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Kenya's Life Lessons through the Lived Experience of Rural Caregivers

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Abstract: This qualitative research study used a phenomenological lens to examine the perspectives of familial caregivers in the Laikipia Region of Kenya. Through the narrative of the caregivers' lived experience, key factors identified included social supports, rewards of caregiving, and lessons to others. Overarching basic themes centered on food insecurity, disease, rejection, lack of support, education challenges, inadequate land ownership, the absence of male support and neglect issues. These unique perspectives can contribute towards our understanding of policy and programming needs for orphaned children and familial caregivers in rural Kenya and within the rural areas of the East African context.

Keywords: Kenya; caregivers; orphans; lived experience; family resiliency

1. Kenya's Life Lessons through the Lived Experience of Rural Caregivers

Research throughout the continent of Africa has been increasing in the last decade. In recent years, a shift has occurred from studies examining needs in the urban areas to the needs of rural communities. This shift is in part due to the unique challenges facing rural areas such as migration of males to the urban areas in search of gainful employment, transportation access issues, unequal medical and mental health care, and food insecurity (Ginsberg 2011; Harrison et al. 2014; Schatz and Seeley 2015). While the previous list is not exhaustive, it does provide the reader a basic overview of the added pressure in rural areas throughout the world. In Kenya, a country in Sub-Saharan Africa, additional struggles are noted to include tribal strife, lack of access to clean water, reduced access to education, and the increasing number of deaths due to the HIV / AIDS pandemic (Govender et al. 2012; Oramasionwu et al. 2011; World Health Organization (WHO) Regional Office for Africa (2017)). Notably, HIV related deaths of parents have deprived many households of able-bodied members while leaving behind young orphans, cared for by older siblings, or cared for by other available family (Harrison et al. 2014; Heymann and Kidman 2009; Lee et al. 2014; Schatz and Seeley 2015). In recent years, the World Health Organization (WHO) Regional Office for Africa (2017) noted drought, food insecurity, cholera, measles, leishmaniosis, and dengue fever as causing increasing numbers of deaths throughout the country of Kenya, thus adding pressure with the continued AIDS/HIV Pandemic.

2. Familial Caregivers

Globally, a growing number of children are labeled as Orphans and/or Vulnerable Children (OVC) (Lee et al. 2014). Vulnerable children are those that live-in households with a major physical illness and high levels of poverty that effect physical and emotional health and development of that child(ren).

In Kenya, it is estimated that 2.6 OVC are in country with 1.8 of these children being orphans and another 750,000 considered vulnerable children. Approximately, 15% of Kenyan OVC are double orphans having lost both parents, 33% are 10–14 years old, 22% experience severe or moderate hunger and all vulnerable children tend to be in the lowest 2% of wealth within the county (Lee et al. 2014).

Increasing numbers of female headed households tend to care for orphan children in East and South Africa (Harrison et al. 2014; Mugisha et al. 2013; Schatz and Seeley 2015). Harrison et al. (2014) found that the female's social role in both South Africa and East Africa focuses on being mothers, caregivers and wives. As the middle generation of females are seeing higher death rates due to disease, Schatz and Seeley (2015) noted that this increased the pressure and thus the burden for female grandparents and great grandparents to step in to care for familial orphans. The added pressure of male migration for employment and chronic illness are also key determinants of grandparent caregiving (Schatz and Seeley 2015; Zimmer and Dayton 2003). Specifically, in rural Kenya, research points to the caretaking of orphans being increasingly provided by grandmothers (Harrison et al. 2014; Mugisha et al. 2013; Oburu 2004; Oppong 2006; Oramasionwu et al. 2011; Schatz and Seeley 2015), mostly because of the high mortality rates due to HIV/AIDs, drought, food insecurity, cholera, measles, leishmaniosis and dengue fever (Lee et al. 2014; World Health Organization (WHO) Regional Office for Africa (2017)). Kenya still has approximately 1,600,000 dying from AIDS related illnesses in 2016 alone (UNICEF 2017).

The burden associated with caregiving may differ depending on the cultural context. However, overall, there is concern that older adults do not have the material and health resources to take care of the orphaned children (Govender et al. 2012; Ice et al. 2012). In Kenya, the caregiving role has changed household composition numbers and these large numbers in each household tend to overstretch the little income of the elderly caretakers (Muga and Onyango-Ouma 2009; Mugisha et al. 2013). Much of the research in Kenya, to date, focuses almost exclusively on health outcomes of caretakers such as in the areas of physical and mental health, stress, blood pressure, glucose and body mass index (Chepnengo-Langat 2014; Ice et al. 2008, 2010). In addition, the majority of research on this issue in Kenya centers on caregivers in the urban areas such as Nairobi slums (e.g., Chepnengo-Langat 2014; Chepnengo-Langat et al. 2011) and rural research exclusively for the Luo tribe found in Western Kenya (Ice et al. 2010; Oburu 2004).

Another area of research suggests the need for a family and community safety net to help orphaned vulnerable children throughout countries in Africa (Richter et al. 2009). A safety net would include emotional, social and programming support to wrap services around a family that would assist the unit to stay together while helping to meet the basic needs and emotional needs of the family. Such a safety net is noted to promote healthy development and security to increase the likelihood of successful long-term outcomes (Betancourt et al. 2010) by enhancing caregiver resiliency to ameliorate the negative effects of caregiving on orphans and caregivers. Aldwin and Igarashi (2015) define caregiver resiliency as the ability of caregivers to meet ongoing demands by utilizing resources within their social-cultural environment. However, few studies have examined caregiver resiliency, especially among grandparents living in the rural areas of Kenya. To this end, as noted previously, the focus on many studies both in urban and rural areas of Kenya has been on the health outcomes of caregivers (e.g., Chepnengo-Langat 2014; Ice et al. 2008, 2012). Others view caregivers as 'ravaged' or 'devastated' (Richter et al. 2009). The lack of research in rural areas of Kenya is further noted in the focus of resiliency research almost exclusively within Nairobi, Kenya (Beyer et al. 2016; Fotso et al. 2009). Perhaps more focus on the unique urban resiliency factors that act as a resource and safety net for orphans and caregivers might contribute to the way we think about familial caregivers in Kenya. This would help to tease out specific risk and protective factors that contribute to resiliency allowing policy to be written to support positive change.

This gap in the literature leaves questions for Non-Governmental Organizations (NGOs) attempting to work with specialized rural populations in Kenya. Further research is needed to examine the lived experiences of caregivers' resilience. Furthermore, the idea of a safety net should

be further addressed for best outcomes for both caregivers and orphans to better understand what specific social supports and services could help to support vulnerable children and families.

To assist with answering questions concerning the experiences of familial caregivers, this research study examined one of the largest tribes in Kenya, the Kikuyu tribe. Using a qualitative research design with a phenomenological lens, this study sought to understand the lived experience of Kikuyu caregivers raising familial orphans. In examining a larger ethnic tribe, the information received from the research allows for making an impact on a larger group of people within the many rural areas of Kenya. Guided by a phenomenological perspective and gaps in the previous literature on familial caregivers in Kenya, this study aimed to answer the following research questions: (1) What is the individual lived experiences of familial caregivers in the Laikipia region of rural Kenya, (2) How do risk and protective factors contribute to family outcomes and (3) What are the lessons learned from the wisdom of the familial caregivers. Overall, this study was expected to help gain understanding of the lived experience of rural Kenyan caregivers by asking “What is your lived experience of being a caregiver of an orphaned family member?”

3. Methods and Procedure

3.1. Sampling

This study used a convenience sample of grandparents recruited in collaboration with a local Non-Governmental Organization (NGO) in the Laikipia Plateau of Kenya. The Laikipia Community Empowerment Center (LCEC) is a grassroots NGO in Kenya working to reduce poverty in the Laikipia region through empowerment and strengthening community social entrepreneurship. The focus of projects are rural centers; Sipili and Ol Moran, Kenya with the closest city, Nyahururu (36,450 K), being several hours by bus on dirt roads (Mpya 2012). LCEC already had a connection with the group called the “Grannies Project”. This project centered on a group of Kenyan caregivers that banded together with various micro-enterprise programs. Examples of past and continuing projects include selling chicken eggs, making tribal crafts to sell in the regional and national markets and most recently a poultry project. Various members of the group are involved with different micro-enterprise projects. However, the money earned from all of the projects are then shared and divided equally in order to help all families to care for the basic needs of each and every family. The whole population of caregivers currently in the “Grannie Project” were invited to be part of the research through an advertisement in Swahili and English provided to the grandmothers by an LCEC contact. Those willing to participate were interviewed during a scheduled trip of the researcher to Kenya.

Demographic information was gathered to understand the specifics of the sample. Ages ranged from 34 to 90 years old. The mean age was 65.6. All of the caregivers had either raised his/her own children or were currently raising his/her own children. The mean number of own children was 7.5. The mean number of orphaned children being cared for was 2.8. All of the families, except one, were of the Kikuyu tribe, the largest tribe in Kenya. One female was from the Kalenjin tribe. Of the 14 caregivers, 2 were males and 12 were female caregivers. Relations to the orphans included: 10 grandmothers, 1 couple that consisted of a great grandmother and great grandfather and another couple that consisted of an aunt and an uncle. The causes of parental death included: 5 from AIDS or HIV related complications, 1 from tuberculosis, 4 from cancer, one from diabetes, 1 from malaria, 1 from pesticides infecting the lungs, and 1 from an unknown reason.

3.2. Informed Consent

Upon approval by the research Institutional Review Board at Western Kentucky University, the informed consent for the study was administered in both English and Swahili. While many of the caregivers were considered English proficient, Swahili was the most commonly spoken language and Kikuyu was the native language of birth. As such, providing Swahili helped to ensure that all participants had a deeper understanding of informed consent. In addition, a local interpreter

was present to assist with the research process. The interview started with the informed consent. The informed consent contained the purpose of the research, procedures for the research (including audio taping), risks and benefits of the research, voluntary nature of participation, participant's right to stop at any time and the procedures used for confidentiality. The informed consent was obtained as a signature by those that felt comfortable and by others his/her "sign" in some cases. The "sign" was an "X" with a physical stamp of the thumbprint of the person. An inkpad was provided and used for this purpose for those participants that preferred this local means of a signature.

3.3. Method

This study used a qualitative research method with a phenomenological theoretical lens. The central research focused on the lived experience of familial caregivers of vulnerable orphaned children in rural Kenya. To allow this information to emerge from the participant's view, unstructured in-depth interviews were conducted. The following research questions were posed with the use of a translator to start the unstructured interview: (1) What experiences have led to you raising your familial orphan; (2) How do you experience raising your familial orphan(s); and (3) What consequences have come from your raising these orphans? Interviews were considered complete when each participant exhausted the topic. Interviews were taped on a digital USB recorder. Interviews were conducted in English, Swahili, and the local dialect called Kikuyu or a combination of these languages. The participant was given the choice of language for the interview. A local research assistant provided interpretation services as needed. Interviews were completed in each caregiver's home while children were at school to increase privacy and reduce distractions. The researcher took field notes during the interviews. These notes included information such as what was heard, seen or thought during the audiotaping. Each field note and digital interview was labeled with a letter and a date (i.e., Participant A: 14 June 2016, Participant B: 15 June 2016). A password was used for protection of data on this specific laptop. Nightly interviews were listened to and main points recorded by hand as a backup to the data due to the possibilities of equipment problems (Easton et al. 2000). The laptop, written records and CDs remained with the researcher at all times to ensure security of data. After an interview was complete, the participants were invited to write any other thoughts or comments that they would like to provide to the investigator in an essay format. A specific date was given to provide these notes to the researcher. This invitation was expected to capture: information they were uncomfortable sharing verbally or other thoughts that were noted after the interview. The participants were invited to write in the language of choice for this essay (Swahili or English). The field research assistant translated as needed. In order to increase rigor in this study, triangulation of data sources occurred with the variety of data collection methods (unstructured interviews, field notes and essays for some participants).

3.4. Data Analysis

Data was analyzed using the following steps: (1) bracketing and phenomenological reduction: Listening to audio recordings repeatedly to get the "gestalt" of the participant's meaning; (2) delineating units of meaning: important statements (non-redundant) are extracted and then counted to determine most important themes for that participant; (3) clustering of units of meaning to form themes; (4) summarizing each interview and return to data of each single participant to insure that the main thoughts have been captured; and (5) extracting general and unique themes from all the interviews and making a composite (Groenewald 2004). The data was analyzed while still in the field to insure themes were determined as close to the data gathering as possible.

4. Results

In the analysis, more than one overarching theme was noted. Findings seemed to break down into large sections or subsets that included: social supports, rewards of caregiving and lessons to others

(see Table 1). While this was an expected outcome, it is interesting to note that, within each of these areas, central themes emerged in each subset.

Table 1. Findings.

Themes	Supports	Rewards	Lessons
Food Insecurity	Church/Spirituality	Reminder of Lost Loved Ones	Positive Attitude toward Self and Orphans
Disease	NGOs	Elimination of Loneliness	Future Security
Rejection	Orphan Skills	Assistance with Daily Living	Love of Orphans = Blessings
Lack of Support	Neighbors	Female = Fulfillment Male = Lineage	Treat Orphans as Own
Education Challenges	Intrinsic Feelings	Biblical Mandate	Encourage Positive Self Concept of Orphans
Inadequate Land Ownership		Avoiding Shame	
Absence of Male Support			
Neglect			

Overarching basic themes of the analysis centered on risk factors such as food insecurity, disease, rejection, lack of support, barriers to education, inadequate land ownership, and absence of male support and neglect issues.

4.1. Food Insecurity

All of the families stressed worries over access to food in part due to the actual increased number of members living in the household. More money was needed in order to adequately provide needed nutrition for family members. Most of the participants pointed to food insecurity as the main factor for becoming involved in the “Grannie Project”. This involvement allowed for a creative way to use his/her gifts to make much needed money to provide food for the family. Before these projects, most of the families reported attempting to provide for the family via growing of small personal gardens, raising chickens for meat and eggs and use of goats and cows for milk. At times, trade was an option that helped in obtaining goods that a particular family may not have at that time. Thus, for example, one family would trade goat milk for sugar with another family. While this was still very much a part of the participants providing for the family, access to cash from the micro-enterprise projects was stressed as an important factor to further support the needs of the growing family. This money seemed important, especially for the purchase of food supplies such as sugar, flour, and beans. This money was also mentioned to be helpful for materials to make clothing, school supplies and school fees (secondary education costs).

One caregiver noted, “My greatest challenge is a shortage of food and no suitable work. I have a positive relationship with friends and neighbors and so I go to them in my times of need” while another stated ““my main problem is no food and no land ownership”. To overcome food insecurity, another caregiver “gets food by credit when needed at the store as the owner trusts me to repay him”.

4.2. Disease

Disease was of great concern for all of the families. All of the families had lost a child or loved one and thus was taking care of a familial orphan. Most of the grandparents had lost more than one child to disease or a preventable accident. Many had lost spouses as well. Access to appropriate medications and consistent healthcare was difficult in this rural area and, as such, people died of diseases such as diabetes, tuberculosis, typhoid, and malaria. One family, consisting of a caregiver couple, great grandfather (82) and great grandmother (76), were caring for three grandchildren ages 9–15 years. Two of the three had contracted HIV from the mother who had died of AIDS related complications. The great grandparents reported difficulty getting the children to the next largest city (over 1 ½ h by bus) to receive appropriate HIV medications. Both the cost and the distance on the bus were hard for

these aging caregivers. If the child was seriously ill, then the family had to take the child even further by bus for medical care. This story was not unique as noted in the theme of disease from all of the participant families.

4.3. Rejection and Stigma

Rejection was another theme noted. Many of the female caregivers talked of being abandoned by husbands due to the stress of caring for so many children. The females saw this as a “godly mandate” to take care of the children and so continued the caretaking role even if the husband abandoned the family. One female shared a story of coming home and finding the home cleared out and her husband gone. She slowly rebuilt and made a home for her and all of the orphans. Her words were, “When I took in the orphans my husband said to them “go raise your mother from the dead to help you”. I refused to leave the orphans and my husband left with everything. We had to sleep on sacks.” Another grandmother stated, “After years of struggle, my husband tried to come back home after abandoning me. He had no genuine love for the orphans and I decided I would rather be a formal separation with him than for him to return to mistreat the children.”

In addition to rejection by husbands, the caregivers that had taken on orphans who were HIV infected shared feelings of isolation from other community members out of the stigma, fear, and lack of educations surrounding the HIV/AIDS Virus. One area that the HIV impacted families felt less judged was with the “church family”. This acceptance at church led one caregiver to state, “I feel God has placed a burden in my heart to build up others in similar circumstances. Prayers and hard work equal the key factors to success.”

4.4. Barriers to Educational Challenges

Educational challenges were noted in part due to the distance from local homes to the primary and/or secondary school for the region. Reported school distances ranged from 3 miles to 10 miles. Children had to walk or ride bikes to attend school. Bikes were only available to children through NGO projects in the secondary school system for the top female and male of the class. Such projects were not noted in the primary schools in the area. Children without access to a bicycle had to leave early enough to walk to school and be on time. Less female than male children attended secondary school. Family members, the translator and a local secondary school principal shared issues of female drop out related to pregnancy, access issues, and complications of the menstrual cycle. The principal stressed that many female children do not attend school during the menstrual cycle due to not having sanitary napkins. He had started a pad project in which female students could gain access to sanitary napkins at school. Less access to school means lower grades and/or possibly lower outcomes on the test to move to secondary school. Only one female child, from the Laikipia region, has been successful in going on to the college level of education. That particular female is now in a Master’s program in Nairobi as well.

4.5. Land Ownership

Inadequate land ownership was a problem noted by the female single head of household families. Local laws did not allow for females to own land unless a husband had abandoned them and/or the husband had died seven years ago. Several of the females stressed worry that the husband “would show back up” as they were approaching that seven-year mark. At seven years, it was explained to the researcher that the female would then have to petition the chief to obtain ownership over the land. The chief “knowing of my story will give me my land after 7 years”.

4.6. Lack of Support

Absence of support from male partners or husbands and overall a lack of support and neglect were noted by a majority of the families. As mentioned earlier, part of this was due to abandonment of husbands. In addition, mostly, the “Grannies Project” was also composed of women supporting

women. As such, the theme of females as supportive and helpful was noted through much of the discussion with various participant families. This also goes hand in hand with the theme of neglect. These caregivers were caring for the children as well as being responsible for all of the daily duties of the family (i.e., cooking, cleaning, obtaining water, washing clothes, growing food, preparing firewood) with little to no help. The abandonment and expectation to take care of everything left for female-headed households, along with the children, at a higher risk for vulnerability. The orphans then took on a helpful role for some due to the number of responsibilities in daily life. Examples include one grandmother explaining that “the older children helped with the younger children when I was sick” and another “they help with farming the land for food”.

5. Positive Outcomes of Raising Orphaned Children

5.1. Supports

The participants naturally shared about the supports that were present in his/her lives. This was a discussion that the participants typically started to mention after all of the hardships. Supports included the church/spirituality, regional NGOs, assistance with daily living from the older orphans, neighbors and intrinsic feelings (see Table 1).

Church and spirituality was a part of each of the participant families. All attended church service as well as worshiped together more informally. Phrases such as “my godly duty” or “blessings from god” were noted throughout the translations. One grandmother stated, “I believe nothing happens without a reason. By God positioning me as a guardian, I must always be ready for something greater.” All of the families felt that they drew support not only from the church community but a personal relationship with God. One grandmother’s words seem to sum up this thought: “I learned to depend only on God. I am hopeful of a bright future.” After finishing the interviews, the “Grannies Project” invited the researchers to a celebration in which food, dancing and singing to God was part of the time together.

All of the families had contact with local NGOs. One example was that the “Grannies Project” was a part of the Laikipia Community Empowerment Center (LCEC). In addition, the local catholic mission at Ol Moran, Kenya provided basic medical care and food supplies to families. Another Catholic mission provided medical aid for those with HIV in the nearby town of Nyahururu, Kenya. Whether by the micro-enterprise, medical assistance or food support, all of the families reported support from these various organizations.

The orphans’ ability to help with daily living skills was noted as a support. Older orphans would help with cleaning, cooking, gardening, milking, reading school notes and caring for younger children in the home.

Many of the families noted that the “Grannies Project” had brought them even closer to the neighbors. The spirit of communal support of others and looking at the whole was evident in the stories of all of the families. The idea of “we” was more important than “I” in getting tasks done and helping others. In addition to this being part of the collectivistic culture, it was also a part of the religious focus of the families as evident by the information shared.

Another support listed was the intrinsic feeling of love and affection that increased in the care of familial orphans. It was noted, “Doing for others makes you forget about life’s stress”. Caring for these family members seemed to bring about increase self-efficacy and feelings such as love, caring, and intimacy.

5.2. Rewards

The families shared about the rewards or fulfillment they get from familial caregiving (see Table 1). This section, along with supports, seemed to be a natural part of the story after telling the hardships in the initial themes noted. Rewards included reminder of lost loved ones, elimination of loneliness,

assistance with daily living, fulfillment for female caregivers and continued lineage for male caregivers, biblical mandate, and avoiding shame.

The families stressed the sense of loss with the death of family members. For most, they had multiple losses of his/her own children, sisters/brothers, and such. Providing for the familial orphan was reported to help the “spirit” of the lost loved one live on as a reminder of that person. It was noted that, when talking about this, participants’ faces seemed to glow when remembering the lost loved one with fondness. They reported feeling comforted by this strong bond with the familial orphan. One caregiver noted, “My granddaughter is named after my daughter. She reminds me of my daughter much of the time. At times, I am sad but most of the time it helps me to still feel my daughter’s love.” In addition, due to the loss of so many loved ones, participants pointed to a decrease in loneliness by having the children in the home. Symptoms listed such as sleep issues, sadness, loneliness and emptiness seemed to have disappeared with the number of children now needing care.

Assistance with daily living chores was again listed in this area as a reward. With a mean age of 65.6, assistance with daily chores required to run a household was quite helpful. Many of the caregivers had his/her own medical issues but focused more on the needs of the children rather than self. Having assistance truly helped these families to survive.

Male and female caregivers looked at roles differently. The female saw caregiving as a natural extension of being a woman. It is “what women do” and fulfills that motherly role expected within the society. On the other hand, the two men in the study focused on the need to continue the lineage of the family name. Both males in the study stressed a feeling of being “ashamed” of men that had abandoned many of the women in the “Grannies Project”. They seemed to be calling those men and their manliness into question.

All of the families mentioned the biblical mandate of caring for those that are vulnerable as a reason for taking in the familial orphans. In turn, this decreased shame that would come to the family if someone did not take care of these needy children. One grandmother stated, “God put in me a heart to reach out to others and help to strengthen their faith. Every time I hear of a granny who is in need with orphans I reach out to encourage them with my example.”

5.3. Lessons to Others

All of the families, before finishing the interviews, wanted to share with the world some of the most important things they have learned about caregiving with orphans. The following were some of the things that participants shared: a positive attitude toward orphans helps to build a positive attitude in yourself, caring for children equates to future security, loving and caring for orphans means blessings from God, orphans must be treated the same as other children and positive caregiving means that orphans will develop a positive self- concept. These lessons seemed to fit with other themes throughout the interview.

6. Discussion

This research study helped to understand the lived experience of familial caregivers in the rural region of the Laikipia Plateau in Kenya. Themes, from this lived experience, noted some underlying principles of family resilience to include risk and protective factors for familial caregivers (Van Hook 2014; Walsh 2012). Family resilience “involves the potential for recovery, repair and growth in families facing serious life challenges” (Walsh 2012, p. 399). In family resilience, coping and change are undergirded by strengths and resources. The risk factors of these families noted in the unstructured interviews focused on food insecurity, disease, neglect, education barriers, and lack of social support. These risk factors are increasingly noted throughout the world especially in rural areas and underdeveloped or developing countries (Cluver and Gardner 2007; Richter et al. 2009; Ice et al. 2012). It is important to note that these risk factors were balanced out by the strengths, supports and rewards that the participants automatically shared as part of the interview process. These protective factors were shared without a specific question that attempted to get participants to look for the

positive internal and external supports and rewards. As such, it is evident that the families were able to adapt to the stressors faced as a solid way to then survive and perhaps find ways to thrive. Supports were from a variety of sources to include internal factors (such as caregiving knowledge, and nurturing demeanor) and external protective factors such as the church/spirituality, regional NGOs, assistance with daily living from the older orphans and neighbors. The positive nature of the families seemed to provide a “protective bubble” comprised of personality, spirituality, and intrinsic characteristics that were further made impervious by the supports of neighbors, family, church and NGOs. This model of internal and external support seems to have created a caregiver resiliency that is working to provide a future for these children.

6.1. Implications for NGOs

Findings from this study have implications for organizations and researchers working within rural communities to address the needs of vulnerable and underserved populations. Grassroots NGOs such as LCEC have an important role to play in addressing the needs of these communities. It is therefore critical for such NGOs to capture and nurture protective factors such as the ones identified in this study in strengthening families and finding the needed solutions at the grassroots level. Through their work in partnership with the local communities, these NGOs can significantly contribute to the wellbeing of families through promotion of health literacy, access to health resources, disease eradication initiatives and economic empowerment ([International Institute of Sustainable Development \(IISD\) \(2013\)](#)). Engaging the local communities through community based participatory approaches will also ensure that the voices of people at the local level (such as the participants in this study) are heard and provision of services is congruent with their needs ([Small et al. 2014](#)).

The findings and implications of this study should be interpreted with caution due to the exploratory nature of this qualitative study. This study also used a convenience sampling of only a small number of caregivers’ one ethnic group (Kikuyu) in this region. In this case, the findings cannot be generalized to other tribes in different rural areas of the country.

One of the key strengths of the study is a good sample size for a phenomenological qualitative research design and a range of caregivers (i.e., age, gender) which offered different perspectives on care giving. Another major strength of this study is that using the phenomenological lens allowed for an in-depth view of the lived stories of the participants and provided rich data that can guide the creation of programs to strengthen resources within families and communities. In addition, Tewksbury (2009) suggests that qualitative methods help to uncover the unique ways people function in dynamic social situations.

6.2. Questions to Address

This study raises questions for the researchers and non-governmental organizations working with grassroots communities: How can social supports be further supported for these particular families? How can such a study be replicated in a different rural region in the country? Taking into consideration the social and culture differences, how can we use lessons from Laikipia region of Kenya to inform communities in different parts of rural areas in the country? The LCEC plans to continue working with the grandparents on the “Grannies Project” and hopes to have these participants teach and empower others throughout the Laikipia region by sharing their experiences while caring for orphaned children. This would allow for creation of a useful model in the particular region to be disseminated for others in similar circumstances.

Another question this research brings up centers around the idea of familial placement of children. This seems to work in developing positive outcomes for children in this particular research study. How does familial placement work compared to children living in orphanages throughout Kenya? Further research is needed to ascertain how familial care outcomes fare compared to orphanage care found in the larger cities of Kenya.

6.3. Policy Implications and Change

Soon after independence, Kenya developed a rural development program in 1963 (Kirori 2015). This development policy has had two separate phases that attempted to strengthen the economic structure of rural areas. Phase I focused on the decentralization of services to allow local/district governments to focus on the unique needs of the area in terms of economic development, food security, employment and trade centers. Phase II, 1986–2001, turned the focus to the export of products and services along with encouraging micro-enterprise projects to alleviate poverty. The policy implementation has been plagued by difficulties including lack of legal frameworks for the finances of the districts, problems between the districts, issues with coordination between districts and national level needs. Kirori (2015) asserts that even the difficulties of implementation that some improvements were made especially centering around allowing local governments to be the experts on what is needed in that particular area of the country. However, this research does point out that a major flaw in the system remains the lack of legal authority for some decisions to be enforceable as well as “lack of financial autonomy” (p. 51).

Kirori’s (2015) research, along with the experience of caregivers noted in this study, calls for continued needs to strengthen the rural development policies of the Kenyan government. With the numbers of caregivers dying and the increase in OVC, the structure and thus the very fabric of rural areas is in a state of transition. New policies could help to make changes to further aide healthcare needs, economic development, food security and familial support. This has been, in part, attempted through allowing an increasing number of NGOs to assist in the rural areas. Further analysis is needed to help undergird the needed change to support Kenya’s most vulnerable.

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References

- Aldwin, Carolyn M., and Heidi Igarashi. 2015. Successful, optimal, and resilient aging: A psychosocial perspective. In *APA Handbook of Clinical Geropsychology*. Edited by Peter A. Lichtenberg and Benjamin T. Mast. Washington: American Psychological Association, pp. 331–59.
- Betancourt, Theresa S., Mary K.S. Fawzi, Claude Bruderlein, Chris Desmond, and Jim Y. Kim. 2010. Children affected by HIV/AIDS: SAFE, a model for promoting their security, health, and development. *Psychology, Health and Medicine* 15: 243–65. [[CrossRef](#)] [[PubMed](#)]
- Beyer, Linda I., Jay Chaudhuri, and Barbara Kagima. 2016. Kenya’s focus on urban vulnerability and resilience in the midst of urban transitions in Nairobi. *Development Southern Africa* 33: 3–22. [[CrossRef](#)]
- Chepngeno-Langat, Gloria. 2014. Entry and re-entry into informal care-giving over a 3-year prospective study among older people in Nairobi slums, Kenya. *Health & Social Care in the Community* 22: 533–44. [[CrossRef](#)]
- Chepngeno-Langat, Gloria, Nyovani Madise, Maria Evandrou, and Jane Falkingham. 2011. Gender differentials on the health consequences of care-giving to people with AIDS-related illness among older informal carers in two slums in Nairobi, Kenya. *AIDS Care* 23: 1586–94. [[CrossRef](#)] [[PubMed](#)]
- Cluver, Lucie, and Frances Gardner. 2007. Risk and protective factors for psychological well-being of children orphaned by AIDS in Cape Town: A qualitative study of children and caregivers’ perspectives. *AIDS Care* 19: 318–25. [[CrossRef](#)] [[PubMed](#)]
- Easton, Kristen L., Judith Fry McComish, and Rivka Greenberg. 2000. Avoid common pitfalls in qualitative data collection and transcription. *Qualitative Health Research* 10: 703–8. [[CrossRef](#)] [[PubMed](#)]

- Fotso, Jean Christophe, Penny A. Holding, and Alex C. Ezeh. 2009. Factors Conveying Resilience in the Context of Urban Poverty: The Case of Orphans and Vulnerable Children in the Informal Settlements of Nairobi, Kenya. *Child and Adolescent Mental Health* 14: 175–82. [CrossRef]
- Ginsberg, Leon H. 2011. *Social work in Rural Communities*, 5th ed. Washington: Counsel on Social Work Education Press.
- Govender, Kaymarlin, Susan Penning, Gavin George, and Tim Quinlan. 2012. Weighing up the burden of care on caregivers of orphan children: The Amajuba district child health and wellbeing project, South Africa. *AIDS Care* 24: 712–21. [CrossRef] [PubMed]
- Groenewald, Thomas. 2004. A phenomenological research design illustrated. *International Journal of Qualitative Methods* 3: 1–26. [CrossRef]
- Harrison, Abigail, Susan E. Short, and Maletela Tuoane-Nkhasi. 2014. Re-focusing the gender lens: Caregiving women, family roles and HIV/AIDS vulnerability in lesotho. *AIDS Behavior* 18: 595–604. [CrossRef] [PubMed]
- Heymann, Jody, and Rachel Kidman. 2009. HIV/AIDS, declining family resources and the community safety net. *AIDS Care-Psychological and Socio-Medical Aspects of AIDS/HIV* 21: 34–42. [CrossRef] [PubMed]
- Ice, Gillian H., Amy Zidron, and Elizabeth Juma. 2008. Health and health perceptions among Kenyan grandparents. *Journal of Cross-Cultural Gerontology* 23: 11–29. [CrossRef] [PubMed]
- Ice, Gillian H., Jaja Yogo, Victor Heh, and Elizabeth Juma. 2010. The impact of caregiving on the health and well-being of Kenyan Luo grandparents. *Research on Aging* 32: 40–66. [CrossRef]
- Ice, Gillian H., Aalyia F. A. Sadrudina, Amy Vagedesa, Jaja Yogo, and Elizabeth Juma. 2012. Stress associated with caregiving: An examination of the stress process model among Kenyan Luo elders. *Social Science and Medicine* 74: 2020–27. [CrossRef] [PubMed]
- International Institute of Sustainable Development (IISD). 2013. Available online: <http://www.iisd.org/> (accessed on 1 October 2017).
- Kirori, Gabriel N. 2015. Rural development policies in Kenya: A descriptive analysis over the 1970–2001 period. *European Journal of Business, Economics and Accountancy* 3: 35–53.
- Lee, Veronica C., Patrick Murithi, Ulrike Gilbert-Nandra, Andrea A. Kim, Mary E. Schmitz, James Odek, Rose Mokaya, and Jennifer S. Galbraith. 2014. Orphans and vulnerable children in Kenya: Results from a nationally representative population based survey. *Journal of Acquired Immune Deficiency Syndrome* 66: 89–97. [CrossRef] [PubMed]
- Mpya, Kenya. 2012. Laikipia County. Available online: <http://www.kenyampya.com/index.php?county=Laikipia> (accessed on 1 October 2017).
- Muga, Geoffrey O., and Washington Onyango-Ouma. 2009. Changing household composition and food security among the elderly caretakers in rural western Kenya. *Journal of Cross-Cultural Gerontology* 24: 259–72. [CrossRef] [PubMed]
- Mugisha, Joseph, Francien Scholten, Sebastian Owilla, Nirmala Naidoo, Janet Seeley, Somnath Chatterji, Paul Kowal, and Ties Boerma. 2013. Caregiving responsibilities and burden among older people by HIV status and other determinants in Uganda. *AIDS Care* 25: 1131–48. [CrossRef] [PubMed]
- Oburu, Paul Odhiambo. 2004. Social Adjustment of Kenyan Orphaned Grandchildren, Perceived Caregiving Stresses and Discipline Strategies Used by Their Fostering Grandmothers. Doctoral dissertation, Goteborg University, Goteborg, Sweden.
- Oppong, Christine. 2006. Familial roles and social transformations: Older men and women in sub-Saharan Africa. *Research on Aging* 28: 654–68. [CrossRef]
- Oramasionwu, Christine U., Kelly R. Daniels, Matthew J. Labreche, and Christopher R. Frei. 2011. The environmental and social influences of HIV/AIDS in Sub-saharan Africa: A focus on rural communities. *International Journal Research Public Health* 8: 2967–79. [CrossRef] [PubMed]
- Richter, Linda M., Lorraine Sherr, Michele Adato, Mark Belsey, Upjeet Chandan, Chris Desmond, Scott Drimie, Mary Haour-Knipe, Victoria Hosegood, Jose Kimou, and et al. 2009. Strengthening families to support children affected by HIV and AIDS. *AIDS Care-Psychological and Socio-Medical Aspects of AIDS/HIV* 21: 3–12. [CrossRef] [PubMed]
- Schatz, Enid, and Janet Seeley. 2015. Gender, ageing and carework in east and southern Africa: A review. *Global Public Health* 10: 1185–200. [CrossRef] [PubMed]

- Small, Eusebius, Cecilia Mengo, and Brendon Ofori. 2014. Rethinking poverty: Community based participatory research, promising practices. *African Journal of Social Work* 4: 1–19.
- UNICEF. 2017. For every child end AIDS. Available online: <https://www.unicef.org/aids/> (accessed on 26 November 2017).
- Van Hook, Mary Patricia. 2014. *Social Work Practice with Families: A Resiliency Based Approach*, 2nd ed. Chicago: Lyceum Books.
- Walsh, Froma. 2012. *Normal Family Processes, Chapter 17: Family Resilience Strengths Forged through Adversity*, 4th ed. New York: Guilford Press, pp. 399–427.
- World Health Organization (WHO) Regional Office for Africa. 2017. *WHO Health Emergencies Programme: Weekly Bulletin on Outbreaks and Other Emergencies*. Brazzaville: Congo. Available online: <http://www.afro.who.int/health-topics/hivaids> (accessed on 1 October 2017).
- Zimmer, Zachary, and Julia Dayton. 2003. *The Living Arrangements of Older Adults in Sub-Saharan Africa during a Time of HIV/AIDS*. New York: The Population Council.



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