PSYCHOSOCIAL CHALLENGES FACING LOW INCOME WOMEN LIVING WITH HIV/AIDS IN NAKURU MUNICIPALITY, KENYA

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A Research Project Report Submitted to the Graduate School in Partial fulfillment of the Requirements for the Award of Master of Arts Degree in Guidance and Counseling of Egerton University.

EGERTON UNIVERSITY

FEBRUARY, 2011

DECLARATION AND RECOMMENDATION

DECLARATION

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

Signature……Date……

TERESA ORIOKI

EM16/1729/06

RECOMMENDATION

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

Signature……Date……

DR. M.C. CHEPCHIENG

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DEDICATION

This research project report is especially dedicated to my dear husband, Mr. Shadrack Nyantika and my children, Edwin, Nelson, Alex, Winnie and Albert whose love, care and understanding have been my source of inspiration.

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ABSTRACT

Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) have been in existence for more than twenty years and women account for nearly half the 40 million People Living With HIV/AIDS (PLWHAs). HIV/AIDS has devastating psychosocial challenges on the infected low-income-earning women and it is worse if they are staying in an urban area. HIV/AIDS has economic implications on the infected and her family. Much study has been done on the transmission and prevention of HIV/AIDS but limited study has been done on the challenges facing low income earning women living with HIV/AIDS. Earlier studies have been done in Kenya aimed at establishing general challenges facing people living with HIV/AIDS. More detailed information is required on the psychosocial challenges faced by low-income earning women living with HIV/AIDS. This information may provide the basis for advocacy, mitigation policies and the design of effective interventions. To this end, the purpose of this study was to establish the psychosocial challenges faced by low-income earning women living with HIV/AIDS in the estates of Kaptembwa, Bondeni and Free Area in Nakuru Municipality. Based on descriptive survey design, the study targeted a population of 700 women who were being given Home Based Care out of which, using purposive and convenience sampling, a sample size of 248 women were selected and served with questionnaires. The data was analyzed using descriptive statistics being facilitated by the Statistical Packages for Social Sciences (SPSS) version 11.5 for windows. The analyzed data or findings are presented in tables and graphs. The findings of the study reveal that most of the low income earning women living with HIV/AIDS are suffering from shame, stigma, anger, trauma as well as being discriminated against. They also face negative reaction from family members and most of them are not empowered to cope with the scourge. The findings of the study may benefit the Ministry of Health and other Non-governmental to come up with effective strategies for protection of people living with HVI/AIDS (PLWHA), stigma reduction programmes and preventive measures of new infections among women. The study recommends NGOs, Ministry of Education and Counsellors to sensitize the public on the HIV/AIDS and its psychosocial challenges, carry out family counselling, provide ARVs freely and encourage voluntary counselling and testing (VCT).

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AIDS: Acquired Immunodeficiency Syndrome- is a stage of illness where the body of the infected women is no longer able to fight off common diseases, as result of its weakened defense system.

HIV: Human Immunodeficiency Virus- Which attacks the body's immune system- the part which fights diseases,

ICROSS: Internationals Community for the Relief of Starvation and Suffering. This is a NGO that provides Home Based Care to PLWAS in Nakuru Municipality.

NACC: National Aids Control Council

NASCOP: National AIDS Control Program.

PLWAS: People living with AIDS and was previously known PLWHAS,

PRB: Population Reference Manual.

SPSS: Statistical Package for Social Sciences

JNAIDS: Joint United Nation Program on HIV/AIDS.

USAID: United States Agency for International Development.

WHO: World Health Organization.

PLWHA: People Living With HIV/AIDS

CHAPTER ONE: INTRODUCTION

1.1 Background Information

Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) pandemic has been in existence in the world for twenty six years and has disproportionately affected women and young girls than men and young boys (UNAIDS/WHO, 2006). Globally, women account for nearly half the 40 million people living with HIV/A1DS (PLWHA) (UNAIDS/WHO, 2006). In sub-Saharan Africa, 59 percent of adults with HIV are women (UNAIDS/WHO, 2006). In Kenya, the number of women infected is twice that of men and in Nakuru District women account for 60% of the entire PLWHA (NASCOP 2006). In the year 2007, 24.5% of people in Kenya tested H1V positive, whereby 34.8% were women whereas 16.5% were men (NACC, 2008). This alarming trend is caused by the vulnerability of women to HIV. The rates of HIV infection among women and girls are a cause for deep concern, but when combined with the workload that women take on as well, the situation becomes challenging. Poverty and HIV/AIDS have turned the care burden for women into a crisis with far-reaching social, health and economic consequences (NACC, 2006). Low-income earning women are the most hit and the problem is magnified if the woman is the breadwinner and more so in a female-headed household.

Globally, there are now 40 million people living with HIV/AIDS. These include men, women and children with approximately 17.7 million being women (UNAIDS/WHO, 2006). Young women are 1.6 times more likely to be living with HIV/AIDS than men, and sub-Saharan Africa is the most devastated as 77 percent of all HIV- positive women live in the region (UNAIDS/

WHO, 2006). Since 1985, the number of women living with HIV/AIDS and those that are newly infected are 2.8 million while those who died in the year 2006 are 2.1 million (UNAIDS, 2006) Since the first case was diagnosed in Kenya in 1984, it was estimated that at the end of 2006, over 1.5 million people had died from AIDS related illness, resulting in 1.8 million children left as orphans (NACC, 2007). It is also estimated that 1.09 million people in Kenya are living with HIV today with two thirds being women (NACC, 2007). The gender difference is most pronounced among young people and female prevalence is nearly five times higher than male prevalence. There is significant regional variation in prevalence rates. The urban prevalence is nearly twice that of rural areas (NASCOP, 2004). In the Rift Valley, by 2005, a total of 16,832 people died from AIDS related illnesses. It is estimated that a total of 171,000 people in Rift Valley are HIV positive and of these, 4.9 % are women while the prevalence rate for men is 3.8%. The National and Provincial HIV prevalence estimates are as shown in Table 1 and 2.

Table 1: National HIV estimates for 2006

Adults 15-49	**Prevalence**	**Number HIV+**
Total (Range)	5.1 (4.6-5.8)	934,000 (700,000-1,200,000)
Male	3.5	320,000
Female	6.7	614,000
Urban	8.3	400,000
Rural	4.0	534,000
Total		**934,000**

Source: National Aids Control Program (2007)

Table 2: Estimated Adult H IV prevalence by province in 2006

Province	Number HIV+	Prevalence (%)		
		Total	**Male**	**Female**
Nairobi	197,000	10.1	8.0	12.3
Central	96,000	4.1	1.7	6.5
Coast	93,000	5.9	5.0	6.9
Eastern	72,000	2.8	1.1	4.4
North Eastern	9,000	1.4	0.9	1.8
Nyanza	183,000	7.8	6.1	9.6
Rift Valley	171,000	3.8	2.6	4.9
Western	112,000	5.3	4.2	6.4
Total	**934,000**	**5.1**	**3.5**	**6.7**

Source: National Control Program (2007)

From Table 2, there is no doubt that women are the most infected and affected by HIV/AIDS. Women's rates of new infection surpass men's because of the risk and vulnerability of women to HIV. Factors affecting the spread of HIV/AIDS among women and girls are: poverty, early marriage, and lack of education, wife inheritance, gender discrimination, violence, and culture of silence (NACC, 2007). Complex social and cultural barriers have made talking about sexuality or insisting on protection from HIV so difficult that even educated middle class women say they are unable to protect themselves, while low- income earning women have even less power to do so. Biological factors also contribute to women's greater vulnerability to HIV. The vagina has a greater area of susceptible tissue compared with the male urethra and often sustains microtrauma during sexual intercourse. In addition, HIV infected semen typically contains a higher viral concentration than do vaginal secretions (UNAIDS/WHO, 2006).

Women living with HIV/AIDS face many socio-economic challenges such as poverty, lack of economic empowerment, lack of access to care and medication and they also face stigmatization and discrimination, violence and abandonment (NACC, 2007). AIDS pandemic has enormous influence on the social status of the households, which comes in various forms. There is increased medical and health expenditures and decreased income. The result is a loss of savings, assets and property in the affected households. This problem is magnified if the infected woman is the breadwinner. Absenteeism from work due to poor health makes the affected households poorer than they would have been without HIV/AIDS. Households experience the immediate impact of HIV/ AIDS because families are the main caregivers for the sick and suffer AIDS-related financial hardships (PRB, 2006). The vicious cycle of HIV/AIDS and poverty reduces resources to invest in health and education of children and therefore increases the risk of the other members of the household acquiring HIV infection (UNAIDS 2006).

The Government of Kenya, International donors, local and International Non Governmental Organizations (NGO' S), faith based organizations and many other facets of civil society are involved in activities and services to prevent HIV/AIDS (NASCOP, 2005).These efforts are critical but as long as women and adolescent girls are unable to earn an income and exercise their rights to education, health and property, or are threatened with violence, they will continue facing psychosocial challenges. The situation becomes more challenging to low- earning women who have psychosocial problems such as low self esteem and discrimination even before they got infected.

During the period of illness, they may face challenges like stigma, discrimination, isolation, fear, depression, and also are attacked by opportunistic diseases. During the period of illness caused by AIDS, the loss of income and the cost of the care and treatment for the infected family member can impoverish households (PRB, 2006). This study was aimed at establishing the psychosocial challenges facing low-income earning women living with HIV/AIDS within Nakuru Municipality.

1.2 Statement of the Problem

Women living with HIV/AIDS face psychosocial challenges, and it is worse if the infected woman is a low income earner. HIV/AIDS has economic implications on the infected and her family and it becomes more challenging if the infected low- income earning woman is staying in an urban area like within Nakuru Municipality. Earlier studies that have been done in Kenya have been on transmission and prevention on HIV/AIDS (NACC, 2005). Studies have also been done in Kenya aimed at establishing general challenges facing women living with HIV/AIDS in Kenya (NASCOP, 2005). Limited study has been done on the psychosocial challenges facing low income earning women living in Nakuru Municipality. Women infected and affected by HIV/AIDS have difficulties accessing basic services and protecting their rights, including access to health services, shelter, education, food and land rights. More detailed information is required on the psychosocial challenges faced by low —income earning women living with HIV/ AIDS. This information is to provide the basis for advocacy, mitigation policies and the design of effective interventions. This study therefore was aimed at establishing the psychosocial challenges that face low- income earning women living with HIV/ AIDS within Nakuru Municipality.

1.3 Purpose of the Study

The purpose of the study was to establish the psychosocial challenges faced by low-income earning women living with HIV/AIDS, within Nakuru Municipality.

1.4 Objectives of the Study

The following objectives guided the study:

i. To establish the psychosocial challenges facing low income earning women living with HIV/AIDS within Nakuru Municipality.
ii. To determine how low income earning women living with HIV/AIDS manage their psychosocial challenges.
iii. To compare the and psychosocial challenges faced by married and single low income earning women living with HIV /AIDS in Nakuru Municipality .

1.5 Research Questions

The research questions for the study were:-

i. What are the psychosocial challenges facing low-income earning women living with HIV/AIDS in Nakuru Municipality?
ii. How do women of low-income living with HIV/AIDS in Nakuru Municipality manage the and psychosocial challenges facing them?
iii. What are the and psychosocial challenges facing married and single low income earning women living with HIV/AIDS?

1.6 Significance of the Study

The results of the study may be useful to the government of Kenya and Non Governmental Organizations in coming up with key strategies for the treatment and care for women with HIV/AIDS. The findings may also benefit the Ministry of Health and other organizations to come up with effective strategies for protection of the rights of people living with HIV/AIDS (PLWHA), Stigma reduction programmes, encouraging PLWHA whose rights have been violated to seek legal redress through the justice system and also in prevention of new infections among women. The findings of this study might be useful to the guidance and counselling professionals for the improvement of their helping relationship with the low income earning women living with HIV/AIDS. The findings may also help the government of Kenya to come up with ways that will assist to reduce infection and provide information to women to enable them use these tools correctly.

1.7 Scope of the Study

The study was carried out in Kaptembwa, Bondeni and Free Area estates within Nakuru Municipality and it targeted both married and single low- income earning women living with HIV/AIDS. The focus of the study was to establish the psychosocial challenges facing them.

1.8 Limitations of the Study

The findings of the study will be generalized to the Nakuru municipality only. There were some seropositive clients who were reluctant at first to give any information due to stigma, denial, disclose, grief and shame that this scourge is associated with. Also, some of these PLWAs had full- blown AIDS and were so ill with the same or opportunistic infections that they were not

able to answer all the items in the questionnaire. There was also a potential limitation of the sensitivity of the respondents who feared that a stranger may use the information given against them. However, with the assistance of the leaders of the Home Based Care centers, the researcher was able to get their responses.

1.9 Assumptions of the Study

The study was based on the following assumptions:

i. The psychosocial challenges that face low-income earning women living with HIV/AIDS were dependent on HIV infection and low income.

ii. The respondents would co-operate and give the required information honestly and accurately.

1.10 Definition of Terms

In this study the terms that were irrationalized are defined as follows:

Affected Family: This is the family in which there is a woman living with HIV/AIDS.

Female-Headed Household : This is a household that is headed by a female single-parent who is the single income earner in the family and she is the one responsible for the financial management of the household.

Household: A unit of economic viability whether or not its members are physically disperse at any given time.

Low— income earning women: Women who earns less than KShs 2 000 per month.

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

Psychological Challenges: Emotional and mental consequences such as anger, stigma, denial and fear facing women living with HIV/AIDS.

Seropositive Person: This refers to person who tests HIV positive in the blood test.

Social challenges: These are challenges such as shame, discrimination and rejection encountered during interpersonal relationships in socialization both at home and in other social places.

Trauma: An emotional shock producing long lasting harmful effects on the individual.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This chapter reviews and summarizes the global overview of the HIV/AIDS infection. This chapter also highlights the following topics: Global overview of psychosocial challenges facing HIV positive women, how the low- income women manage these challenges they face a conceptual framework and the theoretical framework of the study.

2.2 Global Overview of the HIV Infection

Human Immunodeficiency Virus (HIV) and Acquired Immune syndrome (AIDS) pandemic has been in existence for twenty six years and has disproportionately affected women and young girls than men and boys. AIDS is caused by HIV, which attacks the body's immune system, the part of the body that fights diseases. AIDS is a stage of the illness where the body is no longer able to fight off common diseases as a result of its weakened defense system (NASCOP, 2004).

HIV is spread through blood, semen, vaginal secretions, and breast milk. The most common method of transmission is unprotected sexual intercourse with a HIV-positive person. Other routes include transfusions of HIV-infected blood or blood products; tissue or organ transplants; contaminated needles, syringes or other skin piercing equipment; mother to child transmission during pregnancy, birth, or breast-feeding. HIV is extremely fragile. It cannot survive outside the body's fluids or tissue and cannot penetrate unbroken skin (PRB 2006). Globally, young women are 1.6 times more likely to be living with HIV/AIDS than men, and sub-Saharan Africa is the most devastated as 77 percent of all HIV- positive women live in sub- Saharan Africa. Since 1985, the number of women living with HIV/AIDS and those that are newly infected are

2.8 million while those who died in the year 2006 are 2.1 million (UNAIDS, 2006). It is estimated that 1.4 million people in Kenya are living with HIV today of whom two thirds are women (UNAIDS, 2006). The gender difference is the most pronounced among young people and female prevalence is nearly five times higher than male prevalence. Prevalence rates also show significant regional and rural. Urban variation, with urban prevalence 10% nearly twice that in rural areas (5-6%) (NASCOP, 2004). In the Rift Valley, by 2005, a total of 16,832 people died from AIDS related illnesses. Those who died from Nakuru District are 4,624. Nakuru has got the highest number of deaths and has got a prevalence rate for women of 60% of all cases (NACC, 2006).

2.3 Challenges Facing Low-Income Earning Women Living with HIV/AIDS

Low- income earning women living with HIV/ AIDS face a lot of challenges which make it difficult for them to accept their status, cope and live positively. These challenges are psychosocial.

2.3.1 Psychosocial Challenges Facing Low-income Earning Women

The available evidence shows that AIDS epidemic is having an enormous effect on household, which come in various forms: increased medical and health expenditures and decreased income. The result is a loss of savings, assets and property in the affected households because HIV/AIDS imposes significant additional costs. This is magnified when the infected person is the bread winner. Absenteeism from work due to poor health as the disease progresses affects households and they become poorer than they would be without HW/AIDS. About 56% of the population in Kenya lies below the poverty line, subsisting on less than one dollar per person per day.

HIV/AIDS pushes affected households deeper into poverty. The vicious cycle of HIV/AIDS and poverty reduces resources, depleting the country of human capital in both the present and the next generation. Children who are in the affected households lack basic needs as a result of the poverty and HIV/AIDS related illnesses (Muindi, Kombo, Kithinji, & Wainaina, 2003).

AIDS threatens personal and national well- being by negatively affecting health, lifespan, and productive capacity of the individual and critically, by severely constraining the accumulation of human capital and its transfer between generations. The economic challenges facing low income women living with HIV/AIDS are first felt by the infected and their families particularly their spouses and children, since the hardest hit group is the 15-49 years old, which is the most economically productive group in the family. This group contributes income and labour to the family and when they are affected their households loose their contribution. However, the infected person is likely to loose a job and experience poverty as a result of high expenditure on treating AIDS. This situation may lead to loss of independence and this can be very humiliating to a person who was previously able and self-reliant. This will lead to loss of identity and self-esteem. When this happens, the individual will feel hopeless, and loss self -determination to forge ahead (NASCOP, 2005).

Absenteeism from work due to AIDS will make one experience a loss of status and loss of control since one will be vulnerable to the effects of the disease anytime. This may make one to have frequent hospital visits, absenteeism from work, lack of vigor and general despair. Finally, one loses trust in self and others and lapses into a state of hopelessness, which is likely to lead to death as times progress (NASCOP, 2003).

Household resources are compromised as the financial capacity to work is reduced. Money is diverted away from food, school and other expenditure so as to pay for the drugs to treat the opportunistic infections and hospitalization bills. Many Kenyan women cannot afford the cost of the medicine. Therefore the cripplingly high medical costs plus lost wages, guarantee that the family falls into poverty and destitution. The patient needs a well balanced diet but due lack of money, poor nutrition makes it more likely for a patient's HIV positive status to progress into AIDS sooner than would have been the case if adequate and well balanced meals were available NASCOP, 2005).

The family members who may not be infected will get affected in various ways. The opportunistic diseases which attack the HIV/AIDS patient will also affect the family.
Tuberculosis can easily spread through casual contact with other family members caring for the patients. This means that more family resources will be spent on health at the expense of other family needs such as education, nutrition and clothing (NASCOP, 2005).

When a person is diagnosed to be HIV positive, she is gripped with fear of publicity due to Stigma and workmates, friends, family members and the community will not like to associate with the sick person for fear of infection. Worse still, the sick individual may be judged as promiscuous. This may make her to resign from her job hence worsening the economic situation of her household (NASCOP, 2002).

The cost of medication and all related health issues takes a large portion of income both on household and national level. Muraah and Kiare (2001) reveal that another problem an

Individual has to contend with is the treatment of opportunistic infections such as tuberculosis, pneumonia and thrush for people suffering from HIV/AIDS. There are times when they will suffer from uncomfortable symptoms such as diarrhea, nausea, headache, fever and coughs and will need sedating care to deal with them (NASCOP, 2004).

In some cases the breadwinners have to quit their sources of income to take care of the ailing ones and thus reducing the source of finances for medical attention. Poverty in some cases has forced the health providers and patients to opt for lower doses of prescribed medication or choose less effective alternatives in order to save money. Diseases add to the burden of illness and shorten life expectancy (World Bank, 2000), due to the limited resources there is a smaller likelihood that the sick will seek or get treatment for STD' s with which they may be infected.

Educating children is a challenge to women living with HIV/AIDS. Most of these women have children who have been infected and many of these infected children do not survive to enroll in formal education, There are those who have been forced by circumstances to quit school so as to take care of their infected mothers. Others have no source of income to meet their educational needs due to the loss of the breadwinners. Other family members have to relinquish their jobs to take care of the infected family (NASCOP, 2.005).

Stigma is an attribute that is deeply discrediting and results in the reduction of a person or a group from a whole and usual person to a tainted, discounted one. Regarding others negatively, an individual or group confirms their own normalcy and legitimizes their devaluation of the other (Goffman, 1963).

Parker and Aggleton (2003), in turn, suggest that stigma can become firmly entrenched in a Community by producing and reproducing relations of power and control. Stigma is used by producing and reproducing relations of power and control. Stigma is used by dominant groups to legitimize and perpetuate inequalities, such as those based on gender, age, sexual orientation, class, race or ethnicity. By doing so, dominant groups effectively limit the ability of stigmatized groups and individuals to resist because of their entrenched marginal status. Furthermore, the stigmatized often accept the norms and values that label them as having negative differences (Golfhuin, 19963). As a result, stigmatized individuals or groups may accept that they 'deserve" to be treated poorly and unequally, making resistance to stigma and resulting discrimination even more difficult. Research shows that this internal stigma is manifested in many ways including self-hatred, self-isolation and shame (Alonzo & Reynolds, 1995).

Stigma discrimination blame and collective denial were potentially the most difficult aspects of the HIV/AIDS epidemicto address but also addressing them was key to overcoming it. (Mann, 1987). Stigma stillremains one of the most significant challenges in developing countries for all HIV and AIDS programs, across the prevention to care continuum. Stigma increases vulnerability to HIV and worsens the impact of infection. Fear of being identified with HIV keeps people from learning their serostatus, changing behavior to prevent infecting others, caring for people living with HIV and AIDS, and accessing HIV and AIDS services. Additionally, stigma intensifies the emotional pain and suffering of people living with HIV and AIDS, their families and caregivers (Bond & Nbubani 2000)

Nonetheless, HIV-related stigma remains poorly understood, particularly in developing countries. While studies investigating stigma have a longer history in developed countries like the US, most of this work has focused on the stigmatizing attitudes of individuals, rather than stigma as a societal phenomenon (Crandall, 1991; Crandall & Moriarty, 1995). The influence that stigma has on an infected person is that the individual suffers from a sense of rejection, as other people will not want to socialize with the: infected person. The infected person will then suffer from discrimination on the job, at home and in other social places. At these places, the individual is likely to be served with dishes specifically put aside for him/her. Even at the point of collection of used dishes, those used by the infected individual are likely to be isolated for sterilization.

As the HIV/AIDS infected women experience a series of negative feelings such as guilt, fear, loss of confidence and hope, grief, anxiety, denial and depression, they find it hard to live positively. Further more, the stigma related to HIV infection may lead to social isolation. Often, families do not disclose their HIV status to family members and their community for fear that they and their children will be mistreated. Florida Department (2000) asserts that this isolation prevents families from obtaining valuable social support during difficulty.

Due to illness of women, primary care responsibilities often fall to extended family member. In fact, grandmothers often become the primary caregiver for multiple children. Unlike other terminal illnesses, HIV/A1DS infection is further complicated by the stigma related to the transmission of HIV infection. Many families isolate themselves from their extended family and communities to protect themselves and their children from maltreatment. Thus they are cut off

from valuable supports. In conjunction with coping with the psychological and emotional effects of being infected with or affected by HIV/AIDS, these individuals are forced to deal with a multitude of stressors with little support. HIV/AIDS Surveillance Report (2000) suggests that those factors place these individuals and their family members at risk for mental health disorders, developmental deficits and behavioral problems such as drug or alcohol use, school failure, inability to maintain a job, and criminal behavior. These issues complicate the women's ability to access medical care and comply with complicated medication regimes. These reveal the psychological and social issues, which have influence on families who live with HIV/AIDS clients, NASCOP, 1999).

2.3.2 Managing the Psycho-Social Challenges facing Women Living with HIV/AIDS

For a long time, people have thought that being HIV positive was an automatic death sentence. Many people who are HIV positive live productively for 10 years or more. They manage the Psychosocial Challenges by living positively and taking good care of themselves. They eat well, get enough rest and exercise and attend promptly to any illness or infection. They also avoid habits like smoking and drinking and they act involved in family and work affairs. Living positively is a way to manage the HIV/AIDS infection that keeps a person as health as possible for as long as possible. They also manage their challenges by joining Home Based Care which means counselling and care of persons infected and affected by HIV/AIDS that is extended from the hospital or health facility to the patient's home. Home-based care consists of clinical care, nursing care, counselling and social support. A patient who is nursed in a familiar environment usually suffers less stress and anxiety than one who is far from home in a strange hospital or clinic.

2.4 Theoretical Framework

This study was built on various theories in psychology in an attempt to establish the psychosocial challenges facing low - income earning women living with HIV/AIDS. When a woman has been infected with HIV/AIDS, she is gripped with fear of publicity, feels humiliated, and suffers from stigma and discrimination (UNAIDS, 2006). Various psychological theories may be applied in helping low- income earning women living with HIV/AIDS. In this study, Person Centered Theory by Carl Rogers and Rational Emotive Theory by Albert Ellis (1955-1989).were used. These are affective approaches to counselling in which the counsellor focused on the client's feelings and gave secondary consideration to thoughts and behaviors.

2.4.1 Person Centered Theory

This theory guided the study. Carl Rogers (1902-1987) developed this theory and it emphasizes the importance of the quality of the relationship between the client and the counselor. Rogers is strongly committed to the belief that all persons should have the right to their own opinions and thoughts and should be in control of their own destiny, free to pursue their own interests in their own way as long as they do not trample on the rights of others. Any person can reach self-actualization if only given the necessary conditions for growth (George & Christian, 1990). This theory insists on the client being given unconditional positive regard. The counselor creates a warm and caring environment, never disapproving of the client (Santrock, 2000). The warm atmosphere offered by the counselor to the individual helps to improve his self-concept and gain insight (Feldman, 1996). The techniques utilized are genuineness, accurate empathy and active listening and the counselor is non-directive to the client (Craig, 1996).

2.4.2 Rational Emotive Theory (RET)

Rational Emotive Theory is also another that guided this study. Albert Ellis (1955-1989) developed this theory and he emphasizes that all normal humans think, feel and act, and that they do so simultaneously. Their thoughts affect and often create their feelings and behaviors. Their emotions affect their thoughts and actions, and their acts affect their thoughts and feelings. Ellis (1974) maintained that emotional disturbances are simply the result of an individual mistaken, illogical idea about a particular situation. Emotions frustration, depression, anxiety, self pity and feelings of worthlessness are inappropriate. These emotions tend to bring about poor results such as alteration of behavior of other people. Low-income earning of women living with HIV/AIDS suffering from emotional disturbances find it difficult to live positively. They feel that because they are affected by HIV/AIDS, they are worthless and they should be in isolation. The counselor using RET will engage in active, directive teaching to the client to abandon irrational thinking and lead her to a more satisfying emotional state.

2.5 Conceptual Framework

This study is conceptualized as shown in figure I

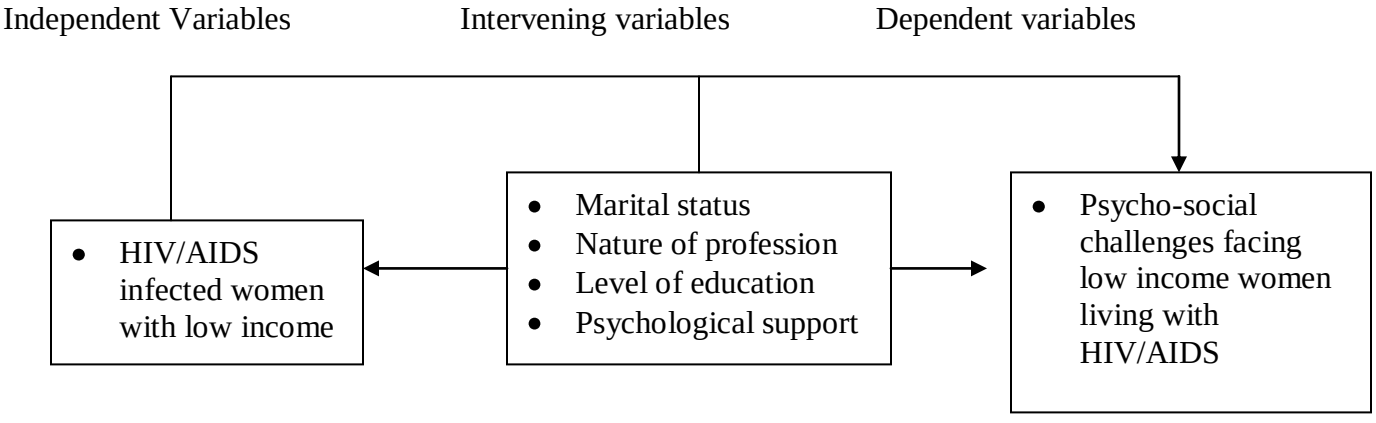


Figure I: Psycho-social Challenges facing low- income women living with HIV/AIDS.

Figure II: is a summary of the social -psychological challenges facing low-income earning women living with HIV/AIDS. The independent variables are HIV/AIDS and low income and dependent variables are the psychosocial challenges facing low income earning women living with HIV/AIDS. HIV/AIDS and low income as independent variables directly affects the psychosocial status of women. After being infected they face psychosocial challenges. However, there are intervening variables like marital status, nature of profession, level of education, and psychological and social support that may have an impact on these women socially and psychologically. These were controlled by studying some of them, like marital status and level of education.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

The focus of this study was on the psychosocial low income earning women living with HIV/AIDS. This section specifies the design used in the study, location of the study, sampling procedures and data collection instruments, data collection procedures and finally how data was analyzed.

3.2 Research Design

The research design applied in this study was descriptive survey. A survey was preferred over other designs because it allowed the researcher to derive extensive data from a larger sample of respondents within a short period of time (Mugenda & Mugenda, 1999). In this design, HIV/AIDS and low income variables were not manipulated because they had already occurred. Using this design, the researcher was able to establish the psychosocial challenges facing low-income earning women living with HIV/AIDS.

3.3 Location of the Study

This study was carried out in the estates of Kaptembwa, Bondeni and Free Area in Nakuru Municipality in Rift Valley Province of Kenya. These were the estates in which most low-income earning women stayed and HIV/AIDS prevalence rates were high among the low income earners.

3.4 Population of the Study

This research targeted 700 HIV/AIDS infected women who lived in Nakuru municipality. These were the HIV/AIDS infected women who had joined Home Based Care organizations that deal with HIV/AIDS positive people within Nakuru Municipality.

Table 3: Population of the study

Name of Home Based Care	**Number of Female Clients**
Love and Hope	170
Catholic Diocese of Nakuru	110
Badili mawazo	80
I cross	130
Red Cross	210
Total	**700**

Source: International Community For The Relief Of Starvation and Suffering (ICROSS, 2009)

3.5 Sampling Procedure and Sample Size

The researcher used a table suggested by Kathuri and Pals (1993) as shown in Appendix 2 for determining the sample size. According to the table, a population size of 700 should have a samp1e size of 248. Purposive sampling was used in the selection of the respondents. In this type of sampling, items for the sample were selected deliberately by the researcher on the basis that the sample was representative of the whole (Kothari, 1985). In purposive sampling, the researcher used cases that had the required information with respect to the objectives of the study. The criteria for choosing the particu1ar cases were based on their HIV status and economic level (monthly earnings). Homogeneous sampling design was used because the study focused on a particular subgroup that was considered to have similar characteristics.

3.6 Instrumentation

The researcher developed a questionnaire and used it in collecting data from low income women living with HIV/ AIDS regarding the psychosocial challenges facing them. Using the questionnaires, information on all variables was collected. Closed-ended questions were used to collect data, which provided a general picture of the variables of the study. The respondents were provided with checklists where they ticked the appropriate responses.

3.6.1 Validity of Instruments

The instruments were constructed based on the objectives of the study. The instruments were subjected to validation by using the researcher and the researcher's supervisor to review them. The researcher saw it that the instruments were clear and precise and would achieve the stated objectives. The researcher then sought the opinions of the experts from Egerton University, department of Psychology, Counselling and Education Foundations. The experts were asked to give their opinion on clarity, ambiguity, level of language used and any other information on the questionnaire in order to make the instruments valid.

3.6.2 Reliability of the Instruments

The researcher piloted the research instruments to enhance their validity and reliability in one Home Based Care center, Tumaini na Fadhili, within Nakuru Municipality that did not take part in the study. Necessary improvements on the instruments were made. In addition, the consistency levels of the research instruments were vital in determining whether the data to be generated from these instruments was to be reliable. The Cronbach's Alpha Co-efficient, which is an appropriate tool for summative test, was used to test reliability. A reliability co-efficient of 0.763

was obtained and therefore was considered acceptable as recommended by Kathuri and Pals (1993).

3.7 Data Collection Procedures

After satisfying the requirements of Egerton University, Department of Psychology, counselling & Education Foundation, the researcher obtained a research permit from the International Community For the Relief of Starvation and Suffering (ICROSS), to conduct research within the Nakuru Municipality. This was followed by a visit to various home based care centers within the Municipality to seek for permission from the leaders of the organizations as well as making appointments on the day of administering the questionnaires. Once permission was granted, the researcher carried out research on the selected respondents.

The researcher administered the questionnaires directly to the respondents because she had access to all the members of a particular group in one place and at the same time. The researcher had an opportunity to explain the study and answer any questions that respondents had before they completed the questionnaires. Once the questionnaires were administered, the raw data was organized in a manner that facilitated analysis.

3.8 Data Analysis

Data collected was coded and analyzed using descriptive statistics in form of percentages, mode and frequencies (Mugenda & Mugenda, 1999). Descriptive statistics enabled the researcher to meaningfully describe a distribution of scores. The Statistical Package for Social Sciences (SPSS) version 11.5 for windows computer software was used to aid data analysis (Fraenkel &

Wallen, 2006). The use of the computer helped the researcher to save time and to increase the accuracy of results (Mugenda & Mugenda, 1999).

CHAPTER FOUR: RESULTS AND DISCUSSION

4.1 Introduction

The purpose of this study was to establish the psycholosocial challenges facing low-income women living with HIV/AIDS within Nakuru Municipality. Data collected from the HIV/AIDS-status women using questionnaires were analyzed based on the study objectives replicated below:

i) To establish the psychosocial challenges facing low income earning women living with HIV/AIDS.

ii) To compare the psychosocial challenges faced by married and single low income earning women living with HIV /AIDS.

iii) To determine how the low-income earning women living with HIV/AIDS manage the psychosocial challenges they are facing.

The results of the analyzed data were interpreted, discussed and presented in appropriate sections as under the following themes:

i) Demographic characteristics of the low income earning women living with HIV/AIDS in Nakuru Municipality.

ii) Psychological challenges facing low income earning women living with HIV/AIDS in Nakuru Municipality.

iii) Social challenges facing low income earning women living with HIV/AIDS in Nakuru Municipality.

iv) Psychosocial challenges facing married versus single women living with HIV/AIDS in Nakuru Municipality.

v) How low-income earning women living with HIV/AIDS in Nakuru Municipality manage the psychological and social challenges facing them.

4.2 Demographic Characteristics of Subjects

The low income HIV/AIDS-status women living in the areas of Kaptemwa, Free Area and Bondeni were required to provide personal but relevant data in regard to their ages, marital status and monthly earnings.

4.2.1 Ages of Low Income Women Living with HIV/AIDS

Data about the ages of low-income women living with HIV/AIDS in the areas of Kaptembwa, Free Area and Bondeni in Nakuru Municipality are tabulated in Table 4

Table 4: The Ages of Low Income HIV/AIDS-Status Women

	AGE BRACKET (YEARS)				
RESIDENCE	**Below 20**	**20-30**	**31-40**	**Above 40**	**TOTAL**
Kaptembwa	4	23	35	10	**72 (29%)**
Free Area	4	28	33	13	**78 (32%)**
Bondeni	5	17	19	31	**72 (29%)**
No response	5	8	8	4	**25 (10%)**
TOTAL	**18**	**76**	**95**	**58**	**247 (100%)**

Table 4 shows that the age distribution of the HIV/AIDS-status women was fairly representative from all the four areas in the Municipality. The disparities in ages are further amplified by Figure 2.

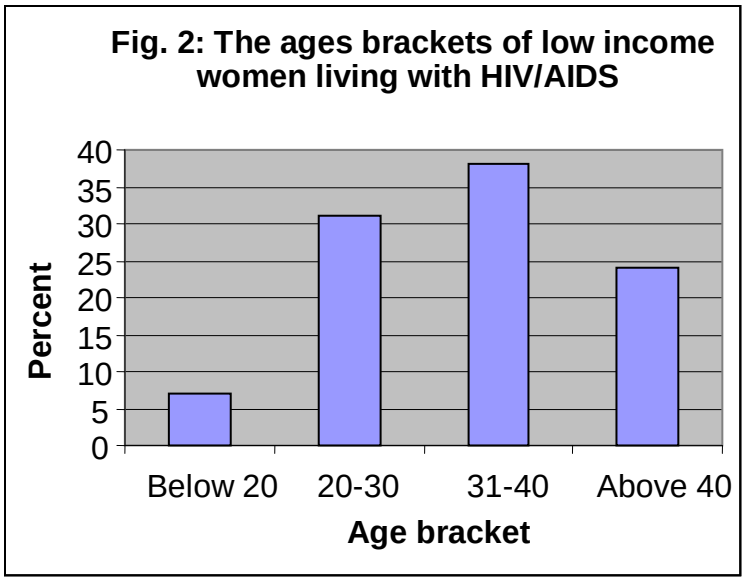


Figure 2 shows that the age distribution of the respondents was fairly representative of all the age brackets with those between 31 and 40 years old being the majority as represented by (38%) women followed by those aged 20-30 years old as said by (31%) women. The results support the report that was given by NASCOP (2006) which stated that most infected women and girls were in the age bracket of 15- 35. Since the results also show that the women living with HIV/AIDS had their ages cutting across all the age brackets, it implies that HIV/AIDS infection does not discriminate, that is, anybody irrespective of age or place of residence can get infected by HIV/AIDS. That is why HIV/AIDS had infected even those below 20 and above 40 years even if those mostly infected lay between 20 and 40 years.

4.2.2 Monthly Earnings of Low Income Women Living with HIV/AIDS

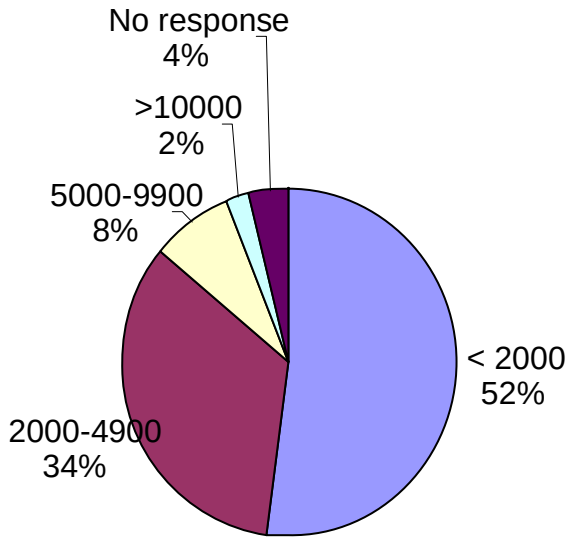
The monthly earnings of low income women living with HIV/AIDS were cross-tabulated according to their marital statuses. The findings are represented in Table 5.

Table 5: Monthly Earnings of Women Living with HIV/AIDS per Marital Status

Monthly Earnings (KShs)	MARITAL STATUS				
	Single	**Married**	**Widow**	**Divorced/ Separated**	**TOTAL**
Less than 2000	25	27	57	20	129 (52%)
2000-4900	15	25	26	19	85 (34%)
5000-9900	8	8	3	0	19 (8%)
More than 10000	2	1	0	1	4 (2%)
No response	3	4	2	1	10 (4%)
TOTAL	**53**	**65**	**88**	**41**	**247 (100%)**

From Table 5, the monthly earnings ranged from KShs 2,000 to more than KShs 10,000 though slightly over half of women, being (52%), had an income of less than KShs 2,000. Those who had an income more than KShs 5,000 per month were only (4%) These findings are in agreement with earlier report by UNESCO (2003) which stated that women earn a tenth of the world's income for doing two-thirds of its work. This means that most women live in poverty and have relatively low economic status. Disparities in the distribution of the earnings across the various income brackets of the low income women are presented in Figure 3.

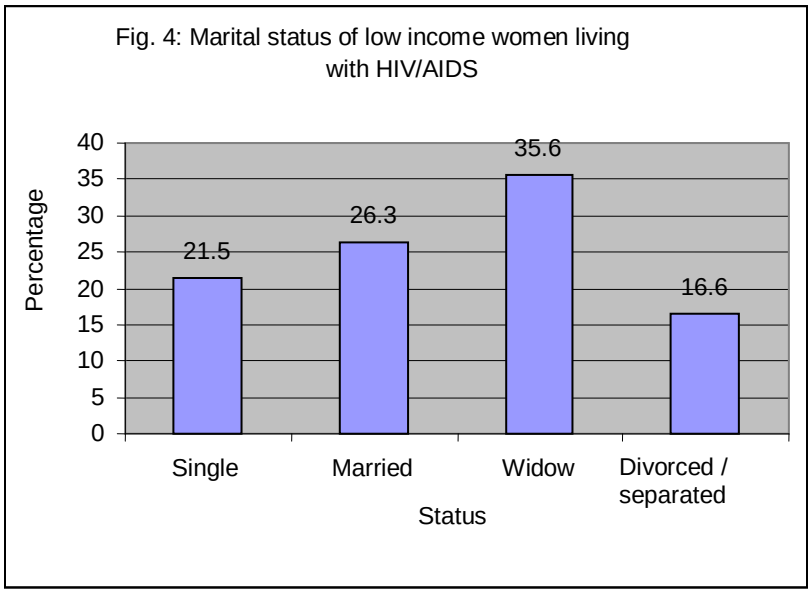
Fig. 3: Monthly earnings of low-income women with HIV/AIDS



As Figure 3 shows, majority of the low income women living with HIV/AIDS had an income of less than KShs 2,000 and very few with KShs 10,000 and above. This income translates to a range of KShs 67-333 per day, an amount which is below the International Poverty Line of US $ 70 (about KShs 490 as at 2009 exchange rates). This implies that the women would find it very difficult to meet their daily basic needs leave alone affording drugs for coping with HIV/AIDS unless they are assisted.

4.2.3 Marital Statuses of Low Income Women Living with HIV/AIDS

The findings of the marital status of the low-income women living with HIV/AIDS are presented in Figure 4.



It is clear from Figure 4 that despite all categories of low income women being infected, the majority were widows, who were (35.6%), followed by the married, who were (26.3%) as opposed to the singles, who were (21.5%) and the divorced/separated who were (16.6%). This means that the majority of the infected women were those within marriage or had one time been in marriage that is, the widows and divorcees, as compared to singles implying that a new wave of HIV/AIDS infections is spreading rapidly among couples, giving rise to devastating effects. These results support earlier report by NASCOP (2005) which say that women are more vulnerable to HIV because of social, economic, cultural and biological reasons. This worsens for married women who fear their husbands or partners will abandon them if they try to control how and when they have sex or whether their partners use condoms.

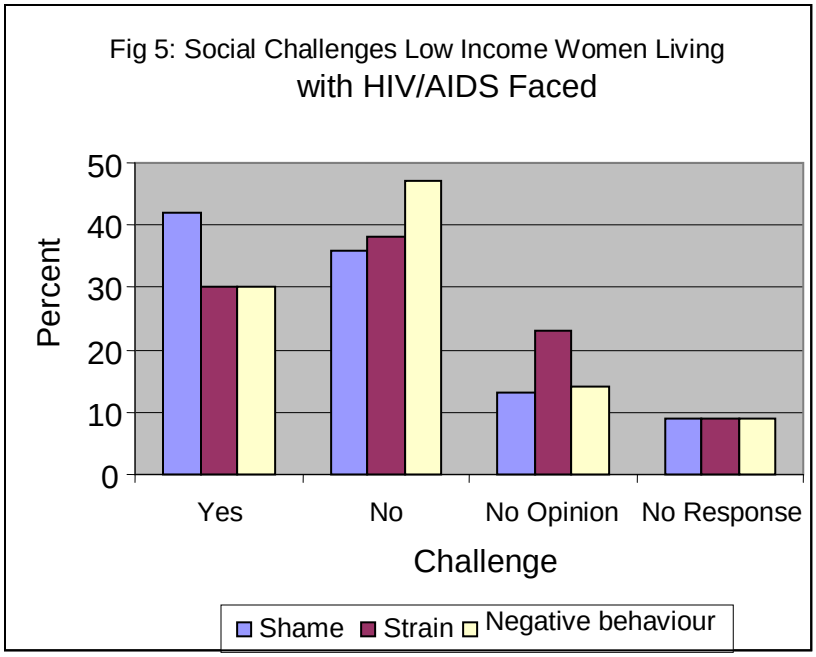
4.3 Psychosocial Challenges Facing Low Income Women Living with HIV/AIDS

Objective one of the study sought to document the psychosocial challenges facing low income women living with HIV/AIDS in Nakuru Municipality. The people living with HIV/AIDS face many social challenges, but the study was meant to determine those ones faced by the women in the selected areas of study. The findings are presented in Table 6.

Table 6: Social Challenges Facing Low Income Women Living with HIV/AIDS

Social Challenges	**Yes**	**No**	**No Opinion**	**No Response**	**Total**
	f (%)	**f (%)**	**f (%)**	**f (%)**	**f (%)**
Does shame affect you due to your status?	104 (42%)	89 (36%)	33 (13%)	21 (9%)	**247 (100%)**
Do you feel that your status strains family members?	75 (30%)	95 (38%)	56 (23%)	21 (9%)	**247 (100%)**
Has your status led to negative change of family members' behavior?	74 (30%)	117 (47%)	34 (14%)	22 (9%)	**247 (100%)**

Table 6 shows that the social challenges facing the low income women living with HIV/AIDS were shame, feelings of straining family members who supported them and problems of coping with negative change of family members' behavior due to their status. The findings are again presented in Figure 5.



Results in Figure 5 show that not all low income earning women living with HIV/AIDS get ashamed, strain their families, or face negative reaction from family members due to their status. Despite this revelation, still a section of the women say that such challenges did not face them. Shame emerged as the greatest social challenge facing (42%) women compared to straining families or negative reaction from family members being faced by (30%) and (30%) women respectively. In overall, the proportion of women living with HIV/AIDS facing various social challenges was lower than those who did not. This implies that the society is increasingly accepting HIV/AIDS victims. The results also show that a small proportion of women had no response or opinion about the social challenges they faced. Perhaps they may have regarded the HIV/AIDS matter as being sensitive to disclose. Besides the aforementioned social challenges, the low income HIV/AIDS-status women faced psychological challenges too. These findings also support earlier report by NASCOP (2005) which indicates that most people living with HIV/AIDS suffer from shame and feel that they are straining their families. They don't easily disclose their HIV status.

4.4 Psychological Challenges Facing Low Income Women Living with HIV/AIDS

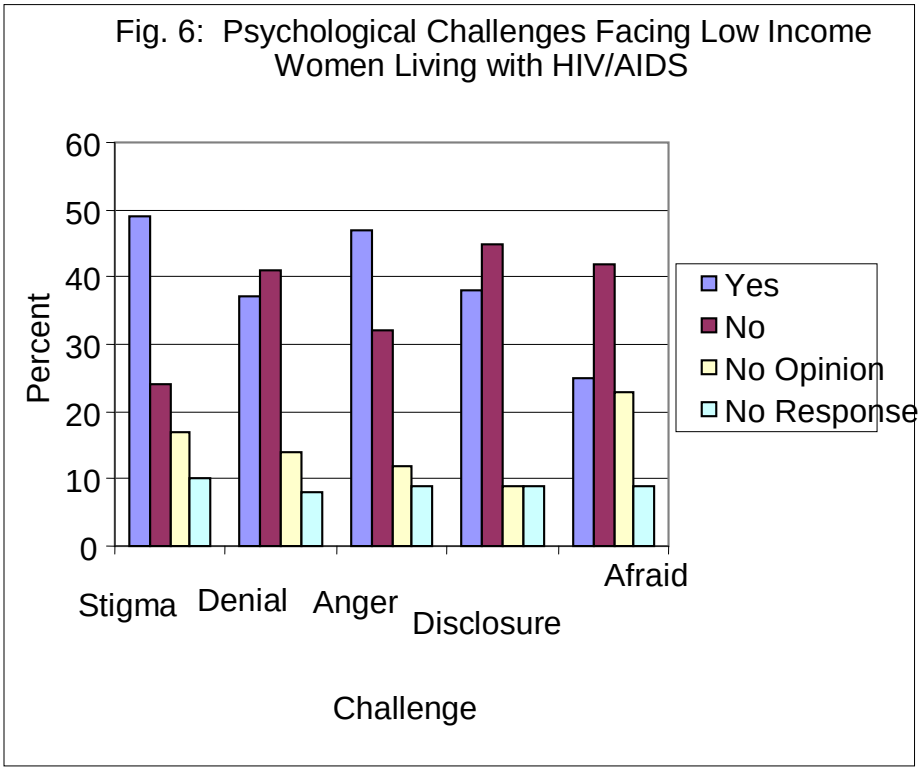
Objective two of the study sought to document the psychological challenges facing low income women living with HIV/AIDS in Nakuru Municipality. According to the women's responses, the psychological challenges facing them were stigma, denial, anger, disclosure and fear of infecting family members with HIV/AIDS. The results are presented in Table 7.

Table 7: Psychological Challenges Facing Low Income Women Living with HIV/AIDS

Psychological Challenge	**Yes**		**No**		**Not Sure/No Opinion**		**No Response**		**Total**	
	f	**%**	**f**	**%**	**f**	**%**	**f**	**%**	**f**	**%**
Does stigma affect you due to your status?	121	*49.0*	59	*23.9*	42	*17.0*	25	*10.1*	247	**100.0**
Does denial affect you due to your status?	91	*36.8*	102	*41.3*	35	*14.2*	19	*7.7*	247	**100.0**
Does anger affect you due to your status?	115	*46.6*	80	*32.4*	29	*11.7*	23	*9.3*	247	**100.0**
Does disclosure affect you due to your status?	93	*37.7*	110	*44.5*	23	*9.3*	21	*8.5*	247	**100.0**
Do you feel afraid of infecting family members with HIV/AIDS	62	*25.1*	104	*42.1*	58	*23.5*	23	*8.9*	247	**100.0**

Table 7 clearly shows that despite some women expressing no opinion and not giving a response at all, the leading psychological challenges affecting low income women living with HIV/AIDS are stigma as indicated by (49.0%) of the women, followed by anger (46.6%) and denial (36.8%) as well as disclosure (37.7%). Being afraid of infecting family members with HIV/AIDS was the least challenge (25.1%).

The findings are presented in Figure 6



In Figure 6, the proportion of women who did not feel afraid of infecting family members are 42.1% against 25.1% who thought that they could do so, they do not fear disclosing their status (44.5%) or even denying their HIV/AIDS status (41.3%) was more than those who accepted to face the challenges. However, most of the women accepted to be stigmatized (49.0%) and angered (46.6%) by their status than those who said no. The findings show that the society is increasingly accepting HIV/AIDS victims or those infected by HIV/AIDS are becoming bold enough to accept their status and even reveal it. This means that issues or matters pertaining to HIV/AIDS may soon be publicly dealt with without any fear or reservation in line with the saying that "if not infected by HIV/AIDS, you are affected". This public acceptance will greatly contribute towards the effective management of the transmission and effects of the scourge in society. But still a small proportion of women did not either express their opinion when asked which psychological challenges they faced. Perhaps the women may have regarded the

HIV/AIDS matter as being sensitive to disclose. These findings are in agreement with earlier report by NASCOP (2005) which stated that Stigma still remains one of the most significant challenges in developing countries for all HIV/AIDS programs. Stigma worsens the impact of infection because it intensifies the emotional pain and suffering of people living with HIV/AIDS.

4.5 Challenges Facing Married versus Single Women Living with HIV/AIDS

Objective three of the study sought to compare the psychosocial challenges faced by married and single low income women living with HIV /ADS in Nakuru Municipality. The variables under comparison were stigma, shame, denial, anger, disclosure, being afraid of infecting others, straining family members and facing negative reaction from family members due to the status.

4.5.1 Comparison of Married and Single Women based on Stigma

The low income HIV/AIDS-status women were required to respond to the question: Does stigma affect you due to your HIV/AIDS status? Their responses are presented in Figure7.

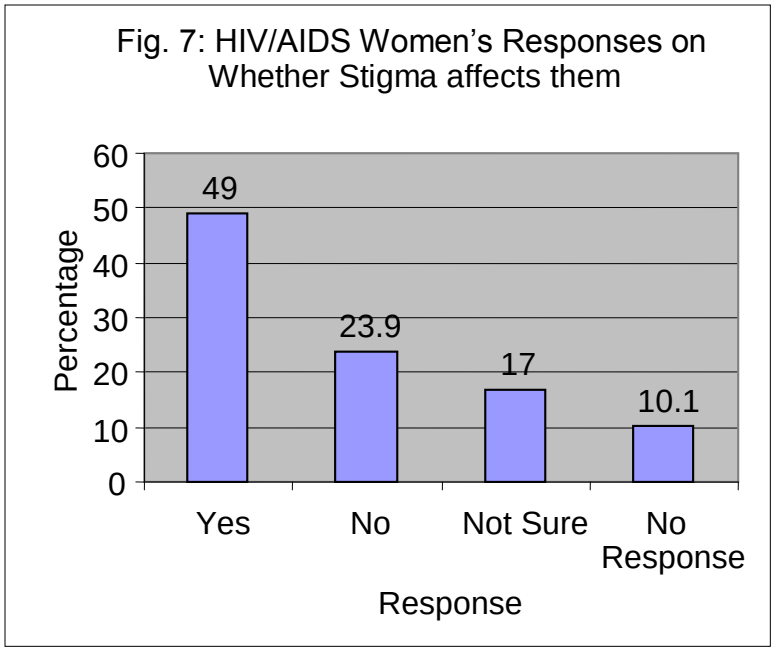


Figure 7 shows that most women, (49.0%) accepted being stigmatized by their HIV/AIDS status compared to (23.9%) who were not. A small number of them (10.1%) did not respond while (17.0%) had no opinion.

4.5.1.1 Reasons for Low-income HIV/AIDS Women feeling being stigmatized

The women living with HIV/AIDS, based on their marital status, were further asked to give reasons for being stigmatized or not being stigmatized by their status. Table 6 presents the reasons as to why they were being stigmatized by HIV/AIDS status while Table 7 gives reasons of those not stigmatized.

Table 8: Reasons for being stigmatized by HIV/AIDS Status

REASON (S)	**SINGLE**	**MARRIED**	**TOTAL**
It was hard for me to cope	1 (1.6%)	1 (1.7%)	**2 (1.7%)**
Self-stigma	6 (9.8%)	6 (10.0%)	**12 (10.0%)**
Discrimination	7 (11.5%)	7 (11.7%)	**14 (11.6%)**
Neglect (I was left to die)	3 (5.0%)	3 (5.0%)	**6 (5.0%)**
Stigmatized and abused by the community	8 (13.1%)	8 (13.3%)	**16 (13.2%)**
Afraid to disclose to family	2 (3.3%)	2 (3.3%)	**4 (3.3%)**
Self-pity	4 (6.6%)	4 (6.7%)	**8 (6.6%)**
No response	30 (24.8%)	29 (24.0%)	**59 (48.8%)**
Total	**61 (50.4%)**	**60 (49.6%)**	**121 (100.0%)**

According to Table 8, the proportion of single women (50.4%) and married women (49.6%) of low income living with HIV/AIDS stigmatized by their status was almost the same even if the singles were slightly higher (0.8 %). From the analysis of the views of the women, the reasons they gave for being stigmatized were varied and ranged from the self to the community. However, the key reasons leading to stigma were insults by the community, discrimination and self- pity. A large number of women, both single and married combined, who were (48.8%) did not give reasons for being stigmatized. May be they regarded HIV/AIDS being a sensitive and personal matter. These findings are in agreements with earlier report which indicated that the influence that stigma has on an infected person is that the individual suffers from a sense of rejection and experiences a series of negative feelings such as fear, self-pity, grief and denial (NASCOP, 2005).

4.5.1.2 Reasons for Low-income HIV/AIDS Women feeling not being stigmatized

Table 9 presents the reasons of the women who were not stigmatized by their HIV status.

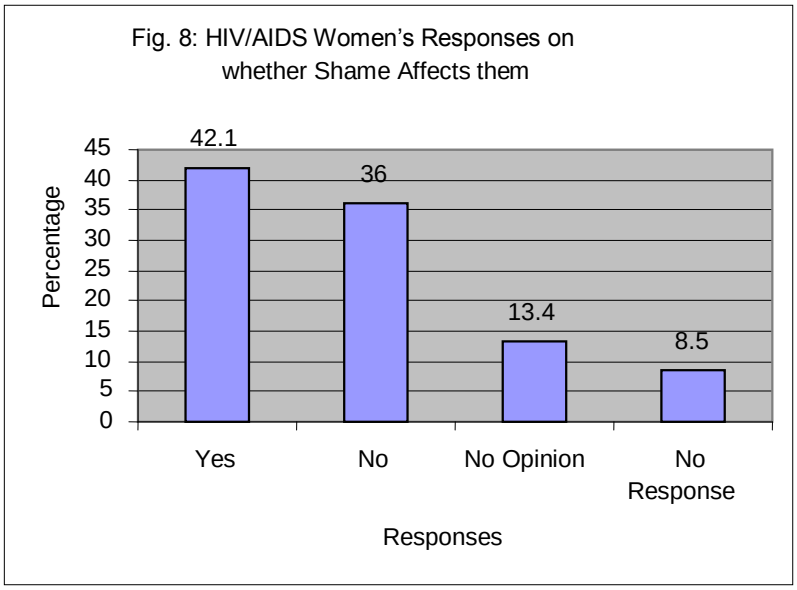
Table 9: Reasons for not being stigmatized by HIV/AIDS Status

	SINGLE	**MARRIED**	**TOTAL**
REASON (S)	f %	f %	**f %**
I have accepted my status	18 (30.5%)	23 (39.0%)	**41 (69.0%)**
HIV/AIDS is a common disease just like others	5 (8.5%)	5 (8.5%)	**10 (17.0%)**
Empowered to deal with HIV/AIDS	-	8 (13.6%)	**8 (14.0%)**
TOTAL	**23 (39.0%)**	**36 (61.0%)**	**59 (100.0%)**

According to responses of women in Table 9, most of the women whether single (30.5%) or married (39.0%), were not stigmatized. This is because HIV/ AIDS is being regarded as a common disease just like any other and they are being empowered to deal with it. However, the married women were not as stigmatized as the singles with their HIV/AIDS status. But it is only the married who were empowered with knowledge to deal with it. It emerges that the women living with HIV/AIDS were mainly able to deal with stigma due to their ability to accept the situation as it is and also efforts of NGOs in handling HIV/AIDS matters coupled with empowerment. These results are in support of earlier report by NASCOP (2005) which indicated that most women living with HIV/AIDS who are most stigmatized are the single women.

4.5.2 Comparison of Married and Single Women based on Shame

The low income HIV/AIDS-status women were required to respond to the question: Does shame affect you due to your HIV/AIDS status*?* Their responses are presented in Figure 8.



Results in figure 8 indicates that (42.1%) women were ashamed by their HIV/AIDS status vis-à-vis the (36.0%) who were not. A small proportion of them, being (13.4%) did not respond to the question while (8.5%) had no opinion. Those who accepted to be ashamed gave out the following reasons for being ashamed.

4.5.2.1 Reasons for Low-income earning HIV/AIDS Women Feeling Ashamed

Table 10 presents the reasons of the women who were ashamed by their HIV/AIDS status.

Table 10: Reasons for being ashamed by HIV/AIDS Status

REASON (S)	SINGLE f (%)	MARRIED f (%)	TOTAL f (%)
Stigma attached to HIV/AIDS	3 (2.9%)	20 (19.2%)	23 (22.1%)
Self-pity	18 (17.3%)	18 (17.3%)	36 (34.6%)
Misconception on spread of HIV/AIDS	12 (11.5%)	6(5.8%)	18 (17.3%)
Still I fear to tell anybody	6 (5.8%)	-	6 (5.8%)
Self-denial	6(5.8%)	-	6 (5.8%)
Still young	6(5.8%)	-	6 (5.8%)
I was isolated/discriminated against	6(5.8%)	3 (2.9%)	9 (8.6%)
Total	**57 (54.8%)**	**47 (45.2%)**	**104 (100.0)**

According to Table 10, married women (19.2%) felt more stigmatized about their HIV/AIDS status than singles (2.9%). Both the singles and the married suffered from shame due to self-pity. Only the singles suffered from fear to disclose, self-denial and being young to contract HIV/AIDS. The women living with HIV/AIDS were mostly ashamed of their HIV/AIDS status due to not only possible discrimination but also due to community misconceptions on the way HIV/AIDS is transmitted which portrays the infected as immoral (NASCOP, 2005).

4.5.2.2 Reasons for Low-Income Earning HIV/AIDS Women not feeling Ashamed

Table 11 reveals why the women who were not ashamed by their HIV/AIDS status.

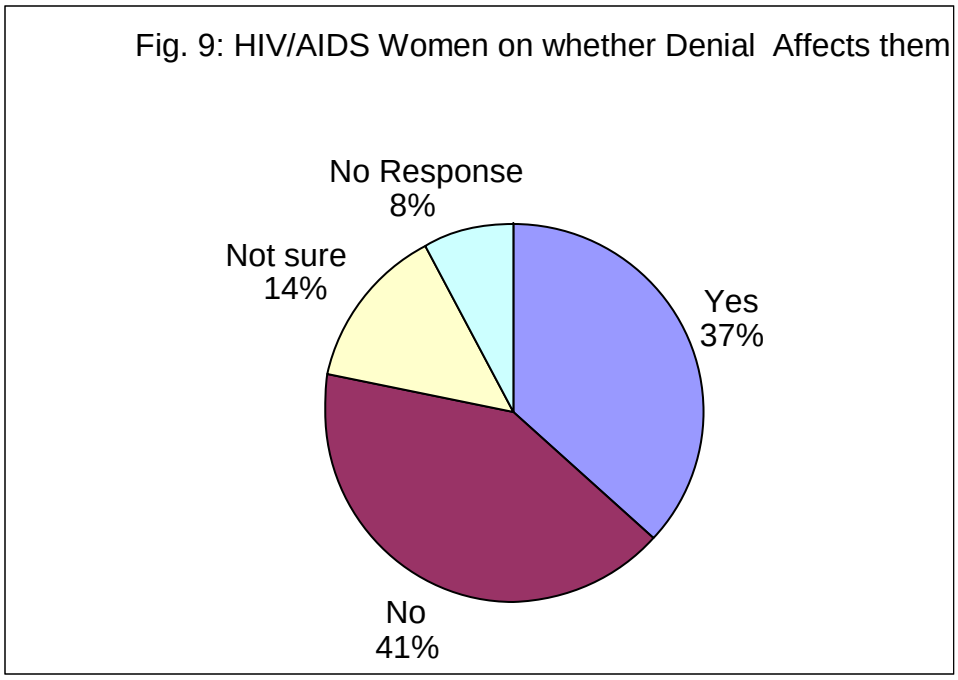
Table 11: Reasons why women were not ashamed by HIV/AIDS Status

REASON (S)	SINGLE	MARRIED	TOTAL
I have accepted my status	6 (6.7%)	33 (37.1%)	39 (43.8%)
I am just health like anybody negative	6 (6.7%)	-	6 (6.7%)
The HIV/AIDS can be managed	6 (6.7%)	-	6 (6.7%)
No response	10 (11.2%)	28 (31.5%)	38 (42.7%)
Total	**28 (31.5%)**	**61 (68.5%)**	**89 100.0)**

Results in Table 11 reveal that both groups of women, singles (6.7%) and the married (37.1%) did not feel ashamed of their HIV/AIDS status since they had accepted their status, even if the married were the majority in this respect. Accepting the situation as well as understanding how the HIV/AIDS can be managed helped the women not to be ashamed about their status. These findings are in contrast with earlier findings which stated that stigma, discrimination and denial were the most difficult aspects of HIV/AIDS to address (UNAIDS, 2002). However, the idea that the singles who did not feel ashamed since they appeared health just like anybody may prompt many people to contract HIV/AIDS since it is a false belief among people that persons who appear 'health' are not infected.

4.5.3 Comparison of Married and Single Women based on Denial

The low income HIV/AIDS-status women were required to respond to the question: Does denial affect you due to your HIV/AIDS status? Their responses are presented in Figure 9.



Based on Figure 9, the women's responses to denial in regard to their HIV/AIDS status were varied. Majority of the women (41%), did not deny their HIV/AIDS status, followed by (37%) of them who denied. However, a few women (14%) were not sure and (8%) had no response.

4.5.3.1 Reasons for Low-income HIV/AIDS-Status Women Deny

The (37%) women who accepted to deny their HIV/AIDS status gave out the reasons presented in Table 12.

Table 12: Reasons why women are in denial of their HIV/AIDS Status

REASON (S)	**SINGLE**	**MARRIED**	**TOTAL**
I had not accepted my status	37 (40.6%)	21 (23.1%)	58 (63.7%)
Fear of HIV/AIDS stigma once known	9 (9.9%)	6 (6.6%)	15 (16.5%0
I believed my partner was clean	3 (3.3%)	-	3 (3.3%)
I was ashamed since I was a Christian	6 (6.6%)	-	6 (6.6%)
I feared being discriminated by family/society	3 (3.3%)	6 (6.6%)	9 (10.0%0
Total	**58 (63.7%)**	**33 (36.3%)**	**91 (100.0%)**

According to responses in Table 12, it is mostly the singles who are mainly affected by denial of their HIV/AIDS status. For instance, most of the women 63.7% were in denial as they had not accepted their status and 16.5% feared being stigmatized. This is because they feared discrimination by the society once their status is known. However, only the singles (9.9%) deny their HIV/AIDS status because they believed their partners were clean as well as being ashamed of it because they were Christians. The major consideration of denying the HIV/AIDS status was fear of the reaction of the family members or the community once the status is revealed and also by 'trusting' that their sexual partners were clean. These results are in agreement with earlier report by NASCOP (2002) which stated that a person living with HIV/AIDS suffer from shock, fear and remain in denial for long time.

4.5.3.2 Reasons for Low-income Earning HIV/AIDS Women Not Denying Their Status

The women who said that they did not deny their HIV/AIDS status gave out the following responses in Table 13.

Table 13: Reasons why women do not deny their HIV/AIDS Status

REASON (S)	**SINGLE**	**MARRIED**	**TOTAL**
My husband also died/was infected	-	15 (14.7%)	15 (14.7%)
I was empowered to cope with HIV/AIDS	10 (9.8%)	23 (22.5%)	33 (32.4%)
I am accepted	-	23 (22.5%)	23 (22.5%)
Use of Anti-retroviral (ARVs) has boldens me	-	8 (7.8%)	8 (7.8%)
No response	8 (7.8%)	15 (14.7%)	23 (22.5 %)
Total	**18 (17.6%)**	**84 (82.3%)**	**102 (100.0%)**

According to Table 13, most women who accepted their HIV/AIDS status were the married women as opposed to the singles. For instance, except for the (9.8%) single women who said that

they were empowered to cope with HIV/AIDS, the rest of the single women (7.8%) did not respond as compared to married women. Besides being empowered to cope with HIV/AIDS as said by 22.5% women, the other reasons given by married women (14.7%) to explain why they did not deny their HIV/AIDS status were that their spouses had either died or were infected ,they were accepted (22.5%) and that they were using the anti-retrovirals (ARVs) as said by 7.8% women. It emerges that the empowerment of women to cope with HIV/AIDS and by being accepted by others can make those infected to come out to the light and this will go a long way in minimizing not only the spread of the pandemic but will also alleviate the suffering of the infected. Therefore, by not denying their status the women were abreast in the fight against the HIV/AIDS scourge. These findings are in agreement with earlier report by (UNAIDS, 2002) which stated that with counselling and joining support groups people living with HIV/AIDS (PLWAS) learn to accept their status and live positively.

4.5.4 Comparison of Married and Single Women based on Anger

The low income HIV/AIDS-status women were required to respond to the question: Does anger affect you due to your HIV/AIDS status? Their responses are presented in Figure 10.

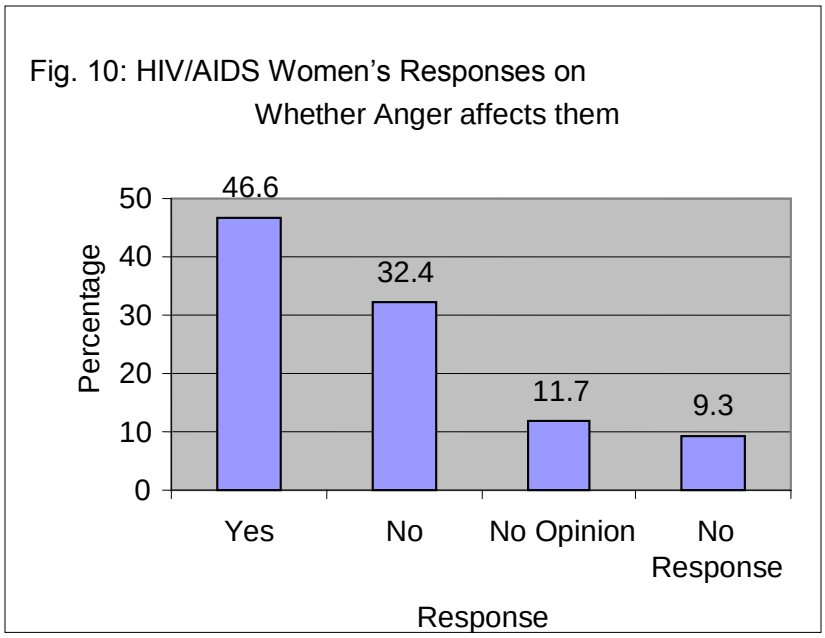


Figure 10 show that the majority of the women (46.6%) accepted that they get angered by their HIV/AIDS status compared to (32.4%) who said they are not angered. Others (11.7%) did not express their feelings whereas the rest (9.3%) did not respond. The reasons why the women got angered or not angered by their HIV/AIDS status are presented in Table 14 and Table 15 respectively.

4.5.4.1 Reasons for Low-income Earning HIV/AIDS Women Feeling Angry

The reasons why the (46.6%) low-income women living with HIV/AIDS got angered by their status are presented in table 14.

Table 14: Reasons for low income women being angered by their HIV/AIDS status

REASON	SINGLE	MARRIED	TOTAL
Fear of dying	7(6.1%)	-	**7(6.1%)**
Why me?	17(14.8%)	7(6.1%)	**24(20.9%)**
Failure to provide for self/family	7(6.1%)	4(3.5%)	**11(9.6%)**
How did I get it?	35(30.4%)	24 (20.9%)	**59(51.3%)**
No response	9 (7.8%)	5 (4.3%)	**14(12.2%)**
Total	**75(65.2%)**	**40(34.8%)**	**115 (100.0%)**

Table 14 indicates that single women (65.2%) were angered more than married women (34.8%) were. The major reason why they got angered by their status is when they were reflecting on how they got it as said by (51.3%) women. Others (9.6%) also got angered by their failure to provide for themselves and families. However, married women in contrast to singles were not angered by the prospects of death arising from their HIV/AIDS. These findings support earlier report which stated that HIV/AIDS victims usually get angered by the way the HIV/AIDS is transmitted to them while some don't understand why HIV/AIDS is particularly affecting themselves, implying that the HIV/AIDS infection as well as how it is spread needs to be demystified (UNAIDS/ UNFPA/UNIFEM,2004).

4.5.4.2 Reasons for Low-income Earning HIV/AIDS Women Not Feeling Angry

The (32.4%) low-income women, both single and married women, indicated that they were not angered by their HIV/AIDS status due to the reasons presented in Table 15.

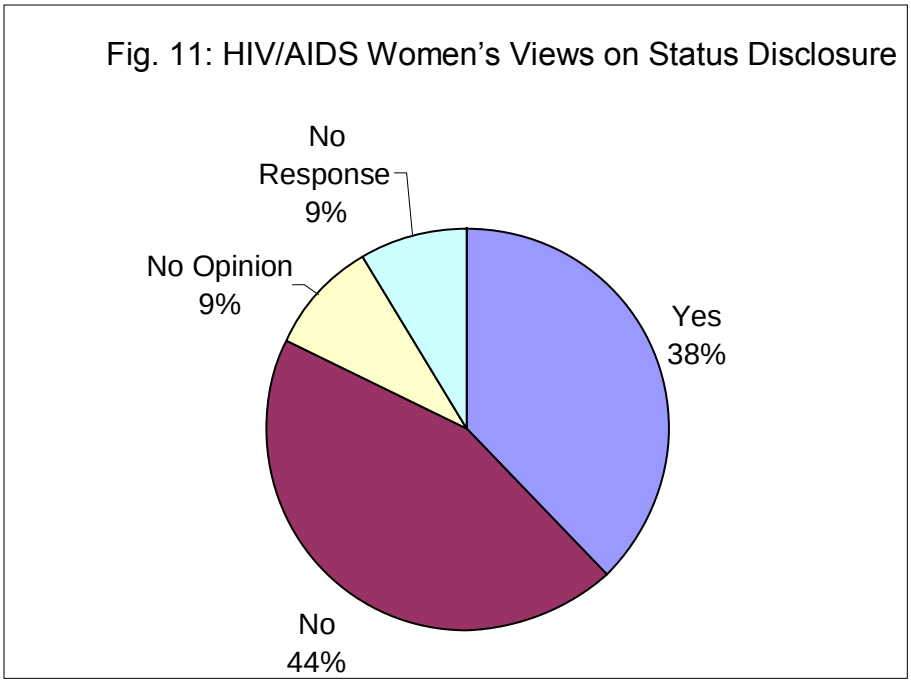
Table 15: Reasons for low income women not being angered by their status

REASON (S)	SINGLE	MARRIED	TOTAL
Life has to continue	24 (30.0%)	9 (11.2%)	**33(41.2%)**
HIV/AIDS is just like any other disease	8(10.0%)	-	**8(10.0%)**
I have accepted my status	8(10.0%)	4 (5.0%)	**12(15.0%)**
No response	17(21.2%)	10(12.5%)	**27(33.8%)**
Total	**57(71.2%)**	**23(28.8%)**	**80(100.0%)**

Referring to Table 15, the proportion of single women who were not angered by their HIV/AIDS status were more than the married women. For example, (30.0%) singles as opposed to (11.2%) were not angered since life has to go on despite the HIV/AIDS condition. Other single women (10.0%) had accepted their status compared to married women (5.0%) and finally, only singles (10.0%) and none of the married were not angered by their HIV/AIDS status since life has to go on. From the findings, it emerges that accepting one's status and being empowered to deal with HIV/AIDS is very critical in managing anger among the infected (UNAIDS/WHO,2006). However, a fairly large number of women (33.8%) did not give reasons for not getting angry with their status.

4.5.5 Comparison of Married and Single Women based on Disclosure

The low income HIV/AIDS-status women were required to respond to the question: Does the idea of disclosing your HIV/AIDS status affect you? Figure 11 presents their views.



Findings in Figure 11 indicate that 44% of the women said that disclosing their HIV/AIDS status does not affect them thus would not mind disclosing their status while (38%) said they would be affected and therefore would not like to disclose their status. However, (9.3%) did not express their feeling while (8.5%) did not respond. The reasons why the women wouldn't mind or will mind to disclose their status are presented in Table 14 and Table 15 respectively.

4.5.5.1 Reasons for Low-income Earning HIV/AIDS Women getting affected by Disclosure

The reasons why the (38%) low-income women living with HIV/AIDS got affected by the prospect of disclosing their HIV/AIDS status are presented in Table 16.

Table 16: Reasons for HIV/AIDS-status women getting affected by disclosure

REASON (S)	SINGLE	MARRIED	TOTAL
My husband/child also positive	-	42 (45.2%)	**42(45.2%)**
I fear my status being known	12(13.0%)	-	**12(13.0%)**
Fear of discrimination	-	11 (11.8%)	**11(11.8%)**
No response	14(53.8%)	14(20.9%)	**28(30.1%)**
Total	**26(28.0%)**	**67(72.0%)**	**93(100.0)**

Results in Table 16 indicate that the married women (72.0%) constituted the largest proportion of women who got affected by the prospect of disclosing their HIV/AIDS status vis-à-vis singles who were (28.0%). It is only the singles (13.0%) who expressed fear of their status being known. Married women (45.2%) got affected because the husband or child was also positive. It is only the married women who got affected by disclosure due to resultant discrimination, rejection or isolation by family members. These results support a report that was given by NASCOP (2005) which stated that most people living with HIV/AIDS feared to disclose their HIV status due to fear of rejection and isolation.

4.5.5.2 Reasons for Low Income Earning HIV/AIDS-status Women not getting affected by Disclosure

The reasons why the (44%) low-income women living with HIV/AIDS do not get affected by the prospect of disclosing their HIV/AIDS status are presented in Table 17.

Table 17: Reasons for HIV/AIDS-status women not getting affected by disclosure

REASON (S)	SINGLE	MARRIED	TOTAL
I live my own life	14(12.7%)	-	**14(12.7%)**
I have caring friends/relatives	8(7.2%)	-	**8(7.2%)**
For the benefit of the community	-	35(31.8%)	**35(31.8%)**
I am empowered to cope with HIV/AIDS	-	18(16.4%)	**18(16.4%)**
People know my status	-	35(31.8%)	**35(31.8%)**
TOTAL	**22 (25.0%)**	**88(80.0%)**	**110(100.0%)**

Results in Table 17 indicate that most married women are not affected by disclosure as compared to the single women. This is because most married women (16.4%) have been empowered to cope with their HIV status. Others (31.8%) do self disclosure for the benefit of the society.

4.5.6 Comparison of Married and Single Women based on Fear of Infecting Others

The low income HIV/AIDS-status women were required to respond to the question: Do you feel afraid of infecting family members with HIV/AIDS? Figure 12 presents their views.

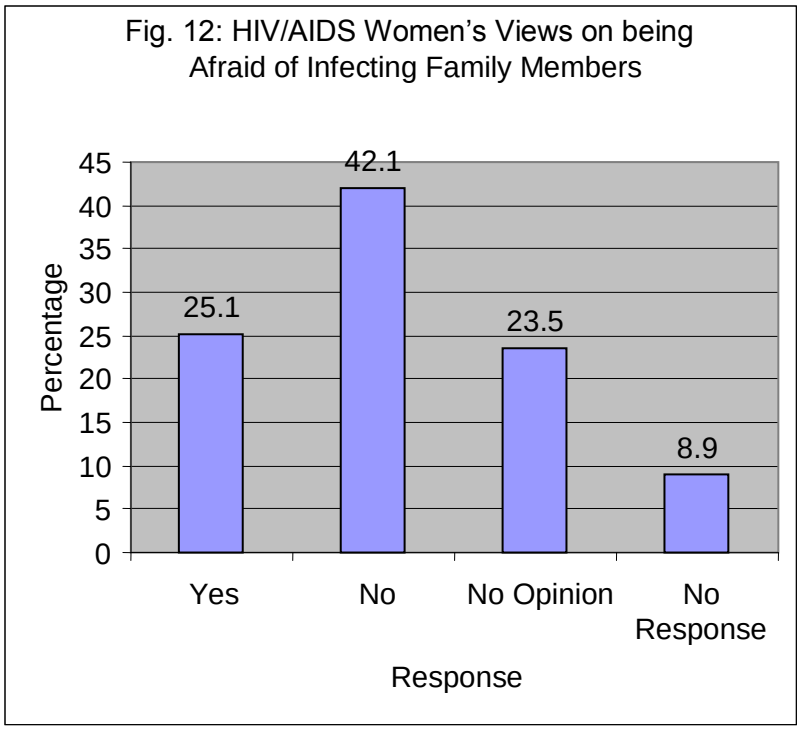


Figure 12 indicates that majority of the women (42.1%) were not afraid of infecting their family members with HIV/AIDS against (25.1%) women who accepted that they would infect them. A fairly large number of women (23.5%) were not sure of infecting them while (8.9%) did not respond. The reasons why they were afraid or not afraid by their HIV/AIDS status are shown in Tables 18 and 19 respectively.

4.5.6.1 Reasons for Low Income Earning HIV/AIDS Women Getting Afraid of Infecting Family Members

The reasons for the (25.1%) women who accepted that they would infect their families with HIV/AIDS are presented in Table 18.

Table 18 Reasons for HIV/AIDS Women Getting Afraid of Infecting Families

REASON (S)	**SINGLE**	**MARRIED**	**TOTAL**
Because I can't share some objects	-	2 (3.2%)	**2(3.2%)**
They don't know how to handle a sick person	2 (3.2%)	-	**2(3.2%)**
Because they don't know my status	10 (16.1%)	2 (3.2%)	**12(19.4%)**
Because there is no cure	2 (3.2%)	-	**2(3.2%)**
Because we share almost everything	2 (3.2%)	-	**2(3.2%)**
Because I don't know how it is transmitted	2 (3.2%)	-	**2(3.2%)**
They don't take precautions when handling me	24 (38.7%)	7 (11.3%)	**31(50.0%)**
I fear for the unborn baby	-	2 (3.2%)	**2(3.2%)**
They are not trained on self-protection	-	2 (3.2%)	**2(3.2%)**
My child is suckling	-	2 (3.2%)	**2(3.2%)**
TOTAL	**43(69.4%)**	**19(30.6%)**	**62(100.0%)**

Results in Table 18 indicate that the largest proportion of low-income earning women living with HIV/AIDS who got afraid of infecting family members with HIV/AIDS were the singles who were (69.4%) compared to the married women who were (30.6%) citing reasons such as members not knowing their status (16.1%) as well as members not taking precautions when handling them (38.7%). It is only the singles that were afraid of infecting their families because they don't know how to handle a sick person (3.2%), there is no cure (3.2%), they shared almost everything (3.2%) and they don't know how it transmitted. It is only the married who feared for the unborn baby.

4.5.6.2 Reasons for Low Income Earning HIV/AIDS Women not Being Afraid of Infecting Family Members

The reasons why the (42.1%) women were not afraid of infecting their family members with HIV/AIDS are presented in Table 19.

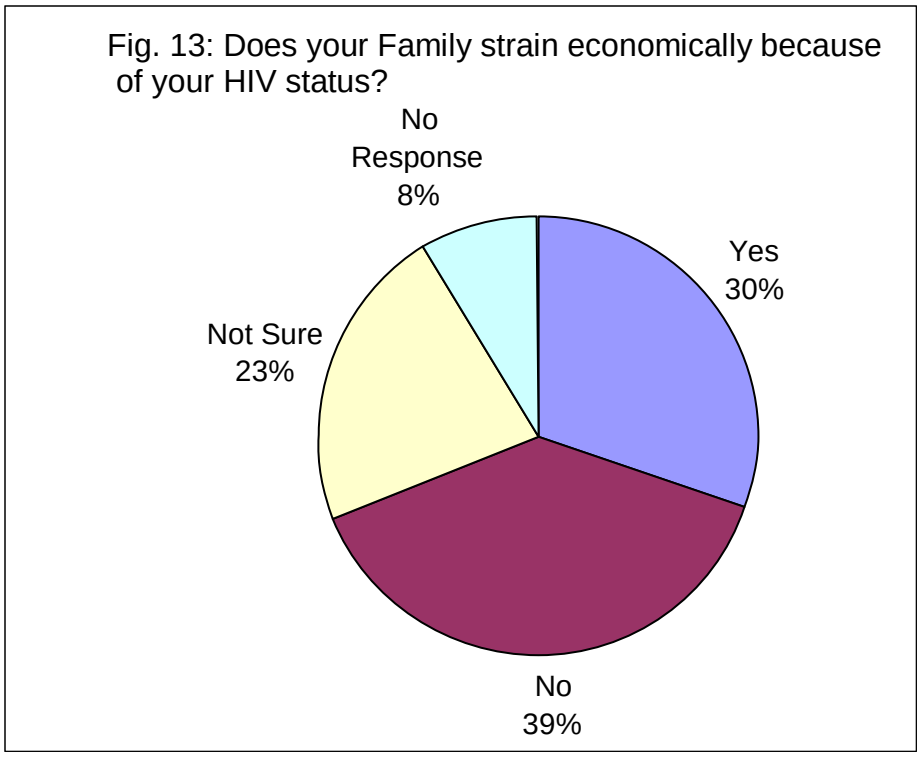
Table 19: Reasons for HIV/AIDS women not being afraid of infecting their families

REASON (S)	SINGLE	MARRIED	TOTAL
HIV/AIDS is not contagious	4 (3.8%)	4 (3.8%)	**8(7.7%)**
They all know my status	4 (3.8%)	4 (3.8%)	**8(7.7%)**
I know how to protect myself	12(11.5%)	-	**12(11.5%)**
I have learnt how to cope with it	12(11.5%)	16 (15.5%)	**28(27.0%)**
We take precautions	8 (7.7%)	20 (12.3%)	**28(27.0%)**
No response	9 (8.6%)	10 (9.6%)	**19(18.3%)**
Total	**49(47.1%)**	**55(42.9%)**	**104(100.0%)**

Results in Table 19 indicate that the largest proportion of low-income women living with HIV/AIDS who did not get afraid of infecting family members with HIV/AIDS were married women who were (42.9%) compared to the singles who were (47.1%) citing reasons such as HIV/AIDS is not contagious, they know how to protect themselves and know how to take precautions. From the views of the women, it shows that some of them had misconceptions about how HIV/AIDS is spread thinking that it is only through sex that it can be done. Otherwise some of them were empowered to cope with it.

4.5.7 Comparison of Married and Single Women based on Family Strain

The low income HIV/AIDS-status women were required to respond to the question: Do you feel that your HIV/AIDS status strains family members? Figure 13 presents their views.



In Figure 13, majority of the women who were (39%) said that they do not strain their families when in need of support compared to (30%) who accepted that their HIV/AIDS status strain their families. A fairly large number of women (23%) were not sure whether they strain their families while (8%) did not respond. The reasons why the women felt that they do not or they do strain their families in supporting them are presented in Table 18 and Table 19 respectively.

4.5.7.1 Reasons for Some Low-income HIV/AIDS Women Straining Families

The reasons for the (30%) women who felt that their HIV/AIDS status strained their families are presented in Table 20.

Table 20: Reasons for HIV/AIDS women feeling that they were straining their families

REASON (S)	SINGLE	MARRIED	TOTAL
A lot of money is used on my treatment	29(38.7%)	0	**29(38.7%)**
Because I am financially handicapped	13(17.3%)	0	**13(17.3%)**
At times children don't go to school	7 (9.3%)	0	**7(9.3%)**
Caring for me when bedridden/sick	7(9.3%)	4 (5.3%)	**11(14.7%)**
They fear being infected	2(2.7%)	0	**2(2.7%)**
No response	13(13.7%)	0	**13(17.3%)**
Total	**71(94.7%)**	**4(5.3%)**	**75 (100.0%)**

Table 20 indicates that an overwhelming majority of the respondents, being (94.7%) singles, accepted that their HIV/AIDS status seriously strained their families compared to married women who were only (5.3%). The women said that they strain families when they fall sick, the family members have to take extra care of them something which is financially and emotionally. They further indicated that some of them strained families not only because of the tender care or drugs they constantly need when sick but because the women's children also became a burden to the families since they also need to be supported. These findings also support earlier report by NASCOP (2000) which stated that the families of women living with HIV/AIDS had economic constraints.

4.5.7.2 Reasons for Some Low Income HIV/AIDS Women not Straining Families

The reasons for the (39%) women who felt that their HIV/AIDS status was not straining their families are presented in Table 21.

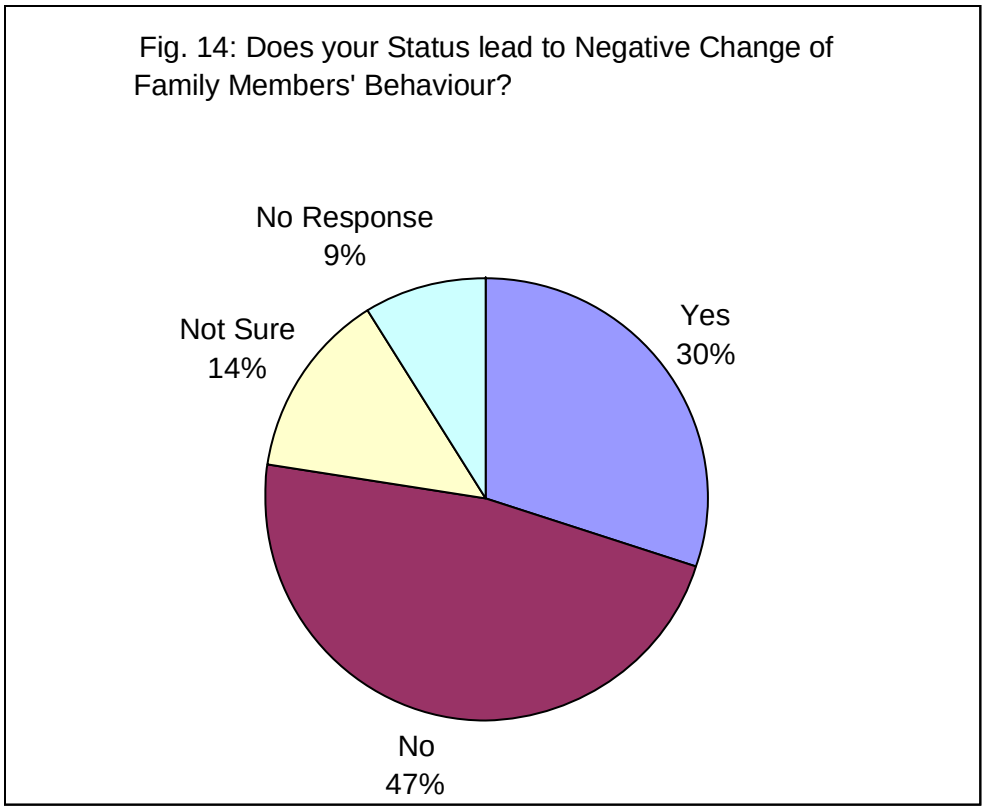
Table 21: Reasons for HIV/AIDS women not straining their families

REASON (S)	SINGLE	MARRIED	TOTAL
I take care of myself	38 (40.0%)	29 (30.5%)	**67(70.5%)**
I depend on well-wishers	7 (7.4%)	-	**7(7.4%)**
No response	12(12.6%)	9(9.5%)	**21(22.1%)**
Total	**57(60.0%)**	**38(40.0%)**	**95 (100.0%)**

Table 21 reveals that most of the women both single (40.0%) and married (30.5%) were able to take care of themselves though the proportion of the singles was higher. Some of them said that they don't bother their families with anything as they go on with income generating activities. Moreover, only the singles (7.4%) depended on well-wishers.

4.5.8 Family Members Behaviour towards the HIV Positive Women

The low income HIV/AIDS-status women were required to respond to the question: Has your HIV/AIDS status led to negative change of family members' behaviour towards you? Their responses are presented in Figure 14.



As shown in Figure 14 majority of the women who were (47%) said that their HIV/AIDS status did not evoke negative behaviour or reaction from their families towards them compared to (30%) whose HIV/AIDS status prompted negative behaviour or reaction from their families. A small section of women (14%) were not sure whether the reaction of the family members' behavior was caused by their HIV/AIDS status. Earlier report also support these findings by stating that most people living with HIV/AIDS suffered from rejection and poor treatment from family members (UNAIDS, 2002).

4.5.8.1 Reasons for the Women's HIV/AIDS Status Evoking Negative Family Behavior

The reasons why the (30%) women's HIV/AIDS status did evoke negative behavior from their families are presented in Table 22.

Table 22: Reasons for the Women's HIV/AIDS Status Evoking Negative Family Behavior

REASON (S)	SINGLE	MARRIED	TOTAL
Being chased away/abandoned	-	30(20.3%)	**30(40.5%)**
They regard me as being immoral	8(10.8%)	-	**8(10.8%)**
Being discriminated against	4(5.6%)	8(10.8%)	**12(16.2%)**
Family members do not pay a visit	4(5.6%)	8(10.8%)	**12(16.2%)**
Some family members live in fear	4(5.6%)	-	**4(5.6%)**
We don't share utensils	8(10.8%)	-	**8(10.8%)**
Total	**28(37.8%)**	**46(62.2%)**	**74 (100.0%)**

Table 22 shows an overwhelming majority of the respondents, being (62.2%) married women, accepted that their HIV/AIDS status evoked negative behavior from family members with most of them (20.3%) saying that they are either being chased away or abandoned by the families. As for the singles they were regarded as immoral (10.8%), some family members lived in fear (5.6%) or did not even share utensils (10.8%) something which married women did not face. However, the two categories of women equally faced discrimination; single (5.6%) and married (10.8%) and family members did not visit them. The views of the women indicate that the negative reaction from family members was brought about by some fear and myths held regarding the HIV/AIDS scourge or the responsibility associated with it (NASCOP, 2002).

4.5.8.2 Reasons for Family members Not Evoking Negative Behaviour towards the HIV Positive Women.

The reasons why the (47%) women's HIV/AIDS status did not evoke negative behavior from their families are presented in Table 23.

Table 23: Reasons for Family members Not Evoking Negative Behaviour towards the HIV Positive Women.

REASON (S)	SINGLE	MARRIED	TOTAL
No one knows my status	18 (15.4%)	20 (17.1%)	**38(32.5%)**
They still love me in my status	18 (15.4%)	20 (17.1%)	**38(32.5%)**
Because I look so much okay	8 (6.8%)	9 (7.7%)	**17(14.5%)**
No response	13 (11.1%)	11 (9.4%)	**24(20.5%)**
Total	**57 (48.7%)**	**60 (51.3%)**	**117 (100.0%)**

Table 23 indicate that the proportion of low income married women suffering from HIV/AIDS (51.3%) who did not face negative reaction from family members was slightly higher than the singles who were (48.7%). The key reasons for this 'acceptance' among family members were that no one knew their status as said by (15.4%) singles and (17.1%) married as well as the love from their families as said by a similar number.

4.6 Management of the Challenges by the Low Income Earning Women Living With HIV/AIDS.

Objective two of the study sought to determine how the low-income women living with HIV/AIDS managed the psychosocial challenges they face in Nakuru Municipality. The low income HIV/AIDS-status women were required to reveal the steps they had taken to manage the psycho-social challenges facing them due to their HIV/AIDS status. Their responses are presented in Figure 15.

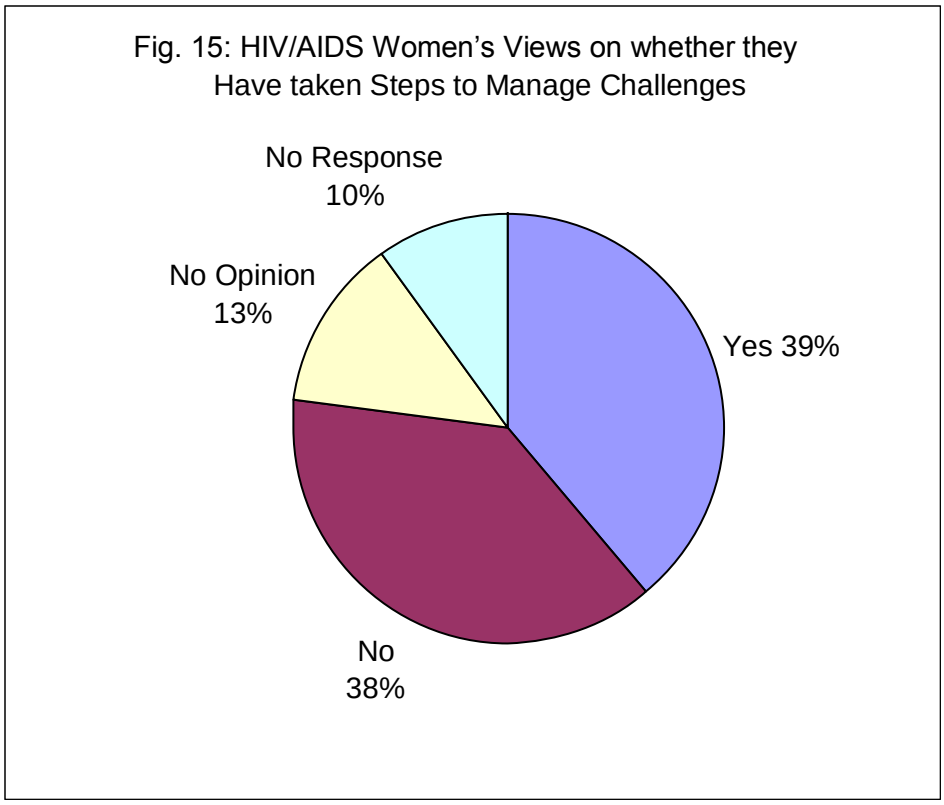


Figure 15 shows that the proportion of HIV/AIDS women (39%) who took some measures to cope with the challenges facing them was slightly higher compared to (38%) who did not. Whereas (13%) women were not sure on whether they took steps, (10%) did not respond. The management steps the (39%) women took is presented in Table 22.

4.6.1 Management Steps Adopted by Low-Income HIV/AIDS Women

The steps the (39%) out of the 247 low income living with HIV/AIDS adopted to cope with the challenges facing them are presented in Table 24.

Table 24: Measures adopted by HIV/AIDS women to cope with challenges they faced

	SINGLE		MARRIED		TOTAL	
STEPS	**f**	**%**	**f**	**%**	**f**	%
Through social support groups	24	24.7	6	6.2	30	30.9
By being counselled	5	5.2	6	6.2	11	11.4
Through going for training	2	2.1	1	1.0	3	3.1
Because I am keeping poultry	-	-	2	2.1	2	2.1
Through micro-finance support	-	-	2	2.1	2	2.1
By taking a balanced diet	1	1.0	-	-	1	1.0
Stress management	3	3.2	1	1.0	4	4.2
Identifying with people living with HIV/AIDS	1	1.0	-	-	1	1.0
Visiting/sharing with friends	2	2.1	1	1.0	3	3.1
Regular medical attention	2	2.1	-	-	2	2.1
Educating others	1	1.0	1	1.0	2	2.1
Living with others, not alone	1	1.0	-	-	1	1.0
TOTAL	**53**	**54.6**	**44**	**45.4**	**97**	**100.0**

From Table 24, an overwhelming majority of single women who were (24.7%) depended on social support groups like Badili Mawazo, Love and Hope Centre, as compared to the married women who were (6.2%). The singles ensured that they took a balanced diet, identified with people living with HIV/AIDS and sought regular medical attention. Counselling also emerged as one of the key steps in managing the HIV/AIDS scourge for both singles (2%) and the married women (2%). The views of the low income women living with HIV/AIDS indicate that the measures to cope with the scourge can not be taken by the victims alone but should get financial, material (including food) and emotional support from the entire society (UNAIDS/UNFPA/UNFEM 2004).

4.6.2 Opinions of Low-Income HIV/AIDS Women on Family Counselling

The low income HIV/AIDS-status women were required to express their views on the role of family counselling to cope with the HIV/AIDS scourge. Hence, they were asked: Do you think your family needs counselling due to this scourge? Figure 16 presents their views.

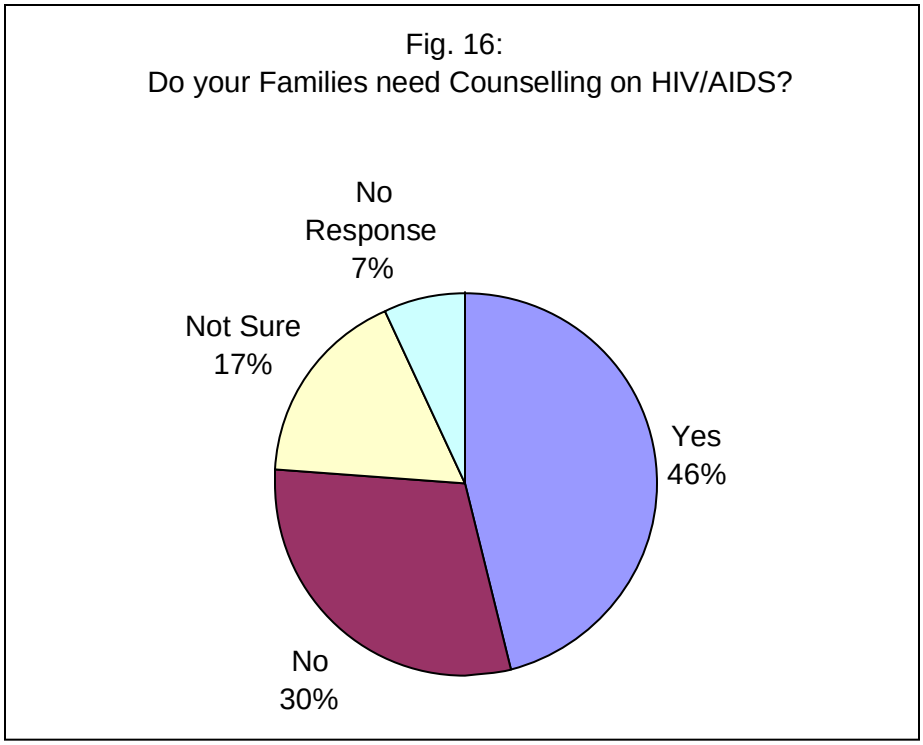


Figure 16 shows that the majority of the women who were (46%) accepted that their families need counselling on the HIV/AIDS scourge to (30%) who did not see need for their families to be counselled. However, (17%) women were not sure of the need for family counselling, (7%) did not respond. Whereas the (46%) women who advocated for family counselling to cope with HIV/AIDS gave out reasons presented in Table 23 in support of it, the (30%) who did not see need never gave reasons for their opposition.

4.6.3 Reasons for Support of Family Counselling to Cope with HIV/AIDS

The reasons given by the (46%) women who supported the use of family counselling as one of the key steps of managing the HIV/AIDS scourge are presented in Table 25.

Table 25: Reasons for Support of Family Counselling to Cope with HIV/AIDS

	SINGLE		**MARRIED**		**TOTAL**	
REASON	**f**	**%**	**f**	**%**	**f**	**100**
So as to cope with HIV/AIDS	11	9.6	2	1.8	13	11.4%
Know more to appreciate HIV/AIDS	39	34.2	25	21.9	64	56.1%
To take precautions always	4	3.6	13	11.4	17	15.0%
To know their status	2	1.8	2	1.8	4	3.5%
Know how to handle HIV victims	10	8.8	4	3.6	14	12.2%
So that I can disclose to them	-	-	2	1.8	2	1.8%
Total	**66**	**58.0%**	**48**	**42.2%**	**114**	**100%**

On overall, according to Table 25, an overwhelming majority of single women (34.2%) and married (21.9%) supported counselling to enable them to know more about HIV/AIDS and assist them live positively. The others strongly given in support of counselling were to enable them cope with the scourge and know how to handle the HIV/AIDS victims. Whereas it is only the married women who supported counselling to enable them disclose their status (1.8 %) of the singles did not. In regard to the reasons advanced in support of family counselling, views of the low income women living with HIV/AIDS indicate that the use of counselling to manage HIV/AIDS can't be complete without encompassing families. Thus counselling activities should be directed to both the victims and their families with whom they live since the victims need family members' support to cope with it. These findings support earlier research which indicated that

family counselling was necessary so that people living with HIV/AIDS can get proper Home Based Care (NASCOP, 2005).

4.6.4 Nature of Public Support for Low-Income HIV/AIDS Women

The low income HIV/AIDS-status women were required to reveal whether they were receiving public support due to their HIV/AIDS status. Their responses are presented in Figure 17.

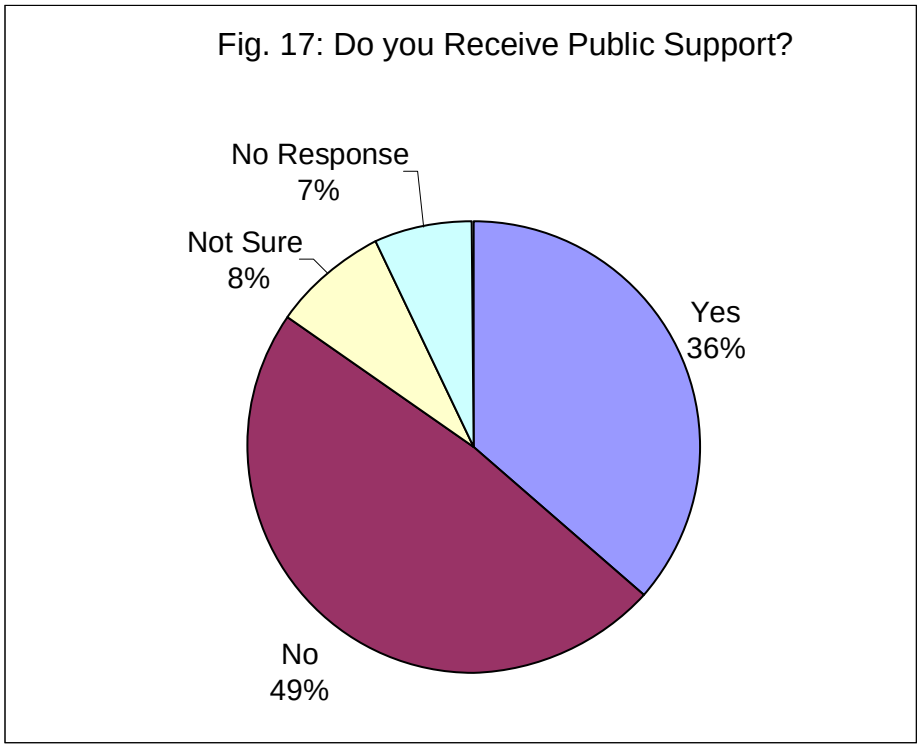


Figure 17 indicates that most women, who were (49%), did not receive public support in coping with HIV/AIDS as opposed to the (36%) who benefited from public support as presented in Table 26. However, (8%) women were not sure of receiving any public support while (7%) did not respond.

Table 26: The kind of support HIV/AIDS-status women received from the public

NATURE OF SUPPORT	SINGLE		MARRIED		TOTAL	
	f	%	f	%	f	%
Foods	16	17.8	7	7.8	23	25.6%
Medication/drugs	24	26.7	8	8.9	32	35.6%
Clothes	13	14.4	-	-	13	14.4%
Counselling	8	8.9	1	1.1	9	10.0%
Being friendly/show love	8	8.9	1	1.1	9	10.0%
Providing fare	3	3.3	1	1.1	4	4.4%
Total	**72**	**80.0%**	**18**	**20.0%**	**90**	**100.0%**

From Table 26, medication/drugs, foods and clothes were the leading kinds of support given to the low-income women living with HIV/AIDS. The other kinds of support were counselling, being friendly and providing fare though in a small scale. These findings are in agreement with earlier report by NASCOP (2005) which stated that the public is getting continued sensitization on HIV/AIDS. But still only few people living with HIV/AIDS are getting public support.

CHAPTER FIVE: SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the summary, conclusions and recommendations made from the study. It also highlights areas recommended and suggested for further research.

5.2 Summary of the Findings

The purpose of this study was to establish the psychosocial challenges facing low-income women living with HIV/AIDS within Nakuru Municipality. In summary, the following are the major findings of the study:

i. The social challenges facing low income earning women living with HIV/AIDS were shame, feelings of straining family members and problems of coping with negative change of family members' behaviour due to their HIV status. They also suffered from fear, discrimination, rejection or isolation by family members.

ii. The psychological challenges facing both single and married women living with HIV/AIDS were stigma, denial, anger, disclosure and fear of infecting family members with HIV. The leading psychological challenge they faced was stigma. Single women were more stigmatized than the married ones.

iii. Most married women living with HIV/AIDS managed well the psychosocial challenges they faced. The married women wouldn't mind to disclose their status to the community. They coped well because they had caring friends and relatives, got public support and were counseled to live positively.

iv. Despite all categories of low income earning women, the majority of the infected were those within marriage or who had one time been in marriage. However, single women faced more psychosocial challenges like stigma, shame, denial, anger and discrimination.

5.3 Conclusions

Based on the aforementioned findings of the study, the researcher concludes that the low income women living with HIV/AIDS were facing various psychosocial challenges such as stigma, shame, denial among others. The disparities that existed among the singles and the married reveals that one's marital status determined the extent to which one is ashamed, stigmatized or willing to disclose the HIV/AIDS status. Despite public support for the low-income women living with HIV/AIDS it is inadequate and mostly material, yet emotional support was also crucial in the management of HIV/AIDS. This implies that a lot more needs to be done in the fight against the scourge.

5.4 Recommendations

In view of the above conclusions, the following recommendations about the psychological and social challenges facing low-income women living with HIV/AIDS within Nakuru Municipality can be made.

i. Counselling on HIV/AIDS should be emphasized not only to the infected but also to the families or people handling the HIV/AIDS victims. Family counselling, especially will go a long way to alleviate the psychological and social problems such as negative reaction of family members, discrimination in society among other problems.

ii. The low-income women should be encouraged to engage in income generating activities to enable them raise enough money to keep themselves and their families.

iii. Since it emerged that HIV/AIDS is rapidly spreading among the couples than the singles, then measures should be taken to stop the spread because it leads to more people getting HIV/AIDS.

iv. The society or community should be sensitized on how to handle and cope with people living with HIV/AIDS. This is because some low-income women living with HIV/AIDS were being discriminated against or isolated yet the community or family members will either be affected or infected by the scourge also.

v. The government and other stakeholders should construct voluntary counselling and testing centres (VCT) near the grassroots throughout the country to take care of HIV/AIDS victims and also those seeking such services even if not infected.

5.5 Suggestions for Further Research

The researcher recommends further research to be done on the following aspects of HIV/AIDS.

i. A survey should be done on the prevalence and factors contributing to the rapid spread of HIV/AIDS among low income earning women.

ii. A survey to be done on the effectiveness of Voluntary Counselling and Testing (VCT) on low- income earning women.

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APPENDIX A

QUESTIONNAIRE FOR LOW INCOME WOMEN LIVNG WITH HI V/AIDS

Please do not indicate your name on the questionnaire and be informed that all responses will be strictly treated as confidential.

Please tick the appropriate response.

1. Your age bracket.

Below 20 years ( ) 20-30 years. ( ) 30-40 years. ( ) Above 40 years. ( )

2. Your marital status.

Single ( ) Married. ( ) Widow. ( ) Divorced/Separated. ( )

3. What is your source of income? Small-scale business. ( ) Relatives. ( )

Well-wishers. ( ) Sell of family property. ( )

4. How much do you earn per month? Less than one thousand ( ) 2-5 thousand shillings ( )

5-10 thousand shillings ( ) more than ten thousand shillings ( )

5. Highest level of education attained. None. ( ) Primary level. ( ) Secondary level. ( )

College level, ( ) University level. ( )

6. In which estate do you live?

Kaptembwa ( ) Free Area ( ) Bondeni ( ) Others ( )

7. Do you encourage your care takers to use gloves as a precaution measure?

Yes. ( ) No. ( )

8. If no why? I fear being stigmatized. ( ) I don't know the importance. ( )

Gloves are expensive. ( ) Gloves cannot protect them from being infected. ( )

Would you say that the following disturbances affect you as a result of your status?

9. Stigma.

Yes ( ) No ( ) Not sure ( )

Give reasons for your answer_____

10. Shame.

Yes ( ) No ( ) Not sure ( )

Give reasons for your answer_____

11. Denial.

Yes ( ) No ( ) Not sure ( )

Give reasons for your answer_____

12. Anger.

Yes ( ) No ( ) Not sure ( )

Give reasons for your answer_____

13. Disclosure

Yes ( ) No ( ) Not sure ( )

Give reasons for your answer_____

14. Are you afraid that you could infect your family members with HIV/AIDS?

Yes ( ) No ( ) Not sure ( )

Give reasons for your answer_____

15. Do you feel that you strain members of your family?

Yes. ( ) No. ( ) Not sure. ( )

Explain_____

16. Has your status caused negative change of behavior among your family member?

Yes ( ) No ( ) Not sure ( )

Explain_____

17. Have you taken any steps to manage the psychosocial challenges you are facing?

Yes ( ) No ( ) Not sure ( )

Explain_____

18. Do you think your family needs counselling because of this scourge?

Yes ( ) No ( ) Not sure ( )

Give reasons for your answer_____

19. If a donor was to provide assistance to your family which one would you prefer?

Health care ( ) Food and clothes ( ) Shelter ( ) Counselling ( )

20. How do you manage your household chores?

_____

21. Is the family isolated by the community because of living with a zero positive person?

Yes ( ) No ( ) Not sure ( )

Explain_____

22. Are you receiving a social support from the public because of your HIV status?

Yes ( ) No ( ) Not sure ( )

Specify_____

23. Do your neighbors associate with you freely?

Yes ( ) No ( ) Not sure ( )

Explain_____

APPENDIX B

DETERMINATION OF SAMPLE SIZE

N	S	S	N	S	N	S	N
10	10	140	103	550	226	4500	354
15	14	150	108	600	234	5000	357
20	19	160	113	650	241	6000	361
25	24	220	140	700	248	7000	364
30	28	230	144	750	254	8000	367
35	32	240	148	800	260	9000	368
40	36	250	152	1200	291	10000	370
45	40	260	155	1300	295	15000	375
50	44	270	159	1400	302	20000	377
55	48	280	162	1500	306	30000	379
60	52	290	165	1600	310	40000	380
65	56	300	169	1700	313	50000	381
70	59	320	175	1800	317	75000	382
75	63	340	181	1900	320	10000	384
80	66	360	186	2000	322		
85	70	380	191	2200	327		
90	73	400	196	2400	331		
95	76	420	201	2600	335		
100	80	440	205	2800	338		
110	86	460	210	3000	341		
120	92	480	214	3500	346		
130	97	500	217	4000	351		

N=Population Size

S=Sample Size

Source: Kathuri, J.N.and pals, D. (1993).