EXPERIENCES OF INFORMAL FAMILY CAREGIVERS OF THE AGED IN KESSES SUB COUNTY, UASIN GISHU COUNTY-KENYA

BY

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DECLARATION

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DEDICATION

I dedicate this thesis first to God for having given me good health in writing this work. Second to my mother Christina Cherotich Maindi who has always been a champion of educational encouragement to me. To my husband John and our children James; Miriam; Joanne and Susan for their utmost understanding during the times I missed out in some of the family's functions while writing this Thesis. Thank you family for such unwavering support.

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ABSTRACT

Demographic trends show an increase in the elderly population globally. According to the 2009 Kenya Population and Housing Census there were 1.3 million people who were above 65 years of age and this is expected to increase significantly by 2030 due to improved health care and nutrition. This implies that more and more old people will require increased assistance from informal family caregivers. The purpose of the study was to explore the experiences of informal family caregivers of the elderly in Kipchamoo, Kesses and Cheptiret locations of Kesses Constituency in Uasin-Gishu County. The objectives of the study were: to document the characteristics of caregivers; to describe the types of caregiver-support given to the elderly; to evaluate the caregivers gained experiences and to asses caregivers coping strategies. The Exchange theory, propounded by Homans (1961) guided the study. The theory proposes that, social behavior is the result of an exchange process. Descriptive phenomenological research design was used to study the lived experiences of informal family caregivers. Snowball sampling technique was used to select 40 informal family caregiver participants. Caregivers who were eligible for inclusion in the study were aged 18 years and above looking after older persons aged 65 years and above in a home environment. Data was collected using semi structured interviews developed to capture the characteristics and lived experiences of informal family caregivers. Trustworthiness of the data was established through credibility, transferability, dependability, and confirmability. Data was analyzed based on the themes and presented through verbatim or direct quotations. Tables were used to present summarized responses on characteristics of caregivers, types of care-giver support and caregiver gained experiences. Caregivers were aged 41years on average with majority having 36 years and above. More females than males provided informal caregiving with most of them married. Major types of support provided by informal caregivers included: Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), emotional and financial support. The major caregivers gained experiences were life skills, life cycles, wisdom blessings and negative impacts on their daily lives. Finally, the coping strategies adopted by caregivers to protect themselves from harmful stress of caregiving work included: sharing of responsibility among family members; proper planning; obtaining available assistance from neighbours and friends and going to church for moral support and spiritual nourishment. It is recommended that the government: should assist in training of family caregivers to build capacity and develop support programmes to address negative impacts of caregiving, and formally acknowledge the unique role of informal family caregivers through public policy pronouncements.

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DEFINITION OF TERMS

Activities of daily living- (ADL) are the everyday activities involved in personal are which include cooking, cleaning, grooming, bathing, medication management, feeding, dressing, toileting, transferring in and out of bed/ chair (Clark, 2012; Hooyman; Kiyak, 2006).

Caregiver burden- The degree to which caregivers perceive their physical or emotional, social life, and financial status as suffering as a result of caring for their elderly person, that result in observable and perceived costs to the caregiver. These are measured as caregivers assessed feelings of frustration, anger, drain, guilt or helplessness as a result of providing care to frail elderly such as frequent complains of persistent headaches and missing time for personal social interactions with peers and others, financial strains and general medical body aches (Andren & Elmstahl, 2008; Chang, 2009).

Cash Transfer Programme- A social protection programme that was started by the Kenya Government in 2006 to provide monthly stipend to households with destitute elderly people aged 65 years and above who are selected using a targeted criteria (GOK, 2012).

Elderly/Care receivers –are Persons that are 65 years and above whom because of their frailty or sickness require care of a family member or other relative (Lecovich, 2008; Quadagno, 2005)

Family caregiving- refers to the caring for or looking after an elderly person by an unpaid/or an informal agreed upon salaried person assisting the elderly in daily tasks such as house cleaning, cooking of food, feeding, giving medication, doing laundry, social support as well as providing emotional support (Elmstahl, 2008; Schulz & Tompkin, 2010).

Informal family caregivers: These are persons 18 years of age or older that include relatives, spouses, children and friends who provide in-home care – usually on an unpaid basis to the elderly (Andren & Elmstahl, 2008; Schulz & Tompkin, 2010).

Instrumental activities of daily living- (IADL) are more complex tasks that are necessary for independent living of the elderly which include shopping, communicating via telephone, managing money and finances, managing medication and managing transportation (Clark, 2012; Hooyman; Kiyak, 2006).

Lived experience- is the immediate experience that occurs in a person's life world before he/she has reflected on (van Manen, 1990).

CHAPTER ONE

INTRODUCTION

1.1Overview

This section introduces the study while highlighting background of the study, statement of the problem, objectives and research questions. It also covers rational/justification, significance as well as definition of terms.

1.2 Background of the study

Population aging is a global phenomenon. Globally, society is aging at an unprecedented rate, with the proportion of people 60 years and older predicted to more than double by 2050 (OECD, 2011). Demographic trends have clearly shown an increase in the elderly population globally, with developing countries surpassing developed nations in the rate of increase of older people in the next 25 years (OECD, 2011; Carmel & Pollack, 2013). The increase in the number and proportion of older persons is as a result of various factors including improvements in technology, medical care and nutrition, as well as increases in wealth and education (United Nations, 2010). In line with global trends, the average age of the population aged 65 years and above in Kenya has been increasing rapidly. According to the 2009 Kenya Population and Housing Census (GOK, 2009) there were 1.3 million people who were above 65 years of age. Considering the population increase by about 1 million yearly and a declining crude mortality rate from 11/1,000 in 2007 to 8.2/1,000 in 2013, the number of those aging is expected to increase significantly by 2030.

In Kenya, like in most African countries, more and more relatives and friends find themselves providing most of the family care giving of the elderly in their homes. Family caregivers go through a myriad of experiences which include social, psychological, physical and health consequences (Dunn, 2014).Caregivers have been known to have high levels of work stress, depression burden, and burnout. They therefore run the risk of depression, elevated levels of hostility and anxiety, loss of self and missed social opportunities (Andren & Elmstahl, 2008; Chang, 2009).

The physical demands or stress of caregivers' work can lead to physical illness. Caregivers are known to sometimes get so involved in caregiving that they neglect their own physical and mental well-being (Dunn, 2014;Nankwanga, Neema, & Phillips, 2013). Evidence from literature demonstrates that care giving is burdensome and therefore caregivers need to possess certain skills and knowledge to better handle problems that are common among the elderly persons (Del-Pino-Casadao*et al.*, 2011; Chang, 2009).

Notwithstanding the burdensome nature of caregiving, literature also abounds with positive outcomes of the caregiving experiences. It is acknowledged that caregiving has certain benefits and rewards to the caregiver that include feeling more useful, feeling needed and adding meaning to ones sense of self(Adeosun, 2013;Nankwanga, Neema, & Phillips, 2013. There is also a feeling of fulfillment for meeting a duty and enjoyment derived from caregiving itself (Cohen, Harris, &Pieper, 2003).). Caregiving can therefore be rewarding and challenging to individual caregivers. Caregiving requires one to restructure one's goals, behaviour and the responsibilities associated with caregiving (Andren, & Elmstahl, 2008; Carmel & Pollack, 2013).

1.3 Statement of the problem

Almost everyone it seems has a family care giving story to tell. According to the 2009 Kenya Population and Housing Census (GOK, 2009) there were 1.3 million people who were aged 65 years and above. The number of those aging and will be expected to be cared for by informal family caregivers is set to increase significantly by 2030. This, therefore, will put pressure on those providing care and support to the elderly persons.

Studies show that caregivers experience some heavy burden when caring for the aged that often lead to their heightened emotional and mental health problems (Dunn, 2014; Quadagno, 2005). Some of the burdens caregivers face is due to the variety of tasks they perform that include shopping, household work, and bathing, dressing, and eating; restricted social contacts; mental fatigue and feeling of stress or strain. These physical and psychological problems often result in burnout and depression (Adeosun, 2013; Carmel & Pollack, 2013; Nankwanga, Neema, & Phillips, 2013). As the Kenyan population continues to age, family caregivers are faced with increasing demands for caregiving while the knowledge of the nature and magnitude of informal caregiving is limited.

There is therefore need for an in-depth caregiver-focused research that explores the subjective experiences of family caregivers and to understand the unique experiences of caregiving by family caregivers within the context of rapid socio-economic changes and population trends in which there is a growing aging population. Lived experiences are everyday experiences that are real to those experiencing them. Hence using in-depth data to find out what family caregivers are doing, thinking and gather the information on the meaning that lived experience has on their lives.

This study is anticipated to enhance the understanding of care giving from the caregiver's point of view. The findings are pertinent for the effective implementation of Government programmes for example the Cash Transfer Programme for the very poor older persons in society that was initiated in Kenya in 2006 (GOK, 2012). Since informal caregiving is complex and evolutionary this study is expected to add to the existing knowledge on the family caregivers, their lived experiences and the caregiving phenomenon in Kenya considering that relatively very few studies have been undertaken on lived experiences of informal care givers.

1.4 Purpose of the study

The purpose of the study is to explore the experiences of informal family caregivers of the elderly in Kesses Constituency in Uasin Gishu County to gain insights and a deeper understanding of the caregivers and their lived experiences from the caregiver's perspective through an in-depth analysis.

1.5 Research Objectives

Research objectives comprise both broad and specific objectives respectively.

1.5.1 Broad research Objective

To explore the experiences of informal family caregivers of the elderly in Kesses Constituency in Uasin Gishu County.

1.5.2 Specific research objectives

The study was guided by the following specific objectives:

i. To document the socio-demographic characteristics of informal caregivers in Kesses Constituency, Uasin-Gishu County
ii. To describe the types of informal caregiver-support given to the elderly in Kesses Constituency, Uasin-Gishu County
iii. To evaluate the informal caregivers gained experiences in caring for the elderly in Kesses Constituency, Uasin-Gishu County
iv. To asses informal caregivers coping strategies in Kesses Constituency, Uasin-Gishu County

1.6 Research Questions

The study was guided by the following questions:

i. What are the socio-demographic characteristics of informal caregivers in Kesses Constituency, Uasin-Gishu County?
ii. What types of informal caregiver-support is given to the elderly in Kesses Constituency, Uasin-Gishu County?
iii. What are the gained experiences of informal caregivers in caring for the elderly in Kesses Constituency, Uasin-Gishu County?
iv. What are the coping strategies of informal caregivers in Kesses Constituency, Uasin-Gishu County?

1.7. Justification of the Study

According to the Kenyan Government the aging population is growing significantly and this is likely to increase dramatically the need for caregiving of the elderly by family members. In addition very few studies focusing on the experiences of family caregivers and caregiving of the elderly in Kenya have been done. In light of this reality, there is need to explore the interactions between the family caregivers and the elderly care-receivers in order to gain an insight and an in-depth understanding of the experiences and challenges from the caregivers perspectives. This insight will aid in social policy development. This study is also pertinent considering that the Kenya Government in 2006 launched Older Persons Cash Transfer (OPCT) to provide appropriate social protection in old age. This study could also provide a foundation for further research around caregiving that could lead to the promotion and recognition of caregiving as an important social phenomenon.

1.8 Significance of the Study

The findings of this study will increase the awareness of policy makers on issues affecting informal caregivers and caregiving. This understanding will enable policy makers to develop policies and programmes that will address the challenges informal family caregivers face. This study will also improve public understanding of the roles of family caregivers. An insight into the experiences of family caregivers will also help the National and County Governments to graft strategies and plans that will positively improve the roles of family caregivers and caregiving for effective and efficient care delivery for the elderly. Further, the study findings will contribute and enrich academic research on experiences of caregivers especially knowing that relatively few studies on experiences of informal caregivers have been done in Kenya.

1.9Scopeof the study

The study was done to explore the experiences of informal family caregivers of the elderly from the caregiver's perceptive. The inclusion criteria was informal family caregivers who were eighteen years and above looking after older persons of 65 years and above in their home environment in Kipchamoo; Kesses and Cheptiret locations of Kesses Constituency, Uasin Gishu County, Kenya. The purpose was to find out, using in-depth data, what people are doing, thinking and gather the information on the meaning that lived experience has on their lives.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

Caregiving arises out of a response to the need for support which is greater than normally expected due to impairment in functioning. Studies show that caregiving often merges into normal relationship reciprocity, and because it is often outside formal agreements, it is relatively invisible (Dunn, 2014; Clark, 2012). Studies carried out in Australia, the UK and Canada estimate that about one household in twenty has a primary caregiver, that is, a caregiver who feels most responsible for the person cared for (Quadagno, 2005; Del Campo et al., 2000; National Center of Elder Abuse, 2002). Studies have shown that although both men and women are involved in caregiving, more women provide care, and provide more personal care and social support than men. The caregiver role varies with the age and nature of the impairment of the care receiver. Caregivers take responsibility to ensure the wellbeing of the care receiver that often includes ongoing monitoring and attending to any other support that is required by the care receiver.

In Kenya the knowledge of the nature and magnitude of informal caregiving is limited. According to the 2009 Kenya Population and Housing Census, there were 1.3 million people who were above 65 years of age and the number of those aging and might need care is expected to increase significantly by 2030 (GOK, 2009). The family is the major source of caregiving either in person or employing somebody to stand in for them especially for working professionals. Majority of the elderly live with their children or relatives hence family members play a major role in providing

care and support for them. Informal caregivers assist with the tasks that elderly are unable to do for themselves.

2.2 Informal Caregiving

Informal caregiving, also known as familial care, may be explained as the provision of care to a friend or family member with little or usually no formal training; informal caregivers also do not often get paid for their care efforts. The caregivers' functions vary from recognized and intentional assistance in performing many or all daily activities, to unrecognized ones where minor activities like assisting in purchasing items, moving things around the house and checking on welfare is routinely performed (Schulz & Tompkin, 2010). These can be primary (i.e. main caregivers) or secondary caregivers (i.e. caregivers who help recipients but are not main caregivers) or part of a community/family of multiple caregivers who assist or aid a friend or family member in the activities of daily life.

According to Blum (2009), informal caregiving is complex and the relationships are dynamic. This means informal caregiving has no defined limits, and the caregiving experience could get worse rapidly or get better, often depending on changing circumstances of the recipient. It is also a situation rife with stress, social tension, financial distress and even depression, especially in caregivers of people with chronic illnesses (Borg & Hallberg, 2006). Informal caregiving is the most common form of caregiving situation around the world. The reason for this ranges from policy shifts and privatizing reforms within the health sector in the West (Giesbrecht, Crooks, Williams, & Hankivsky, 2012), to the comfort and cost-effectiveness it offers in Asia (Goh, Lai, Lau, & Ahmad, 2013).

In Africa, the lack of formal care structures (private or public), the high-priced cost of the few such formal care institutions, and the socio-cultural rejection of contracting out the care of family and friends ensures that informal care is more prevalent (Adeosun, 2013; Carmel & Pollack, 2013; Nankwanga, Neema, & Phillips, 2013; Sudhinaraset, Ingram, Lofthouse, & Montagu, 2013). The quality of care provided by informal caregivers may be poor relative to what a professional caregiver could provide, but the low-cost, alongside socio-cultural norms means that it still remains the most popular option of caregiving (Cross & MacGregor, 2010).

2.3 Characteristics of Informal Caregivers

Every instance of informal caregiving is unique, as differences exist on many fronts such as the relationship between the care recipient and the caregiver, the intensity of care offered, the gender of the caregiver and socio-economic elements like race, income, geographical location, level of education and, of course, age (Magana, Ramirez-Garcia, Hernández, & Cortez, 2007). Although, informal caregivers are usually family members of the person receiving the care, there are many variations to the relationship between the caregiver and care receiver, even within the context of family members (Montgomery, Rowe, & Kosloski, 2007). Caregivers could also be friends and volunteers who provide care either as primary caregivers or as secondary/tertiary caregivers. Generally, the relationship between the caregiver and recipient is said to be vital to the health outcomes of both parties (Fredriksen-Goldsen, Kim, Muraco, & Mincer, 2009).

Within the context of family, caregivers can be nuclear or extended family members; they could be parents caring for sick children, or grandchildren; they could also be children caring for parents; it could also be a spousal care situation. Spouses and adult

children, especially daughters and daughters-in-law, constitute the largest sub-group of informal primary caregivers (Kyei-Arthur, 2013). Extended family members usually take care of relations when nuclear family members are deceased, unavoidably distant geographically or impaired in some other way (Montgomery et al., 2007). Family caregivers undertake this care not solely out of obligation, but also out of an expectation of personal satisfaction and accomplishment that comes with the altruism of caring for someone else (Brodaty & Donkin, 2009).

Non-family members can also become informal caregivers. This often happens in circumstances such as when a strong sense of familiarity exists between caregiver and recipient, or the non-related caregiver is geographically proximate to the recipient. It can also occur if the recipient is socially isolated (maybe lacking close-by relatives), and the caregivers' time situation is flexible that is, the person has few competing responsibilities, and has more time, opportunity, and desire to help others (Felmlee & Muraco, 2009). There are other informal caregivers who intentionally decide to volunteer to care for others, without having an initial relationship with the recipients.

These voluntary caregivers are usually members of the community who are otherwise unemployed or not tied to strict obligations, and who may not receive or need training to care for people in their homes. They could be aged, retired people in the community, young socially-minded people, and they could volunteer full-time or part-time and may be classed as independent volunteers (that is people self-driven to provide care) and organized volunteer (people providing care voluntarily within an organizational framework) (Choi, Burr, Mutchler, & Caro, 2007). Volunteers are often people without previous caregiving experience who take on household chores, and aid with the care of the recipient. They are mostly female, usually motivated by a

combination of the desire to help, the positive feedback received from care recipients and strong community support (Marincowitz, Jackson, & Fehrsen, 2004).

In European countries caregiving differences exist by gender, with 2 out of every 3 informal caregivers being female (Suthers, 2006). The roles males play often is less Caring for an elderly family member demands a significant amount of energy from the caregiver placing them at risk of physical and mental health decline resulting from the stress of caregiving, less regular and less holistic in comparison to that of females (Brodaty & Donkin, 2009; Jacobs, 2014). The sex of caregivers changes with age as there are in some way, more male caregivers than female at ages above 75 due to men usually having better health in old age (Organisation for Economic Cooperation and Development [OECD], 2011). Income, location and education also play some role in determining who a caregiver is, although there is no general consensus on what role they play (Do, Cohen, & Brown, 2014; Duci, Ajdini, & Dhembo, 2014).

2.4 Experiences in Caregiving work

Informal caregivers provide services that are broadly divided into two categories: activities of daily living (ADL) and instrumental activities of daily living (IADL) (Clark, 2012; Hooyman & Kiyak, 2006). The former refers to those daily activities necessary to meet the older person's basic needs, such as dressing, feeding, bathing, grooming, and physically moving the elderly person. The later refers to complementary activities of daily living which help a person to live as independently as possible such as cooking, shopping for groceries, taking patients to see the doctors, buying medicines at the chemist.

Caring for an elderly person is a challenging task. Quite often the caregiver experience stress because of the burden of caring for the elderly. This becomes acute particularly when the elderly has a negative attitude towards the caregiver. The caregiver may also feel isolated when relatives refuse to help, and may become angry with the elder person, especially if he or she is a spouse. Caregiving offers many personal rewards, yet despite its rewards the caregiving role is also complicated, bewildering, and frustrating. It places exceptional challenges on caregivers informs of psychological symptoms such as increased stress, anxiety, and depression (Barker, 2002; Haley et al., 2004; Quadagno, 2005).

Caregivers are reported to experience behavioral actions that affect physical health such as poor nutrition and decreased physical activity (Del Campo *et al.,* 2000; National Center of Elder Abuse, 2002). Caring for an elderly family member demands a significant amount of energy from the caregiver placing them at risk of physical and mental health decline resulting from the stress of caregiving (Haley *et al.,* 2004; Proulx & Snyder, 2009).Those heavily involved in caregiving, experience significant and wide-ranging changes to their lives. In comparative studies of caregivers with working situations such as farms and hotels, caregivers often have been reported to have poorer physical health and higher use of medication than others. Caregiving is associated with increased rates of depression and anxiety, less life satisfaction and a feeling of being burdened (Neema, & Phillips, 2013; Hooyman & Kiyak, 2006).

The literature suggests that caregiving is also associated with financial impacts including direct costs to both the caregiver and care receiver (Chang, 2009; Carmel & Pollack, 2013; Nankwanga, Neema, & Phillips, 2013). There are often significant and multiple costs arising from caregiving. An older person with many health problems is

likely to demand more energy, time and money from the family system for medical costs, transport costs and modifications facilities around the home to suit the nature of the recipient's disabilities (Hooyman & Kiyak, 2006; Beach et al., 2005).

Studies also show that women are more likely to reduce hours of paid employment compared with men caregivers. Caregivers use various strategies to try to fit employment with caregiving, including changing to a less demanding job, moving closer to work, and using lunchtimes, holiday leave and sick leave for care-giving purposes (Hooyman & Kiyak, 2006 Adeosun, 2013; Carmel & Pollack, 2013). Despite the demands of caregiving, studies (Beach et al., 2005;Nankwanga, Neema, & Phillips, 2013) show that most caregivers provide care gladly and feel positive about the role. However, those who have heavier caregiving commitments are more likely to feel negative.

A number of studies (Clark, 2012; Lecovich, 2008; Quadagno, 2005; Del Campo *et al.*, 2000)suggest that emotional closeness between the caregiver and care receiver in a relationship is an important factor in explaining the level of caregiver burden. The quality of the prior relationship between caregiver and receiver influences how positively caregivers perceive their role (White, Townsend & Stephens, 2000). Thus relationship between caregiver and receiver is dynamic and evolving. The relationship commitment means that many would-be caregivers have to care for their family member regardless of the personal cost involved.

Caregiving to a family member or friend with a chronic impairment creates stress and burden, both physically and emotionally. How caregivers perceived the caregiving experience influenced the caregiver's emotional response to the demands and responsibilities of caregiving (Carmel & Pollack, 2013). Caregiver burden is the

caregiver's subjective appraisal of the experiences of caregiving (Adeosun, 2013; Carmel & Pollack, 2013; Nankwanga, Neema, & Phillips, 2013). Empirical studies (Clark, 2012; Hooyman & Kiyak, 2006) have suggested that caregiving activities lead to subjective burden involved many aspects of caregiving including the caregiver's physical health and a restriction in the caregiver's social activities. Therefore, the care recipient's behavior and physical needs resulted in a gradual increase in stress and burden for the caregivers (Adeosun, (2013). Perceived burden mediated how caregivers appraised and coped with the stresses that evolved from the multiple facets of caregiving (Del-Pino-Casado, Frias-Osuna, Palomino-Moral, Pancorbo-Hidalgo, 2011). Adeosun, (2013) examined burden in caregivers in Lagos, Nigeria using a representative sample (N = 1,110) of informal caregivers of older family members. They found that caregivers who were living in the household with care recipient reported greater burden than caregivers who did not live in the same household with the elderly.

2.5 Coping strategies of informal caregivers

Del-Pino-Casado *et al.,* (2011) Clark, 2012; Hooyman & Kiyak, 2006 conducted a literature review of empirical research on the effect of different coping strategies on subjective burden among caregivers. Findings (Del-Pino-Casadao*et al.*, 2011; Clark, 2012) suggested that caregivers engaged in different styles of coping to manage the subjective burden. The methods of coping used included problem-focused coping, emotion-focused coping, approach, and avoidance. Problem-focused coping entailed caregivers solving challenging problems, and emotion-focused coping was the caregiver's inclination to managing emotions. According to Del-Pino-Casado*et al*., approach coping involved caregivers' attempt to reappraise, modify, and solve

problems and avoidance coping falls into two categories. The first category is the caregiver's attempt to cope with feelings of burden behaviorally and the second is the attempt to cope with feelings of burden cognitively (Del-Pino-Casado*et al.,* 2011, Clark, 2012; Hooyman & Kiyak, 2006). Findings from this research suggested a positive association between avoidance coping and subjective burden in caregivers. Avoidance coping was an ineffective coping strategy (Del-Pino-Casado, *et al.,* 2011).

2.6 The nature and extent of informal caregiving

According to current research, the nature of the relationship between the dependent elder and his/her caregiver varies across the world and along ethnic group lines. Research studies in North America and Europe shows that caregivers are more likely to be spouses, whereas in Africa, caregivers are more likely to be adult children, extended relatives, or friends (Haley *et al.,* 2004; Barker, 2002). In general caregivers in Africa are more likely to be younger, unmarried, with less formal education, and fewer financial resources (Dunn, 2014; Clark, 2012). Because of the caregivers' lower income and higher poverty rates, the financial stress of care giving may pose greater emotional burden on caregivers in Africa (Hooyman & Kiyak, 2006).

In Kenya, the care receivers are likely to depend on intergenerational relatives to meet their health needs. In Africa, as compared to U.S.A. and Europe caregivers are more likely to provide more hours of higher-intensity care (Clark, 2012; Hooyman & Kiyak, 2006). Many African caregivers are also actively caring for other people in addition to the frail elderly, such as minor children, grandchildren, and other family members (Barker, 2002). Even though African caregivers are caring for severely debilitated elders and other family members, they are less likely than white European caregivers to use formal care services like nursing homes. Numerous studies have

reported that African family care giving of dependent elderly persons is performed within a collectivistic structure composed of different people with varying levels of involvement in daily care giving activities (Haley et al., 2004; Clark, 2012; Hooyman & Kiyak, 2006).

Since kinship ties are a more powerful force in African families, many investigators concluded that African caregivers receive significant support from their network of family members. However, more recent studies suggest that earlier research may have overestimated the availability and extent of support that African caregivers receive from other family members (Barker, 2002). The studies suggest that adult children of dependent elderly persons may be adversely affected by the other commitments in their own lives, which may severely limit the amount of assistance they can offer their frail elderly parents.

In the midst of an extended family network, one primary caregiver emerges who bears the burden of being the sole caregiver, and has few opportunities for shared responsibility and shared decision making (Barker, 2002; Kyei-Arthur, 2013).Where there are several care providers in a household the primary caregiver will be someone who identifies himself/herself as providing more care activities of daily living to the elderly compared to other caregivers in the family (Haley et al., 2004).

Among Africans, care giving of elderly persons is of a high cultural-value and an encouraged activity, and is considered to be an expected part of adult development. Some authors suggest that Africans often consider care giving as an expression of traditional values, such as repaying the debt to parents for being cared for as a child, as continuing a family tradition of mutual concern, or setting an

example for one's own children. Family members tend to provide personal care, while friends tend to provide emotional support (Haley et al., 2004).

2.7 Overview of literature Review

The knowledge gap that this study intends to fill is to attempt to understand the unique lived experiences of family caregivers within the context of rapid socio-economic changes and a growing aging population. Lived experiences are everyday experiences that are real to those experiencing them. The study usedin-depth data to find out what family caregivers are doing, thinking and collected the information on the meaning that lived experience has on their lives within the context of Kesses Constituency, Kenya.

2.8 Theoretical Framework

Theory provides a sound reasoning on which to base research designs and explain study results. According Andren & Elmstahl, (2008) & Bryman (2012) theory is not only scientifically necessary, but also highly practical and useful. It informs the development of research questions, suggests variables and measures, and aids in interpreting study results (Bryman, 2012; Mark, *et al*., 2016). There are several different theories and frameworks that have been used to understand family care giving processes and the interactions between the informal caregiver and the elderly care-receivers in order to gain insight and better understanding of the experiences and challenges of informal care givers. One such theory is the Exchange Theory advanced by Homansin 1961(Dunn, 2014; Clark, 2012).

The Exchange Theory is considered to be useful in explaining the relationships between the caregiver and the care recipient. The Exchange Theory originated with

the work of Homans (1961) and was further developed by Blau (1961). Durant &Christian (2006) & Zafirovski (2005), point out that Exchange Theory analyzes interactions between two parties by examining the costs and benefits to each. Cohen, Colantonio & Vernish, (2002) further state that, in an exchange relationship, resources that may be used to reward others may include assistance with personal grooming, housework, money, information, affection, approval, labour, compliance, or various types of material support. If one actor has a lower capacity to reward the other person in the relationship, then the actor with less exchange resources is assumed to be more dependent in the relationship.

Dowd (1975, 1980) is considered to be among the first people to use the exchange theory in social gerontology. He advanced the argument that aging affects exchange relationships in the sense that generally people desire to profit from social interaction with others and that profit consists of a perception that the reward coming from the interchange outweighs the costs (Durant &Christian 2006; Kyei-Arthur, 2013). According to exchange theory, relationships between the caregiver and care recipient depend on the capacity of the actors to mutually reward one another with something of value (Emerson, 1972).

According to Zafirovski (2005) the ability to profit from an exchange depends on the exchange resources that the actors bring to the exchange. When resources are reasonably equal, then a mutually satisfying interdependence may emerge. However, if one of the actors has substantially fewer exchange resources, then the actor's ability to profit from the exchange can be sharply restricted. In other words, actors attempt to maximize their rewards and minimize their costs in their interactions with others. Exchange relations that get too far out of balance may lead to unstable relationships

that could have negative consequences for both the caregiver and care recipient, such as stress, role strain, feelings of guilt, and feelings of dependency (Durant &Christian 2006).

Further, Cohen, Colantonio &Vernish, (2002) posit that exchange relationships among family members develop at different intervals over the life course of the parties involved and may be shaped in different ways by various factors, including resources, social class, gender, ethnicity, personality, health, residence, and the duration, intensity, and quality of the relationship between the caregiver and care recipient. In the context of this study, the caregivers are considered to acquire the reward in the form of emotional satisfaction through the love of their care giving work. Durant and Christian (2006), suggest that one of the most common patterns of exchange relationships occurs within the context of the family, where adult children are the caregivers for their aging parents. This is mostly the case in the majority of Kenyan families.

Zafirovski (2005) submits that the basic assumption of exchange theory is that individuals establish and continue social relations on the basis of their expectations that such relations will be mutually advantageous. He further states that the process of social exchange is assumed to be governed by reciprocal relations. Exchange is therefore defined as social interaction characterized by reciprocal stimuli which would not continue in the long-run if reciprocity is violated. Whereas the motives for caregivers may differ as to why they decide to take up the responsibility of caring for the elderly it is, however, evident that they do benefit in their interactions with the elderly (Cohen, Colantonio &Vernish, 2002).

In the context of this study Exchange Theory is used to examine the experiences of the informal caregiver in terms of his or her role status, role strain, role conflict and role overload. Role strain may arise where an individual who may be a sibling, spouse or relative feels that the other family members are not performing their share of caregiving while role conflict on the other hand occurs when the two roles a person is holding are clashing as in the case where an informal caregiver also works as in a full-time career job. In the case of role overload the individual who is an informal family caregiver is simply overwhelmed. The individual is torn between the demands of his/her work and the responsibilities of taking care of the elderly and has to sacrifice her/his time or money to attend to the responsibilities. All these challenges have to be addressed to avoid harmful stress (Andren & Elmstahl, 2008 &Adeosun, 2013).

Accordingly, Exchange Theory is considered useful and appropriate theory to gain a better understanding of the caregiver, their caregiving experiences, and caregiving phenomenon in Kenya from a caregiver's perspective.

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

3.1 Introduction

This chapter describes the study area and justifies the research paradigm, research design and methodology that areused to guide the study. The chapter consists of sections that outline research design, target population, sample and sampling procedures, description of research instruments, data collection procedures, and discussion of data analysis procedures. The attendant ethical considerations are also discussed.

3.2 Research Paradigm

Any research undertaking is guided by a research paradigm. According to Kuhn , (1970) a paradigm is a constellation of beliefs, values and techniques held by members of a community **(**Cohen, *et al.*,2007**;** Bryman, 2012;). Creswell (2014) considers a research paradigm to be world views which are general philosophical orientations about the world. A paradigm consists of what reality is (ontology), what constitutes acceptable knowledge (epistemology), how knowledge is derived (methodology), as well as the value of knowledge (axiology) (Mark, Philip, & Adrian, 2016). Mark, *et al*., (2016) among other scholars acknowledges five research paradigms and these are: positivism, critical realism, interpretivism, postmodernism, and pragmatism. Positivism and interpretivism are two ends of a continuum. Positivism is deductive, objective and seeks to test hypothesis, critical realism focuses on explaining what we see and experience; postmodernaism emphasizes the role of language and of power relations, pragrammatism strives to reconcile both objectivism

and subjectivism while interpretivism is deductive, subjective and seeks to interpret the phenomena through the eyes of the participants and focuses on participants making meaning of their lived experiences in specific natural contexts which was the purpose of this study. The interpretivist paradigm informed the choice of the design, sampling, sample size, data generation methods, analysis and interpretation.

3.3 Research Design

A research design is a plan, a framework, strategy or an architectural outline of a research study and sheds light on how the study is to be conducted (Bryman, 2012; Creswell, 2014). It is the glue that holds all of the major parts of the research study together, that is the sampling technique, the sample size, type of data, data generation instruments and the analysis in an attempt to address the research questions (Yin, 2015). The researcher chose a descriptive phenomenological design to explore, describe, interpret and understand the unique experiences of family caregivers in an effort to discover meaning rather than to explain and predict (Bryman, 2012; Mark, et al., 2016). Further subjective experiences involving emotional and psychological issues of caregiving, care giving stress and strain are more meaningfully assessed through a qualitative study than a quantitative study.

The purpose of this qualitative research approach was to attempt to understand the day-to-day lived experiences from the participant's [caregivers'] point of view. Lived experiences are everyday experiences that are real to those experiencing them (Attride-Stirling, 2001). The research is done in natural setting where participants experience the phenomenon under study. This type of research is used to study areas in which there is little knowledge (Cohen, Manion & Morrison, 2007;). However, one of the major weakness phenomenological design is the researcher's bias.

According to Bryman (2012) phenomenological researchers should not allow their own understanding of the phenomenon to influence the findings. Creswell (2014) advises phenomenological researchers to set aside (bracket) all preconceptions, judgments or prejudices towards a particular topic in order to bring an objective analysis of the data through the eyes of the participants. This is indeed what the researcher did in this study. The researcher thus used phenomenological research design to examine lived experiences through the descriptions provided by the family caregivers in Kipchamoo; Kesses and Cheptiret locations of Kesses Constituency, Uasin Gishu County, Kenya. The aim was to find out, using in-depth data, what people are doing, thinking and gather the information on the meaning that lived experience has on their lives.

3.4 Study Area

The study was conducted in three locations namely Kipchamoo, Kesses and Cheptiret locations of Kesses Constituency in Uasin Gishu County (Appendix II). Kesses Constituency covers an area of 692.1Km^2 and comprises 9 locations. According to the 2009 Kenya Population and Housing Census (GOK, 2012)it has a population of 129,054 with a male/female sex ratio of 100:103; 4% (5,162) constitute the aged of 65 years and above. The majority of residents are small holder dairy and crop farmers. The residents are mainly engaged in rural self-employment, small scale business enterprises, manual labourers and formal employment. The three locations were purposely selected as study areas due to their diverse socio demographic characteristics and socio-economic activities. Secondly, according to the Wareng District Development Officer, of the nine locations in Kesses Constituency, Kipchamoo location has the highest number of households on the Older Persons Cash

Transfer Programme with 80 elderly persons followed by Kesses with 75 and Cheptiret with 67. Thirdly, the constituency is fairly accessible with motorable network of earth roads which enabled this study to be undertaken as planned with relatively minimal challenges. This diversity was to help the researcher construct broad and a deeper understanding of the meaning of the perspectives of the caregivers in the study locations to facilitate sampling and not for comparative analysis.

3.5 Study population, Sample and sampling techniques

The target population was family caregivers in all the households with elderly persons aged 65years and above in the three adjacent locations, Kipchamoo, Cheptiret, and Kesses of Kesses Constituency in Uasin Gishu County. The family caregivers were sons, daughters, spouses, relatives, or friends while the elderly person being looked after was either male or female, widow or widower, married or unmarried. The family caregiver was therefore the unit of analysis in this study and their inclusion criteria was those who were eighteen years and above looking after older persons of 65 years and above in their home environment, and deemed to be offering the most care services to the elderly in the family/homestead. Where there were several care providers in a household the primary caregiver was someone whom the researcher skillfully identified as the person providing more care activities of daily living to the elderly compared to other caregivers in the family (Haley et al., 2004).

The researcher first visited the three locations in the company of the respective village elder to acquaint herself with physical location and the distribution of households in the study area prior to the collection of data. The sample size was arrived at through data saturation using snowball sampling technique to select the study participants in each study location respectively.

Snowball sampling technique as shown in figure 3.1 is a non-probability sampling technique that is used to recruit participants to a study where potential participants are hard to identify or have to meet certain criteria to participate in order to ease data collection. It begins with the researcher contacting a person or initial group of persons relevant to the research topic and then uses this person or group to contact others for the research (Cresswell,2009; Cohen, *et al.*2007; Yin, 2015).

The first household was purposively identified with the assistance of the village elder in the three locations; Kipchamoo, Kesses and Cheptiret respectively. The researcher then interviewed the informal caregivers in the identified households and thereafter asked the old person to help identify other older person's homes/households that are known to them. Using this referral process caregivers were interviewed until data saturation or equilibrium was reached when no new insights or categories were produced even with additional interviews (Dudovskiy 2016, Dunn 2014; Skovdal, *et al.,* 2009). Using this referral method the researcher was able to obtain 13 participants from Cheptiret Location, 12 participants from Kipchamoo location and 15 from Kesses location giving an ultimate sample size of 40 family caregivers.

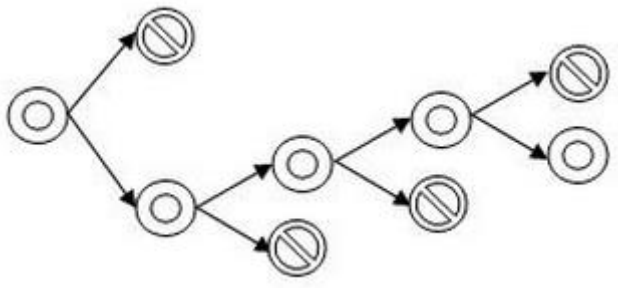


Figure 3. 1: Exponential discriminative snowball sampling

Source: Neuman, W. L. (2014).

The number of participants that were used in this study is comparable to those that are used in many phenomenological studies(Yin, (2015); Cresswell, (2003); Cohen, (2003); Silverman, (2000).

3.6 Data Collection Instruments and Methods

A semi-structured interview guide (Appendix 1) was used to collect data from the participating family caregivers to gain a deeper insight into perspectives of their lives and experiences. The use of semi-structured interviews is derived from the assumption that the circumstances to be explored are complex and dynamic (Yin, 2015; Cresswell, 2014;Neuman, 2014).. The open-ended questions helped to foster a conversational style interview. The aim was to establish trust and build rapport with the participants and thus creating a conducive environment for self-disclosure (Dunn 2014; Skovdal, et al, 2009).Questions were asked to obtain basic demographic characteristics and to explore the lived experiences of the caregivers, such as amount of time spend in caregiving and kinds of help provided to care receivers, caregiver's working situation, caregivers coping strategies and social support that caregivers get from friends and relatives. The researcher's supervisors and departmental lecturers re-viewed the original semi structured interview and made useful suggestions that aligned the questions to the research questions and objectives. The researcher requested the participants if they were willing to be interviewed for the research. The researcher then held conversational interviews with the participants, carefully listened and recorded interviews verbatim.

3.6.1 Trustworthiness

Unlike in quantitative research, many doubts occur during and after a qualitative research process. Often, researchers question the credibility of collected data and

whether enough evidence is gathered to support the claims (Bryman, 2012). According to Veal,(2011) & Bryman (2012) trustworthiness in qualitative research is compared to validity and reliability in a quantitative approach. Nowell, *et al.*(2017) & Creswell, (2014) state that for qualitative research to be recognized and valued it ought to be conducted in a rigorous and methodological manner. Trustworthiness helps to ensure that researchers construct deep understandings of the meaning of the perspectives of the participants. In this study trustworthiness was established through four components of trustworthiness: credibility, transferability, dependability, and confirmability (Nowell, *et al.,* 2017; Creswell, 2014; Mark, *et al*., 2016).

Credibility refers to whether the researcher captured what was intended to be captured or learned in the research (Yin, 2015). Credibility is present when the research results mirrors the views of the people under study. Credibility entails the confidence of the data (Mark, *et al*., 2016).Members check was done by the researcher in this study to assess intentionality, to correct factual errors and to offer the participants the opportunity to add further information in order to ensure that the data collected was a true reflection of the participants' perceptions. One strategy for improving the quality of qualitative data is allowing members check (Bryman, 2012; Neuman, 2014). The strategy ensures that data and interpretations are continuously tested as they are derived from participants from which data are solicited. Credibility was also ensured through prolonged engagement with the family caregivers during the semi-structured interviews which lasted on average 2 hours per session (Mark, *et al*., 2016; Nowell, *et al.,* 2017). Apart from meticulous record keeping and ensuring interpretations of data are consistent and transparent, the findings are supported by rich and thick verbatim descriptions of participants' accounts (Veal, 2011, Neuman, 2014).

Transferability refers to the generalizability of the qualitative findings (Nowell, *et al*., 2017). In order to ensure transferability thick description, research context, and processes have been provided so that those who seek to transfer the findings to their own contexts can make their own judgment of whether the findings are transferable (Lincoln & Guba, 1985; Creswell, 2014).

Dependability involves disclosure of the research process, and the ethical considerations (Creswell, 2014). Dependability has been ensured by maintaining rigor of the research process and providing an audit trail of the findings. Moreover the researcher consulted with her supervisors at every step of the research process, from field work through to data presentation. In addition, data files have been retained to ensure that all data can be traced for verification.

Confirmability is concerned with establishing if the researcher's interpretations and finding are clearly derived from the data (Nowell et al., 2017). Conformability is an overarching term which is established if credibility, transferability and dependability have been achieved (Yin, 2015; Lincoln & Guba, 1985; Creswell, 2014). Confirmability was enhanced through the provision of an audit trail and description of the steps of data analyses that makes it possible for the research process of the study to be tracked. This helped in establishing that the research study's findings accurately portray participants' responses. All the records of the transcripts and field notes are retained and kept in a safe manner such that they can be easily accessed when required by other researchers in order to understand the process that was used and the findings and, where appropriate to replicate the initial study (Nowell, *et al*., 2017)

3.7 Data Collection Procedures

The semi-structured interview guide was administered by the researcher to the sampled caregivers of Kipchamoo, Kesses and Cheptiret locations in their home environments. Where there was several care providers in a household the researcher engaged them in a short conversation to identify the main caregiver knowing it could be sensitive to have asked directly as it might jeopardize the other family members.

As the initiator of the interview, the researcher played an active role in making certain decisions about the progress of the interview. However, it should be noted that in phenomenological interview the researcher and participants are partners in the process of discovery (Creswell, 2014; Neuman, 2014). For their comfort participants were asked to choose the setting of the interview. The setting ranged from inside the house, outside the house and in the kitchen. In presenting descriptive expressions from the participants pseudonyms were created to protect confidentially. All the study participants voluntarily participated and were willing to share their story.

3.8 Ethical Consideration

This study observed ethical guidelines that govern social research. According to Yin (2015) the basic principles of ethical social research include among others; obtaining the necessary authority to undertake the research, voluntary participation and study participants being able to withdraw at any time without consequences, indicating the purpose of the study, protecting identity, not coercing or humiliating study participants and seeking informed consent(Creswell, 2014; Mark, *et al*., 2016; Nowell, *et al*., 2017). The researcher ensured that these ethical considerations were observed.

Data collection procedures comprised of several steps. First, authority to collect data was obtained from National Commission for Science, Technology, and Innovation (NACOSTI). Secondly, the permit issued by NACOSTI was presented to the County executive officer of Uasin Gishu County in charge of education who then granted permission for data collection in writing. In order to establish contact with households in which informal family caregivers reside the researcher worked with the leaders in the community particularly the village elders to identify households on the Older Persons Cash transfer Programme. The researcher provided the village elder with a letter of permission to conduct research from areas under their administrative jurisdiction. The researcher then visited the selected household, explained the purpose of the study to members of the household and obtained informed verbal consent from them to participate in the interview.

3.9 Data Analysis

The researcher used descriptive statistics to generate frequencies and percentages to understand caregivers' socio-demographic characteristics.She then read and re-read the entire description of the experiences of caregivers while identifying and teasing out themes of participants lived experiences. The researcher then integrated and synthesized the themes into a descriptive structure of the meaning of that experience (Giorgi, 2005; Andren, & Elmstahl, 2008). The researcher cleaned up data collected from the interviews and assigned codes to the transcripts used for interviews of caregivers. The researcher used tables to present summarized findings on the socio demographic characteristics of the participants and types of care support and experiences gained by caregivers in their caregiving work. Pseudonyms were created and used to protect confidentially in the presentation of results.

Thematic analysis is a method for identifying, analyzing, organizing, describing, and reporting themes found within a data set (Creswell 2003; Silverman, 2000). In this study thematic analysis allowed the researcher to do an in-depth exploration into the subjective experience of the caregivers. Themes provide focus and insights into how persons make sense of the events and situations in their lives and, are one way of assigning meaning to participants lived experiences (Creswell, 2014; Nowell, *et al*., 2017). As the themes emerged from the data the researcher recorded the stories of informal caregivers as they described their caregiving experiences (Andren, & Elmstahl, 2008). In this study the researcher used themes as a means of arriving at a deeper understanding of the lived experiences of caregivers. The descriptive expressions from participants were then presented under the relevant themes.

CHAPTER FOUR

DATA ANALYSIS, INTERPRETATION AND DISCUSSION OF FINDINGS

4.1 Introduction

This study was undertaken in three locations of Kesses Sub County namely Kipchamoo, Kesses and Cheptiret in order to explore the experiences of informal caregivers of the elderly. This chapter analyzes, interprets and discusses the study findings according to the research questions and objectives as indicated in chapter one sections 1.5 and 1.4.

4.2 Discussion of Findings

4.2.1 Socio-demographic Characteristics of Caregivers

The first objective of the study was to identify the socio demographic characteristics of the caregivers. In understanding caregivers characteristics; age, gender, marital status, educational level, employment status as well relational status with the care recipient were analyzed.

4.2.1.1 Age of Caregivers

Slightly over a quarter of the caregivers 11(27.5%) were aged between 20-29 years, 9 (22.5%) were between 30-39 years, 12 (30%) were aged between 40-49 years while 8(20%) were aged 50 years and above as shown in Table 4.1.

Table 4. 1: Age of Caregivers

Age bracket	Frequency (f)	Percent (%)
20-29 years	11	27.5
30-39 years	9	22.5
40-49 years	12	30.0
50 years and above	8	20.0
Total	40	100.0

Source; (Survey Data, 2017).

Table 4. 2: Age of Caregivers by Gender

Gender	20-29years	30-39years	40-49years	50 years and above	Total
	N %	N %	N %	N %	N %
Male	2 (18)	5(56)	3(25)	1(13)	11(28)
Female	9 (82)	4(44)	9(75.0)	7(88)	29(73)
Total	11(100)	9(100)	12(100)	8(101)	40(100)

Source; (Survey Data, 2017)

The mean age for the caregivers was found to be 41 years, the modal age is 36 years, the lowest age was 20 years while the oldest caregiver was 87 years and this was a husband looking after his 86 years old wife. However, 27.5% of the caregivers were youth below 30 years who in most cases were taking care of their grandparents (Table 4.2). This is consistent with studies done in Africa which show that caregivers are more likely to be younger, unmarried, with less formal education, and fewer financial resources (Dunn, 2014; Clark, 2012). As shown in Table 4.2female caregivers were dominant in all the age categories except the age category 30-39 years where incidentally male were slightly more 5(56%) than female4 (44%).Age of caregivers is very important because of the level of experience, intensity of care, perseverance/endurance as well as cautiousness that care recipient requires depending

on their physical and emotional health characteristics. The younger caregivers are more likely to feel overwhelmed with caregiving work than the older caregivers.

4.2.1.2 Gender of Caregivers

The study found that the majority of the caregivers were females 29 (72.5%) while 11(27.5%) were male. Gender differences is due to gender-role expectations. Moreover females generally have the propensity for nursing care than are men. This finding where female caregivers are in the majority (72.5%) is consistent with past research in both the developed and developing countries in which informal care giving has been found to be dominated by women who comprise 75% of the total caregivers (Montgomery, et al., 2007; Nankwanga, *et al.,* 2013). Other studies have found that the majority of caregivers were female at 71.5% (Chang, 2009, Cohen *et al.,*2002). The research literature also suggests that women as compared to men are more likely to take on the role of a primary caregiver for a spouse or parent (Do, *et al.* 2014; Carmel, & Pollack, 2013).However, it has also been established that the size of gender differences in caregiving may also be influenced by other sample characteristics, such as gender of the care recipient (Cohen *et al.,* 2002).

4.2.1.3 Marital Status of Caregivers

In relation to marital status, 17 (43%) of the caregivers were single, 20 (50%) were married while 2 (5%) stated that they were divorced and 1(3%) were separated from their spouse. Table 4.3 presents the summary of the findings.

Table4. 3: Marital Status of Caregivers

Marital Status	Frequency (f)	Percent (%)
Married	20	50.0
Divorced	2	5.0
Single	17	42.5
Separated	1	2.5
Total	**40**	**100**

Source; (Survey Data, 2017)

This finding is not very different from studies done in Africa which show that caregivers are more likely to be younger, unmarried and with fewer financial resources (Dunn, 2014; Clark, 2012). Marital status may affect the physical health and provision of quality care to the elderly. Studies that include Adeosun, (2013) and Chang, (2009) for instance have found for instance, that a married informal caregiver apart from caring for the elderly also takes care of his/her family which exacerbates physical conditions such as chronic fatigue, sleeplessness, stomach problems and weight change as caregiving burden intensifies.

4.2.1.4 Level of Education of Caregivers

When asked about their level of education, 8(20%) of the caregivers had primary level education, more than half 21 (52.5%) had completed secondary school education, 6 (15%) had dropped out while in secondary school. Only one (2.5%) had college level training while 17% had primary school education. One tenth 4 (10%) of the caregivers said they had no formal education at all. Table 4.4is the summary of the findings.

Table 4. 4: Level of Education of Caregivers

Level of Education	Frequency (f)	Percent (%)
Primary	8	20.0
Secondary Completed	21	52.5
Secondary Uncompleted	6	15.0
College	1	2.5
No Formal Education	4	10.0
Total	**40**	**100**

Source; (Survey Data, 2017)

Overall, most of the caregivers were literate in this study with only a few of them having non-formal education. This is likely to be due to lack of formal employment opportunities and therefore available to provide care. This implies that they can be able to provide certain technical cares such as medication as per doctors' instructions, proper hygiene as well as proper diets that are likely to promote the health of the aged among other services (Giesbrecht, *et al.*, 2012; Cohen, *et al.*, 2002). However this finding is inconsistent with researches that have found that in Africa caregivers are more likely to be with no formal education (Dunn, 2014; Clark, 2012;Do, Cohen, & Brown, 2014; Duci, Ajdini, & Dhembo, 2014).

4.2.1.5 Employment Status of caregivers

Since care giving is informal or family related, the study sought to establish the employment status of the caregivers. The majority 22 (55%) said that they were unemployed while 6 (15%) were in formal employment. It was further established that 12(30%) were working as casuals. Table 4.5 summarizes the findings.

Table 4. 5: Employment Status of Caregivers

Employment Status	Frequency(f)	Percent(%)
Employed	6	15.0
Unemployed	22	55.0
Casuals	12	30.0
Total	**40**	**100.0**

Source; (Survey Data, 2017)

The reason why majority of caregivers are unemployed is because of limited employment opportunities in Kenya. This finding is consistent with studies that have suggested that education, income and location also play some role in determining who a caregiver is (Do, Cohen, & Brown, 2014; Duci, Ajdini, & Dhembo, 2014). Caregiving is almost a fulltime activity and those in employment have to master the difficulty of balancing between family caregiving with employment responsibilities and the demands of parenting their own children. This balancing act can sometimes lead to caregiving–work conflicts resulting in stress and strain. Caring for the elderly requires adequate resources. The elderly who are often fragile require special attention in terms of nutrition, grooming as well as medication. All these require finances. Caregivers who are not in formal employment have to seek financial support from family and friends.

4.2.1.6 Relational Characteristics of Caregivers with Care Recipients

The majority of the caregivers were found to be daughters of care receivers 12(30%), followed by sons 9(22.5%). It was also established that 8(20%) were daughters in-law, 4 (10%) were wives, 3 (7.5%) were relatives 2 (5%) were granddaughters and 1(2.5%) husband and grandson respectively. This is as shown in Table 4.6.

Table 4. 6: Relational Characteristics of Caregivers with Care Recipients

Relationship of Caregivers	Frequency(f)	Percent(%)
Relatives	3	7.5
Daughter	12	30.0
Son	9	22.5
Daughter in-law	8	20.0
Wife	4	10.0
Grand Daughter	2	5.0
Husband	1	2.5
Grand Son	1	2.5
Total	**40**	**100**

Source; (Survey Data, 2017)

The total percentages is +2 due to rounding off effect.

Being an informal care giver, the family and close relatives form a crucial link in the provision of support to their aging members. As indicated above, most caregivers were family members of the care receivers (94%) with the majority being female (65%). This finding echo those observed in many other studies that have been conducted on informal caregivers in both the developing and developed countries that show daughters and wives constituted 71.5% of the caregivers (Cohen, *et al.*, 2002). Similar to the findings by Kyei-Arthur (2013) adult children, especially, daughters (30%)sons (22.5%)and daughters-in-law (20%), constitute the largest sub-group of informal primary caregivers in this study. The daughters, sons and daughters-in-law often feel a sense of moral obligation to provide physical care and emotional support to their aging parent(s). However, some of the disadvantages of children living and taking care of aging parents that have been noted are, loss of privacy, role conflict and added stress (Schulz & Tompkin, 2010).

Gender differences in informal caregiving is because distributing caregiving responsibilities between daughters and sons can be based on gender-role and related expectations, whereas spouses have less choice to select gender-specific caregiving

tasks (Nankwanga, *et al.,* 2013; Schulz, & Tompkin, 2010). However, as noted in the Table 4.6 gender differences in informal caregiving (daughters 30% and sons 22.5%) is relatively smaller particularly in younger individuals who have received a less traditional gender-typed socialization. In as much as this gender role flexibility may be due to social change, it is also as much as a result of job opportunity availability and changing work place dynamics. Income, location and education also play some role in determining who a caregiver is (Carmel, & Pollack, 2013).

4.2.2 Types of informal caregiver-support given to the elderly

The second objective in this study was to describe the types of caregiver-support given to the elderly. Thematic analysis revealed four types of caregivers' support given to the elderly. They include activities of daily living, instrumental activities of daily livings, advice and emotional support and financial support. The care recipients were found to be between the ages of 74 years and 109 years with a mean age of 84 years and a mode age of 76 years. Table 4.7presents responses of type of informal care-support to the elderly. It reflects the number of participants that had descriptive expressions under the respective themes of ADL (Activities of Daily Living), IADL (Instrumental Activities of Daily Living), advice and emotional support and financial support. The row total is the sum of the types of informal caregiver-support given to the elderly. The care givers that indicated 2, for example, means they provided only two types of caregivers' support and those indicating 4 means the provided all the four types of caregivers' support given to the elderly. The column totals are the total number of caregivers who indicated giving support under each informal care-support type.

Table 4. 7: Responses on Types of Informal care Support given to the Elderly

Type Caregivers	ADL	IADL	Advice and Emotional support	Financial Support	Totals 4
1		✓		✓	2
2	✓	✓	✓	✓	4
3		✓		✓	2
4	✓	✓			2
5	✓				1
6	✓	✓			2
7	✓				1
8	✓	✓	✓	✓	4
9	✓	✓		✓	3
10	✓	✓			2
11	✓	✓		✓	3
12	✓	✓			2
13	✓	✓	✓	✓	4
14	✓	✓		✓	3
15	✓	✓	✓	✓	4
16			✓	✓	2
17	✓	✓		✓	3
18	✓	✓			2
19	✓	✓	✓	✓	4
20	✓	✓	✓	✓	4
21	✓	✓		✓	3
22	✓	✓			2
23	✓	✓	✓	✓	4
24	✓	✓		✓	3
25	✓	✓			2
26		✓		✓	2
27	✓	✓	✓	✓	4
28	✓	✓			2
29	✓	✓			2
30	✓	✓			2
31	✓	✓			2
32	✓	✓		✓	2
33	✓	✓	✓	✓	4
34	✓	✓			2
35		✓		✓	2
36	✓	✓	✓	✓	4
37	✓	✓	✓	✓	4
38	✓	✓	✓		3
39	✓	✓		✓	3
40	✓	✓		✓	3
Total	**35**	**37**	**13**	**25**	**110**

4.2.2.1 Activities of daily living (ADLs)

Services that care givers under ADLs provided include: ambulating or moving the care receivers around either within the compound or outside; feeding especially for those aged who cannot feed themselves; dressing and grooming them; taking them to toilet; washing and cleaning them as well as transferring or moving them from one body position to another. These activities are more often done by women than men as they reflect division of labour in other aspects of family life (Clark, 2012; Hooyman & Kiyak, 2006). Thirty five caregivers indicated that they were involved in ADL services.

Pamela, 43 years from Kipchamoo and taking care of her 90 years old mother had this to say;

> 'My mother is 90 years now and she cannot do anything as her vision is also impaired. I therefore literally do everything for her. I wake her up at 9 am, dress her, wash her face, give her breakfast, and take her outside for sunlight while I continue with other chores like washing and lunch preparation. After feeding her in the afternoon, I let her rest for two hours before I wash her and begin planning for dinner as well. I occasionally administer medication if she is on any. These activities are repeated daily'

Similar sentiments were echoed by the majority of the caregivers who participated in the study. Joshua 33 from Kesses who is looking after his 86 year old father indicated that his day is taken up with daily activities that involve helping his father to take a shower, making him tea, taking him to the toilet, cooking meals and preparing his bed. This is what Joshua said:

> 'I wake up very early in the morning; fetch water from the nearby well after which I light the fire and warm his bath water as I prepare his breakfast. I then serve him with breakfast and thereafter wash the utensils. I bring out the blankets particularly on a sunny day to air them out. Around midday I cook

> ugali which is eaten mainly with milk. I usually prepare early supper so that my dad can go to bed early in the evening say at around seven o'clock.

Linet 22 years and taking care of her 76 years old grandmother said she provides services such as house cleaning and home maintenance. This means cleaning kitchens after eating, keeping one's living space reasonably clean and tidy, and keeping up with home maintenance.

> '*After eating, I embark on cleaning the main house and kitchen to ensure that we live in a clean environment, cook lunch, wash clothes, fetch water and prepare supper and make her bed. This is a kind of routine that is repeated every day'.*

4.2.2.2 Instrumental activities of daily living (IADL)

Those caregivers who reported to have been involved in IADLs said to provide services such as managing finances which include paying bills and managing financial assets; communicating via telephone, managing transportation as well as managing medications, which cover obtaining medications and taking them as directed. Studies show that they are typically done by men(Clark, 2012; Hooyman & Kiyak, 2006).

David 42 from Kesses said that while he has hired two other relatives to help him occasionally to take care of his 78 years old father and 70 years old mother, he was in charge of managing the wealth including finances of his parents.

> '*I am in charge of all the properties of my parents. Whenever they feel sick, I hire a taxi take them to hospital for treatment. I am also in charge of their medication since they cannot read. I make sure that relatives who occasionally care for my parents follow physician's instructions*' he said.

Similarly, Dennis39years old from Kipchamoo and taking care of aged parents said the following;

> '*My parents have a large tract of land. I am the one in charge of farming. I make sure that the land has been prepared, planted, weeded and crops harvested but under my father's instructions. I also manage the finances of my parents and I ensure that no one steals from them*'.

Managing communication, such as cell phones to ensure that the care receivers are in touch with their children, relatives and friends who support them socially, emotionally and economically was another activity done by caregivers. For instance, Mercy 29 years from Cheptiret and taking care of her 78 years old grandmother said the following;

> '*I also manage my grandmother's mobile phone. I normally take it to the shopping Centre to recharge the battery so that in case her children call, they can be able to communicate with her.*'

4.2.2.3 Advice and Emotional support

Another caregivers' support provided to the elderly was advice and emotional support. Aging is a process that has challenges and thus, aging persons require assurance and support to be strong and continue living positively. As part of caregiving, Jerald 31 years of age and taking care of his 78 years old mother said that he has been encouraging her mother to be strong and take medication so that she can live for a longer period.

> '*I have been advising my mother to live positively so that she can see her grandchildren graduate and get married so that she can bless them*' he said.

Similarly, Rose 49 years of age and taking care of her 91 years old mother said;

> '*I have been urging my mother to be strong despite her deteriorating health. I always tell her she is a widow and she should be strong for us her children*'

Stephen 46 years from Cheptiret and taking care of his aging parents said that he has been providing emotional support to his aging father with the help of her mother and

their casual worker. This is consistent with study findings that daughters, sons and daughters-in-law often feel obliged to provide physical care and emotional support to their aging parent(s) (Carmel & Pollack, 2013 and Clark, 2012).

4.2.2.4 Financial support

Supporting the old financially for medication, food and general upkeep can be challenging especially when one does not have a steady income. Studies show that in developing countries where there are fewer financial resources, lower incomes and high poverty rates the care receivers are likely to depend on intergenerational relatives to meet their financial needs (Dunn, 2014; Clark, 2012, Hooyman & Kiyak, 2006). In this study it was however established that some of the elderly people being supported still have big farmlands where agriculture is practiced and the produce from the land is then used to support the elderly. Majority of them are also enrolled on the cash transfer programme for the elderly. Judy, 21 years old from Cheptiret location said the following:

> '*My parents have a big land for farming. My brothers practice agriculture, sell the produce and use the proceeds to take care of all of us.*'

In addition, Esther, 52 years from Kipchamoo location who was providing support for her 83 year husband said that they still practice agriculture with their children providing capital for the faming processes;

> '*I mainly support my husband through our farm produce where I practice farming with the assistance from our children who sponsor the farming process*es.'

Similarly, Stella, 46, who was taking care of her 76 years old father, 72 years old mother and 105 years old grandmother, said that she has been receiving support from her old parents who are still practicing agriculture.

Nancy, 45 years from Kesses location who was taking care of her parents (father 76 years and mother 68 years) also said that her parents have enough farming land and the proceeds from farming was enough to take care of the entire family.

> '*My father's farm produce is enough to take care of us.*'

Sentiments from Judy, Esther, Stella and Nancy indicate how farming is still relevant in providing financial support to the elderly within family setting. Through farming, families are able to fulfill their basic needs from the proceeds realized.

Findings also revealed that care givers received financial support from family and extended families and in most cases children of the care receivers send money to care givers to take care of their aged parents. Siblings, uncles, aunties among others have been mentioned as being responsible in providing financial support. For instance, Jane 28 years from Kipchamoo, reiterated that her sister normally sends money either to her or her mother. Jane at the time of the study was taking care of her aged parents.

Similarly, Julie 36 years Kipchamoo resident said that the financial support that necessitates her to take care of her 76 years old mother comes from her siblings.

'….*My brothers and sisters send us money for our upkeep*', she said. Consequently,

Agnes 26 years a worker from Kesses who was taking care of an 89 years old female, said the following;

> '*The children of 'kogo' (grandmother) send money or visit and bring everything that is required.*'

Another source of finances for supporting the aged was found to be self-funding where caregivers themselves provide support without assistance from outside. For

instance, Rita, 49 from Kesses location and a daughter-in-law to the care receiver said that together with her husband, they manage to take care of her father-in-law using their salaries as they are employed.

> '*We have managed to take care of our father very well with both my salary and that of my husband's*' she said.

Similarly, Jerald 31 from Kesses too, who was looking after his 78 years old mother said that he engages in casual jobs like building, working on the farm and any other available jobs in the area as long as he gets paid to support his mother. Similar sentiments were also echoed by John 46 years from Kipchamoo who was taking care of her 78 year old mother.

4.2.3 The gained experiences of informal caregivers

The third objective asked the caregivers to describe their gained experiences in caring for the elderly. As the participants reflected on their lived experience a number of factors appear to have played a role in explaining how they found themselves in the current situation of caregiving as discussed in subsection 4.2.3.1.

4.2.3.1 How Participants Became Caregivers

The study found various factors that played a role for one to become a caregiver. One such factor was living with parents for support. Nancy, 45 years said that she found herself providing care to her parents as she also wanted help from them. She said;

> '*because I needed help from my parents. I have never been married but I have a child to take care of yet I had no source of income.*'

Similar sentiments were echoed by Maureen 28 years old, said that she was caring for her widowed mother who was 90 years because she was unemployed but had one kid

to provide for. Secondly, Stella 46 said that she was not lucky to be married yet she had one child who has completed university with her parents' assistance. She therefore felt obliged to take care of them.

Some caregivers did so by default as they are married to a partner who aged before them. The case of Joy, 69 and taking care of her 78 years old incapacitated husband said that she cares for her husband as she was still healthy and energetic.

> '*After my husband fell ill, he could no longer do anything. I had to abandon my work and be there for him. I do everything for him*' she said.

Joy's sentiments were backed by Rosemary's, another caregiver who said the following:

> '*by the virtue that I am his wife, and this old man has been good to us for all these years when he was a strong man and providing for us. So it is right for him to be taken good care of*'

Others became primary caregivers out of sympathy and feeling of love. For instance, Catherine, 29, had these to say:

> '*I became a caregiver because I saw my parents' sufferings under the care of my brothers. I sympathized with my parents and with the many insults they received from my brothers and their wives. I therefore decided to take care of them*'

The study further established that serving as a source of employment was their main reason why they were caregivers. Salome 20 years had these to say:

> '*I am a caregiver here because I wanted to work and earn something. So while I was looking for a job, the last born son of Kogo asked me to look after his mother in exchange for monthly pay and I accepted*'.

Salome's sentiments are supported by another caregiver Sharon's who said the following: '*I became a caregiver because I wanted a job to get money and this is what I found*'.

Convenience was also found to be the reason why caregivers offered services. Rose 49 said that she was caring for her mother because she has nothing else to do and she lives with her. On the other hand, Stephen said the following:

> '*Since I am the last born son and not yet married and available I found it pleasant to take care of my parents*'.

Similarly sentiments were noted from Robert 36 who was taking care of his aged parents. '*I am a care giver by the virtue that I am the last born in a family of five'*.

Gladys, 25 also reiterated that together with her husband were caring for her 81 years old mother-in-law because the husband is the only child living at home.

> '*We are caring for my mother-in-law by the fact that my husband is the only child at home and therefore automatically provides the services*' she said.

These findings are similar to studies that indicate that family caregivers take care of the elderly not solely out of obligation, but also out of an expectation of personal satisfaction and accomplishment that comes with the feeling of caring for someone else (Brodaty & Donkin, 2009).

4.2.3.2 Gained experiences

Table 4.8presents visual representations of responses of informal caregivers gained experiences. It reflects the number of participants that had descriptive expressions under the respective themes of benefits, reward and costs of caregiving. The lived experiences of caring for the elderly described by each participant is influenced by

their values, gender, resources, personality of caregiver, quality of relationship between caregiver and care-receiver, history and family dynamics (Durant &Christian 2006; Zafirovski 2005). The gained experiences spoken by caregivers were life-skills; life-cycle wisdom and advice from the elderly, source of blessings for caregiving, feeling of happiness; feeling appreciated; a feeling of self-fulfillment and a feeling of disappointment. All these benefits, rewards and costs are consistent with the tenets of the Exchange Theory in explaining the relationships between the caregiver and the care recipient. The caregivers often attempt to maximize their rewards and minimize their costs in their interactions with care-receivers.

The row total is the sum of the experiences informal caregivers gained which in this case is a total of 4.The caregivers that indicated 2, for example, means they gained in only two experiences and those indicating 9 means they gained in all the 9 experiences. The column totals are the total number of caregivers who spoke under each of the experiences.

Table 4. 8: Responses of Informal caregivers Gained experiences

Caregivers	Lifesk	Lifcyle	Wisd	Bless	Happy	Appr	Self-Fulfill	Over Burden	Dis appoint	Total 9
1	✓	✓	✓	✓	✓	✓	✓			7
2	✓	✓	✓	✓				✓		5
3	✓	✓	✓	✓	✓	✓	✓			7
4	✓							✓	✓	3
5	✓		✓	✓	✓	✓	✓			6
6	✓			✓			✓	✓	✓	5
7	✓						✓	✓		3
8	✓	✓	✓	✓		✓	✓	✓		7
9	✓	✓	✓	✓	✓	✓	✓			7
10	✓	✓		✓	✓			✓		5
11	✓	✓	✓	✓	✓	✓	✓	✓		8
12	✓	✓		✓	✓	✓	✓	✓		7
13	✓	✓		✓	✓	✓	✓			6
14	✓		✓	✓	✓	✓	✓	✓		7
15	✓	✓	✓	✓	✓	✓	✓	✓		8
16	✓	✓	✓	✓	✓	✓	✓	✓		8
17	✓		✓	✓	✓	✓	✓	✓		7
18	✓		✓	✓	✓	✓	✓			6
19	✓	✓		✓		✓	✓	✓		6
20				✓	✓	✓	✓	✓		5
21	✓		✓	✓	✓		✓	✓		6
22	✓		✓	✓	✓	✓	✓	✓		7
23				✓	✓	✓	✓			4
24	✓	✓	✓	✓	✓	✓	✓			7
25	✓	✓		✓				✓	✓	5
26	✓		✓	✓	✓	✓	✓			6
27	✓		✓	✓	✓			✓	✓	6
28	✓		✓	✓	✓	✓	✓	✓		7
29	✓	✓	✓	✓	✓	✓		✓		8
30	✓	✓	✓	✓	✓		✓	✓		7
31	✓	✓	✓	✓	✓	✓	✓	✓		8
32	✓					✓	✓	✓		4
33	✓	✓	✓	✓	✓	✓	✓			7
34								✓	✓	2
35	✓	✓	✓	✓	✓	✓	✓			7
36	✓	✓	✓	✓	✓	✓	✓	✓		8
37	✓	✓	✓	✓		✓	✓	✓		6
38	✓		✓	✓	✓	✓	✓	✓		7
39	✓		✓	✓	✓		✓	✓		7
40	✓	✓	✓	✓	✓	✓	✓			7
Total	**37**	**23**	**28**	**36**	**30**	**29**	**33**	**28**	**5**	**227**

Key:Lifsk-Life-skills;lifcye-life-cycle;Wisd-Wisdom;Bless-blessings;Happ-happiness; Apr-Appreciate; self-fulfill -Self-fulfillment; Disappoint -Disappointed

4.2.3.2.1 Life Skills

Life skills are basically the abilities that enable individuals to deal effectively with the demands and challenges of everyday life. With life skills, one is able to explore alternatives, weigh pros and cons and make rational decisions in solving each problem or issues as it arises (Neema, & Phillips, 2013; Carmel & Pollack, 2013). In the context of this study life skills entail the ability of caregivers being able to establish productive interpersonal relationships with those receiving care, the elderly.

Thirty seven study respondents acknowledged to have gained a lot of skills and knowledge required in life through their own experiences as caregivers. For instance, John 46 years and taking care of his 78 years old mother had these to say:

> 'I now know that life is not a bed of roses and I keep on telling my children to be focused in school for better future. After my father died, my mother has been working hard all through until five years ago where she became weak and could no longer do whatever she used to do. I had to step in and provide assistance. I have really learnt that responsibility requires commitment and personal sacrifice.'

Similarly, Esther 52 years old and taking care of her 83 years old husband said:

> '*Looking after my husband has made me gain a lot in life. Furthermore, my husband teaches me a lot of life skills. He always wishes that I live comfortably after he has left this world.*'

These findings concur with a number of studies (Clark, 2012; Lecovich, 2008; Quadagno, 2005; Del Campo *et al.,* 2000) that suggest the quality of the relationship between caregiver and care receiver influences how positively caregivers perceive their role.

4.2.3.2.2 Life cycle

Taking care of the elderly was perceived by some of the caregivers as a life cycle whereby if they do not take good care of the elderly (especially their parents) then they will also be treated the same by their children or grandchildren. This was said by twenty three caregivers. For instance, Nancy 45 years said;

> '*It is a norm for children to look after their parents when they get old so that when your turn comes, your children will be there for you. I also expect that Brian and Sharon my children will take good care of me when I finally get old.*'

Such sentiments were echoed by most of the caregivers in this study.

This quotation portrays that the respondents will continue to provide care to their elderly however burdensome it may be for fear of being neglected by their own children in their old age. This finding concur with empirical studies that show that although caring for an elderly person is a challenging task, family members provide care gladly and feel positive about their role as caregivers (Adeosun, 2013; Carmel & Pollack, 2013; Nankwanga, Neema, & Phillips, 2013)..

4.2.3.2.3 Advice and wisdom from the aged

It is said that old persons are the custodians of wisdom. The study found that receiving advices and wisdom from care receivers was reported to be one of the major gained experiences indicated by twenty eight caregivers. Ben 39 years old from Kipchamoo and who was taking care of his 79 years old father had this to say:

> '*Caring for my father has made me to know and understand a lot of things and some of which I used to take for granted. My father keeps educating me about how a man should care for his children and his entire family. This has made me to be a wonderful father and husband*'

Stephen, 26 years old from Cheptiret and taking care of his parents, mother of 68 years and father of 76 years was advised by his father;

> *'My son he said, be very very careful about which girl to marry……. Do not bring us strangers or girls from families and communities whom do not know……. Marriage is a lifelong commitment and a woman from a good family will make you live longer and in harmony with your brothers and sisters when I am long gone.'*

The verbatim quotes from respondents show that caregiving has the added advantage of the caregivers imbibing traditional knowledge and practices from the elderly. This finding is supported by empirical studies that, among Africans, care giving of elderly persons is of a high cultural-value and an encouraged activity, and is considered to be an expected part of adult development (Nankwanga, Neema, & Phillips, 2013; Haley et al., 2004).

4.2.3.2.4 Blessings

It was found that taking care of the aged is a source of blessing especially when care receivers appreciate the efforts made by caregivers in improving their conditions. Thirty six caregivers said so. For instance, Maureen stated that taking care of her mother is a source of happiness and blessings to her. This has pushed her to cope with all the challenges that come with informal care giving. Similarly, David 42, taking care of his aged parents says;

> '*I think I was lucky to be the last born because in this compound there is no one else but me. All my siblings are away. I am lucky because every day my parents bless me in morning when they wake up and in the evening before they rest. This has really motivated me and I see the hand of God working.*'

Similarly, Catherine had this to say about her feelings and experiences;

> '*I feel happy about being a care giver of my own parents and even my children have had no problem in schooling. My son has just finished university in agricultural engineering and currently helping out my father with farm work. These are the blessings and I think I am the one blessed most*'

She further reiterated that her father has given her a piece of land besides assisting her financial to take care of the entire family.

Emily 32, taking care of her grandmother said that she felt blessed as a caregiver because she has children who needed blessings from their grandmother.

The quotes indicate how family caregivers feel about taking care of their dependent parents. To some caregiving accrues blessing and as a source of family stability and provides an enabling environment for their children to pursue their education with less problems. There is therefore, mutual benefit to be gained from caregiving work. This is line with arguments that have been put forward that aging affects exchange relationships in the sense that, generally people desire to profit from social interaction with others and that profit consists of a perception that the reward coming from the interchange outweighs the costs (Durant &Christian 2006; Kyei-Arthur, 2013).

4.2.3.2.5 Feeling Happiness

As indicated by Brodaty & Donkin, (2009) family caregivers take care of the elderly not solely out of obligation, but also out of an expectation of personal satisfaction and accomplishment that comes with the altruism of caring for someone else. This study found out that some thirty family caregivers were indeed taking care of the elderly simply for the satisfaction that they derived from doing it.

> '*I feel happy and satisfied when my mother in-law is very grateful for the services that I am offering to her*' said Elizabeth 42 years and taking care of 79 years old mother in-law.

Similarly, Rosemary said that, she feels good and happy for being able to take care of her husband.

> '*I feel happy for being able to take care of my husband well. He also appreciates my efforts. However, my dilemma is how will I manage if he dies before me?*'

These quotations concur with research findings that show that family caregivers do benefit in their interactions with the dependent elderly (Cohen, Colantonio &Vernish, 2002).They acquire the reward in the form of emotional satisfaction through the love of their care giving work(Durant and Christian 2006).

4.2.3.2.6 Feeling Appreciated

The study established that taking care of the aged generated a lot of appreciations from the community, friends and relatives and as well as care receivers as suggested by a number of studies(Clark, 2012; Lecovich, 2008; Quadagno, 2005). Rita 49 years who was one among the twenty nine caregivers who spoke about this feeling said that taking care of her mother in-law has made the community to respect her so much. She had these to say;

> '*Taking care of my mother in-law has opened a new door for me. The community respects me so much for taking bold action of caring for the aged Kogo when her children and other close relatives had abandoned her. I really feel appreciated.*'

Similarly, Jully who is 36 years old from Kipchamoo location and taking care of her 76 years old mother said that she feels her efforts of looking after her mother have been appreciated by her family members.

> '*I feel appreciated because in December every year my brothers and sisters shop for me everything from clothes to shoes and household items. This according to them is a way of saying thank you for looking after our mother while they are away. I feel happy.*'

The responses echo empirical research findings that suggest that Africans often consider care giving indicate that Among Africans, care giving of elderly persons is encouraged as an expression of traditional values and as continuing a family tradition of mutual concern, or setting an example for one's own children (Clark, 2012; Haley et al., 2004).

4.2.3.2.7 Self-fulfillment

Taking care of the elderly and especially parents is a form of self-fulfillment. Caregiving is seen by some as a return care for a parent in need and who once cared and provided for them (Barker, 2002).

Thirty caregivers felt it is like repaying the debt to parents for being cared for as a child. Joel 42 years and taking care of his 74 years old mother from Kipchamoo said that his heart is full of joy for taking care of his aged mother. This is what Joel had to say:

> '*It is self-fulfilling when you know you are responsibly taking care of your parents.*'

This feeling is consistent with studies that have shown, family caregivers undertake caregiving not solely out of obligation, but also out of an expectation of personal satisfaction and accomplishment that comes with the altruism of caring for your elderly dependent parents (Brodaty & Donkin, 2009; Jacobs, 2014).

4.2.3.2.8 The feeling of overburden

Caregivers also feel over-burdened, overwhelmed and stressed when providing services and especially, when there is no helping hand. Caring for an elderly family member demands a significant amount of energy from the caregiver thus placing a caregiver at risk of physical and mental health decline resulting from the stress of caregiving (Haley et al., 2004). In the current study twenty eight family caregivers felt overwhelmed and overburdened despite having expressed feelings of happiness in their caregiving work. Irene 48 years from Kesses and taking care of 81 years old mother had these to say:

> '*I feel burdened when every day from morning to evening I am the one taking care of my mother. What is more painful is that we are six children yet others do not care. It is difficult for me to get time to unwound and do my own things*'

Jerald 31 years and taking care of his 78 years old mother said that taking care of his mother has been challenging and tiresome.

> '*Providing care to my mother is very challenging and tiresome. There are some things that are better done by women. I wish my wife was here*' at the time of data collection, Jerald had separated with his wife.

Some of the reasons that caregivers feel overburdened are because of caregiver's restrictions in their social activities and lack of support from the other family members. In support of these sentiments some studies suggest that earlier research may have overestimated the availability and extent of support that African caregivers receive from other family members (Barker, 2002; Jacobs, 2014).

4.2.3.2.9 Feeling Disappointed

Other caregivers when asked to share their feelings stated that they were not happy. Taking care of aging parents sometimes leads to parental interference, role conflict and added stress (Schulz & Tompkin, 2010).

Only five caregivers had this feeling. For instance, Janerose 43 years in Kipchamoo and taking care of her 90 years mother-in-law had this to say;

> '*I feel unhappy and disappointed after all these years of looking after my mother-in-law, she is never grateful. She is nagging and always complaining. I always stay stressed up because of her lack of appreciation'*

Similarly, Anna63 years from Cheptiret and taking care of her 109 year old mother said this;

> 'When I take her bathing water fifteen minutes to half an hour late my mother asks me whether the water well had now moved miles away from the house for me to be this late. This hurts me as she knows for sure that the well is still where it has been and that my being late was because I was attending to the other family members who also require my services. My mother has become very possessive'.

Caring for an elderly person is a challenging task. This becomes acute particularly when the elderly care-receiver, has a negative attitude towards the caregiver. The caregiver may become angry with the elder person, especially if he or she is a spouse. This is consistent with studies that have found that caregiving is associated with increased rates of depression, anxiety and less life satisfaction(Barker, 2002; Haley et al., 2004; Quadagno, 2005).

4.2.3.3Caregivingand effects on Daily Lives

All the participants agreed that caregiving work had exceptional challenges and had in one way or the other affected their daily living. They indicated that they lacked time

to visit friends, lived in isolation and that caregiving had positively impacted on their lives by being a remedy to addiction.

4.2.3.3.1 Lack of time to spend with friends

The study found that caregiving is time involving and thus, caregivers may lack time to visit and hang out with their friends. Lived experienced affects how time is perceived. 'When a man sits with a pretty girl for an hour it seems to be like a minute. But let him sit on hot stove for a minute-and it's longer than any hour'. That is relativity (Andren & Elmstahl, 2008; Chang, 2009). Caregiving work is compared to a stove. It is arduous, burdensome, demanding and stressful and one minute of caregiving work is like one hour. Caregiving has been identified as a chronic stressor that places caregivers at risk for physical and emotional problems. For instance, Emily 32 years from Kipchamoo and taking care of her 78 years old grandmother said the following;

> '*This job is very time consuming. You can't even get some time off to spend out with friends. My grandmother is very possessive, she cannot allow me to go anywhere.*'

Similarly, Maureen 28 years from Kesses and taking care of her 90 years old grandmother said that due to lack of helping hand from her sisters in-law, she lacks time to visit her friends.

> '*Yes it does. I don't have time to visit my friends. They also do not visit me these days. I take care of my grandmother and everything else single handedly. My sisters in-law do not help,*' she said.

As can be noted from the quotes, caring for an elderly family member is time-consuming and demands a significant amount of energy from the caregiver to the extent that they have little time left for themselves. Empirical studies (Adeosun, 2013;

Carmel & Pollack, 2013; Nankwanga, Neema, & Phillips, 2013)have suggested that caregiving activities lead to subjective burden and a restriction in the caregiver's social activities.

4.2.3.3.2 Living in Isolation

It was established that caregivers might be isolated from their friends. The caregiver also feels isolated if they receive no support from relatives in caring for the elderly person (Nankwanga, Neema, & Phillips, 2013). For instance, Janerose said that providing care to her mother in-law has changed her life since she no longer have time to visit friends and whenever her friends visits her, they are chased away.

> 'I would say providing care to my mother in-law is good. However, my life has changed completely. I used to have very many friends who we would share a lot and have fun. But ever since I started caring for my mother in-law, she neither allows me to visit my friends nor allow my friends to visit me. The other time she chased them away with abusive words. This has made me to live in isolation as I have lost most my friends' she said.

4.2.3.3.3 As a remedy to addiction

Spending much of their time in caregiving had a positive impact to some caregivers. For instance, Edward 39 years from Kesses had these to say:

> '*Initially, I was a heavy drinker, alcohol was my companion. I would wake up very early to go drinking but since I started caring for my parents, the urge for drinking reduced gradually as I had no time. Now I can confirm to you that I do not drink alcohol anymore and my health has improved thanks to my parents.*'

This quote points to the long hours associated with caregiving work. The caregiver is required to be around all the time with little to engage in other social- activities. This particularly is acute if the range of services demanded by the dependent elderly include: feeding especially for those aged who cannot feed themselves; dressing and

grooming them; taking them to toilet; washing and cleaning them as well as transferring or moving them from one body position to another. These activities which are labour intensive and time-consuming are consistent with findings from other empirical studies(Clark, 2012; Hooyman & Kiyak, 2006).

4.2.3.4 Emotional Stress

Caring for an elderly loved one is not without its stressors. The responsibility is a heavy load to bear physically, mentally and emotionally. Caregiving has been hypothesized to lead to chronic stress (Schulz & Tompkin, 2010; Clark, 2012). Certain characteristics of the caregivers such as socio-demographic or health characteristics, care recipients (for instance, extent of functional or cognitive limitation of care receivers) and the caregiving experience (such as hours of care provided) may predispose to or be protective against the development of emotional stress. Such predictors of stress may also vary by the relationship of the caregiver with the care recipient (Nankwanga, Neema, & Phillips, 2013).

Working for long hours and being around all the time in order to provide informal care found to emotionally stress the care givers. For instance, some care givers find it stressful when workers are given offs but they will not return. This therefore results in primary care givers to work for long hours as they have no one to alternate with.

David 42 from Kesses said

> '*It can be stressful especially when workers go home for offs and not to turn up. Ensuring that my parents' needs are met without assistance is tiresome and very stressful.*' Similarly, Jerald he also suffers from emotional stress as his aged mother does not want him to go anywhere, '*it is very stressful as my mother does not understand why she has to be left for long hours.*'

Rose, 49 years from Cheptiret and taking care of her 91 years old mother said that she literally has to do everything for her mother as she is too old and fragile. Rose said that number of caregiving tasks is just too overwhelming for her. Work overload has been identified in research studies as one of the causes that lead to high levels of work stress, depression, burden, and burnout (Andren & Elmstahl, 2008; Chang, 2009). This is what Rose said:

> '*It is very stressful because my mother has to be done everything from bathing, clothing, toileting to feeding because of her ill health. She is very fragile*' she said.

It was also established that fear of unknown was a source of emotional stress for primary care givers. Gertrude, 21 years**** stated that she normally experience emotional stress as a result of fearing what will happen in case they are sick.

> '*I feel stressed particularly when they become sick. They are aging and anything can happen. I reach to a point where I feel like crying. It is very stressful*'

Care receivers being too demanding were also found to be another source of emotional stress to primary care givers. Brenda, 28*** and taking care of her aged parents said that her parents have a lot of endless demands and by the time you retire to bed you are very tired. Studies have shown that tension in the relationship with the care recipient due to a myriad of care tasks and demands may cause stress, depression, elevated levels of hostility and anxiety to the caregiver (Kyei-Arthur, 2013, Hooyman & Kiyak, 2006). This is what Rose had to say:

> '*Sometimes the demands of my parents can make me run mad*' she said.

Similarly, Sharon, 39 years from Cheptiret and employed as house helper to take care of aged couples said the following;

> '*it is very stressful especially when they are unwell and you really have to convince them to eat before taking medications pus other things*'.

The study also found that false accusation, nagging and being unappreciative by care receivers stress care givers. Janerose, 43 years from Kesses and who was caring for her mother-in-law reiterated that she goes through stressful moments as her mother-in-law will complain on anything.

> '*It is very stressful because my mother-in-law is that type who complains on anything and everything to her son. You cannot even enjoy your married life*' she said.

Janerose's sentiments were echoed by Gladys, 25 years from Cheptiret and providing care to her 83 years old mother-in-law had these to say:

> '*I dedicate all my time and energy to ensuring that my mother-in-law is well but all she does is to keep on accusing me falsely to her son, my husband. I feel really bad*'

Similarly, Maureen, 28 years and taking care of her 90 years old mother had this to say:

> '*it is stressing in such a way that after working hard to ensure that my mother is well. She does not appreciate what I do. This makes me feel really bad*.'

The study also established that care receivers have preferences which sometimes stress the primary care givers. For instance, King, 22 years from Kesses and taking care of her grandfather says that he goes through hell as his care receiver is very selective. He said the following;

> '*it is very stressful because my grandfather prefers only men to take care of him. He does not allow any woman to wash his clothes*'.

On the other hand, lack of cooperation from family members was also found to emotionally affect primary care givers as it was with the case of Catherine, 43 years from Cheptiret who was caring for her aged parents. She had this to say:

> '*I am not the only child of my parents we are many. However, it is very stressful especially when my brothers are not willing to lend a hand of help in caring for our parents but go ahead to gang up against me and accuse me falsely that I am benefiting from their wealth and inheritance. It is very stressful*.'

4.2.4The coping strategies of informal caregivers

The fourth objective of the study was to explore caregivers coping strategies. Taking care of the elderly can be challenging and sometimes stressing. Caregiving has profound impact on the daily lives of the family caregivers. Care giving is associated with negative impact on physical, psychological and emotional health of the family caregiver (Del-Pino-Casado et al., 2011; Hooyman & Kiyak, 2006 Adeosun, 2013; Carmel & Pollack, 2013). Consequently informal caregivers employ a number of strategies to cope with the negative impacts of caregiving. Coping skills help buffer care giving relieve stress.

4.2.4.1 Sharing Responsibility among family members

It was established that one of the coping strategies employed by care givers was to ensure that there is another service provider who can step in as primary care givers attend to their personal needs. For instance, Rita said that she has employed a house help to help her alternate in order to attend to other issues.

> '*I employed a house help takes care of my father-in-law from morning till afternoon then I take over since I work half day*'.

According to her, she requested her employer to put her on duty from morning to noon so that she can take care of her father-in-law.

David 42 from Kesses who was taking care of his aged parents said that he employed two workers and therefore when he is away working he ensures that at any given time, there is someone who is taking care of his parents.

> '*Since I am employed it is difficult for me to be around the entire time taking care of my parents. I have therefore hired two workers who take care of my parents while I monitor over the phone*' he said.

Similar, sentiments were echoed by Joel 42 and taking care of his father said,

> '*I have employed casual workers available during the day and always calling my mother to monitor*'

Furthermore, Jerald said that he uses his children especially during the weekends and in the evenings.

> '*it is overwhelming because sometimes my mother wants me to be around all times while at the same time I have to look for menial jobs to support all over us. My children help me in the evenings after school and during weekends when they are not going to school*' He said.

Similarly, Gertrude 21 from Kesses who was taking care of her aged parents said that she only get relieved during the holidays after schools have been closed. That is when her siblings are at home to help her in caring for their parents.

As indicated in the quotes caregiving is very challenging, complex and demanding. In most instances caregiving is a full time job. Caregivers tend therefore to resort various strategies to try to fit their other commitments with caregiving such as hiring workers, using own children and siblings. These sentiments echo research findings that show that caregivers often engage the services of secondary caregivers to step in as primary care givers as they attend to their other personal needs (Hooyman & Kiyak, 2006; Beach et al., 2005)

4.2.4.2 Proper planning

Primary caregivers often provide a myriad of services to the dependent elderly. These serves vary from activities of daily living (ADL), instrumental activities of daily living IADL), advice, emotional support to financial support. Caregivers, therefore,

have to plan on how to accomplish all these tasks. They often seek out the services of friends relatives and neighbours to do that.

John 46 says that;

> *'I try to accomplish several tasks such as fetching water and cleaning of utensil in the evening so that I can get some time off. 'These cannot be possible if I do not plan my activities ahead of time. Often I appeal to relatives, friend and neighbours to help out.*

Empirical studies (Haley et al., 2004; Clark, 2012; Hooyman & Kiyak, 2006) indicate that primary caregivers often use secondary caregivers to accomplish their tasks. The secondary caregivers such as friends, neighbours, or relatives assist the elderly in the activities of daily life.

4.2.4.3 Obtaining available assistance from neighbours and friends as necessary

Most caregivers used emotional focused strategies such as seeking advice from friends or relatives. The caregivers indicated that they obtained voluntary help from neighbors and friends to fill a gap in services during emergencies, as well as occasionally for emotional support.

Stephen 26 years old from Cheptiret and taking care of her aged parents said that he normally creates sometimes off to visit his friends with similar situations for encouragement and support and this what he said;

> '*Since I don't have anyone to alternate with, I normally visit my friend who is not far from here and we share a lot concerning our situation*' he said.

Similar sentiments were echoed by thirty three caregivers who were using this strategy to protect themselves from harmful stress.

A number of studies have reported that African family care giving of dependent elderly persons is performed involved different people with varying levels of involvement in daily care giving activities (Haley et al., 2004; Clark, 2012; Hooyman & Kiyak, 2006). As noted in this quote caregivers got together with peers in the same predicament as a way of dealing with the stress of caregiving. This act encourages the care givers to know that they are not alone in the difficulties they were experiencing.

4.2.4.4 Going to church for moral support

It was also revealed that spiritual nourishment acted as a source of relief from caregiving stressors. Pamela, 43 years from Kipchamoo said that since she cares for her mother without any break, going to church every Sunday to pray was her only solace. This was common with the rest of the thirty caregivers who spoke on this coping strategy.

> *'My mother has tied me up as she cannot do anything and I cannot leave her alone. Every Sunday I must attend a 9 o'clock mass to ask God for strength and perseverance so that I can continue taking care of my mother' she said.*

Yet Janet a 37 years old female caregiver says she asks her church to bring prayers to the house. She had this to say;

> *At least once every month I ask the members of my church to bring prayers to my house……we pray, sing and share together the word God. After that I feel relieved and energized. It relieves me from feeling lonely and sometimes empty in my heart without feeling.*

Elizabeth who is 53years and a staunch Seventh Adventist follower feels she is very lucky since her children who are in a day secondary school are at home on weekends and can therefore look after her 83 year mother-in-law as she attends a church service.

> I am able to attend a church service every Saturday since my children are at home…However, unlike before I don't have the same opportunities to take up

> any church responsibility like cleaning the church or visiting sick members of our church community…but thank God I can commune with other Christians and worship God in his house every Saturday with other believers.

Research conducted on subjective burden among caregivers suggested that caregivers engaged in different styles of coping to manage the subjective burden (Del-Pino-Casadao*et al.,* 2011; Clark, 2012). As noted from the quotes in this study caregivers resorted to spiritual consolation to relieve stress and burden of caregiving work. They attended church every Sunday, invited members of the church to bring prayers to the house and voluntarily provided services in the church like cleaning and visiting sick church members whenever they found some time to do so.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the summary of the findings, conclusions and recommendations. The purpose of the study was to explore the experiences of informal family caregivers of the elderly in Kesses Constituency in Uasin Gishu County to gain an insight and a deep understanding of the meaning of the perspectives of the caregivers and their experiences.

5.2 Summary of the Findings

This section presents a summary of research findings in accordance with the research objectives and questions stated in Chapter Section 1.5 and 1.4.

5.2.1 Socio-demographic Characteristics of Caregivers

In relation to age of caregivers, the study found that the average age was 41 years. The most frequently occurring age was 36 years while the youngest caregiver 20 years mostly likely a grandchild while the oldest caregiver was spouse of 87 years. In relation to gender, more females (73%) were found to be informal caregivers compared to men (23%). In terms of marital status, those who were single (43%) were slightly less than those who were married (50%). In terms of education, a majority were found to be literate (90%) with formal education, with most of them having completed secondary education (53%). Few though dropped out of secondary schools (15%) while others had acquired basic (primary) education (20%) and (3%) college training. Similarly, majority (55%) were found to be unemployed, a few (15) with

formal employment while nearly one third were engaged in casual jobs (30%). Finally, the study established that about one third (30%)of the caregivers were daughters of the care recipients followed by sons at 23. Daughters in law constituted a fifth (20%), of the caregivers, wives (10%), workers (8%) and granddaughter(5%). Husbands and grandsons were 3% respectively.

5.2.2 Types of Caregiver Support provided to the Elderly

Four types of care support were identified. First was Activities of Daily Living (ADLs) which included ambulating; feeding; dressing and grooming them; taking them to toilet; washing and cleaning them as well as transferring or moving them from one body position to another among others. Second was Instrumental Activities of Daily Living (IADLs) which included managing finances; transportation; medications as well as answering and calling using cell phones. Third was providing emotional support and advice to the elderly care recipient and finally, provision of financial support.

5.2.3 Gained Experiences of Informal Caregivers

The experiences were gained through: Life skills (where caregivers gained skills that will be projected to their own lives); life cycle (that they care for the aged so that when their time comes they will also be cared for); advice and wisdom (caregivers gained a lot in terms of knowledge and wisdom of the aged who have stayed for a long time and actually accumulated a lot); blessings (caregivers also experienced blessings from the elderly and some were optimistic that through such blessings, their families will succeed).It is possible that tensions in the relationship with the care recipient may cause more stress for women than for men (Barker, 2002; Kyei-Arthur, 2013). Caregiving has profound negative impact on the daily lives of the family

caregivers. Caregivers reported, more hours of care, higher number of caregiving tasks, higher levels of behavior problems, more caregiver burden and depression.

5.2.4 Coping strategies of Informal Caregivers

Looking after the elderly can sometimes be overwhelming and stressful and therefore requires particular strategies to handle them. Sharing of responsibility among family members; proper planning and self-adjustments; obtaining available assistance from neighbours and friends as well as going to church for moral support and spiritual nourishment were the major coping strategies adopted by caregivers. The caregivers seemed to have largely resorted to emotional-focused strategy to alleviate their stress and burden such as seeking advice from friends or relatives and praying.

5.3 Conclusion

Care of the dependent elderly is a common phenomenon in rural areas and the family is the major source of care giving with the majority of caregivers being adult female daughter, daughter in-law, and relatives (73%). Care giving by family members and other close relatives reduces the need for institutional care for the old people. Family caregivers provide both personal and emotional support to the elderly care recipient. Informal family care giving includes not only ADLs and IADLs but also financial and emotional support to the care recipients. ADLs and IADLs require higher level of engagement and devotion to manage daily life of the elderly recipient. As noted in the study caregiving has profound negative impacts on the daily lives of the family caregivers. Most caregivers reported, more hours of care of more than eight hours, higher number of caregiving ADL and IADL activities, more caregiver burden and depression. Many of the caregivers also reported that there was tension in their relationship with the care recipient due to lack of appreciation and cooperation of the

care recipient. This is consistent with the exchange Theory in which the basic assumption is that the process of social exchange is assumed to be governed by reciprocal relations. The tension in the relationship between the caregiver and care receiver is often a source of both physical and emotional stress for the caregiver which tends to affect the quality of the relationship with the care recipient.

Providing care to the elderly has its own share of challenges such as working for long hours, inadequate financial resources among others. In order to continue to provide care services to the elderly, informal caregivers have adapted and adjusted to the pressure and challenges by employing a number of coping strategies. The caregivers have resorted to emotional-focused strategy to alleviate their stress and burden such as praying and seeking advice from friends or relatives. Interventions tailored at these negative caregiver outcomes focusing, for example, on actual and relational stressors and on getting help with ADL assistance is therefore imperative. Hence it becomes necessary to understand the patterns of care giving by family caregivers within the context of rapid societal changes and a growing and aging population. The care recipients in this study were found to be between 74 years and 109 years of age with a mean of 83.63 and a mode of 76 years.

5.4 Recommendations of the Study

Based on the findings of the study the following recommendations are made:-

This study gives basic information on the role of informal caregivers in society. It has demonstrated that informal care to the elderly is critical and pervasive in Uasin Gishu County. However, informal caregiving to the elderly remains highly invisible and undocumented. Therefore there is need for the national and county governments to first acknowledge the important and unique role that informal caregivers play in the

lives of the aged in our society through public policy pronouncements. This will enhance our understanding of the context that influences patterns of caregiving to the elderly in our society, particularly with rapid societal changes and a growing aging population.

Social policies and programs to be developed by both the County and National Government respectively to support the role of informal care givers by way of training to build capacity and to create more awareness. This is pertinent for the effective implementation of Government programmes for example the Cash Transfer Programme for the very poor older persons in society that was initiated in Kenya in 2006. It is instructive to note that the services of informal care givers to the elderly include managing finances, managing medication and shopping among other IADL activities.

As a result of negative impact on physical, psychological and emotional health of family caregivers associated with caregiving burden, the national and county governments should develop intervention programmes to support caregivers to look at their situations in a more positive manner. A platform should be created where informal caregivers can share their experiences with others. Such group support system will assist caregivers to manage stress and burden of caring for the elderly. Since women are more often affiliated to some religious institution than men these religious institutions and NGOs can be roped in to assist in providing counseling support to alleviate stress and strain. The end result will be improved quality care for the elderly.

5.5 Recommendation for Further Studies

Although this study was undertaken to explore and assess the experiences of informal family caregivers of the elderly in order to gain insight and deeper understanding of their experiences, there still exists a gap that future research could explore. Future research could build on this study by examining informal caregivers in terms of their experiences, challenges and effects of caregiving activities from a gender- specific perspective, which is, looking at gender differences in care giving activities. A longitudinal study may be needed as well to monitor if gender differences in caregiving activities are changing over time. Further, the researcher recommends that a similar study be undertaken in different constituencies and counties in Kenya taking into account the cultural differences.

REFERENCES

Adeosun, I. I. (2013). Correlates of Caregiver Burden among Family Members of Patients with Schizophrenia in Lagos, Nigeria. *Schizophrenia Research and Treatment*, 2013(1), 353809.

Andren, S.& Elmstahl, S. (2008). Psychosocial interventions for family caregivers of people with dementia reduces caregivers burden: development and effect after 6 and 12 months. *Scandinavian Journal of Caring, 22, 98-109.*

Attride-Stirling, J. (2001). Thematic networks: an analytic tool for qualitative research. *Qualitative Research*, 1(3), 385–405.

Beach, S., Schulz, R., Williamson, G., Miller, S., Weiner, M., & Lance, C. (2005). Risk Factors for Potentially Harmful Informal Caregiver Behavior. *Journal of the American Geriatrics Society*, 53(2), 255–261.

Blau, Z., (1961). Social Constraints on Friendship in Old Age. *American Sociological Review* 26:229-239.

Blum, K. (2009). Family caregivers. In M. Matzo & D. W. Sherman (Eds.), Palliative care nursing: *Quality care to the end of life* (Third Edit.). Springer Publishing Company.

Borg, C., & Hallberg, I. R. (2006). Life satisfaction among informal caregivers in comparison with non-caregivers. *Scandinavian Journal of Caring Sciences*, 20(4), 427–438.

Brodaty, H., & Donkin, M. (2009). Family caregivers of people with dementia. *Dialogues in Clinical Neuroscience*, 11(2), 217.

Bryman, A. (2012). Quantitative data analysis with SPSS for Windows: A guide for Social Scienial Research Methods. 4th ed. Oxford: Oxford University Press.

Carmel, S., & Pollack, S. (2013). Informal Caregivers: A growing population with growing needs. *Realisations*, 2, 1–10.

Chang, H.(2009). The correlation of home care with family caregiver burden and depressive mood: An examination of moderating functions' *International Journal of Gerontology, 393), 170-180.*

Choi, N. G., Burr, J. A., Mutchler, J. E., & Caro, F. G. (2007). Formal and informal volunteer activity and spousal caregiving among older adults. *Research on Aging*, 29(2), 99–124.

Clark, A.L. (2012). Instrumental activities of daily living: more than just piano-playing? *European Journal of Heart Failure,* 14(6), 565-566

Cohen, C. A., Colantonio, A., &Vernich, L. (2002). Positive aspects of caregiving: rounding out the caregiver experience. *International Journal of Geriatric Psychiatry,* 17, 184-188.

Cohen, H.J., Harris, T. &Pieper, C.F.(2003). Coagulation and activation of inflammatory pathways in the development of functional decline and mortality in the elderly, *American Journal of Medicine, 114, 180-187*

Cohen, L., Manion, L., & Morrison, K. (2007). *Research methods in education* (6th ed.). London: Routledge Falmer.

Creswell, J. (2014). *Research design: Qualitative, quantitative and mixed methods approaches.* Lincoln: SAGE.

Creswell, J.W. (2003). Research Design: Qualitative and Mixed Methods Approaches. (2nded. University of Nebraska, Lincoln: Sage publications.

Creswell, J.W. (2009). Research design, Qualitative and Mixed Methods Approaches. (3rd ed. University of Nebraska, Lincoln: Sage publications.

Cross, J., & MacGregor, H. N. (2010). Knowledge, legitimacy and economic practice in informal markets for medicine: A critical review of research. *Social Science & Medicine*, 71(9), 1593–1600

.

Del Campo, R., Del Campo D, & DeLeon, M. (2000). Caring for aging family members: Implications and resources for family practitioners. *The Forum For Family and Consumer Issues, 5* (2), 1-4

Del-Pino-Casada,R., Frias-Osuna,A., Palomino-Moral,P.A., Pancorbo-Hidalgo,P.L. (2011). Coping and Subjective burden in caregiver of older relatives: a qualitative systematic review. *J Adv. Nurs.*

Do, E. K., Cohen, S. A., & Brown, M. J. (2014). Socioeconomic and demographic factors modify the association between informal caregiving and health in the Sandwich Generation. *BMC Public Health, 14(1), 362.*

Dowd, J., 1975. Aging as Exchange: A Preface to Theory. *Journal of Gerontology* 30(5): 584-594.

Dowd, J.,1980. Exchange Rates and Older people. *Journal of Gerontology* 35: 596 602.

Duci, V., Ajdini, J., & Dhembo, E. (2014). Cancer caregivers' discrimination and its impact to quality of life. *European Scientific Journal*, 10(23), 1-10.

Dunn, J. D. (2014). The Experience of Unpaid Caregivers of Persons Diagnosed with Early Stage Dementia of the Alzheimer's Type: Embracing Unpredictability: *International Journal of Science Commerce and Humanities Volume No 2 No 6*, 138-144

Durant, T. J., & Christian, O. G. (2006).*Caregiving to Aging Parents*. Washington D.C.: Forum on Public Policy.

Emerson, R., 1972. Exchange Theory. In J. Berger et al., (eds.), *Sociological Theory in Progress*, vol. 2 (pp. 38-87). Boston: Houghton and Mifflin.

Felmlee, D., & Muraco, A. (2009). Gender and Friendship Norms among Older Adults: *Research on Aging*. doi:10.1177/0164027508330719

Fredriksen-Goldsen, K. I., Kim, H.-J., Muraco, A., & Mincer, S. (2009). Chronically ill midlife and older lesbians, gay men, and bisexuals and their informal caregivers: The impact of the social context. *Sexuality Research and Social Policy Journal of NSRC*, 6(4), 52–64.

Giesbrecht, M., Crooks, V. A., Williams, A., & Hankivsky, O. (2012). Critically examining diversity in end-of-life family caregiving: implications for equitable caregiver support and Canada's Compassionate Care Benefit. *International Journal of Equity in Health*, 11, 65–82.

Giorgi, A. (2005). The phenomenological movement and research in the human sciences. *Nursing Science Quarterly*, 18(1), 75-82.

Goh, Z.-Y., Lai, M.-M., Lau, S.-H., & Ahmad, N. (2013). The Formal and Informal Long-Term Caregiving for the Elderly: The Malaysian Experience. *Asian Social Science*, 9(4), p174.

GOK, (2009). Kenya Population and Housing Census, Nairobi, Government Printers

GOK, (2012). Wareng District Development Plan, 2008-2012, Nairobi, Government Printers.

Haley, W. E., Gitlin, L. N., Wisniewski, S. R., Mahoney, D. F., Coon, D. W., Winter, L., Corcoran, M., Schinfeld, S., &Ory, M. (2004). Well-being, appraisal, and coping in African-American and Caucasian dementia caregivers: findings from the research study. *Aging & Mental Health*, 8 (4), 316-329. doi: 10.1080/13607860410001728998

Help Age International.(2002). State of the world's older people, 2002. London, U.K., HelpAge International

Homans, G. (1961). *Social Behavior: Its Elementary Forms*. New York: Harcourt Brace Jovanovich.

Hooyman, N., &Kiyak, A. (2006).*Gerontology: A Multi-disciplinary Perspective*. 8th ed. Boston: Allyn and Bacon.

Jacobs, B. J. (2014). When Genders Collide While Caregiving. Retrieved August 11, 2018, from http://www.aarp.org/homefamily/caregiving/info-01-2014/caregiving-family-gender-siblingsjacobs.html

Kyei-Arthur, F. (2013). Physical and Mental Health Outcomes of Caregiving in Accra. *Regional Institute for Population Studies* (RIPS). University of Ghana, Legon, Accra, Ghana.

Lecovich, E. (2008). Caregiving burden, community services, and quality of life of primary caregivers of frail elderly persons. *Journal of Applied Gerontology*, 27(3), 309–330.

Lincoln, Y.S. & Guba, E.G. (1985).*Naturalistic Inquiry*. Newbury Park, CA: Sage Publications.

Magana, S. M., Ramirez Garcia, J. I., Hernández, M. G., & Cortez, R. (2007). Psychological distress among Latino family caregivers of adults with schizophrenia: The roles of burden and stigma. *Psychiatric Services*, 58(3), 378–384.

Marincowitz, G., Jackson, C., & Fehrsen, S. (2004). What helps volunteers to continue with their work? *South African Family Practice*, 46(1), 25–28

Mark, S., Philip, L., & Adrian, T., (2016) *Research Methods for Business Students* (7th edn). Pearson Education limited, Edinburg Gate.

Montgomery, R. J. V., Rowe, J. M., & Kosloski, K. (2007). Family caregiving. In J. A. Blackburn & C. N. Dulmus (Eds.), *Handbook of gerontology: evidence-based approaches to theory, practice, and policy* (pp. 426–454). New York, NY: John Wiley & Sons.

Nankwanga, A., Neema, S., & Phillips, J. (2013). The Impact of HIV/AIDS on Older Persons in Uganda. *In Aging and Health in Africa* (pp. 139–155). New York: Springer publications.

National Center on Elder Abuse. (2002). Preventing elder abuse by family caregivers. San Francisco, CA: Institute of Aging.

Neuman, W. L. (2014).Social *Research Methods: Quantitative and Qualitative Approaches*, (7th edn). London: Pearson.

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Strivingto meet the trustworthiness criteria. *International Journal of Qualitative Methods*, *16*(1), 1609406917733847.

Organisation for Economic Co-operation and Development [OECD]. (2011). *Policies to Support Family Carers. In OECD (Ed.), Help Wanted? Providing and Paying for Long-Term Car* (pp. 121–158). Paris, France: Organization for Economic Co-operation and Development.

Proulx, C. M., & Snyder, L. A. (2009). Families and health: An empirical source guide for researchers and practitioners. *Family Relations*, 58 (4),489-504. doi:10.1111/j.1741- 3729.2009.00568.x

Quadagno, J. (2005). Aging and the life course: An introduction to social gerontology (3rd ed.). New York, NY: McGraw-Hill.

Schulz, R., & Tompkin, C. A. (2010). Informal Caregivers in the United States: Prevalence, Caregiver Characteristics, and Ability to Provide Care. In *The Role of Human Factors in Home Health Care: Workshop Summary* (p. 322). Washington, DC: The National Academies Press. Retrieved from /catalog/12927/the-role-of-human-factors-in-home-health-care-workshop

Silverman, D. (2000). *Doing Qualitative Research: A Practical Handbook*. London:

Skovdal, M., Ogutu, V. O., Aoro, C., & Campbell, C. (2009). Young careers as social actors:

Sudhinaraset, M., Ingram, M., Lofthouse, H. K., & Montagu, D. (2013). What is the role of informal healthcare providers in developing countries? *A systematic review*. PloS One, 8(2), 54978.

Suthers, K. (2006). Women Still Shouldering the Burden: Caregiving in the 21st Century. *The Women's Health Activist*, 31(4), 4–5.

United Nations Department of Economic and social Affairs (2003).*The ageing of the worldspopulation.*hhtp://www.un.org/esa/sodev/ageigin/agewpop.html.

Van Manen, (1990). *Researching Lived Experience: Human Science for an Action Sensitive Pedagogy*. London: Ontario: Althouse Press.

Veal, A.J. (2011) Research Methods for Leisure and Tourism. $th ed. England: Pearson Education Limited.

White, T. M., Townsend, A. L., & Stephens, M. A. (2000). Comparisons of African American and White women in parent care role. *The Gerontologist*, 40(6), 718–728

Yin, R. K. (2015). *Qualitative Research from Start to Finish*. Guilford Publications.

Zafiroski, M. (2005). Social Exchange Theory under scrutiny: A positive critique of its Economic-Behaviorist Formulations. *Journal of Sociology,* 1-40.

APPENDICES

APPENDIX 1: SEMI-STRUCTURED INTERVIEW SCHEDULE FOR INFORMAL CAREGIVERS

Caregivers	**Care receivers**
1. Age…… years	Age……..years
2. Gender……	Gender…….....
3. Marital status…….	Marital status…….
4. Education……..	
5. Employment status…….	

6. Relationship with the care receiver……
7. For how long have you been an informal caregiver?(years….. and…..months)
8. How many days per week are you providing informal care? .....
9. How many hours per day are you providing informal care? .....
10. What are the main activities as informal caregivers do you do in support for your care receiveron a typical day? .....
11. How do you financially support your care giving work?
    ……
    ….....
    .....
    .....
    .....
12. What are some of the good things about being a caregiver?
    ……
    ….....
    .....
    .....
    .....
13. How do you feel about what you have done and are currently doing as a caregiver?
    ……
    ….....
    .....
    .....
    .....
14. Sometimes care giving to the elderly can be overwhelming, how do you manage this?
    ……
    ….....
    .....
    ……..

15. How emotionally stressful would you say that caring for an aged person is?

……
…….....
.....
.....
……..

16. How did you become a caregiver?

……
…….....
.....
.....
.....

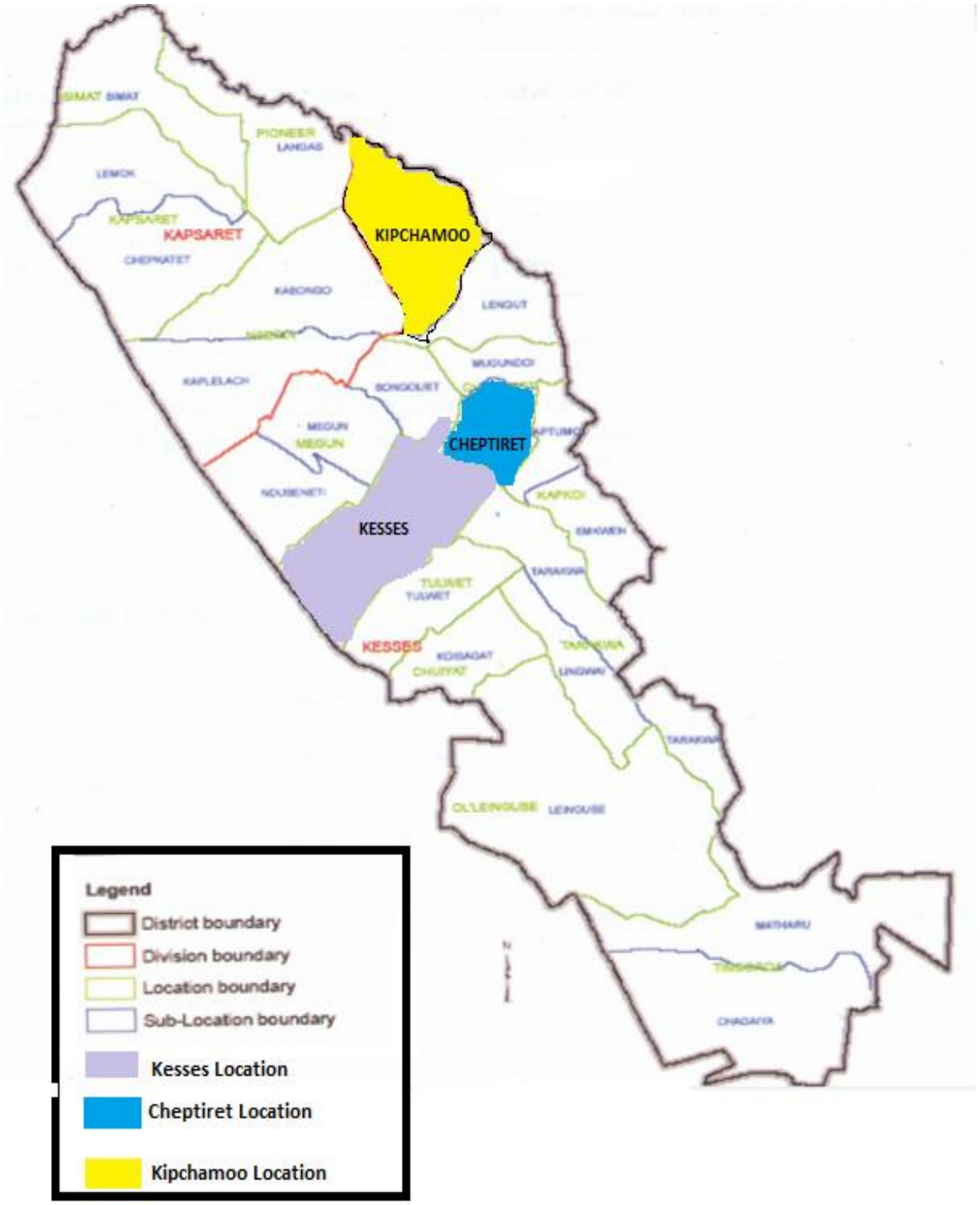
17. Does care giving affect your daily life? Your relationship with others?

……
…….....
.....
.....
.....

18. Does care giving affect your involvement in community? If yes how and why?

……
…….....
.....
.....
.....

APPENDIX II: MAP OF KESSES CONSTITUENCYSHOWING LOCATIONS

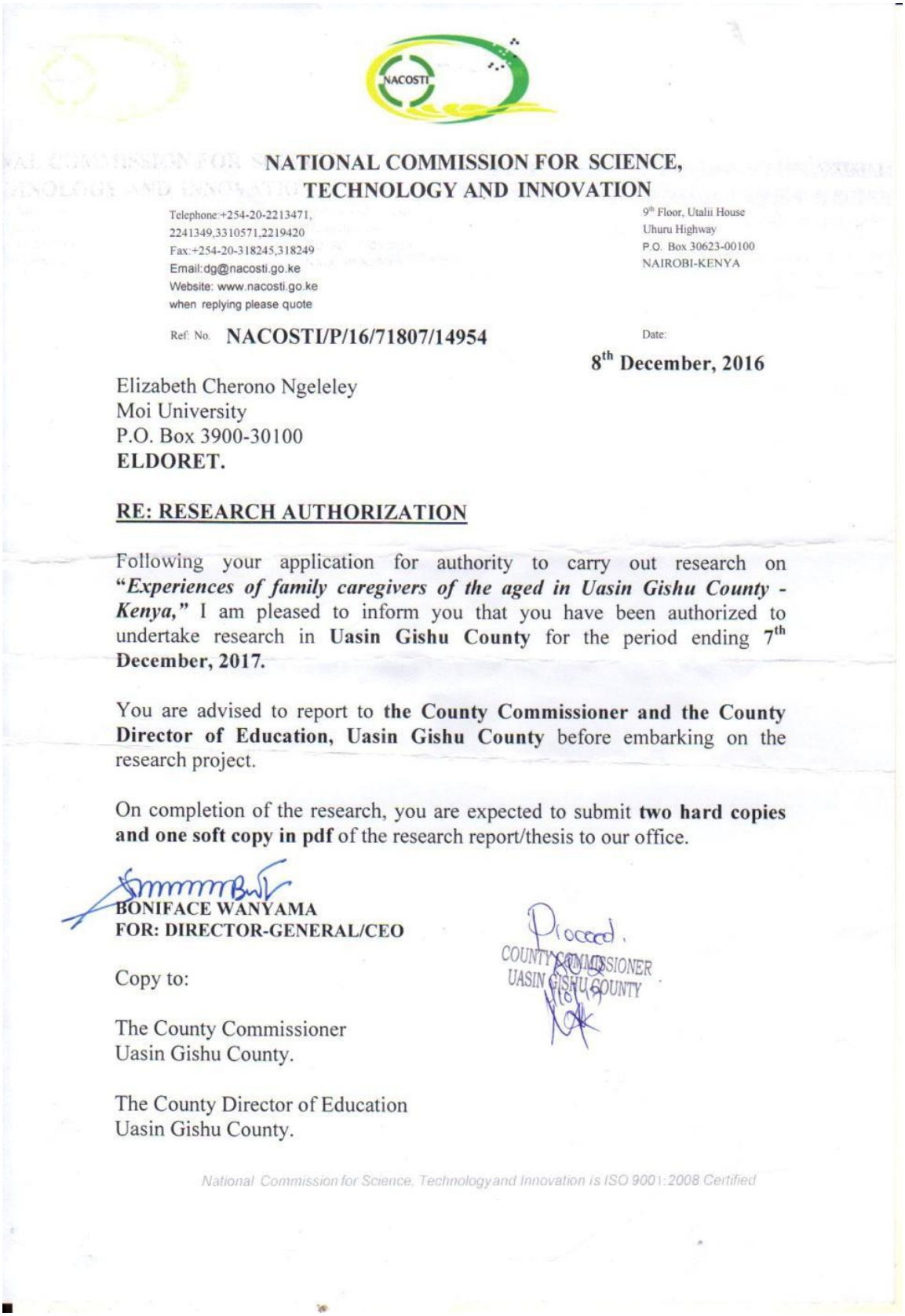


APPENDIX III: HOUSEHOLDS ON OLDER PERSONS CASH TRANSFER PROGRAMME IN KESSES CONSTITUENCY

LOCATIONS	NUMBER OF HOUSEHOLDS
CHEPTIRET	67
KIPCHAMOO	80
TARAKWA	18
KESSES	75
OLENGUSE	48
TIMBOROA	48
CHUIYAT	62
TULWET	63
KAPKOI	56

Source: WARENG DISTRICT SOCIAL DEVELOPMENT OFFICE, 2016

APPENDIX IV: NACOSTI RESEARCH AUTHORIZATION LETTER



NACOSTI

NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

Telephone:+254-20-2213471, 2241349,3310571,2219420
Fax:+254-20-318245,318249
Email:dg@nacosti.go.ke
Website: www.nacosti.go.ke
when replying please quote

9th Floor, Utalii House
Uhuru Highway
P.O. Box 30623-00100
NAIROBI-KENYA

Ref: No. **NACOSTI/P/16/71807/14954**

Date: **8th December, 2016**

Elizabeth Cherono Ngeleley
Moi University
P.O. Box 3900-30100
ELDORET.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on ***"Experiences of family caregivers of the aged in Uasin Gishu County - Kenya,"*** I am pleased to inform you that you have been authorized to undertake research in **Uasin Gishu County** for the period ending **7th December, 2017.**

You are advised to report to **the County Commissioner and the County Director of Education, Uasin Gishu County** before embarking on the research project.

On completion of the research, you are expected to submit **two hard copies and one soft copy in pdf** of the research report/thesis to our office.

BONIFACE WANYAMA
FOR: DIRECTOR-GENERAL/CEO

Proceed.
COUNTY COMMISSIONER
UASIN GISHU COUNTY

Copy to:

The County Commissioner
Uasin Gishu County.

The County Director of Education
Uasin Gishu County.

National Commission for Science, Technology and Innovation is ISO 9001:2008 Certified

APPENDIX V: NACOSTI RESEARCH PERMIT

CONDITIONS

1. You must report to the County Commissioner and the County Education Officer of the area before embarking on your research. Failure to do that may lead to the cancellation of your permit.
2. Government Officer will not be interviewed without prior appointment.
3. No questionnaire will be used unless it has been approved.
4. Excavation, filming and collection of biological specimens are subject to further permission from the relevant Government Ministries.
5. You are required to submit at least two(2) hard copies and one (1) soft copy of your final report.
6. The Government of Kenya reserves the right to modify the conditions of this permit including its cancellation without notice

REPUBLIC OF KENYA

NACOSTI

National Commission for Science, Technology and Innovation

RESEACH CLEARANCE PERMIT

Serial No.A 12281

CONDITIONS: see back page

THIS IS TO CERTIFY THAT:
MS. ELIZABETH CHERONO NGELELEY
of MOI UNIVERSITY , 0-30100 Eldoret
,has been permitted to conduct
research in *Uasin-Gishu County*

on the topic: *EXPERIENCES OF FAMILY CAREGIVERS OF THE AGED IN UASIN GISHU COUNTY - KENYA*

for the period ending:
7th December,2017

Permit No : NACOSTI/P/16/71807/14954
Date Of Issue : 8th December,2016
Fee Recieved :Ksh 1000

.....
Applicant's Signature

.....
Director General
National Commission for Science, Technology & Innovation

APPENDIX VI: RESEARCH AUTHORIZATION UASIN GISHU COUNTY DIRECTOR OF EDUCATION

REPUBLIC OF KENYA

MINISTRY OF EDUCATION, SCIENCE AND TECHNOLOGY
STATE DEPARTMENT OF BASIC EDUCATION

Telegrams: "**EDUCATION**", Eldoret
Telephone: **053-2063342** or **2031421/2**
Mobile : **0719 12 72 12/0732 260 280**
Email: cdeuasingishucounty@yahoo.com
: cdeuasingishucounty@gmail.com
When replying please quote:

Office of The County Director of Education,
Uasin Gishu County,
P.O. Box 9843-30100,
ELDORET.

Ref: No. MOEST/UGC/TRN/9/295

10Th January,2017

Elizabeth Cherono Ngeleley
Moi University
P.O Box 3900-30100
Eldoret

RE: RESEARCH AUTHORIZATION

This office has received your request for authority to carry out research on **"experience of family caregivers of the aged in Uasin Gishu County "**.

We wish to inform you that your request has been granted for a period ending **7th December, 2017**. The authorities concerned are therefore requested to give you maximum support.

We take this opportunity to wish you well during this research.

SAMUEL K. KIMAIYO
For: **COUNTY DIRECTOR OF EDUCATION**
UASIN GISHU .