and a symptom of chronic poverty in the developing world. The onset of AIDS in a household frequently triggers the slide into poverty or, for those already poor, the slide into destitution. The cost of treating the disease and caring for the sick diverts household resources away from productive activities that might provide the means by which households can make positive exits from poverty. HIV/AIDS also contributes to the intergenerational transmission of poverty. It strikes down the economically active population and leaves the young with little hope of equipping themselves with the skills and capacity to find their own way out of poverty. The impacts of HIV/AIDS at micro and macro level, in the short and long term and in different sectors, are increasingly well documented.

At the micro level: Households that are affected by HIV/AIDS face decreasing asset status over time and become less productive. In agriculture, for example, declining capacity to produce crops results from a number of factors: labor shortages resulting from sickness or the displacement of labor as household members become caregivers rather than working in their fields; falling agricultural productivity owing to lack of investment as money that would otherwise be spent on fertilizers and other inputs is allocated towards paying for medicines and funerals; the demise of intergenerational transmission of local knowledge and skills that are crucial for successful agricultural production (Barnett and Blaikie, 1992; Barnett *et al.*, 1995; Gillespie and Loevinsohn, 2003; Slater and Wiggins, 2005).

HIV/AIDS also has implications for food security. Urban households where people are sick and unable to work have reduced entitlements to food. Rural households oriented towards subsistence production struggle to produce enough food and have no surplus labour to supply larger commercial farms or to move into off-farm labor markets. (de Waal, 2003; FANTA, 2001; WHO, 2003).

In conclusion the literature review attempts to answer the research questions by elaborating the roles in HBC of HIV/AIDS. These roles are varied and diversified as the literature shows. HBC not only consumes time but also money to meet the demands of the infected which ranges from nutritional needs to medical attention. HBC therefore affects the poverty situation of the affected family when labor has to be withdrawn in order to take care of the sick, when assets are sold to make up for the lost income and in the face of increasing expenses and dwindling income as a result of occasional labor withdrawal. HBC of HIV/AIDS weakens the production base of the affected household thus predisposing them into poverty or chronic poverty depending on the household's asset base.

2.6 Conceptual Framework

This study employed a conceptual frame work to explain the relationship between HBC of PLWHA and chronic poverty. The conceptual framework used in this study borrows from the vulnerability approach to explore the relationship between HBC of HIV/AIDS and household's poverty level. According to Chronic Poverty Research Centre (CPRC) vulnerability approach posits that there is a direct link between shocks and chronic poverty (CPRC, 2004). CPRC (2004) defines shocks as occurrences of hazards such as

illness, unemployment, macroeconomic and financial crises, conflict, policy change, natural disasters among others. Such shocks are associated with higher incidence of poverty among the affected households as they predispose or make such households vulnerable to being poor.

Study by Bird *et al., (*2003) shows that the incidence of poverty following shocks is higher among households with fewer buffers to protect their living standards. Poorer household with fewer assets and entitlements are therefore more exposed to the possibility that shocks will make them chronically poor than the ones with more assets. Shocks generate poverty, and uninsured shocks are more likely to lead to poverty than insured ones.

In the light of this study, home based care of HIV/AIDS is viewed as a shock hence may lead to chronic poverty. Studies shows that home based care of PLWHA puts a lot of pressure on household, its resources and assets. The decrease in productivity is a reality since most of the people living with HIV/AIDS belong to the 15-55 age groups, which constitutes the active work force of society. Moreover, it often happens that (at least) some of the relatives who are also the care givers stop working, in order to look after the infected. The main consequence of this fall of productivity is felt in income. As a matter of fact, this can decrease to an amount equal to 67 percent of mean income (Morris et al., 2000). The most serious situations are found in rural settings, where most of the time agriculture not only represents the main source of income but also the first means of subsistence.

Income decreases start at the beginning of the symptomatic phase of AIDS and worsen in time, coming to a halt with the death of the infected person. This evolution is due to the diminution of available resources, but it is worsened by a sensible distortion in consumption with a sharp increase in sanitary and medicine expenditure. All these may make the affected household vulnerable to chronic poverty as their assets base is weakened.

The probability of a household sinking into chronic poverty depends on the following, whether or not a household has a form of insurance, asset base of the household and behavioral response adopted by the household in the face of the shock. These responses cover a wide range from reducing the number and quality of meals; postponing health related expenditure; withdrawing children from school and/or engaging in child labor; engaging in informal employment; resorting to adverse incorporation as a means of protection. It is the form of insurance in place, asset base of the household and behavioral response adopted by the household that explain why some households are able to recover from the shocks without necessarily becoming poor while others sink into chronic poverty as a result.

Figure 2.1: The relationship between HBC and household poverty levels

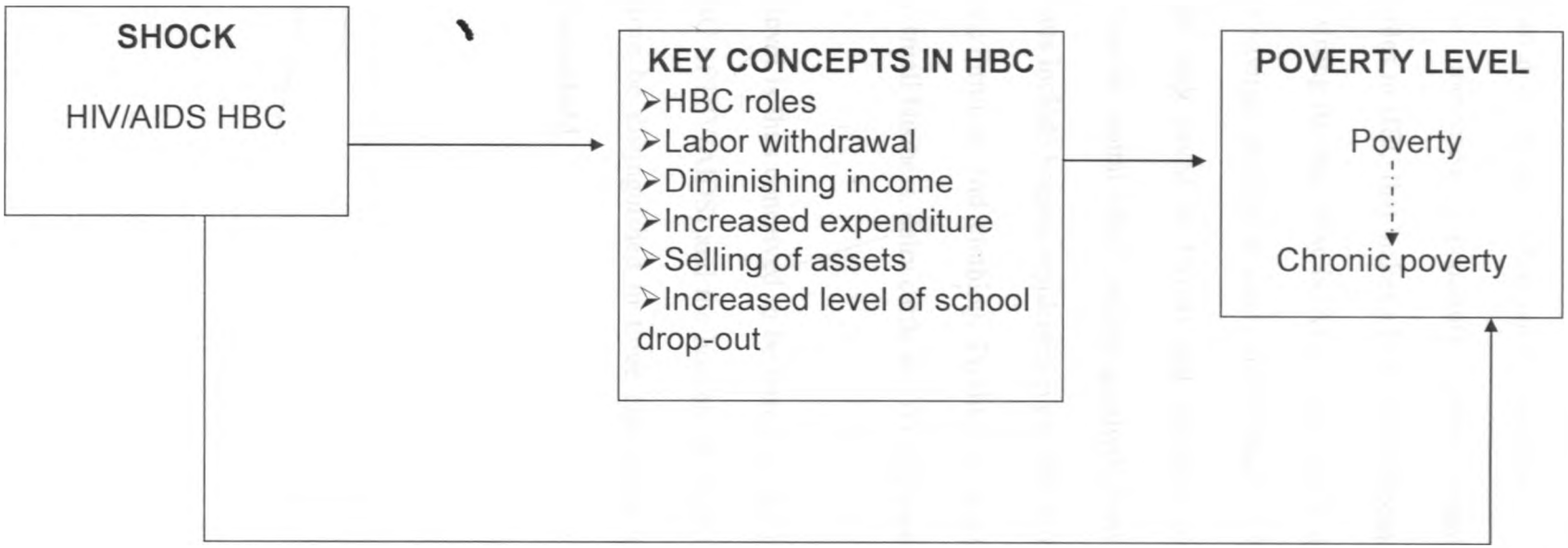


Figure 2.1 shows the relationship between HBC of HIV/AIDS and poverty. From the diagram it is the withdrawal of children from school, increased expenditure, selling of property to cater for increased expenditure, labor withdrawal, diminishing income/production and roles in HBC that makes a household become poor or chronically poor depending on how strong its asset base is. Asset base can be categorized into three categories which include savings, protective assets and productive assets (Donahue et al 2001). Savings include cash saved in formal and informal institutions, livestock, agricultural produce and social capital which include goodwill from relative, friends and neighbors. Protective assets include houses, residential plots and household items such as TVs, radios, refrigerator, furniture and clothing. Productive asset on the other hand include agricultural land, small business, dairy cattle and rental properties among others.

The household poverty level is thus conceived to be based on the complex relationship between the shocks (HBC of HIV/AIDS) and the household asset base. The household poverty level can therefore be distinguished in three categories including chronically poor, poor and non poor household.

CHAPTER THREE

HIV/AIDS HBC AND CHRONIC POVERTY

3.0 Introduction

This chapter presents field findings in relation to literature review and conceptual framework in discussing the implication of HIV/AIDS home based care on chronic poverty among selected households in Ukwala Siaya District. In literature review, NASCOP (2007) pointed out HIV/AIDS as a leading challenge to poverty eradication. The many challenges associated with HIV/AIDS necessitated the adoption of home based care as the best approach to taking care of the infected GOK (2002). HBC has roles which are varied and diversified and consume both time and money as discussed in the literature review. HBC roles weakens production base of the affected and infected household thus making them vulnerable to poverty and chronic poverty.

The study findings show that poverty increases among the affected households. The poverty increases in different channels which the care givers interviewed said that can be direct or indirect. The former depends on the immediate consequences of illness in terms of decreasing productivity and loss of job/income; the latter are caused by coping mechanisms adopted by individuals /households. Under direct channel income decrease is experienced at the beginning of the symptomatic phase of AIDS and worsen in time, coming to a halt with the death of the ill person.

From the findings, it is true that income decreases when the bread winner of the family is the one sick or when a member of the household has to curtail work outside home to

provide care to the sick. Decreasing income is worsened by a distortion in consumption with a sharp increase in sanitary/medical expenditure. Indirect channels are those deriving from household reactions to more direct consequences of the illness like settling hospital bill. Human societies tend to develop reaction mechanisms (coping strategies) and risk management strategies in order to answer difficult situations. This sentiment is in tune with field findings where the care givers invented several survival tactics as will be discussed in the last section of this chapter. The short term strategies adopted by a particular household aims at giving some kind of immediate relief. The short term choices like disposing off an asset aims at responding to sudden income fluctuations or clearing bills. This may have dramatic and unwanted long terms effects like the discussed case where a family decided to sell a motor bike that has been bringing in a steady income.

HBC not only increases expenditures but also diminishes sources of monthly income as reported by the respondents. The roles which will be discussed in section three are very demanding in terms of time and money. It is for this reason that (89.6 percent) of the respondents pointed out that they have missed going to work or attending to their business on different occasions in order to be with the sick. Those doing business, for example associated decline in capacity to transact business with the following factors: a) labor shortages resulting from sickness b) the displacement of labor as household members become caregivers rather than run the business. This resulted in decreasing profit, and eventually using the capital in care related expenses. What followed next is the closure of business and thus loss of livelihood by the family. Majority of the households

(67.2 percent) narrated this as the cause of their poverty. The respondents associated the famine facing them with displacement of labor and not drought or conflict as is usually the case. This sentiment is in tune with the 'New Variant Famine' thesis which posits that a different type of famine is emerging, driven not by drought or conflict but by the effects of HIV/AIDS as it increases the vulnerability of households to shocks and risk (de Waal, 2003; FANTA, 2001; WHO, 2003).

The chapter comprises of four sections. The first section analyses the demographic characteristics of HIV/AIDS care givers and chronic poverty. Section two discusses poverty situation of HIV/AIDS caregivers while section three analyses the nature of HBC roles of HIV/AIDS and chronic poverty. The fourth and final section discusses the coping mechanisms of HIV/AIDS care givers and chronic poverty.

3.1 Demographic characteristics of HIV/AIDS care givers and chronic poverty

The surveyed households in Ukwala provided forty five respondents to whom the questionnaires were administered. This section presents the demographic characteristics of the respondents in relation to chronic poverty. Specifically, it details information on gender, age, training on home based care, marital status, level of education, employment status and monthly income of the respondents in relation to chronic poverty facing them.

3.1.1 Gender

Gender is an important socioeconomic, cultural and demographic factor with regard to poverty and HIV/AIDS. The results presented in Table 3.1 shows that the majority (64.4 percent) of those interviewed were females while (35.6 percent) were males.

Table3.1: Distribution of respondents by gender

Gender	Frequency	Percent
Male	16	35.6
Female	29	64.4
Total	45	100.0

The disproportional representation could be attributed to the labor based migration patterns with more males than women moving to major towns in search of job opportunities. Moreover males succumb faster to deaths related to HIV/AIDS complications than females (Slater R, 2008, UNDP 2006). This underscores the findings elsewhere which showed that up to 90 percent of the care due to illness is provided in the home by women and girls (Global Coalition on Women and AIDS, 2004). When HIV/AIDS enters the household and community, women and girls pay a high opportunity cost when undertaking unpaid care work for HIV/AIDS related illnesses, as their ability to participate in income generation, education and skill building diminishes sharply (Global Coalition on Women and AIDS, 2004). This predisposes them to poverty. Depending on their asset base they later on slide into poverty or chronic poverty.

3.1.2 Age

The results presented in Table 3.2 shows that majority (31.1 percent) of the respondents were aged between 25 and 34 years followed by those between 35 and 44 years (26.7 percent), 55 years and above (17.7 percent).

Table3.2: Distribution of the respondents by age

Age group	Frequency	Percentage
5-14	1	2.2
15-24	5	11.1
25-34	14	31.1
35-44	12	26.7
45-54	5	11.1
55-64	6	13.3
65 and above	2	4.4
Total	45	100.0

This implies that the burden of care giving to PLWHA falls heavily on young people contrary to the general belief that the elderly forms the bulk of the care givers (HAI 2001, HAI 1996). The involvement of the youths in HBC for PLWHA may however, have far reaching effects on the economic well being of the communities in Ukwala and thus stretch the effects of chronic poverty in the area. This is particularly so because the youths are the economically active and productive segment of the population especially those aged between 20 to 45 years yet they are the ones involved in HBC. Their missing

out in income generating activities as they get involved in HBC roles makes them vulnerable to poverty and chronic poverty as discussed in vulnerability approach.

3.1.3 Marital status

The study results on marital status indicated that (55.6 percent) of the respondents were single either because they were never married, separated or widowed. Only (44.4 percent) of the respondents were married and were staying with their spouses. It emerged from FGD that most cases of widowhood were as a result of deaths related to opportunistic infections associated with HIV/AIDS. The presence of a large proportion of singles persons within the study area may have some negative impacts in the fight against HIV/AIDS. It was pointed out in the FGD session that the increasing numbers of widows and the deeply rooted culture of wife custodianship (*ter)* pose a major threat to the community with regard to fight against HIV/AIDS which worsens poverty situation.

3.1.4 Level of Education

Education is an important social and economic factor especially with regard to fight against poverty. Table 3.3 depicts that majority (23.8 percent) of the respondents had secondary education with some training followed by primary incomplete (21.4 percent), secondary incomplete (16.7 percent), secondary complete and University (14.3 percent) respectively, primary complete (7.1 percent) while those with no formal schooling accounted for (2.4 percent).

Table 3.3: Distribution by level of education

Level of education	Frequency	Percentage
No formal schooling	4	2.4
Primary incomplete	9	21.4
Primary complete	3	7.1
Secondary incomplete	7	16.7
Secondary complete	6	14.3
Secondary with some training	10	23.8
University	6	14.3
Total	45	100.0

This statistics shows that many of the caregivers had attained some form of formal education. The trend in the study area is however worrying because those who are educated and are economically empowered are the ones undertaking unpaid care work for HIV/AIDS related illness thus missing out on the opportunity to participate in income generating activities. The reduced participation in productive economic activities may subject their respective households into further poverty.

3.1.5 Training on HBC

Training on HBC prepares caregivers to effectively take up the care giving roles to PLWHA. When asked if they had received information or training on home based care giving, majority (82.2 percent) of the respondents stated that they received this

information informally while 15.6 percent had not received this information and 2.2 percent had partly received the information.

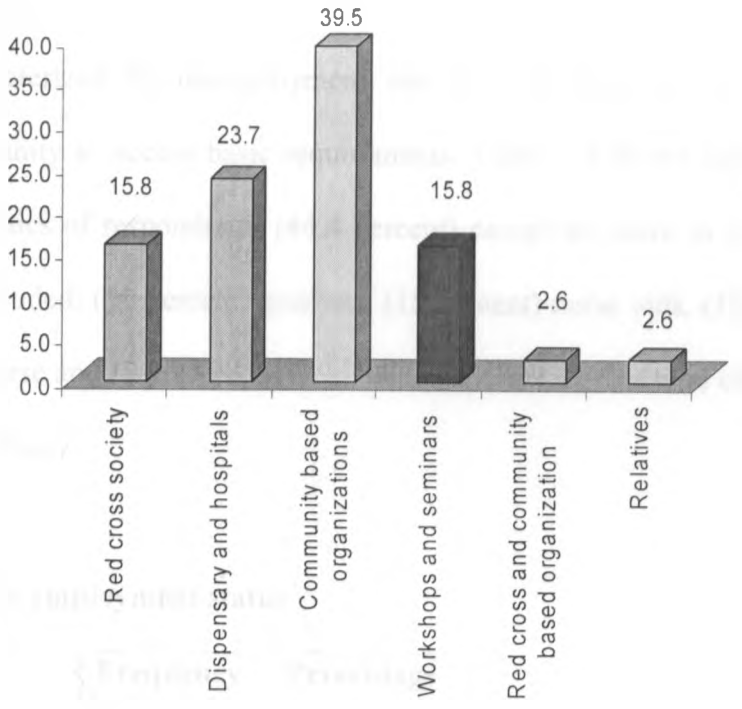


Figure3. 1 Sources of information on HBC for care givers

Those trained reported that the training focused on palliative care, proper use of condoms, treating opportunistic infections, stress management and counseling, behavioral change, catering for nutritional needs of the infected and the importance of knowing ones status. The success of HBC approach for PLWHA will rely on the availability of adequate information to the community members. The above figures show that most of the care givers in Ukwala have not received full training on HBC. Figure 3.1 shows that for those who had received HBC information or training majority (57.9 percent) had

received the HBC information or education from various community based organizations while (23.7 percent) from dispensary and hospitals.

3.1.6 Employment status

Poverty is also characterized by unemployment and low incomes which deny the households the opportunity to access basic requirements. Table 3.4 shows employment and income characteristics of respondents. (44.4 percent) caregivers were in the formal employment which included; (50 percent) teachers, (15 percent) nurse aids, (10 percent) home base caregiver nurse and (5 percent) each as accounts clerk, agricultural officer and district development officer.

Table3. 4: Respondents employment status

Employment status	Frequency	Percentage
Teacher	10	50
Account clerk	1	5
Retired	1	5
Nurse aid	3	15
District development officer	1	5
HBC nurse	2	10
Agricultural officer	1	5
Casual/manual jobs	1	5
Total	20	100.0

Table 3.5 shows (65.6 percent) in self employment which included (61.9 percent) operating small business while the rest were involved in casual or manual type of self employment.

Table3.5: Self employed respondents

Self employment	Frequency	Percentage
Small business	13	61.6
Casual/manual work	4	19
Sex worker	1	4.8
Mechanic	1	4.8
Herdsmen	1	4.8
Tailor	1	4.8
Total	21	100.0

Those in manual type of self employment were engaged in the following activities, mechanics, tailoring, house help, herdsman, commercial sex worker and digging for wages. These statistics show that a good number of the care givers were involved in some form of income generating activity. The new roles they have assumed in HBC limits their chances of participating in the various daily income generating activities. This as a result affects their incomes thus posing the danger of sliding into poverty

3.1.7 Monthly income

The respondents' monthly income varied significantly. Figure 3.2 shows that (4.8 percent) of the respondents had a monthly income of more than KShs 25,000, (19 percent) had KShs 6000 to 9000, (35.7 percent) had KShs 2000 to 5000 and (16.7 percent) earned less than KShs 2000 per month.

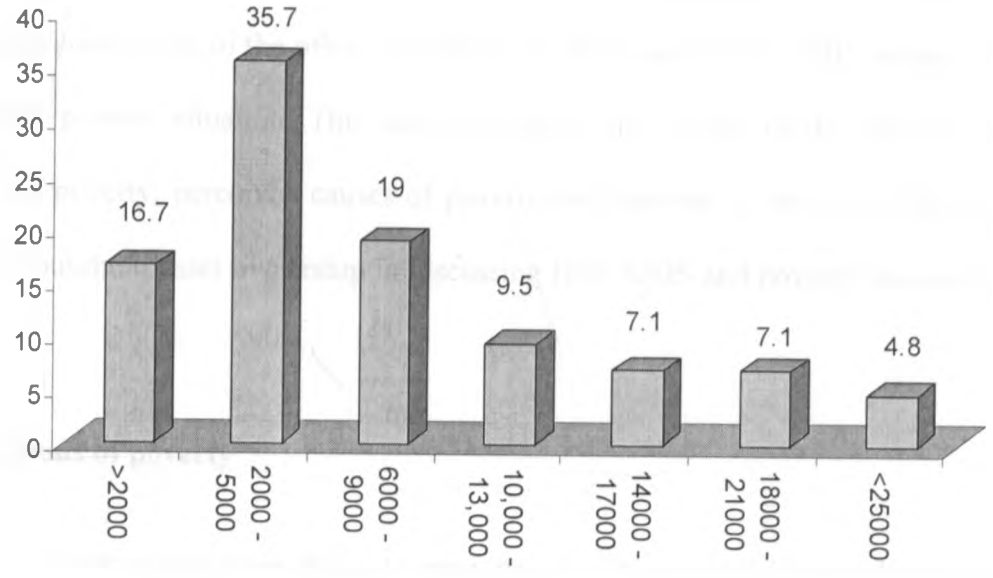


Figure 2.2: Respondents monthly income in KShs

This report indicates that many of the households surveyed survive on very limited resources of less than 1USDollar per day.

3.2 HIV/AIDS and Poverty situation of caregivers in Ukwala

Strong links between HIV/AIDS and poverty have been demonstrated, with AIDS deepening poverty in the affected household (Mehta and Shepherd 2004). Chronic ill health creates immense stress, even among the financially secure. However, stress levels escalate sharply when chronic illness is combined with chronic poverty or entry into poverty. This makes the relationship and effects of poverty and HIV/AIDS to vary from one household/community to the other. The study sought to assess how HBC impacts on the household poverty situation. This section presents the results of the findings on perceptions of poverty, perceived causes of poverty and duration of poverty, effects of poverty and household asset ownership in discussing HIV/AIDS and poverty situation of caregivers.

3.2.1 Perceptions of poverty

Poverty as a concept means many things to many people. The results of the study showed that majority (68.9 percent) of the respondents considered their household as poor while (31.1 percent) felt that their households were averagely. Instructively, none of the caregivers considered themselves as wealthy. This therefore implies that households providing care to PLWHA felt the effects of poverty the most.

The FGD revealed that poverty is perceived by people in different ways. One, poverty was defined as lack of the means of providing material needs or comforts; two, deficiency in monetary/material availability (*dhier*); three, unreliable supply of essential

needs; four, disempowerment because a poor person is voiceless-no one can listen to a poor person; five, poverty is hunger; six, poverty is being sick and not being able to see a doctor; and seven, fear of the future-living one day at a time because of lack of knowledge of what tomorrow will bring. The overwhelming perception of high poverty levels amongst households can therefore be explained by the diverse definitions of poverty by the community members in the study area.

As discussed earlier, poverty is a multi faceted phenomenon caused by a number of factors that vary from one community to the other. Table 3.6 shows that (28.9 percent) of the respondents stated that HIV/AIDS infection is the cause of poverty in their households while (55.5 percent) attributed poverty to either single or a combination of factors such as unemployment, HIV/AIDS, poor leadership at national level and lack of education.

Table3.6: Perceived cause of poverty by care givers

Cause of poverty	**Frequency**	**Percentage**
Lack of education	5	11.1
HIV/AIDS	13	28.9
Unemployment, HIV/AIDS, poor leadership, lack of education	11	24.4
Lack of employment	2	4.4
Unemployment and illiteracy	7	15.6
Disease	7	15.6
Total	45	100.0

The study results are in similar tune to Mehta and Shepherd (2004) observations that shocks resulting from onset of a long and expensive illness such as HIV/AIDS, are among the factors that can drive the poor and many who may have initially been better off into chronic or long-term poverty. This happens when labor is withdrawn to provide the needed care. Withdrawal of labor ushers in diminishing income/decreasing productivity/decreasing investment which when coupled with increasing expenditure can easily plunge a household into poverty.

3.2.2 Duration of poverty

Chronic poverty is a prolonged experience of poverty situation over a long period of time. Most families in Ukwala live on less than a dollar a day with heightened poverty reported in areas facing low rainfall levels and poor soil fertility. The results in Figure 3.3 shows that (35.5 percent) of households that considered themselves as poor stated that they have been poor for 10 years and above while (32.3 percent) have been poor for 1-5 years and the remaining (32.3 percent) 6 – 10 years respectively. If chronic poverty is defined as poverty that is extended in duration for say five years and above, then it can be said that the care givers in Ukwala are faced with chronic poverty. The (32.3 percent) who are not chronically poor also risk becoming chronically poor if no measures are put in place to avert the situation.

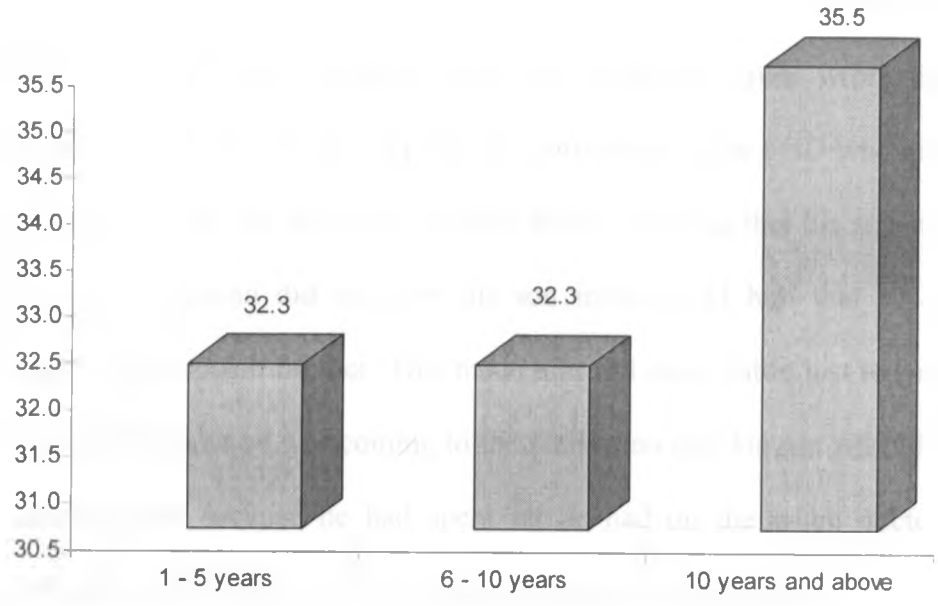


Figure3.3: Duration in poverty of care givers household

The main factor associated with chronic poverty were cited as socioeconomic effects of HIV/AIDS, low agricultural productivity, lack of adequate land, land degradation as a result of over cultivation, high cost of health and education, lack of education, lack of job opportunities and large family sizes. Most households indicated that they have been forced to make sacrifices by selling their assets to educate their children. This they said that they did hoping that their children will be able to deliver them from the poverty facing them. The end result has been very disappointing, the children after clearing their studies and securing jobs ends up contracting HIV/AIDS. The children thus come back to them sick and they are forced to take care of them with barely any resources. This worsens their poverty situation.

Witch craft and negative medicine practice by the magicians was also mentioned as a causes of poverty. This happens when the magicians give wrong diagnosis and overcharge their clients. A case in point is a participant in the FGD who narrated how he sold his cattle to pay for magician services before realizing that his son was HIV/AIDS positive. The magician did not cure his son instead told him that his son has been bewitched by his cousin brother. This made him sell more cattle just to find cure for his only son. By the time he was coming to the realization that his son was HIV positive, he was already poor because he had spent all he had on the witch doctors. The FGD concluded that HIV/AIDS is both a cause and a symptom of poverty.

3.2.3 Effects of poverty

Survey results indicate that poverty among the infected households is manifested in a number of ways, larger household sizes is one of them. The dependency problem was reported as puting economic strain on households which are already experiencing poverty. From Table 3.7, (37.8 percent) of the caregivers had children ranging from four to six in number, while (13.6 percent) had one to three children. There were additional (10 percent) caregivers who had seven to nine children.

Table3.7: Distribution of respondents by dependency relationship

Relationship	Frequency	Percentage
Siblings	6	16.2
Friends	1	2.7
Grand children	9	24.3
Brothers and sister in law	5	13.5
Mother and father in law	2	5.4
Nephew and niece	9	24.3
Step children	1	2.7
Cousins	4	10.8
Total	37	100.0

Most of the households in Ukwala were larger in sizes with bigger number of respondents' children and other relatives staying within these households. Majority of other relatives who stayed with the caregivers were largely orphans, many of whom were integrated into these households due to HIV/AIDS related situation. These dependants are not working thus posing a greater problem of dependency that serve to aggravate the poverty situation in the affected households.

Limited access to social amenities like education is also an aspect of poverty. In Ukwala poverty is evidenced from the proportion of children who are of school going age but are out of school. Table 3.8 shows that children who dropped out of school were either due to lack of school fees and taking care of the sick accounting for 45 percent while the rest

were due to pregnancy and self preferences. Education is very critical in the fight against poverty and HIV/AIDS. The high number of school drop outs by majority of school going children due to lack of school fee as well as taking care of the sick is most likely to have negative effects on the household poverty situation. This is because the young ones are left with little or no hope of equipping themselves with the skills and capacity to find their way out of poverty.

Table3.8: Reason for dropping out of school

Reasons	Frequency	Percentage
Lack of school fee	5	50
Lack of money	1	10
Lack of fees and taking care of the sick	3	30
Early pregnancy	1	10
Total	10	100.0

3.2.4 Household asset ownership

Asset base determines how a household responds to shocks and the ultimate outcome as discussed in conceptual framework. Table 3.9 shows variety of properties and assets owned by the caregivers. The respondents had limited ownership/access to assets. The limited access to assets was attributed to limited income and inability to purchase assets from the on set of illness (HIV/AIDS) due to increased medical related expenses. Not all of the caregivers owned properties and assets, (51.1 percent) of the respondents confirmed that they own various assets and properties while the rest (48.9 percent) said

that they had no assets and properties of their own. Among the caregivers who had properties, (52.2 percent) owned both livestock and pieces of land, (17.4 percent) owned only a piece of land, (8.7 percent) each owned land, motorbike, and livestock or house and a piece of land while (4.3 percent) each had either temporary or semi permanent house and a piece of land, livestock or poultry or camera and bicycle.

Table3. 4: Care givers assets and properties

Properties and assets	**Frequency**	**Percentage**
Livestock and land	12	52.2
House and land	3	13
Piece of land	4	17.4
House, land, livestock and poultry	1	4.3
Land, motorbike and livestock	2	8.7
Camera and bicycle	1	4.3
Total	23	100.0

HBC puts a lot of pressure on asset base of the affected household as discussed in conceptual framework. The findings shows that majority of the households interviewed had a weak asset base. With a weak asset base, the affected and infected households are more prone to poverty and chronic poverty in the face of HIV/AIDS HBC.

3.3 Nature of HBC roles of HIV/AIDS and chronic poverty

In Kenya the declaration of HIV/AIDS as a national disaster was followed by development of home based care by NASCOP as the best approach of taking care of the infected at home. This approach has been seen as impacting negatively on the care givers because of the multiple expenses that are involved in it.

Adverse effect of HBC is that it disrupts the interface between production and domestic labor. Care givers of the affected and the infected by HIV/AIDS are in the center of this interface. The disruption of the domestic-productive labor interface, coupled with other socio-economic factors, may inflict a shock to the livelihood system of the household, thus plunging the family in poverty and eventually chronic poverty. This section analyses the findings on the relationship of caregivers and those under their care and the roles they play in HBC in relation to chronic poverty.

3.3.1 Relationship between the caregiver and PLWHA

Relationship between the caregivers and PLWHA not only determines the ultimate poverty situation of the affected households but also the person who takes up the HBC roles. From the study, it emerged that when the infected were male head of household, the wives were left with no asset since the culture still bars wives from inheriting properties like land and cattle. On the other hand when the infected were the children (sole breadwinners to their parents) the aging parents are left with no one to take care of their basic needs. Such occurrences were reported as some of the case scenarios that

heighten the poverty levels among the affected households. Table 3.10 shows how the care givers are/were related to those who are sick or have died of HIV/AIDS and its complication in the recent past.

Table3. 5: Distribution of how care givers were related to those under their care

PLWHA	Frequency	Percentage
Spouse	21	46.7
Mum	5	11.1
Father	1	2.2
Child	4	8.9
Brother	1	2.2
Sister	3	6.7
Son in law, daughter and son	3	6.7
Son and wife	1	2.2
Grand children	1	2.2
Uncle and aunty	1	2.2
Parents	1	2.2
Self	3	6.7
Total	45	100.0

The results showed that (46.7 percent) stated that those who are sick or have died were their spouses, (11.1 percent) their mother, (8.9 percent) their children, (6.7 percent) each were either sisters, son in law, daughter and children or themselves while (2.2 percent) each were either brothers, sons, grandchildren, uncles and aunties or parents.

FGD alluded that HIV/AIDS has severely stretched traditional coping mechanisms and extended family networks, often to their breaking point. Caring for the sick therefore is no longer communal affair but an individual/a household affair. It was also observed that as many households are infected and affected with HIV/AIDS and in need of care, care giving duties have increasingly shifted to individual members in the household. Children are not spared in the care giving role. With increasing rates of infection, children have been forced to withdraw from school to fulfill care giving duties and to help compensate for lost family income. The FGD pointed out that children faced with such situations usually take digging and herding cattle for wages or becoming house help in the nearby Ugunja Town.

3.3.2 Roles of caregivers within the households

The roles played by caregivers in HBC varied and intensified depending on the stage in which the infected person under their care was in. In general, the respondents defined these stages as: (a) early stages when the family is first called on for assistance or the first signs of HIV/AIDS appear, (b) frequent hospital visits, where (PLWA) is in and out of hospital, (c) bedridden either at home or in the hospital, (d) death and burial and (e) care for orphaned children including payment for their education.

In general the roles played by caregivers in HBC were categorized as counseling, social support, clinical care and nursing care. (a) Counseling is a helping relationship that assists people to understand and deal with their situation. This form of care is mainly provided by those who have attained some form of training or trained community care

givers. (b) Social support care is the creation of an enabling environment for PLWHA. (c) Clinical care is medical care given to the sick at home.

Under clinical care, opportunistic infections and other complications resulting from HIV/AIDS are treated. The complications identified by the majority of the respondents 87 percent included: diarrhea, difficulty in swallowing, difficulty in breathing, swelling of body parts, high temperature (fever), nausea and vomiting, skin or mucous membrane lesions, mouth ulcers, headache, loss of appetite among others. Majority of care givers (76.3 percent) combined self medication with the drugs from clinics. One respondent confessed having a stock of bruffen tablets in the house which she explains that she gives the patient under her care when in pain. Other over the counter drugs most commonly purchased by the respondents included, amoxil for coughs and throat infection, penicillin for wounds, rob ointment for massage, bruffen for reducing pain among others. This meant extra expense on their already tight and overstretched budgets. When asked why they do this they said its either inability to make it for their appointments or frequent and severe attack on the people they take care of or influence from their peers to try alternative drugs/options. (d) Nursing care is assisting the sick to do things they would do on their own suppose they were not sick.

Under nursing care, the care givers played the following roles: bathed, fed and clothed the sick, do their laundry, clean their teeth among other roles. Majority of the respondents confessed that nursing care was the most involving both financially and in terms of man/woman power. In one example, a female care giver estimated that due to regular

diarrhea suffered by a family member who was dying of HIV/AIDS; she was fetching 20 buckets a day. This consumed at most six hours given the distance from her home to the river, to wash clothes, bedding and the patient. The same sentiment was shared by some other care givers interviewed.

Roles played by care givers covers a range of services and activities including physical, clinical, psycho-social, emotional, spiritual, financial and practical care (Figure 3.4). While many care givers confessed to be providing care for spouses and family members out of love and compassion, the fact is that their work remains unsupported and unrecognized. Other roles include bathing and cleaning up the sick person, obtaining and preparing meals in the context of dwindling resources, hand-feeding those too sick to feed themselves, washing clothes and bed sheets, escorting the sick person to and from the toilet, assisting the sick in walking, house maintenance (89 percent of the respondents live in mud-walled with thatched roofs houses which required periodic maintenance and repair as observed by the researcher), emotional support, child care, purchasing and administering drugs or remedies, general household survival needs such as income generation and producing food through subsistence agriculture.

The results showed that (72.9 percent) of care givers got some help from the family members while the rest did not. It emerged from FGD that most of the family members tend to withdraw from the HBC roles when the sick becomes bedridden. The caring role is therefore solely left to those very close to the sick like husbands, wives, mothers and daughters. One case in point is one household that was taking care of their daughter who

was sent from her matrimonial home to her parent's home so that the mother can take care of her. '*Dani*' as the villagers refer to her was faced with double tragedy as she was on the verge of loosing her sole bread winner and at the same time had to be the care giver of her only daughter with barely any resources.

The respondents taking care of the bed ridden confessed that finding suitable food that fit the appetite of the sick and feeding them was very hectic. One woman respondent supported this discussion by saying that on a bad day she prepares more than three different types of food just to ensure that at least if one type of food or another is rejected the sick has an alternative and thus does not go without food. She however complained that this really affects the family budget as the family is either forced to go without food or forfeit some meals like breakfast. Another problem facing the respondents here was the laundry related expenses. One respondent narrated how she spends most of her time washing the patient's bedding and clothes since the patient under her care is not able to go to the toilet. She continued to narrate that in one day she can use up to one full bar soap. Such roles which involve expenses are most likely to add to the impoverishment of the care givers since expenses increases with HBC yet income diminishes. This happens when one member of the household assumes roles in HBC thus missing out on involvement in income generating activities.

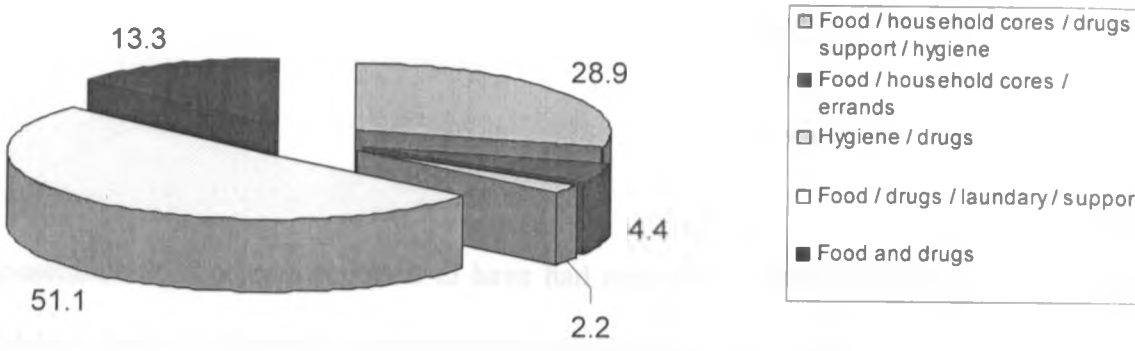


Figure3. 3: The scope of care giving at respondent's household

3.4 Households coping mechanisms and chronic poverty

The coping mechanisms adopted by the households surveyed were varied and diversified. These coping mechanisms were adopted in order to deal with reduction in resources as a result of HIV/AIDS. In instances where the bread winner was the one bed ridden the family had to reorganize itself not only in terms of expenditure but also in terms of time. The coping mechanisms were viewed by respondents as the cushion against adverse effects of increased medical cost for the sick, loss of income due to inability to work, lost labor supply for household production among others.

This section discusses findings on borrowing, reduced consumption, sending away of children to stay with relatives, remarrying, asset disposal and working for shorter or longer hours as some of the coping mechanisms that were adopted by respondents in the study area.

3.4.1 Borrowing

Most of the households 85.8 percent reported to have had resorted to borrowing when faced with hardship. Only 12.2 percent borrowed from banks while the rest borrowed from money lenders/neighbors. This they attributed to the fact that they do not have the collateral that the banks require in order to give loans. The amount of money borrowed ranged from Kshs100 to Kshs1000. There was also the borrowing of items such as food from the sellers and drugs from the chemist. Borrowing was mainly for sustaining the household and not investment. This coping mechanism therefore has the potential of worsening the household poverty situation as it is mainly done for survival. Many houses reported having paid back with some of their assets when their situation worsen and thus failed to get cash. The commonly mentioned type of asset that has been used in offsetting debt is cattle (chicken, cow, goat and sheep). It also emerged from FGD that the ability of a person to be given loan by money lenders depended on how much assets one owns so that incase of default ones property can be confiscated.

3.4.2 Reduction in consumption

This is a coping strategy where the household decides to reduce consumption on basic needs like food, clothing, education and health care. Whatever savings that is made from

reduced consumption goes towards the expenses incurred for the sick person. Some households also reported reduced consumption due to lack of these basic needs and not for saving purposes like others. In such instances reduced consumption is not really a coping mechanism. A good example of reduced consumption as a coping mechanism is the case reported earlier on in the discussion where one care giver made her family go without food in order to cook variety of foodstuff for the sick. Most of the households reported having reduced the number of meals from three to two and some from two to one in order to cope with the new situations they have found themselves in.

Reduced consumption was also common especially with regard to purchase of commodities. 89.9 percent of the households reported that most of the commodities they purchase are the small quantity ones, what is commonly known among them as '*kadogo*'. The commodities available to them in smaller and affordable prices are cooking fat, matchbox, soap, paraffin, sugar, salt among other products.

Withdrawal of children from school also falls under reduced consumption as a strategy. There were cases where children were withdrawn from school due to either lack of school fees or to help with the care provision. Out of those children withdrawn from school to take care of the sick, 87.2 percent of them were girls. This type of coping mechanism had a short term advantage and long term negative impact on the life of children withdrawn from school. The short term advantage is that the sick person is taken care of without withdrawing family labor and school related expenses are reduced as a result. The big

question is what about these children's future? Such children may not be able to move out of poverty as they miss out on acquiring life time skills (education).

Majority of the respondents 64.5 percent did not include buying clothes in their budgets while the rest 15.6 percent spent between KShs 2000 to KShs 10000 and 20.3 percent spent less than KShs 2000 on buying clothes. The majority who did not buy clothes admitted that they no longer buy clothes with their tight budget because to them clothing have become a luxury. They then added that they borrow clothes from their neighbors when they have an important occasion/journey to make.

3.4.3 Sending away children to live with relatives

Under this strategy children were sent a way to go and stay with their relatives who are slightly well off economically. From the FGD it emerged that most children were sent to go and stay with their aunties (father's sister). Only 26.4 percent of children sent to stay with relatives continued with education. The rest ended up as either *shamba* boys, herdsmen or were married off. This method therefore benefited only few people whose relatives had their best interest at heart.

3.4.4 Remarrying

This was a strategy adopted mostly by widower care givers who are old and taking care of their grandchildren orphaned by HIV/AIDS. This mechanism is not common because out of all the respondents only 5 percent reported this. Some of the negative aspects of this strategy reported by the respondent is the siring of children at old age. This happens

when the elderly persons remarry young girls. This strategy therefore presents the problem of increasing the number of dependants to already impoverished households

3.4.5 Asset disposal

Asset disposal is the selling of essential income-generation devices, such as machinery and tools and other household goods. The table 4.11 below presents the assets as three broad categories namely savings, protective assets and productive assets (Donahue et al., 2001)

Table3. 6: Asset category

Assets categories	Examples
Savings	• Cash saved in formal financial institutions (banks), semi-formal institutions (MFIs) or via informal mechanisms. • Small livestock (chickens, goats, etc.) • Agricultural produce (from small gardens or stored harvests) • Social capital (goodwill from relatives, friends and neighbors)
Protective	• Houses • Residential plots • Household items (TVs, radios, furniture, clothing)
Productive	• Agricultural land • Small business capital (tools and equipment) • Dairy and draft animals • Rental properties

In this study selling of assets and properties, an attribute that has implication on chronic poverty which is usually associated with the desire to quickly quench unmet financial need was a major occurrence among these caregivers. It emerged from the discussion that decision to sell an asset was always made by the male head of the house. Women are in most cases not involved and they only learn about this once the transaction has been made. One woman narrated how her husband disposed off their bicycle to obtain cash for his medical expenses. Since the bicycle brought steady income into the household, she only learnt that it was sold when the steady income stopped all over sudden. When she confronted the husband about it he confirmed her worst fear, the bicycle was gone. Its sale meant that the family would soon have no steady of income. A similarly story was shared by a woman who narrated how she grazes the cattle and rears them all by her self but when it comes to selling them she is not consulted. It emerged from discussion that women too do sell assets, the only difference is that women sell petty household assets easily and income generating asset like livestock, bicycle and motorbike when the situation becomes really bad.

Among the caregivers majority 68.8 percent sold one of their assets or properties. This included 38.7 percent of the respondents selling their livestock, 25.8 percent selling machine/automobile (bicycle, motorbike and cars), 22.6 percent selling household tools and furniture while 12.9 percent sold family land. People in this situation are often likely to sell their assets and properties cheaply. Among those care givers who sold their assets and properties about 35.5 percent of them sold their properties for prices ranging from

KShs 5,000 to 10000 often too low compared to their actual value. Only 9.7 percent sold assets for more than KShs 100,000.

Asset disposal was done in stages. First it begun with the household disposing those assets that it perceived as less important then move to the important assets when the situation becomes worse. Among the reasons cited for selling assets by caregivers included 70.9 percent to pay hospital bill and funeral expenses and only 29.1 percent for general expenses.

Three cases captured from the field study were; one household that sold the family motorbike for funeral expenses when the head of the household died. The motor bike initially served as a source of income to the family by ferrying people at a fee. Now with the head/breadwinner of the household gone and the motor bike gone the family could not comprehend what will become of them.

The second case is of a male head of a household who fell ill then disposed off his maize-milling machine to obtain cash for his medical expenses. Since the milling machine brought steady income into the household, its sale meant that the family would soon have no source of income.

Third case is of a household that sold its livestock in order to pay for the services of a magician. This was before they discovered that their son was HIV positive. Implication

of this on the household was being cut off from their own access to fresh meat, milk and eggs

3.4.6 Working longer/shorter hours in the informal sector or self-employment

The most commonly cited coping mechanism by the care givers doing casual work for wages is working for longer hours, perhaps even taking up a second job, if possible. In this study, majority of the respondents 88.9 percent in one way or another worked longer or shorter hours or forgo work altogether. About 33.3 percent caregivers forgo work for HBC and only 8.9 percent took HBC as part of their normal responsibility. One man a care giver who digs for people to earn a living admitted that since the wife become bedridden he has resorted to working for longer and odd hours to provide for and to take care of the wife. He goes to work as early as four in the morning when there is moon, come back at nine to attend to the wife then go back at six in the evening then come back at nine at night. Working longer hours however, seems not to be enough because those who work for long hours still supplement it with selling their assets.

CHAPTER FOUR

SUMMARY, CONCLUSIONS AND RECOMMENDATION

4.0 Introduction

This chapter presents summary conclusion and recommendation of the study. It highlights the main findings of the study and draws conclusion based on the empirical evidence. The recommendations provide possible mechanisms for strengthening HBC and also identify some knowledge gap areas that may require further studies

4.1 Summary

HBC of HIV/AIDS has been viewed as the best approach of taking care of PLWHA GOK (2002). The literature review also discussed HBC of HIV/AIDS as having the advantage of decongesting hospital beds and health personnel, reducing stigma associated with HIV/AIDS, creating awareness and promoting behavior change. What is not clear as was stated in the problem statement is the implication of HBC on the poverty situation of the care givers. The study had one overall objective of establishing if HBC of PLWHA has implication for chronic poverty situation of the affected households.

Critical to the study objective was the finding that home based care of PLWHA worsens the poverty situation of the affected households. This happens when; (a) incomes decline because caregivers are unable to work or caregivers withdraw work outside the home to attend to the needs of the sick family members (b) when monthly expenditure on medical care and the dietary and nutritional needs of the patient and transport expenditure

increased (c) when there is decreased revenue from loss of labor and decreased investment in productive activities like education and savings.

Faced with the hardships resulting from taking care of the sick the affected households therefore adopts the following as the coping mechanism in trying to survive; borrowing from friends and relatives, short-term relief through aid organizations, reduction in consumption of food and other expenditure like education, taking children, particularly girls, out of school to care for the sick and help with other household duties, sending away children to stay with relatives, marrying for the second time to take care of a large number of grandchildren of varying age groups after one own children have died, taking loans, selling assets and using savings and working extra hours in the informal sector or self-employment. As evidenced from the study, most of these coping mechanisms worsens the poverty situation of those affected thus making them to sink further into poverty.

4.2 Conclusion

The study concludes that HBC of PLWHA leads to chronic poverty of the affected households. This happens through the following means: (a) when the sick is the sole breadwinner of the affected household and he/she has to stop working because of his/her health condition. (b) When productive labor is withdrawn in order to provide the needed care at home. (c) When children are withdrawn from school to provide care. (d) When health related expenses set in as a result of the sickness and the family expenditure

escalates. (e) When family adopts some coping mechanisms such as assets disposal and borrowing in order to survive.

HBC of PLWHA sets in impoverishment of the affected household through the above mentioned means since available/expected income is generally reduced. The affected household therefore experience huge emotional and economic suffering. Health related expenses which includes care provision presents the main reasons why the affected households slide into poverty or chronic poverty. This is so because of the chronic nature of the illness which makes people borrow heavily or sell invaluable assets to cover expenses and on top of this withdraw productive labor to provide care for the sick at home. Asset ownership is relatively lower in affected households in general and, in particular, in affected households that have experienced sickness followed by death. A possible explanation could be that these households are relatively more likely to have sold their assets to clears expenses related to HIV/AIDS. This leaves them with low asset base or no assets at all which is a manifestation of poverty. Borrowing on the other hand is very dangerous for household suffering from chronic illness, because morbidity (and mortality) make it difficult and at times impossible to pay the debt. It is for this reason that borrowing could play an important role in perpetuating or worsening the poverty status of affected households especially when their properties are confiscated to clear the debt.

The findings of this study evidences that HBC of PLWHA worsens the poverty situation of the affected households. This further plunge the poor households into chronic poverty

while the non poor households may slide into poverty. A key component of Kenya's struggle to eradicate poverty should therefore focus on decreasing rates of mortality, morbidity and HIV/AIDS infection and supporting those who provide care to PLWHA.

4.3 Recommendation

In the context of chronic ill health, there is a need for adequate budgetary allocations for care givers especially those who do not have access to family support. This may also help to reduce the burden of care on home based caregivers in times of difficulty and opportunistic illnesses. Hospices are needed for terminally ill patients with no one to take care of at home.

Access to Knowledge, Skills and Work to Reduce the Burden of Home-based Care cannot be ignored. To reduce the physical, emotional and financial burden on those providing care at home, counseling and skills must be made more readily available. They should be equipped with knowledge regarding the general provision of care, providing moral support when faced with stigma and discrimination. Caregivers at home must also be informed about the importance of regular medication regimens and correct drug dosage. Further, more awareness is needed on the use related methods for treating infections and the crucial role of nutrition, hygiene and safe cooking techniques. This could prevent the care givers from being cheated by scrupulous medicine men and magicians who are out to make money. Such information can go a long way towards preventing the immune system of the infected from becoming suppressed thus being bedridden.

Furthermore, the need for skills, training and employment is critical, especially when a family or individual is saddled with the financial burden induced by taking care of PLWHA. There is an urgent need to provide social safety nets and link the poor with employment generating projects, networks and support groups.

While this study looked at the implication of HBC of HIV/AIDS on the poverty situation of the affected/infected in Ukwala, information is needed on the challenges facing care givers who are under some sort of support groups. With this information, comparison of challenges facing these two groups can be made and the best practice adopted.

The relationship between HIV/AIDS and poverty presents a very complex kind of relationship. This study looked at one direction of the interaction: HIV/AIDS leading to chronic poverty. Exploration of the relationship between poverty and HIV/AIDS and specifically if poverty can cause new infections will be very important in reducing new infections thus reducing poverty rates.

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Appendix 1: Survey Questionnaire

My name is **Evelyn Awino**, a postgraduate student at the Institute for Development Studies, University of Nairobi. I am conducting a study on the **Implication of Home based care of HIV/AID on chronic poverty situation in Ukwala location.** You are among a group of persons selected for the study. I would highly appreciate if you spare me a few minutes of your time and share your thoughts on this subject matter. The information you give will be treated in confidence and will only be useful in informing this study. Please answer the questions as honestly and openly as possible. There are no ''right or wrong'' answers.

Questionnaire Number.....

Date of Interview.....

I Background information

1 Are you the head of this house?

1 Yes ✓

2 No

2 How old are you

1 0-4

2 5-14

3 15-24

4 25-34

5 35-44

6 45-54

7 55-64

8 65 and above

2 Gender?

1 Male

2 Female

3 Have you attended school?

1 Yes

2 No

4 If yes, what is the highest level of formal education attained

1 Primary complete

2 Primary incomplete

3 Secondary complete

4 Secondary incomplete

5 College

6 University

5 What is your marital status?

1 Single

2 Married

3 Divorced

4 Widowed

5 Separated

6 None of the above

6 If married, what is the age of your spouse.....

7 What is her/his educational level.....

II Family size

8 Do you have children?

1 Yes

2 No

9 If yes, total number of children.....

Alive..... Deceased.....

10 How many are still staying with you? .....

11 Are there other people staying with you who are not your biological children?

1 Yes

2 No

12 If yes, how many

13 What is your relationship with them?

.....

14 Of the children you stay with, how many are of school going age but have dropped out? .....

15 Specify the reason why they dropped out of school

.....

16 For those going to school, who helps in their school related expenses?

.....

17 State their highest level of education

.....

III Employment and income

18 Are you employed? If yes specify form of employment

.....

19 If not employed but self employed specify

.....

20 Is your spouse employed? .....

21 What is your income per month?

.....

22 Specify the source

.....

23 What is your spouse's income per month?

.....

24 What is your monthly expenditure?

Item	Expenditure
Food	
Medication	
School fees	
Clothing	
Others	

25 How many meals do you normally have in a day?

.....

26 Have you ever gone without food?

.....

27 What do you do since morning until the time you go to bed?

Activity	**Time (i.e. from to)**

IV Assets/Property

28 Name the properties/assets you own

1 .....

2 .....

29 If land is mentioned as one of the assets, specify the size and ownership i.e. registered in whose name?

.....

30 If animals are mentioned specify the type and the number

.....

V HIV/AIDS and home based care

31 Is HIV/AIDS a common problem in this area? .....

32 If yes, who is the most affected?

.....

33 What do you think causes HIV/AIDS?

.....

34 Is there any member of your household who is sick or who died in the recent past?

.....

35 If yes, what are they suffering from or what was the cause of their death?

.....

36 How are/were you related to them?

.....

37 How old are/were they? .....

38 If the answer for number 34 is HIV/AIDS, how did you learn about it? Explain

.....

39 Have you received education or information on home based care? .....

40 If yes, from where did you get the information from?

.....

41 What is home based care all about?

.....

42 Who takes care of the sick person in your household?

.....

43 Do any of your household members assist with the care?

.....

44 What exactly do the care of the sick involves? Explain

.....

45 Which of the following expenses do you incur in the process of taking care of the sick? Please indicate the amount per month.

1. Food ....
2. Transport to hospital for check up .....
3. Clothing.....
4. Drug.....
5. Laundry.....
6. If other specify.....

46 Where do you get money to offset these expenses? Explain

.....

47 How do you balance the care giving role and your livelihood/work? Explain

.....

48 Would you say that the care giving role has affected your daily routine or that of the family members? .....

49 If yes, explain how

.....

50 Would you say that the care giving role has affected your household consumption? .....

51 If yes, explain how

.....

52 Have you sold any of your assets to help in taking care of the sick? .....

53 Specify what was sold and for how much

.....

54 If yes, what circumstance led to this? Explain

.....

VI Perception on poverty

55 How would you rate your house hold?

1 Wealthy

2 Average

3 Poor

56 If poor, for how long has your household been poor?

1 1-5 years

2 6-10 years

3 10 years and above

57 In your opinion, what are some of the causes of poverty?

.....

58 What circumstance/s landed you into poverty?

.....

59 How have you been coping with the situation?

.....

Appendix 2: Focused Group Discussion survey guide

1. How do you define poverty in this area?
2. What are the characteristics of the poor in this area?
3. What are the main causes of poverty in this area?
4. What other factors escalates poverty situation?
5. What group of persons is vulnerable to poverty?
6. What makes such groups vulnerable to being poor?
7. What interventions are in place to help people cope with poverty
8. In your opinion, what can be done to address poverty issues in the area?
9. Is Home based care of HIV/AIDS a factor that pushes house holds to poverty. Explain how