THE EFFECTS OF GENDER ON THE ECONOMIC STATUS AND SOCIAL INTERACTION OF HIV/AIDS INFECTED YOUTH IN KAMPTEMBWO LOCATION, NAKURU COUNTY

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DECLARATION AND RECOMMENDATION

Declaration

This thesis is my original work and has not been presented for the award of degree in any other university.

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Recommendation

This thesis has been submitted for examination with our approval as University supervisors.

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DEDICATION

This work is dedicated to my husband John and our children Mary Immaculate and Peter for their continued support, prayers and encouragement.

COPY RIGHT

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ABSTRACT

Human immunodeficiency virus (HIV) is a virus that damages cells of the body's immune system. Acquired immunodeficiency syndrome is a collection of symptoms and infections resulting from damages caused by HIV in the immune system. HIV/AIDS affects both the young and the old regardless of their gender, economic or social status. It is a killer disease which has continued to pose a grave threat to the health, economic, social and living standards of the community and more so to the young people living with HIV/AIDS. The social and economic well being of young men and women living with HIV/AIDS is in one way or the other influenced by their status. The core aim of the study was to establish the effects of gender on the economic status and social interaction of HIV/AIDS infected youth in Kaptembwo Location. It further aimed to establish the social, demographic and economic characteristic of HIV/AIDS infected youth as well as to determine the social interaction pattern of the said youth in Kaptembwo Location. The location has an estimated total of 36,404 households out of whom 80 infected persons were sampled. The research instruments used to collect primary data were interviews where 30 people living with HIV/AIDS were interviewed, face to face interview was done to 10 people, and focus group discussions comprised of 10 while questionnaires were administered to 30 people of which 25 came back comprising a good sample. Secondary data was used to supplement primary. Snowball method was used to identify the sample whereby the researcher made contact with two cases in the population with the support of medical personnel and community social workers who later linked the researcher to the members to get the desired sample. This study adopted the social action theory which explains the way an individual reacts to phenomena that affects them. Data analysis was done using both interpretations of raw data, critical analysis and inferential statistics with the help of statistical package for social scientist (SPSS). The study found out that majority of the male respondents had poor social interaction as compared to females. Further the females felt less appreciated and loved than the male counterparts. The results of this study shows there is a need for the government and relevant stakeholders to develop strategies that enhances interaction activities for youth living with HIV/AIDS.

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LIST OF ACRONYMS AND ABBREVIATIONS

AAWORD:	Association of African Women for Research and Development
AIDS:	Acquired Immunodeficiency Syndrome
ARV:	Anti-Retroviral Drugs
DRH:	Division of Reproductive Health
FGM:	Female Genital Mutilation
GOK:	Government of Kenya
GDP:	Gross Domestic Product
HIV:	Human Immunodeficiency Virus
KAIS:	Kenya AIDS Indicator Survey
KDHS:	Kenya Demographic and Health Survey
KNASP:	Kenya National AIDS Strategic Plan
KNBS:	Kenya National Bureau of Statistics
KNLS:	Kenya National Library Services
KPSAN:	Kenya Private Sector Advisory Network
MOHA:	Ministry of Home Affairs
MOH:	Ministry of Health
NACC:	National Aids Control Organization
NASCOP:	National AIDS & STI Control Programme
NASW:	National Association for Social Workers
NCAPD:	National Co-Coordinating Agency for Population and Development
NGO:	Non-Governmental Organization
OVC:	Orphans and Vulnerable Children

PLWHA:	People Living With HIV/AIDS
RHO:	Reproductive Health Outlook
SES:	Socio-Economic Status
SPSS:	Statistical Package for Social Scientist
STI:	Sexually Transmitted Infection
UNAIDS:	United Nations Programme on HIV/AIDS
UNICEF:	United Nations Children's Emergency Fund
WHO:	World Health Organization

CHAPTER ONE

INTRODUCTION

1.1 Background to the study

Human immunodeficiency virus (HIV) is a virus that damages cells of the body's immune system. Acquired immunodeficiency syndrome is a collection of symptoms and infections resulting from damages caused by HIV in the immune system. HIV/AIDS affects both the young and the old regardless of their gender, economic or social status.

An estimated 39 million people are globally infected with the HIV virus. 23 million happen to be from Sub-Sahara Africa and 1.6 million from Kenya. Women in Kenya are more vulnerable to HIV infection compared to Kenyan men, with the national HIV prevalence at 7.6 per cent for women and 5.6 per cent for men GOK2 (2014). Nakuru County with a population of approximately 1.603,325 people has a prevalence of 5.3 per cent of people living with HIV/AIDS. The total number of adults living with HIV in the county is 53,700 and children living with HIV are 7,898 according to the government of Kenya 2014 County profiles. This study focused on Kaptembwo location which has a population of approximately 112,937 people of which more than 130 people had openly disclosed their status of HIV/AIDS.

The most affected are in the bracket of the most productive members of the population as noted in a study done by the Ministry of Health. The study further noted that reduced income and increased poverty in the household imply decreased purchasing power of the household and thus contribute to deficient demand for goods and services (MOH, 2005).

Young people are disproportionately affected by the epidemic. Stigma, discrimination and a lack of openness also contribute to the spread of the virus. Stigma also leads to denial of basic rights including access to healthcare, education, housing, employment and legal redress. Various sectors; such as education, agriculture and health, also experience the pandemic, its impact affects the quality, access, equity, supply and demand for services because the majority of their employees are between the age of 20 and 40 years (Whiteside, 2008; UNAIDS, 1999). The affected person experiences hardships due to the pandemic such as loss of income earning opportunities as a result of sickness need for care, money diverted away from food, schools and other household expenditures to pay for medical costs, funeral expenses and the caring of

orphans. Over 60% of those infected live in the rural areas where the socio-economic conditions are worsening due to poverty and unemployment according to study done by the ministry of health in 2005.

1.2 Statement of the problem

The HIV pandemic remains one of the challenges in the realization of economic, social and political development of a country. This is because the disease weakens the body, following its mutating nature. It is costly to manage the disease as most of the resources are diverted to cater for hospital bills. The time for school and work is interrupted by the periods of illness and hospital admissions. Eventually, a number of young people, students and professionals succumb to the AIDS related illnesses. The losses of this people particularly those under the age of thirty-five, with proportions of men and women varying according to age group calls for intervention. In Kaptembwo location, Nakuru County, which is home to more than 100,000, is a slum characterized with high population, limited resources, poor hygiene, congestion and low socio-economic status. The young people are the hardest hit by the effects of the pandemic either directly or indirectly. With this in mind, the study sought to establish the effects of gender on the economic status and social interaction of HIV/AIDS infected youth within the aforesaid area.

1.3 Purpose of the study

The purpose of this study was to assess the effects of gender on the economic status and social interaction of HIV/AIDS infected youth in Kaptebwo Location of Nakuru County.

1.4 Objectives of the study

1. To establish the social demographic and economic characteristic of HIV/AIDS infected youth in Kaptebwo Location.
2. To describe the social interaction pattern of HIV/AIDS infected youths in Kaptembwo location.
3. To determine the effect of gender on the economic status of HIV/AIDS infected youth in Kaptebwo Location.
4. To find out the effect of gender on the social interaction of HIV/AIDS infected youth in Kaptebwo Location.

1.5 Research questions

1. What is the social demographic and economic characteristic of HIV/AIDS infected youth in Kaptebwo location?
2. What is social interaction pattern of HIVAIDS infected youth in Kaptembwo location?
3. What is the effect of gender on the economic status of HIV/AIDS infected youth in Kaptebwo location?
4. What is the effect of gender on the social interaction of HIV/AIDS infected youth in Kaptembwo location?

1.6 Research hypothesis

Ho_1. There no statistically significance relationship between gender and economic status of HIV infected youth in Kaptembwo location.

Ho_2. There is no statistically significance between gender and social interaction of HIV infected youth in Kaptembwo location.

1.7 Significance of the study

The findings of this study are expected to add knowledge and to improve our understanding of the effects of gender on the economic status and social interaction of youth living with HIV/AIDS by providing data within the context of Kaptembwo area. The findings will inform the government policy makers with a view of incorporating economic and social interactions trends of youths living with HIV/AIDS while developing a comprehensive HIV/AIDS policy which will be done through publication, write-ups and dissemination of information.

It is hoped that in the view of the findings of the study, Non-governmental Organizations, development partners and other stakeholders will develop necessary interventions strategies to help address the issues identified. The study will also direct future research in areas of gender and HIV/AIDS.

1.8 Scope of the study

The study was conducted in Kaptembwo location, Nakuru County, Kenya. Nakuru County has an estimated population of approximately 1,603,325. Contact was established with two cases in the population with the help of medical personnel and community social workers who later

linked the researcher to the members to get the desired sample. These are the people who are directly involved in handling issues of those living with HIV/AIDS. The study targeted people living with HIV/AIDS (PLWHA) in the age bracket of 18 and 34 years.

1.9 Limitation of the study

The study was limited by the fact that some of the potential respondents considered the HIV topic sensitive and personal hence unwilling to share information freely. The respondents were however assured confidentiality.

1.10 Assumptions of the study

The assumptions of the study are: -

1. There is a sizable population of youth that is affected by HIV/AIDS.
2. Those affected interact with one another.
3. The sizeable population is of both genders.
4. The interaction is also influenced by their gender.

1.11 Definition of terms

HIV: Human Immunodeficiency Virus is a virus which damages cells of the body's immune system making the immune system unable to fight infections.

AIDS: Acquired Immunodeficiency Syndrome is a collection of symptoms and infections resulting from the specific damage to the immune system caused by HIV.

Relationships: Refers to how individuals relate with each other in the community. In this study, it implied how the youth relate with their peers, parents and the community.

Socio-economic factors: These are social and economic experiences and realities that help mold one's personality, attitudes, and lifestyle. For example education is a socioeconomic factor that can shape how one views the world and can contribute to social growth. It can also lead to increased earning capacity, which may contribute to quality-of-life issues.

Vulnerability: Refers to the probability that an individual (or group) being in a situation or behaviour that exposes them to HIV.

Infected: Refers to a person who is living with the human immunodeficiency virus that causes AIDS.

Workplace: Refers to occupational settings, stations and places where workers spend time for gainful employment.

Slum: Refers to very low income neighbourhoods

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Epidemic: An epidemic is a rate of disease that reaches unexpectedly high levels, affecting a large number of people in a relatively short time.

Social network: A network of social interactions and personal relations. It allows one to connect with other people of similar interests and background, various ways to interact with other users, ability to setup groups, etc.

Youth: Youth is time of life when one is young, but often means the time between childhood and adulthood. In the study youth refers to ages between 18 and 34 years.

Gender: Refers to the socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women.

CHAPTER TWO

LITERATURE REVIEW

2.0 INTRODUCTION

This chapter reviews literature on the effects of gender on the economic status and social interaction of the HIV infected youth. The literature is reviewed using the following sub-headings: On HIV/AIDS and the youth,/youth and religion, HIV transmission, gender and HIV/AIDS, socio-economic status, poverty, social wellbeing, social networks, education as a strategy to combat HIV/AIDS, health/ women and reproductive health, effects of HIV/AIDS and interventions. The theoretical framework that guided the study is also discussed.

2.1 HIV/AIDS and the youth

According to Kenya private sector advisory network strategic plan 2011-2015, AIDS is subtracting decades of achievements in socio-economic development in Africa, and undermining the countries' efforts to reduce poverty and enhance living standards. Due to the numerous programmes that have been instituted, the spread of HIV/AIDS has been slowed down in some parts of the world, Kenya included.

HIV/AIDS impedes an individual from providing essential services to the community. Stigmatization affects and damages the social interactions of people living with HIV/AIDS (PLWHA) with others. Such fears and stigmatization attitudes towards PLWHA displayed by general population could potentially lead to discrimination against PLWHA. (Varas-Diaz et al. 2005; Brown et al. 2003).

The acquired immunodeficiency syndrome (AIDS) was publicly reported on 5th June, 1981, in the morbidity and mortality Weekly Report produced by the Centers for Disease Control (CDC) in Atlanta in the USA (Whiteside, 2010). The first case of AIDS was reported in Kenya in August 1984 and since then; about 2 million people are now living with HIV, with about 1.2 million children orphaned and a prevalence of 6.9%. In 1999, AIDS was declared a National disaster leading to the establishment of the National AIDS Control Council, KAIS (2007). The council was established to coordinate resources for prevention of HIV transmission and

provision of care and support to the infected and affected. An estimated 29 per cent of adult deaths occur yearly, 20 per cent of maternal mortality and 15 per cent deaths of children under the age of five due to AIDS related illnesses GOK2 (2014)

In Kenya, the response to HIV and AIDS relies on preventive strategies where information on modes of transmission are provided to enable people identify and avoid risky behaviour that could expose them to infections. According to Kenya Private sector advisory Network strategic plan 2011-2015 Campaigns that desire to minimize the prevalence, if not to eradicate the scourge, have been launched. These advocate abstinence and condom use as protective strategies for school-going adolescents and youth aged 15 to 24 MOH (2005). Having accurate HIV and AIDS knowledge about transmission and prevention is important for avoiding HIV infection and ending the stigma and discrimination of infected and affected persons.

Having understood what HIV/AIDS is, its impact on the life of human beings is clearer day by day. The age of sexual debut and marriage has risen, and condom use has increased. Many challenges remain, particularly those that relate to the position of women. According to Kenya National AIDS control council 2009-2013 Strategic Plan on Delivering Universal access gender disparities in Kenya are high; prevalence among adolescent girls aged 15-19 years is six times that of men in the same age group (3 per cent of all young women in that age group, as compared to less than 0.5 per cent of young men). According to the Government of Kenya 1(2014) the new estimates confirm a decline in HIV prevalence among both men and women at National level with female prevalence being at 7.6% and men 5.6% GOK1(2014). In Nakuru County the prevalence rate stands at 5.3 per cent with a total of 61,598 people living with HIV/AIDS GOK2 (2014). A recent released HIV and AIDS County profiles by the Government of Kenya shows that stable and married couples are the most affected, as they account for 44 per cent of the new adult infections GOK2 (2014)

2.2 Youth and Religion

Young people and adolescents are still a neglected group, despite their specific psychological and biological needs, high prevalence of sexual abuse and high risk of STIs, HIV and pregnancy (DRH, 2005). Most of the young people between ages 15-17 are social and political beings, impatient to express themselves, organize and engage in the social and political affairs of their

communities and nations Waal et al, (2002). Among young people, the odds of being infected by HIV are higher among young women aged between 15-25 compared to young men with 4.5 per cent being women and 1.5 men by 2012 (GOK3, 2014). According to Barnett and Whiteside (2006), young women are disproportionately affected by HIV. Women and girls make up almost 57 per cent of adults living with HIV in Sub-Sahara Africa. They bear the brunt of new infections, with an average of 13 young women living with HIV for every 10 infected young men and the gap continue to widen. Waal and Ardent (2002) noted that young people in Africa address crucial social issues with real political implication. The breakdown in the transmission of social values and traditions that young people's resistance implies may leave some groups of young people as a black slate, susceptible to forms of extremist mobilization.

Young people continue to be at the growing center of the pandemic (Summers et al. 2002). According to Kenya National AIDS Control Council 2009-2013 Strategic Plan on Delivering Universal Access to Services, young people below the age of 30 form over two thirds of the population and with little opportunities to earn a decent income, succumb to criminality, prostitutions which expose them to HIV/AIDS or violent deaths or jail. The median age of infection for women in Africa early twenties, implying that a substantial minority of girls are HIV positive before they turn 18 years as noted by Waal et al, (2002).New HIV infections in Kenya are estimated to have stabilized at an average of 88,620 among adults and about 12,940 among children annually by 2013 (GOK1,2014).

The emphasis on behavioural approaches to youth sexual health, which aims to educate young people about risks and reproductive decision-making, is prominent in Kenya (Cho et al., 2011). The Plan of Action recognizes that "improving young people's reproductive health is therefore key to improving the world's future economic and social well being" (NCAPD, 2005. 12). Love and care should be given to people living with HIV/AIDS. According to Slattery, 2004 we need to openly accept such people in our families and communities, show them love and compassion, care for them, feed them, nurse them, pray with them, see and serve and love Christ in them.

The Pentecostal churches and militant movements are examples of youth-based movements in Africa which are marked by powerful youth orientation, and by the message that personal moral salvation can redeem or transform a public moral order. Schools are a locus for sexual behaviour between teachers and pupils and among pupils themselves Waal and Ardent (2002).

Most young people can be found in school being one of the modes of social interaction and hierarchy that exist; students learn exploitative relationships, command modes of authority, and gender inequalities at school, which demote social change in society. According to Tozy (1996), the recourse of more and more young people to Pentecostal churches throughout the continent represents a social phenomenon closely related to the aims and aspirations sustaining young people's participation in performance. They also offer opportunities for participation in civil society that are so often denied to young people both in political life and the established church alike as well as identity and a modicum of protection, representing a field of civil society capable of pressurizing the state by threatening a withdrawal of support.(Gifford, 1995; Young and Kante, 1992). Behind the religious doctrine lie the frustrations that emerge when these well-educated and economically successful young people come up against the demands of a gerontocratic structure that blocks their progress and seeks to confine them within an age-based hierarchy (Waal et al, 2002)

Religious groups as noted by Young and Kante, in general, have a reputation for responding to the issue of HIV in negative terms. Factors that influence this perception have included judgmental comment from religious leaders; debate about condoms; and an obstructive stance towards policy development, particularly regarding drug use, commercial sex, and harm reduction approaches. The religious sector has been largely unwilling to engage in any way that could imply dilution of moral standards. As a result, people with HIV have experienced rejection by religious people, congregations or institutions. Slattery feels that the breakdown in the area of sexual morality is the reason why AIDS is spreading so rapidly. He says that in the past people were guided and helped by religious and cultural beliefs and certain customs and practices to excise self-control and responsibility in the area of human sexuality (Slattery, 2004)

2.3 HIV/AIDS transmission

HIV transmission occurs through behaviours that pose a risk for exposure. Transmission is not limited to one particular race, ethnicity, gender, relationship or affiliation, or community membership as noted by national association of social workers (NASW) 2005.Yet it is common among blacks and homosexual couples. Women and girls are physically more vulnerable to HIV infection than men. This is noted by the government of Kenya's recent County profiles where women prevalence stands at 7.6 per cent and 5.6 per cent for men GoK2 (2014). According to

Njeru et al. (2004), the HIV virus is present in semen and is transmitted to women and girls through sexual intercourse.

Although physiology affects women's greater risk of transmission, it is women's and girls' relative lack of power over their bodies and sexual lives, supported and reinforced by their social and economic inequality, that renders them vulnerable to contracting HIV and coping with HIV/AIDS WHO(2003).According to the National AIDS Control Council 2009-2013 strategic plan on Delivering Universal Access, Kenyan girls' and women's vulnerability to HIV infection can be gauged by statistics as 28 per cent of men aged 15 to 49 years who believes that a woman has no right to request a man to use a condom. "Men who prefer 'dry sex' contribute to tearing of the vagina canal which allows the virus to enter the woman's bloodstream through male semen. Women and girls have a great service area of mucus membrane in their genital organs and as the semen is retained inside the body there is greater exposure to the virus" (WHO, 2003). Waal and Argent (2002), also agree that women are more biologically susceptible to HIV infection than men, and the gap is wider for younger ages when girls' partly immature genitalia increase susceptibility. Hence early sexual activity is a high risk factor for young women, a partner of her own age is much less likely to be infected with HIV than one who is five or ten years older. They also have less mature tissue and are often victims of coercive or forced sex GOK (2013). According to UNAIDS/WHO (2004g) heterosexual intercourse accounts for most HIV diagnoses among women, and the main risk factor for many women is the often-undisclosed risky behaviour of their male partners.

In many African cultures, sex education is a taboo subject at the same time, cultural practices for young people such as male circumcision and female genital mutilation can contribute to the spread of the virus, if the tools used are not properly sterilized. Jackson (2002) notes that the worst violation of women's rights is the practice of female genital mutilation (FGM), which denies women the right to sexual pleasure as well as the increased likelihood of tearing and scarring during sexual intercourse or child birth increases vulnerability to HIV infection GOK (2013).

Although contraceptive services for HIV-positive women is one of the four cornerstones of a comprehensive program for prevention of mother-to-child transmission of HIV (PMTCT), a review of PMTCT programmes found that implementers have not prioritized family planning (Rutenberg and Baek, 2004). While there is increasing awareness about the importance of

family planning and HIV integration, data about family planning from PMTCT clients is lacking.

2.4 Gender and HIV/AIDS

Gender is a range of physical, mental, and behavioural characteristics distinguishing between masculinity and femininity. It also refers to the socially constructed roles, behaviour, activities and attributes that a particular society has towards men and women. AIDS is a "disease with a woman's face and the epidemic shows the 'destructive nature of gender inequality and injustice Njoroge (2004). Dube (2001) also notes that gender inequalities are second only to poverty in being a major driving force behind the spread of HIV and AIDS.

Women are affected by some of the outcomes of the epidemic: they are burdened with the care of people who suffer from AIDS-related diseases, and they are faced with the economic/financial consequences, such as the costs of medicine and a loss of household income. According to Barnett and Whiteside (2006), the global HIV/AIDS epidemic has deep roots in social and economic inequalities on which the effects of unusual levels of illness and death profoundly affect the lives of many individuals and many societies for decades to come. Women are at a greater risk of HIV infection than men because of the lower socioeconomic status. Women's lower socio-economic status in Africa makes them more vulnerable to HIV infections either because they lack bargaining power in sexual relationships or in marriage markets (Were and Kiringai, 2003).

Women suffer from the stigmatization of people living with HIV because HIV related stigma is a gendered phenomenon (Shisanya, 2008). Stigma and discrimination are universally experienced by persons living with and affected by HIV/AIDS. Stigmatization leaves a person with a "spoiled" social identity, which must be managed in interaction with others. The stigma attached to HIV/AIDS reduces social interactions and networking among workers. Stigmatization of people living with HIV/AIDS may not only reduce social capital but may also stifle innovations (Dixon and Robert, 2002).Additionally, gender inequities in social and economic status as well as lack of access to preventive services, education, and health care, increase women and girls' vulnerability to HIV/AIDS. Females are increasingly at risk of HIV or AIDS; studies show young women are three times more vulnerable to HIV infection than

their male counterparts. Young women, who are often vulnerable as a result of having little or even no control over their own sexual activity, now make up more than 60 percent of those aged 15 to 24 infected worldwide (UNAIDS,2004b; Inter Action,2005). Unequal property and inheritance rights, lack of marital rights, and the use of "transactional sex" in exchange for food, shelter, or other basic necessities exacerbate women's vulnerability (UNAIDS,2004b).

The diagnosis of HIV or the affiliation of living with a family member with HIV/AIDS, can elicit stigma and discrimination that can affect the health and mental health status of individuals, families and entire communities. This may contribute to increased isolation and added health and mental health concerns, ranging from anxiety and depression to traumatic responses and substance abuse (Ellenberng, 1998). According to Slattery, 2004 disclosure of one's HIV/AIDS status is important as it gives them confidence and courage to deal with the disease as they struggle with all kinds of emotions such as anxiety and fear about their future, anger and guilt about what was happening to them, loneliness and depression as they feel they may be isolated from relatives and friends.

Gender dimensions of HIV and AIDS should be recognized. Women are more at risk than men from heterosexual sex (Hubley, 2002). Equal gender relations and empowerment of women are vital to successful prevention of the spread of HIV and AIDS. (Njeru et al. 2004). 'Power imbalance between genders considerably explains why women are more vulnerable to HIV/AIDS than men to a large extent'. This is because sexual contact in heterosexual relations takes place within the gender relations between men and women; a gender imbalance directly impacts upon sexual relations and thus can be critical in view of the sexual transmission of HIV (Shisanya.2002).

According to the National HIV and AIDS 2006-2010 strategic framework gender issues that perpetuate the dominance of male interests and lack of self -assertiveness on the part of women in sexual relations put both men and women at risk. Women are taught to never refuse their husbands sex regardless of the number of extra-marital partners he may have or his non-willingness to use condom. Barker and Ricardo (2005) also agree that if women have a specific vulnerability to HIV, this is related to the behaviour of men that is itself informed by the norms of masculinity that, in the end, also put men themselves at risk. Female condoms are also

available in the private sector but they are expensive, costing an average of KES 120 in a pharmacy-around 40 times the cost of a male condom from the private sector (MOH, 2005).

2.5 Socio-economic status

Socio-economic status (SES) is often measured as a combination of education, income and occupation. It is commonly conceptualized as the social standing or class of an individual or group. Social and economic stratification is a condition of human existence which produces wide differences in life patterns, cultural standards and methods of socialization of the child which reflect themselves in important ways in the personality structure and behavior of both child and adult(AAWORD, 2004). The burden of caring for an HIV-positive family member or for children orphaned by HIV/AIDS is felt more in particular by women, who are often the main care givers (Whiteside, 2010). The main responsibility for care falls on women and girls who may have to spend several extra hours a day dealing with the needs of chronically ill relatives, in addition to their existing workloads and income generation if a male income-earner becomes ill Moley (2004). The government of Kenya manual of 2013 also notes that women and girls provide the primary care to the sick and orphaned children. Stigma and discrimination against them has made the fulfillment of other responsibilities such as provision of food, energy and income exceedingly difficult GoK (2013).

The unprecedented impact on the social, demographic and economic factors underpinning development is matched by extreme 'burdens of suffering' among individuals, households and communities Villarcal (2006). Though socio economic factors receive some attention in the Kenyan policy, there is still a need for a more concerted effort on improving the economic situation of the youth and creating an enabling social environment NCAPD (2005). Lack of access to credit as well as loss of property to relatives is some of the problems faced by women. Men are able to access such facilities and have collateral security hence they are able to buy drugs and meet other needs. Large income disparities remain despite weak evidence of links between poverty and HIV risk, socio-economic disparities lead to social exclusion especially to women GoK (2009).

At the household level the effects of HIV infection are obvious: the cost of medical care and related areas will increase, for example, if the infected person is an adult, then production and

income of the household will be reduced Kelly (2000). AIDS also affects macro indicators such as GDP per capital economic growth, level of investment, reduced labour productivity as a result of absenteeism and loss of experienced workers, possible changes in labor supply and demand, reduced industry profits and falling domestic savings (Nyaga et al. 2004). AIDS also drains the human and institutional capacities that drive sustainable development. This, in turn, disrupts production and consumption, erodes productivity in public sectors, and ultimately diminishes national wealth (World Bank, 2003).

The HIV/AIDS pandemic has an impact on labour supply, through increased mortality and morbidity. This is compounded by loss of skills in key sectors of the labour market. Lower domestic productivity reduces exports, while imports of expensive healthcare goods may increase. The decline in export earnings will be severe if strategic sectors of the economy are affected, such as mining in South Africa (South African Research, 2000). The long period of illness associated with AIDS also reduces labour productivity as noted in the research and, due to that the cost reduces competitiveness and profits. According to the Government of Kenya County profiles, the pandemic has negatively affected the country's economy by lowering per capital output by 4.1 per cent. Economists agree that HIV/AIDS may affect economic growth through two factors. The first is the illness and death of productive members; the second is through the diversion of resources from savings (and eventually investment) to care (Kaplan et al. 2004).

The increased mortality in regions with the HIV and AIDS pandemic result in a smaller skilled population and labour force that will be predominantly young people, with reduced knowledge and work experience leading to reduced productivity (Greener, 2002). Greener further notes that by killing off mainly young adults, AIDS seriously weakens the taxable population, reducing the resources available for public expenditures such as education and health services not related to AIDS resulting in increasing pressure for the state's finances and slower growth of the economy. The income effects on increased spending on health care by the household lead to spending reduction as well as a substitution effect away from education and towards health care and funeral spending (Over,1992). In severely affected communities, HIV/AIDS has an impact on children, families and continuous affliction rate of deaths in young adults leads to social and

economic impacts which increase with the severity and duration of the epidemic (Foster and Williamson 2000).

2.5.1 Poverty

Poverty is the lack of basic necessities such as food, shelter, medical care and security, which are thought necessary based on shared values of human dignity, as noted by Brandshaw (2006). More than 56% of Kenyans currently live below the poverty line. However, regional disparities are such that in some parts of the country, as many as 65% live below the poverty line and have less than a dollar per day to spend on everything needed to live(MOH, 2005).'Extreme poverty deprives people of almost all means of managing risk themselves' World Bank development report, 2000/01). HIV is more likely to be a death sentence to the poor than for those who can care for themselves and afford treatment.

Poverty on incidence is the headcount index of percentage poor people in a given district, which is falling below the poverty line and comprises the proportion of people who cannot afford to purchase the basic basket of goods to allow the minimum nutrition requirement (NASW, 2005). Poverty gap, also referred to as depth of poverty shows how much poorer the people are relative to the poverty line. AIDS affects the entire household, with family members losing their most productive years, resulting in permanent poverty as the illness reduces the ability to work, and increases medical costs, as well as funeral expenses.

Poverty in Kenya is a function of a number of interrelated factors: untapped or poorly used human resources, low levels of industrialization, inadequate or poorly maintained infrastructure, issues of governance and economic policy, and socio-demographic factors. (MOH. 2005).It is also noted that the everyday psychosocial issues for persons live with or affected by HIV/AIDS are compounded by poverty, homelessness, addictions, unsanitary living conditions, war and trauma, discrimination, and societal indifference (NASW 2005). Rapid urbanization in Kenya has presented development challenges leading to deteriorating living conditions and growing urban poverty.

Young people form a large proportion of those moving from rural to urban areas in search of livelihood opportunities; in the process most find urban slums as the first entry points into the cities where health facilities as well as socio-economic amenities are a challenge. NASW also noted that one's vulnerability to HIV/AIDS exists within a broader context of poverty, seen in

the lack of access to education, lack of economic opportunities, and the lack of, or inability to access health-related services.

Despite the robust pace of economic development, women's poverty has increased due to unequal situations in the labour market. Women's poverty is directly related to the absence of economic opportunities and resources, including credit, land ownership, and inheritance, as well as minimal participation in the decision-making process. Men are economically stable and hold important dockets and have the biggest percent are of managerial and administrative jobs (Fox, 2004).

Where there is poverty, health risks increase due to poor water supplies, inadequate food and shelter, increased drug use and sex trade (Kaplan et al. 2004). Kelly(2000) also notes that the socio-economic impacts of HIV/AIDS include increases in household poverty that result in financial barriers to education (inability to pay fees, purchase uniform, and school materials and opportunity costs when children may be called on to support household livelihoods, attitudinal impacts on participation in education especially for those affected by HIV-related stigma and discrimination. Studies show that when a family member has AIDS, average income falls by 52 per cent to 67 per cent, while expenditure on health care quadruples (UNAIDS, 1999 a).While increasing poverty levels continue to fuel the spread of HIV, the pandemic itself exacerbates those levels in households and families with people living with HIV/AIDS (MOH. 2005).The increased cost of health care that HIV/AIDS is causing, is a result of the prolonged disease process and multiple opportunistic infections. As labour forces decline due to the effects of HIV/AIDS and co-occurring health and mental health problems, health needs increase within communities that already experience health disparities (Kaplan et al. 2004).

2.5.2 Social wellbeing

Socially, poor women are ostracized in a system where much value is placed on material wealth and appearances. In fact, in some cases, the poor would strive to be more endowed materially at the expense of the health and nutritional needs of members of the household. Poor self-esteem and a sense of powerlessness, for example, often prevent women from participating in programmes which are, themselves, designed to alleviate poverty. Most women are forced into early marriage in some communities. Some are not yet physically mature and may be prone to

physical trauma and infection during sex. If the wounds inflicted are from an infected person, there is likelihood of infection of this virus.

Young people are subject to the same social influences as adults that make it difficult for them to act against the prevalent gender norms that discourage shared decision-making between women and men that implicitly condone violence against women. Some new cases of HIV infection are linked to gender-based violence in homes, schools, the work place and other social spheres (GOK, 2013)

Men and women lead gendered lives because they make different choices, in life and are presented with different opportunities. These opportunities are shaped by social structures such as legal rules, norms of behavior, ongoing institutions and hierarchies, patterns of competition in different fields/markets; and lack of skills by women to access market outside. Each individual in a society occupies a different position in relation to a structure which may be unique to every individual (Villarcal, 2006). The models that people construct to make sense of the country are themselves structures, if they are widely shared. Countries have denied women their right of self-ownership as well as the society they live in.

In some communities, married women are regarded as minors/children hence cannot carry out any extra effort aimed at improving their livelihoods, if their husbands get to appropriate all of the benefit. Lack of control over self has been most evident in cases of forced marriages and bride wealth used to purchase a wife hence regarded as property. This has negative implications for women especially the ones who are regularly beaten by their husbands (ACORD, 2002). As noted by NACC (2002), for married women, inheritance patterns, economic subordination and the absence of restraint on the number of sexual partners a man may have all weaken marriage as a productive institution against HIV transmission.

Unequal gender power relations in the socioeconomic sphere are mirrored in cultural attitudes and practices relating to sexual norms and behavior, for example in some cultures ‘promiscuity’ in men is common and culturally acceptable while for women it is violation of cultural norms to insist on condom use. Female condoms are too expensive for women to afford due to the limited resources as well as religious perspective of condom use and different interpretations of female

and male sexuality (GOK, 2013). The social stigma surrounding HIV/AIDS can lead to feelings of guilt, shame, remorse and anger further complicating the parent-child relationship (Miller and Murray, 1999).

2.6 Social networks

The multitude of new social networking Web sites has changed the way individuals communicate and form relationships (Haythornthwaite, 2005). These social networks allow individuals to create a personal profile and form connections with other individuals with whom they can relate and share current and future experiences. Teenagers have ranked such sites as one of their preferred methods of communication, along with cell phones and Instant Messenger (Lenhart et al. 2007), making them a great way to reach this audience with information. A recent Pew study noted that 33% of the youth surveyed create pages on networking sites for organizations or groups to which they belong (Lenhart et al. 2007).However, Kickbusch et al. (2002) focus on personal and social skills development such as self-confidence, negotiation, and assertiveness and the resulting individual health related behaviour associated with interactive health literacy.

If the young people are assisted to acquire this information, they become empowered and can solve issues that come their way. A study done in India indicated that India's largest private mobile phone service provider has developed games on HIV/AIDS awareness for mobile phones using the reliance info comm. network, thus becoming the world's biggest social initiatives devices in the field of social welfare (Ghosh, 2007). However, not many youth know such programmes and also a majority of the poor youth may not be in a position to own a mobile phone.

2.6.1 Education as a strategy to combat HIV/AIDS

Education is a prerequisite ingredient to development. Empowering women with basic skills is important for their self-reliance and for making informed health choices. Low education levels and low economic status cause women to be dependent on men. According to Whiteside (2008), prolonged absenteeism from school not only reduces the future earnings of an individual, but also futures variations in productivity and the scope of specialization. The tendency of uneven

gender distribution in employment leads to low paying and less skilled jobs for women. Low representation of women in decision-making contributes to gender discrimination on tackling needs

In June 2001, at the UN General Assembly Special Session on HIV/AIDS, nations agreed to a set of targets to promote girls' and women's empowerment as "fundamental elements in the reduction of the vulnerability of women and girls to HIV/AIDS" (UNIFEM. 2002). Gradually, however, it became clear that treating women as special beneficiaries in alternative development projects meant that woman's issues often became mere appendages to development interventions. While policies advocated involving women, they did not necessarily promote gender mainstreaming in policy programmes, Gender and Budgeting project planning and implementation.

Education on HIV/AIDS creates an environment in which all personnel are free from infection. A review by Hargreaves and Glynn (2002) of 27 studies containing appropriately analyzed individual level data on relationship between HIV prevalence and education attainment in developing countries concluded that in Africa, most studies have shown higher education levels to be associated with a greater risk of HIV infection. However, in several serial cross-sectional studies in Uganda and Zambia shows greater decreases in HIV prevalence were observed for individuals with higher education levels, especially among younger age groups. In addition, schooling is generally considered as a factor increasing access to and understanding of health promotion campaigns Kilian and Ndyanabangi (1999), Flukesne and Kasumba (1997) and Flukesne et al.(2001)

The education sector has the responsibility of addressing HIV/AIDS through Education by developing skills, values, providing information, influence beliefs and changing attitudes to promote positive behaviours that combat the scourge. This has been done through character change i.e. avoiding young boys and girls for any relation, "Acha Mpango wa Kando". *Stop extra-marital affairs.*

Information provided on HIV and AIDS must be current, accurate, factual and comprehensive and presented in a manner, language and terms that are understandable and contribute to positive behaviour change. Appropriate information, education and communication (IEC)

materials and programmes on HIV and AIDS have been made available to all concerned in all sectors, e.g., materials with HIV and AIDS messages such as T-shirts, posters etc. Anyiro (2010). Stigmatization leaves a person with a "spoiled" social identity, which must be managed in interaction with others (Goffman, 1963). Goffman argues that when a person's stigmatized identity is not immediately known in interaction, she or he may be able to "pass". Passing requires what Goffman calls techniques of "information control," where the central issue is "managing information" about one's stigma.

HIV and AIDS education also plays a vital role in reducing stigma and discrimination. Around the world, there continues to be a great deal of fear and stigmatization of people living with HIV, but can also fuel the spread of HIV by discouraging people from seeking testing and treatment. Most communities are intolerant to people with HIV or suspected of having HIV. This people turn out to be resentful towards society and may keep spreading the virus. Both the individual and society's attitude to HIV is critical for both prevention and care. Individuals living in fear of exposure and ridicule are unlikely to change behaviour (Whiteside, 2008). For example today's youth are growing up in a world changed by HIV/AIDS, but many still lack comprehensive and correct knowledge about how to prevent HIV/AIDS infection and deal with it.

The subject of sexuality and reproductive health is still surrounded by taboos, misconceptions and cultural myths in our continent. In spite of the various efforts in the past, young people in particular are often overlooked and sidelined (UNESCO, 2005). It is imperative for all of us to recognize that our strong cultural identities and nuances as well as a significant level of ignorance on how these work and influence our behavior are at the root of the HIV-AIDS pandemic. For too long now, we have been hiding in cultural excuses and "no-go comfort zones" as ways to avoid scientific investigation which would provide empirical evidence for appropriate and customized messages and interventions.

HIV/AIDS has a heavy impact on the education system from demand for education, supply of education as a result of sickness, psychological, economic strain and also impact on supply and demand on the cost of education (World Bank, 2002). HIV is damaging the education systems which can provide the "social vaccine" and promote good health and nutrition of school age

children, that is, it kills teachers, increases rates of teachers' absenteeism, and increases the number of orphans and vulnerable children who are likely to attend school and more likely to drop out (World Bank, 2002). Once the people who are living with HIV/AIDS are well educated, it will enable them make informed choices.

2.6.2 Health/ Women and Reproductive Health

Women's social and economic vulnerability and gender inequality also lie at the root of their painful experiences in coping with the stigma and discrimination associated with HIV infection. HIV positive women bear a double burden: they are infected and they are women. In many societies being socially ostracized, marginalized and even killed are very real potential consequences of exposing one's HIV status. Yet, HIV testing is a critical ingredient for receiving treatment or for accessing drugs to prevent the transmission of HIV from a woman to her child. Health has a positive and significant effect on economic growth (Bloom et al., 2001). However, an increasing number of PLWHA are unable to tolerate the toxity and/or severe side effects that are common with the medication (ARV and prophylaxis treatments), while others experience unexpected health deterioration, or the drugs simply "fail the patient" (Kaplan et al. 2004).

HIV attacks certain cells in the immune system (T-cells) that fight infection hence leaving the body vulnerable to diseases (Granich, 1999). The capacity of an affected household to obtain an adequate amount and variety of food, and to adopt appropriate health and nutritional responses to HIV/AIDS, especially for the already vulnerable ones, is grossly reduced. On the other hand, both HIV/AIDS and malnutrition compromise the immune system, resulting in increased susceptibility to severe illnesses, which reduce the quality of life and shorten life expectancy (MOH, 2005). HIV/AIDS also affects the health system by undermining its capacity to perform, and by eroding the quality of care and the state of health facilities (Whiteside, 2001). Health referral systems are distorted as demand for quality care and desire for anonymity force AIDS patients to bypass primary care facilities and choose more expensive tertiary institutions (IEA/SID, 2001)

2.7 Effects of HIV/AIDS

There is high death rate of people in their productive ages as well as a rapid growth in the number of AIDS orphan and needy children (Slattery, 2004). The high burden of HIV/AIDS in Kenya according to the government of Kenya county profiles of 2014 accounts for an estimated 29% of annual adult deaths, 20% of maternal mortality and 15% of deaths of children under the age of five. Negative cultural attitudes especially where illiterate people still consider HIV/AIDS as a curse and witchcraft-thus they do not want to talk about it as well as not wanting to shun from irresponsible behavior remain a challenge to the society. Slattery 2004 noted that when young people die of HIV/AIDS, their families and relatives believe that such death is as a result of witchcraft by some jealous or evil persons. The pandemic also suppresses the immunity of the patient and this exposes them to many opportunistic diseases which have to be treated from time to time (MOH, 2005)

The cost of treatment is far beyond the patient's financial status. Most of the patients become unproductive and their responsibilities have to be taken by other members of the community (Barnett and Whiteside 2006). Long-term economic growth and development depends on investment in people, and human capital which is particularly threatened by the scourge. HIV/AIDS is assumed to affect growth through reduced savings and investment, and by reducing the size of the labour, which lowers efficiency and productivity (Whiteside, 2008). In Kenya the epidemic has also negatively affected the country's economy by lowering per capital output by 4.1 per cent (GOK2, 2014)

Some people living with HIV/AIDS still experience stigma and shame as they struggle to come to terms with the terrible disease, which is causing such great pain and suffering in families and communities (Slattery, 2004). A person living with HIV/AIDS is seen as a disgrace to the community and many condemn them as immoral or even promiscuous and therefore responsible for what has happened. This make them feel guilty and rejected.

2.8 Interventions

In Kenya, the response to HIV and AIDS pandemic relies on preventive strategies where information on modes of transmission are provided to enable people identify and avoid risky behavior that could expose them to infection. Having accurate HIV and AIDS knowledge about

transmission and prevention is important for avoiding HIV infections and ending the stigma and discrimination of infected and affected persons GOK (2009).

According to KAIS (2007), as stated in Kenya National Strategic Plan 2009/10-2011/13, the Mode of Transmission (MOT) modeling exercise confirmed that heterosexual contact remains the main mode of transmission in all areas of Kenya. The high sero-status discordance rate suggests that marriage, and regular unions may well be a 'high risk' situation with variable patterns of initial introduction of HIV into the union. Social norms regarding relationships, gender roles/imbalances, stigma and discrimination, fear and risk perception, and fertility intentions present difficult prevention challenges and apart from testing, 'discordant couples' are virtually impossible to identify and target with services.

HIV testing and counseling is provided through voluntary counseling and testing provided in many site countrywide. About 63 per cent of men know their status and 80 per cent of women are aware of their HIV status GOK4 (2014). According to Slattery 2004, if one has AIDS, he/she should feel free to talk about. He further says that "the people of Uganda, beginning from the president and the government, have moved from silence, denial and finger pointing to a greater deal of openness and public discussion on HIV/AIDS.

Prevention of mother to child transmission (PMTCT) is done to HIV positive pregnant woman who receives antiretroviral prophylaxis to reduce the risk of mother-to-child transmission of HIV. The PMTCT services in Kenya are free and integrated into Maternal and Child Health (MCH) services. This services includes other interventions, such as HIV testing and counseling to pregnant mothers, preventive treatment with antiretroviral (maternal and infant), counseling and support for appropriate infant feeding, access to safe obstetric care and family planning services GOK(2010). About 70 per cent HIV-pregnant women receives antiretroviral GOK4 (2014).

The current status of condom use promotion and distribution is at 43 per cent among men aged 15-24, 14 per cent use among men 25-64 years with partner of discordant or unknown HIV sero status in the past 12 months while 11 per cent consistent condom use among women 15-24 years and 5 percent among women 26-64 years with partner of discordant or unknown HIV sero status in the past 12 months GOK4 (2014)

Voluntary medical male circumcision is another intervention measure that is on-going. About 530,000 men have undergone through the voluntary medical circumcision. People living with HIV/AIDS are encouraged to speak openly and freely about their status as noted in the Ugandan government where people have moved from silence, denial and finger pointing to a greater deal of openness and public discussion of the scourge (Slattery, 2004).

The strategic plan is based on assessments of vulnerabilities at both 'macro' and 'micro' levels. At the 'macro' levels, many of the underlying vulnerabilities that contribute to the spread of HIV remain strong. Kenya remains a deeply unequal nation in terms of income disparities and gender norms, roles and relations. In the context of the Kenyan HIV epidemic, indications of specific deprivation among the urban poor and women are clear: lack of control of human capital, rights, assets and information; and the denial of entitlements to inheritance and equality of opportunity, e.g., for education and care. Social exclusion also limits, and sometimes entirely prevents, people's voice and participation within their communities in shaping them, implementing, monitoring and evaluation actions that are likely to have a considerable impact on their own lives, for example, the failure of both the urban and rural poor to access health services, or to access social capital for support and social protection, compound vulnerability to infections.

2.9 Theoretical framework

The study was guided by the social action theory which is a community-oriented model that is used to increase the problem-solving ability of entire communities through achieving concrete changes towards social justice. Individuals within communities come together to redress the imbalance of powers or privileges between a disadvantaged group and society at large. The theory which was founded by Max Weber examines smaller groups within the society and the subjective states of an individual. The theory sees the society as a product of human activity and that Social action creates the structures, which Weber calls 'duality of structure'. Weber says that a 'social action' was an action carried out by an individual to which an individual attached a meaning and that all human action is directed by meanings. People act in a certain way because of built-in habits but Bandura views a person as the producer and the product of his or her environment (Bandura, 1986)

The theory notes that anything done with a motive/intention is a social action. Weber acknowledges the existence of classes, status groups and parties. Human behaviour is shaped by an individual. Weber believes that bureaucratic organizations are the dominion institutions in society, and that institution consists of individuals carrying out rational social actions designed to achieve the goals of bureaucracies. The theory is concerned with individual roles within the family as opposed to the family's relationship to wider society. Weber argues that the way in which roles are constructed in the family is not merely a matter of individual negotiation, but a reflection of how power is distributed in wider society.

This study adopted the social action theory as propounded by Max Weber in decision-making and problem-solving. The study hoped to explain the way individuals react to phenomena that affects them as affected by the environment that surrounds them. The actions are driven by this perception of the milieu socially, physically and psychologically. That human action is the sum total of the environment they find themselves in and also the socialization.

2.9.2 Conceptual Framework

This section covered a description of the independent variable (Gender) the dependent variables and intervening variables.

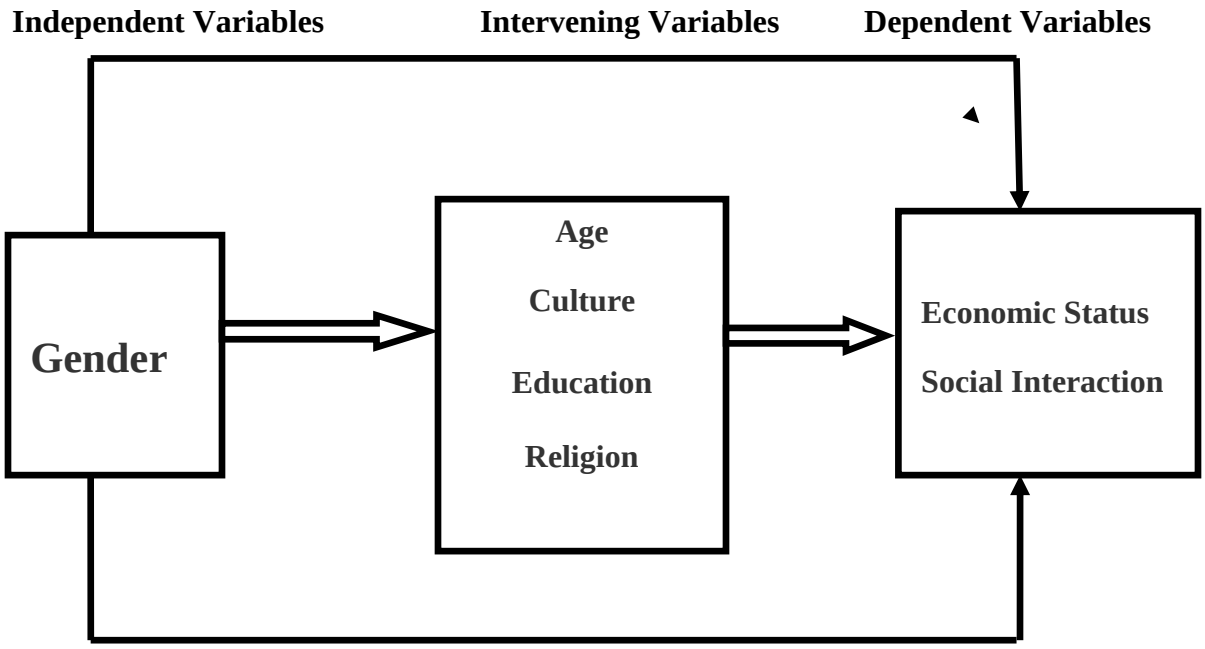

Figure 2.1: Conceptual framework

The figure above shows variables involved in the study.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

In this chapter, the researcher explored the methodology used in this research. This includes aspects such as research design, research site, population targeted by the researcher, sample and sampling procedures, instrumentation, validity, reliability, data collection procedure, data analysis and ethical considerations.

3.1 Research site

The study was conducted in Kaptembwo location, Nakuru County, Kenya. Kaptembwo is located to the western part of Nakuru town about 5km from the central business district (see map in appendix 3). Nakuru County has an estimated population of approximately 1,603,325. Nakuru West Sub- County consists of four locations, namely, Viwanda, Baruti, Kapkures and Kaptembwo with an estimated population of approximately 154,781 people, 80,963 of whom are males and 73,818 are females. Kaptembwo Location has a population of approximately 112,937 out of whom 58,711 are males and 54,226 are females. The location occupies an area of 8.6 sq. km with a total of 36,404 households. The analysis of population of Nakuru district according to the Nakuru District Development Plan for 2008-2012 revealed that the district has a youthful population of 74.4 per cent were 30 years and below.

The economic activities of the area include, small-scale farming, hawking and small-scale business. A number of the infected people depend on well wishers for their upkeep. About 70% of the population lives below the poverty line. The place has poor infrastructure network with most household not served with electricity, poor drainage system, poor sanitation and road network. The education sector is characterized by high enrolment rates, inadequate physical infrastructure and low staffing levels. The location was chosen because the area has a high population with low income earners. This condition is closely associated with high prevalence of HIV/AIDS. Thus the prevailing conditions of living among the youth provided a more

representative finding which is going to be helpful for further study (Kenya National AIDS strategic plan for 2009-2013)

3.2 Research Design

A research design according to Kothari, 2004 is the arrangement of conditions for collection and analysis of data in a manner that aims to combine relevance to the research purpose with economy in procedure. It constitutes the blueprint for the collection, measurement and analysis of data. It provides a plan or framework for data collection and its analysis. The researcher in this study employed a case study design of Kaptembwo location which has a total of 36,404 households. The raw data was collected using interviews, face to face interview, focus group discussions and questionnaires while secondary data was collected from books, journal, and internet in the month of August 2013. Data was analyzed using both interpretations of raw data, critical analysis and inferential statistics with the help of Statistical package for social scientist (SPSS). The findings are presented in form of tables, frequencies and explanation

3.3 Study Population and unit of analysis

The study population which was drawn from social support groups consisted of infected youth in Kaptembwo location, Nakuru County. The age of this target population was between 18 and 34years. This was the most sexually active age group and hence the most vulnerable to HIV/AIDS (Kenya National AIDS strategic plan for 2009-2013)

3.4 Sample and sampling procedures

According to Daniel, 1999 a sample size for the study can be calculated, that is:

$$\mathbf{n=z^2pq/d^2}$$

Where,

p is the proportion in population possessing the characteristic of interest which in this case is prevalence of HIV among the youth

q is the proportion of population without the characteristic

d is the desired interval which in most epidemiological studies is set at 0.05. The desired confidence interval for your study was 95% and z for this is 1.96. According to KAIS (2012), HIV prevalence was 5.6. Therefore;-

$n=1.96^2 \times 0.056 \times 0.94 / 0.05^2$

n= 80

The researcher employed snowball sampling techniques. This sampling procedure is normally used when it is difficult to identify members of the desired population. (Dominowswick, 1980). In this case this was the most appropriate method due to the negative stigma associated with HIV/AIDS persons. Since it was difficult to identify members of the desired population, the researcher made contact with two cases in the population with the support of medical personnel and community social workers in the month of August 2013 who later linked the researcher to the others until the sample was 90(ninety).

These are people who have openly declared their status and have joined support groups in various centers where they are helped to cope with their daily activities. The researcher created rapport with the members and were assured confidentiality. They were requested to provide the information needed for successful completion of the study.

The structured questionnaire had fourteen questions seeking information from youth living with HIV/AIDS in relation to their age, gender, education level, economic status as well as their social interaction. The target group included infected youth between ages eighteen years and thirty four and excluded those below age eighteen and above thirty four respectively.

3.5 Methods of data collection

The research instruments used to collect primary data were:

3.5.1 Interviews

30 people living with HIV/AIDS were interviewed using the interview guide (see appendix 2)

3.5.2 Face to face interview

Face to face interview was done to 10 leaders who had worked with the HIV infected youth

3.5.3 Questionnaire

30 structured questionnaires were administered to the HIV infected persons (see appendix 1)

3.5.4 Focus group discussions

A focus group discussion comprising of 10 people was used.

Secondary data was used to supplement primary.

3.6 Validity

To achieve content validity, the researcher sought assistance from the supervisors on development of the questionnaire which was the primary instrument for data collection. Validity in data collection means that the findings truly represent the phenomenon the researcher claims to measure. Adjustment was made to accommodate the recommendations from the university assigned supervisors and experts.

3.7 Reliability

A pilot study comprising 10 people from the comprehensive unit of Nakuru Provincial hospital was used for piloting the questionnaire and changes to accommodate the adjustment necessary were undertaken before the instrument was fielded. In this study the value of coefficient of at least 0.7 was used. The consistency of measure for this study was done by use of Cronbach's Alpha, a reliability coefficient that indicated how well the items in the data collection instrument are positively correlated to one another (Hatcher, 1994). Cronbach's Alpha has a reliability index of 0.7. This is considered moderately high on a scale of 0.00-1.00 as it tends to 1.00 in attitudinal measurement scales and above the 60 percent generally accepted as a cut off for reliability.

3.8 Data collection procedure

The researcher obtained clearance from the graduate school and Egerton ethical committee. A research permit was also sought from the National Commission for Science, Technology and innovation (NACOSTI), County Commissioner Nakuru and the County Director of Education Nakuru. The researcher personally administered questionnaires to the PLWHA

3.9 Data processing and analysis

The collected questionnaires were checked to ensure that they are adequately and appropriately filled. The foregoing minimizing chances of non-responses and extreme outliers. The raw data was then coded and analyzed with the aid of statistical package for social sciences (SPSS) software version 17. The data was presented in form of tables. Qualitative data was categorized into appropriate themes and pattern then summarized using frequencies and percentages.

3.10 Ethical consideration of study

The informants were identified and objectively selected as the subjects who provided information for this study. Informants were requested to provide the information needed for successful completion of the study. Any information given was kept strictly confidential and also anonymous and utilized only for the purposes of which it is intended.

CHAPTER FOUR

DATA ANALYSIS PRESENTATION AND INTERPRETATION

4.0 Introduction

This chapter presents the analysis of data from the fielded items in the study questionnaire. The findings are analyzed and presented using both descriptive and inferential statistics with the help of Statistical package for social scientist (SPSS) software.

The data is presented in form of tables. The responses are presented followed by a brief interpretation guided by the research objectives and a discussion on research findings from the analysis of the data.

4.1 Demographic and Economic Characteristics of the Respondents

This section presents the distribution of respondents based on demographic data that includes age, gender, marital status, level of education and economic characteristics. The findings are presented in tables 4. 1 to 4. 5

Table 4.1 Distribution of Respondents' Gender

Gender	Frequency	Percentage
Male	45	56.7
Female	35	43.3
Total	80	100

Table 4.1 shows that 57 per cent of the respondents in the study were male and 43 per cent were female. These are people who have openly declared their status and have joined support groups in various centers where they are helped to cope with their daily activities.

Table 4. 2 Respondents' Age brackets (N=80)

Age bracket (Years)	**Male**		**Female**	
	Frequency	Percentage	Frequency	Percentage
18-24	3	6.6	2	5.7
25-34	42	93.3	33	94.2
Total	**45**	**100**	**35**	**100**

Table 4.2 above shows that 93% and 94% of male and female respondents respectively were between the ages of 25 years and 34 years.

Table 4.3: <u>Respondents' Marital Status (N=80)</u>

Marital Status	**Male**		**Female**	
	Frequency	**Percentage**	**Frequency**	**Percentage**
Single	10	22.2	3	8.5
Married	9	20	4	11.4
Divorced/Separated	8	17.7	3	8.5
Widowed	8	17.7	8	22.8
Cohabitating	10	22.2	17	48.5
Total	45	100	35	100

It was noted that the marital status of male respondents was fairly distributed between single, married, divorced/separated, widowed and those that were cohabiting as opposed to females nearly a half of whom were cohabiting (Table 4.3).

Table 4.4: Respondents' Monthly Earning (N=80)

Earning per month (Kshs.)	Male		Female	
	Frequency	Percentage	Frequency	Percentage
100-1500	4	8.8	4	11.4
1501-3000	12	26.6	7	20
3000-4500	17	37.7	20	57.1
4501-6000	9	20	2	5.5
Over 6000	3	6.6	2	5.7
Total	45	100	35	100

Table 4.4 shows that gender had no effect on income with a p value of 0.168. This showed that there was no statistically significant relationship between gender and income.

Table 4. 5: <u>Relationship between Marital Status and income</u>

Income	Marital status																				
	Single				Married				Divorced				Widowed				cohabitating				Total (%)
	M	%	F	%	M	%	F	%	M	%	F	%	M	%	F	%	M	%	F	%	
100 - 1500	1	1.25	-	-	1	1.25	-	-	-	-	-	-	3	3.75	1	1.25	2	2.50	-	-	10
1501-3000	1	1.25	1	1.25	-	-	1	1.25	2	2.50	1	1.25	7	8.75	2	2.50	4	5.00	-	-	23.75
3001-4500	5	6.25	2	2.50	1	1.25	1	1.25	4	5.00	2	2.50	1	1.25	1	1.25	3	3.75	17	21.25	46.25
4501-6000	2	2.50	-	-	3	3.75	2	2.50	1	1.25	1	1.25	-	-	1	1.25	-	-	1	1.25	13.75
Over 6000	1	1.25	-	-	3	3.75	1	1.25	-	-	-	-	-	-	-	-	-	-	-	-	6.25
Total	10	12.5	3	3.75	8	8.75	5	6.25	7	8.75	4	5	11	13.75	5	6.25	9	11.25	18	22.5	100

Table 4.5 shows that 46% of the respondents earned Kshs 3001-4500, twenty-five percent of these were cohabiting.

There was a statistically significant relationship between marital status and income with a p-value of 0.017.

Table 4.6: Respondents' Level of Education (N=80)

Level of Education	**Gender**			
	Males		**Females**	
	Frequency	Percentage	Frequency	Percentage
Primary	25	55.5	20	57.1
Secondary	10	22.2	9	25.7
College	4	8.8	4	11.4
University	6	13.3	2	5.7
Total	45	100	35	100

Table 4.6 shows level of education against gender. The findings indicated that gender had no effect on the level of education as respondents seemed evenly distributed in attainment of education with a p value of 0.721.

Table 4.7: **Relationship between Income and level of Education**

Income	**Level of Education**																
	Primary				**Secondary**				**College**				**University**				**Total (%)**
	Males %		Females %		Males %		Females %		Males %		Females %		Males %		Females %		
100 -1500	3	3.75	5	6.25	-	-	-	-	-	-	-	-	-	-	-	-	10
1501-3000	10	12.50	7	8.75	2	2.50	-	-	-	-	-	-	-	-	-	-	23.75
3001-4500	16	20.00	4	5.00	6	7.50	10	12.50	1	1.25	-	-	-	-	-	-	46.25
4501-6000	-	-	-	-	1	1.25	-	-	2	2.50	4	5.00	1	1.25	3	3.75	13.75
Over 6000	-	-	-	-	-	-	-	-	1	1.25	-	-	2	2.50	2	2.50	6.25
Total	29	36.25	16	20.00	9	11.25	10	12.50	4	5.00	4	5.00	3	3.75	5	5.95	100

Table 4.7 above shows earnings against education level. The findings showed that majority of the respondent with secondary education and below (79%) earned relatively lower than those that had college/university level of education. Although it was established that the higher the education level the higher the income earned this was not statistically significant as p value was 0.222.

4.2 Respondents' social Interactions

Table 4.8: Rating of Respondents per their performance in Religious Activities (N=80)

Performance in religious activities	Males		Females	
	Frequency	Percentage	Frequency	Percentage
Excellent	2	4.4	3	8.6
Good	10	22.2	28	80
Fair	10	22.2	3	8.6
Poor	23	51.1	1	2.8
Total	45	100	35	100

The researcher sought to find out the respondents' performance in religious activities. This included the way they participate in church programmes with leadership positions being rated as excellent at 80%. Members of choir and youth groups were rated doing well between 69% and 79%. Those who only attended church services were rated as doing fairly between 50% and 69%. Those not involved in religious activities were rated as doing poorly at 49% and below.

Table 4.8 showed religious performance against gender. The findings indicated that a majority of females performed well in religious activities unlike males who did poorly. The p value was 0.00 which meant that there was a statistically significant relationship between religious activities and gender.

Table 4.9: Respondents on Stigmatization encountered with peers (N=80)

Response	Males		Females	
	Frequency	**Percentage**	**Frequency**	**Percentage**
Yes	41	91.1	20	57.1
No	4	8.9	15	42.9
Total	45	100	35	100

Table 4.9 shows the level of stigmatization in relation to gender. The study found out that more males than females' encountered stigma while with their peers at 91%. This showed that there was a statistically significant relationship between stigmatization and gender with a p value of 0.00 which is less than 0.05. Hence gender determines the level of stigmatization.

Table 4.10: Relationship between Stigmatization and level of Education

Stigmatization	**Primary**				**Secondary**				**College**				**University**			
	M	%	F	%	M	%	F	%	M	%	F	%	M	%	F	%
Yes	20	25.00	24	30	10	12.50	3	3.75	1	1.25	2	2.50	-	-	1	1.25
No	1	1.25	-	-	4	5.00	2	2.50	4	5.00	1	1.25	5	6.25	2	2.50
Total	21	26.25	24	30	14	17.50	5	6.25	5	6.25	3	3.25	5	6.25	3	3,75

Table 4.10 shows level of stigmatization in relation to education. There was statistically significant relationship between stigmatization and level of education with a p value of 0.025. Thus the lower the level of education the higher the level of stigmatization.

Table 4.11: Interaction/Socialization with Peers/groups (N=80)

Response	Gender			
	Males		Females	
	Frequency	Percentage	Frequency	Percentage
Excellently	1	2.2	1	2.8
Very well	6	13.3	-	-
Well	10	22.2	3	8.8
Fairly well	8	17.8	8	22.8
Poorly	20	44.4	23	65.6
Total	45	100	35	100

In Table 4.11 the researcher sought to find the respondents way of interacting/socializing with their peers. This included the way they participated in community programmes. A leadership position was rated as excellent at 80% and above. Those involved in sports were rated as doing very well between 70% and 79%. 60 % and 69% were for respondents who participated well in Self-help groups. Those who were involved in youth groups were rated between 50% and 59% for doing fairly well. 49% and below was for those who were not in any way involved in any community programmes. Although the findings show that females had higher proportion with poor peer interactions, there was no statistically significant relationship between the two variables whose p value was 0.059.

Table 4.12: Talking freely on status (N=80)

Response	Males		Females	
	Frequency	Percentage	Frequency	Percentage
Yes	8	17.8	27	77.1
No	37	82.2	8	22.9
Total	45	100	35	100

Table 4.12 shows that a majority of the male respondents did not talk freely about their status at 82%, while 77 % of female respondents indicated otherwise. It was further established that gender had a statistically significant relationship with talking freely about status where the p-value was 0.00. This suggests that one's gender affects the way one talks about one's status; the women were freer.

4.3 Respondents' on the Relationship between Gender and Social Interaction.

Table 4. 13: Gender and Social interaction (N=80)

	Males		**Females**	
Response	**Frequency**	**Percentage**	**Frequency**	**Percentage**
Never	12	26.7	0	-
Rarely	12	26.7	0	-
Sometimes	10	22.2	12	34.3
Always	11	24.4	23	65.7
Total	45	100	35	100

Table 4.14 shows the level of interaction with others. The study indicates that more female interacted more with others than the males. The p- value was 0.059, which shows a non-significant association.

Table 4.14: Love by others (N=80)

Response	**Males**		**Females**	
	Frequency	Percentage	Frequency	Percentage
Yes	27	60	2	5.6
No	18	40	33	94.3
Total	45	100	35	100

Table 4.15 shows love by others. The findings established that a majority of (94%) of females' respondents felt unloved (94%). The study further indicated that the p- value was 0.00 which suggests that females felt more unloved than males.

Table 4.15: Appreciation after Performing Tasks (N=80)

Response	**Males**		**Females**	
	Frequency	Percentage	Frequency	Percentage
Never	6	13.3	10	28.6
Rarely	10	22.2	22	62.9
Sometimes	17	37.8	2	5.7
Often	12	26.7	1	2.8
Total	45	100	35	100

Table 4.15 shows the level of appreciation after performing a given task. The findings indicates that gender had influence on performance of a given task where more female (63%) rarely felt appreciated. The level of significant was at 0.00 which meant that there was statistically significant relationship between appreciation and gender. The level of appreciation after performing a given task therefore depends on one's gender.

4.4 Respondents' on the Relationship between Gender and Economic Status.

Table 4.16: Impact of Gender on Income (N=80)

Response	**Males**		**Females**	
	Frequency	Percentage	Frequency	Percentage
Never	14	31.1	-	-
Rarely	19	42.2	-	-
Sometimes	2	4.4	4	11.4
Always	10	22.2	31	88.6
Total	45	100	35	100

Table 4.16 shows the feelings of respondents on whether gender affects income. The study findings indicate that more females (89%) felt gender always had impact on the income while 42% males felt that gender rarely affects income. However, the level of significance was at 0.168.

DISCUSSION

The findings shows that a majority of the respondents with secondary education and below (79%) earned relatively lower than those that had college/university level of education. In particular it was established that the higher the education level the higher the income earned. However, females with university level of education seemed to be earning less than male with college level of education. This concurs with Fox Mp et al, 2004 who notes that despite the robust pace of economic development, women's poverty has increased due to unequal situations in the labor market. Weber however, argues that the way in which roles are constructed in the family is not merely a matter of individual negotiation, but a reflection of how power is distributed in wider society http://books.google.co.ke

On the other hand, the study shows that a third of the population was cohabiting 96% of who were earning less than ksh.4500 and a majority being females thus putting them at high risk of HIV infection/re-infection. This agrees with the findings of Whiteside, 2008 who states that low education levels and low economic status causes women to be dependent on men. Were and Kiringai, 2003 also notes that women's lower socioeconomic status in Africa makes them more vulnerable to HIV infections either because they lack bargaining power in sexual relationships or in a marriage context.

According to Max Weber, People act in a certain way because of built-in habits while Bandura views a person as the producer and the product of his or her own environment (Bandura, 1986,file:///c:/users/hp/Desktop/max.weber,DifferentTheoriesofsocialAction, Definitions of social Action.htm)

The study notes that a majority of the female respondents were involved in religious activities as opposed to majority of the male respondents. While both gender encountered stigma with their peers, the study establishes that this was more common with male respondents than female. However, it was noted that there was a statistically significant relationship between

stigmatization and level of education in that, the lower the level of education the higher the level of stigmatization. It also establishes that more males interacted poorly with their peers compared to their female respondents who also were found not to be talking freely on their status. According to Slattery 2004, if one has AIDS, he/she should feel free to talk about. He further says that "the people of Uganda, beginning from the president and the government, have moved from silence, denial and finger pointing to a greater deal of openness and public discussion on HIV/AIDS.

While the female respondents felt that gender to a reasonable extent affected their interaction, most of them also felt not loved by others as compared to the male respondents. Equally, more of the female respondents felt rarely appreciated after performing a given task. This may be attributed to the fact that social action as expounded by Max Weber is a product of an action carried out by an individual to whom an individual attaches meaning, either positive or negative. file:///c:/users/hp/Desktop/max.weber,DifferentTheoriesofsocialAction, Definitions of social Action.htm)

A majority of the leaders who were interviewed indicated that they socialized well with PLWHA. However, they felt that the gender factor sometimes had an impact on the way PLWHA interacted with one another. The study further shows that a majority of leaders interviewed had a feeling that male and female performed almost the same in their tasks and their gender had no effect on work performance.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

This study set to understand the effects of Gender on the economic status and social interaction of HIV/AIDS infected youth in Kaptembwo location, Nakuru County. The study was guided by the following research objectives: to determine the effects of gender on the economic status and social interaction among the HIV/AIDS infected youth as well as establishing their social, demographic and economic characteristic. The study was also guided by the following research questions: - What is the social demographic and economic characteristic of HIV/AIDS infected youth in Kaptebwo location? What is social interaction pattern of HIVAIDS infected youth in Kaptembwo location? What is the effect of gender on the economic status of HIV/AIDS infected youth in Kaptebwo location? What is the effect of gender on the social interaction of HIV/AIDS infected youth in Kaptembwo location?

5.1 Summary of findings

The study achieved its objectives very well. It was quite representative as the distribution in terms of gender was almost equal. It further went on to target a population that had in one way or another found a support group after first accepting and recognizing their status. The idea of support group was to help them cope with their daily activities while at the same time giving moral support.

In objective one the study concentrated on a youthful population which is currently the most prone to the scourge of HIV and AIDS. The majority population ranged between 24 to 34 years which falls within Kenyan definition of youth. The marital status varied in both gender in the sense that most males were fairly distributed between single, married, divorced/separated and widowed while large majority of females were cohabiting.

In objective two the study discovered that most of the respondents had good social interaction which could be attributed to the fact that they were first and foremost in support groups. Secondly most respondents were active in religious activities in one way or another varying from being members of the choir to youth church groups. It is also worth noting that among the

respondents, females were more involved in religious activities as opposed to males suggesting that gender had an effect on religious activities. Males were found to be more stigmatized as opposed to females. This can be connected to the level of social interaction where more females were more involved in religious activities as opposed to males. This in itself helps counter stigmatization and builds self confidence.

Education was also found to have an influence on stigmatization with lower education levels respondents encountered more stigma as opposed to higher education levels. This can be attributed to the awareness levels and ability to understand the plight and nature of the person. The more educated the more aware the person is, and hence lowering the level of stigmatization.

On feelings of appreciation and self-worth, the study found that indeed gender had some influence on how performance of tasks were perceived in that more males felt more appreciated than the females. This can be attributed to the roles that are traditionally associated with females vis a vis male roles in society.

In objective three, Gender did not necessarily affect income levels though marital status affected how much one earned. Education levels were also not affected by gender with the distribution almost even between the genders. However, level of education highly influenced level of income with those with higher education earning more than those who had lower level of education. Nevertheless, it has to be noted that the difference was not very significant as the P value was 0.222.

In objective four, the respondents were asked to explain in their own perception what they felt about gender and economic status. Majority of females felt that gender greatly influenced economic status with males being dominant. Most females felt that males were often in a better position to earn more than the female counterparts as opposed to the males who felt that gender did not play any significant role in the economic status of a person. This perception again can be attributed by the thought and prescribed notions of society where it is believed that a male can perform a more tasking and difficult task as opposed to a female and as such more money due to the nature of the work one does in relations to its remuneration.

All in all, the study shows that there is a significant relationship between gender and economic status and social interaction among HIV/AIDS infected youth in Kaptembwo location in Nakuru County.

5.1 Conclusions

From the foregoing research findings, the study arrived at the following conclusions: - , there is a relationship between the level of education and the income earned. The higher the level of education other factors held constant the higher the income earned. There is also a relationship between marital status and income earned. Those who were married earned more than the others. It may also be concluded that better income led to stable relationships given that a large majority who earned lower income were either single or cohabiting.

There is an inverse relationship between the level of education and stigmatization. The higher the level of education, the lower the stigma on those infected. This could be attributed to the fact that those who have higher level of education are able to research for more information on how to manage their condition hence are able to accept them and live more positively.

The study concluded that gender has influence on income earned. Male earned more than their female counterparts despite the level of education. This could be attributed to the notion that male's roles are superior to those of female hence enabling them to earn better.

The study also concluded that there is a relationship between gender and social interaction whereby more females than males performed better than their male counterparts in religious activities and in leadership positions. The male on the other hand felt loved and appreciated as opposed to their female respondents.

5.2 Recommendations

The study recommends that those living with HIV/AIDS need to be supported in attaining higher levels of education to enable them earn better income and help them settle in stable relationships to prevent further re-infections.

The study recommends that the government should spearhead strategies of demystifying the HIV/AIDS pandemic in the country. It should do so through its various agencies and also involve stakeholders that include non-governmental organizations, religious organizations among others.

Though there is an aspect of this going on, it's the study's recommendation that it should be enhanced especially among the youth living with HIV/AIDS and more so the males.

The studies also recommend that the government should develop programmes that would early detect infections among youths in order to support them through bursaries and scholarships to enable them further their education and reduce level of stigmatization.

The study further recommends research as to why cohabiting is very prevalent among the youth despite the dangers that exist in society today with the prevalence of the HIV/AIDS menace.

It is also recommended that continuous awareness campaigns be enhanced to improve the awareness that there are no specific jobs for either gender.

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APPENDICES

APPENDIX 1: Questionnaire for Youth Living With HIV/AIDS

Dear Respondents

My name is Kamande Francisca and I am a Masters Student at Egerton University currently undertaking a research on the effects of HIV/AIDS pandemic and gender on the economic status and social interaction of the infected youth in Kaptembwo location, Nakuru County. The questionnaire seeks information that is purely for academic purposes. You are kindly requested to respond to the questions honestly so as to enable the researcher accomplish the objectives of the study. Responses and personal details will be treated with utmost confidentiality.

Tick Appropriately

1. Gender: a) Male ( ) b) Female ( )

2. Age: a) 19-24 ( ) b) 25-30 ( ) c) 31-36 ( )

3. Marital Status: a) Single ( ) b) Married ( )

c) Divorced/separated ( ) d) Widowed ( ) e) Cohabitating ( )

4. How much do you earn per month?

a) 100-1500 ( )

b) 1501-3000 ( )

c) 3001-4500 ( )

d) 4501-6000 ( ) e) Over 6000 ( )

5. What is your level of education?

a) Primary ( ) b) Secondary ( ) c) College ( ) d) University ( )

6. How do you rate your performance in religious activities?

a) Excellent ( ) b) Good ( ) c) Fair ( ) d) Poor ( )

7. Do you encounter stigmatization while with your peers?

a) Yes ( ) b) No ( )

8. How do you interact/socialize with your peers/group?

a) Excellently ( ) b) Very well ( ) c) Well ( ) d) Poorly ( )

e) Fairly well ( )

9. Does your gender have any impact on your income?

a) Never ( ) b) Rarely ( ) c) Sometimes ( ) d) Always ( )

10. Are you able to talk freely about your status to your group/peers?

a) Yes ( ) b) No ( )

11. Do you think your gender affect your interaction with others?

a) Never ( ) b) Rarely ( ) c) Sometimes ( ) d) Always ( )

12. Do you feel loved by others?

a) Yes ( ) b) No ( )

13. How often do you feel appreciated after performing a given task?

a) Never ( ) b) Rarely ( ) c) Sometimes ( ) d) Often ( )

APPENDIX 2: Interview Guide

1. How long have you been in service.....
   ……?

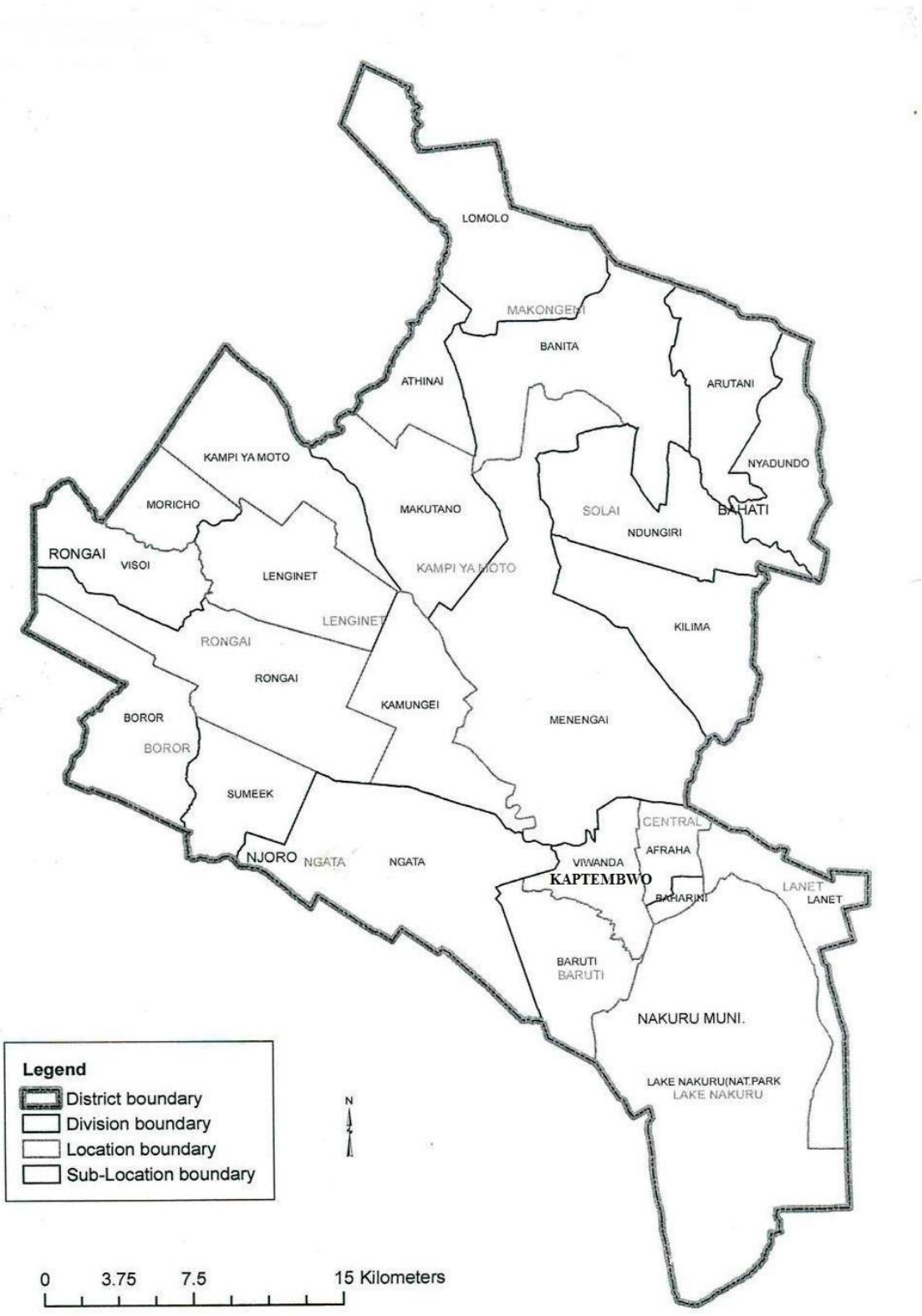
2. How have you been socializing with youth living with HIV/AIDS….....
   ……?

3. How would you rate performance of youth living with HIV/AIDS in terms of their gender…….
   ……

4. Do you think gender has any impact on the social interaction of those infected...
   ……

5. Do you think gender has any impact on the economic status of those infected.....
   ……

APPENDIX 3: Nakuru County Map



APPENDIX 4; Research Authorization from National Council for Science & Technology

REPUBLIC OF KENYA

NATIONAL COUNCIL FOR SCIENCE AND TECHNOLOGY

Telephone: 254-020-2213471, 2241349, 254-020-2673550
Mobile: 0713 788 787 , 0735 404 245
Fax: 254-020-2213215
When replying please quote
secretary@ncst.go.ke

P.O. Box 30623-00100
NAIROBI-KENYA
Website: www.ncst.go.ke

Our Ref: **NCST/RCD/12A/013/72**

Date: **21st August, 2013**

Francisca Nyambura Kamande
Egerton University
P.O.Box 536-20115
Egerton.

RE: RESEARCH AUTHORIZATION

Following your application dated ***5th August, 2013*** for authority to carry out research on "***The effects of HIV/AIDS pandemic and gender on the economic status and social interaction on the infected youth in Kaptembwo Location, Nakuru Municipality,"*** I am pleased to inform you that you have been authorized to undertake research in **Nakuru County** for a period ending **30th September, 2013.**

You are advised to report to **the County Commissioner and the County Director of Education, Nakuru 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.

SAID HUSSEIN
FOR: SECRETARY/CEO

Copy to:

The County Commissioner
The County Director of Education
Nakuru County.

"The National Council for Science and Technology is Committed to the Promotion of Science and Technology for National Development".

APPENDIX 5; Research Permit

PAGE 2

THIS IS TO CERTIFY THAT:
Prof./Dr./Mr./Mrs./Miss/Institution
Francisca Nyambura Kamande
of (Address) Egerton University
P.O Box 536-20115, Egerton.
has been permitted to conduct research in
Nakuru Location
Rift Valley District
Province
on the topic: The effects of HIV/AIDS pandemic and gender on the economic status and social interaction of the infected youth in Kamptembwo location, Nakuru Municipality.
for a period ending: 30th September, 2013.

Applicant's Signature

PAGE 3

Research Permit No. NCST/RCD/12A/013/72
Date of issue 21st August, 2013
Fee received KSH. 1000

For Secretary
National Council for Science &Technology

APPENDIX 6; Research authorization letter from the ministry of education

MINISTRY OF EDUCATION, SCIENCE AND TECHNOLOGY

Telegrams: "EDUCATION",
Telephone: 051-2216917
Fax: 051-2217308
Email: cdenakurucounty@yahoo.com
When replying please quote
Ref. NO. CDE/NKU/GEN/1/21/166

COUNTY DIRECTOR OF EDUCATION
NAKURU COUNTY
P. O. BOX 259,
NAKURU.

19TH September, 2013

TO WHOM IT MAY CONCERN

FRANCISCA NYAMBURA KAMANDE

The above referred person from Egerton University is hereby authorized vide NCST/RCD/12A/012/72 Research authority from one National Council for Science and Technology to conduct a research entitled "The effects of HIV/AIDS pandemic and gender on the economic status and social interaction on the effected youth in Kaptembwo Location, Nakuru Municipality for a period ending 30th September, 2013.

She would therefore be visiting diverse groups with a view to collect various research data within the said location

Any assistance extended to her is hereby appreciated.

SAMMY MALABA
FOR: COUNTY DIRECTOR OF EDUCATION
NAKURU COUNTY

APPENDIX 7; Research authorization letter

OFFICE OF THE PRESIDENT
Ministry of Interior and Coordination of National Government

Telegram: "DISTRICTER" Nakuru
Telephone: Nakuru 051-2212515
When replying please quote

THE DISTRICT COMMISSIONER
NAKURU DISTRICT
P.O. BOX 81
NAKURU.

Ref No. ED.12/10 VOL.VI/264

16th July 2013

TO WHOM IT MAY CONCERN

RE:- RESEARCH AUTHORIZATION
FRANCISCA NYAMBURA KAMANDE

The above named has been authorized to carry out a research on the *effects of HIV/AIDS pandemic and gender on the economic status and social interaction on the infected youth* in Kaptembwo location, Nakuru Municipality for a period ending 30th September 2013.

Please accord her all the necessary assistance to facilitate her research

T.K. SANKEI
DEPUTY COUNTY COMMISSIONER
NAKURU SUB COUNTY