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Psychological Challenges Facing Women Living With HIV/AIDS: A Case of Nakuru Municipality, Kenya

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Abstract: **HIV/AIDS is a critical concern in Kenya, ever since the HIV/AIDS virus was identified, many campaigns have been put in place, and people have been made aware of the various effects of the virus. However, much emphasis has been on the physiological effects, but little concern has been given to the major psychological effects the virus can have on individuals who contract the HIV virus. There is strong evidence that people who have been diagnosed with HIV are more likely to develop a mental health or psychological problem such as anxiety or depression. The purpose of this study was to explore and describe the psychological challenges faced by people who are living with HIV/AIDS in Nakuru municipality and how they cope with those challenges. A sample of 248 out of a target population of 700 was used. The instruments used to collect data were questionnaires and interviews schedules. The data was analyzed using descriptive statistics. The findings of the study revealed that most of the women living with HIV/AIDS suffer stigma, anger, trauma, denial and fear of disclosure. The disparities that existed among the singles and the married revealed that one's marital status determined the extent to which one was stigmatized, angered, traumatized, and experienced denial or fear of disclosure. These findings have implications for developing interventions to support the psychological needs of people living with HIV, to accurately reflect the views and needs of the target users.**

Keywords: **Psychological Challenges, Pandemic, Affected family, Mental health, Serostatus.**

1. INTRODUCTION

Background to the study:

People living with HIV face long-term challenges to their psychological well-being, challenges that are principally associated with stigma and discrimination. O'Connell et al (2003) reported that the quality of life of PLHIV is affected negatively because the impact of having the infection extends beyond the physical realm to affect psychosocial-spiritual wellbeing. The challenges PLHIV face are diverse and complex, yet it seems the extent of the psychosocial problems faced by PLHIV have not been rigorously reviewed or described. The psychological or internal challenges a person with HIV/AIDS faces vary from individual to individual. Each HIV/AIDS situation is as unique as the people involved. There are individuals who might face catastrophic changes not only in their personal and job relationships, but in their physical bodies and in their self-images and self-esteem."(Watstein & Chandler, 1998). As a result of these changes in both working and personal relationships, the behaviour of those infected may change. They may become withdrawn, aggressive, and rude to colleagues and friends. This may be because the infected person may feel (or imagine) being victimized. Infected, and in some cases, affected, people can experience a decrease in self-esteem as they are no longer confident in themselves or what they can achieve. This is likely caused by the stigma within society against infected and affected people. They are seen as lesser persons and are at times devalued. This in itself is of course detrimental to the person's well-being.

The National Aids Trust (NAT) (2010) reported that there is strong evidence that there is higher prevalence of mental health problems amongst people living with HIV compared with the general population. People with a mental health problem are at greater risk of HIV infection, and people who have been diagnosed with HIV are more likely to develop a mental health problem, for example anxiety or depression. There is also evidence that a range of psychological interventions can make a considerable difference to the long-term health and well-being of someone living with HIV, including how well they manage their condition and adhere to treatment. There are powerful public health arguments for investing in psychological support services for people living with HIV; those receiving appropriate support are less likely to miss medication or engage in unsafe sex – both scenarios in which the risk of onward HIV transmission to other people is increased (NAT, 2010).

Human Immunodeficiency Virus (HIV) and Acquired Immune syndrome (AIDS) pandemic has been in existence for over 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 defence system (NASCOP, 2006). 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; of 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 (NASCOP, 2008).

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 of in rural areas (5-6%) (NASCOP, 2005). In the Rift Valley province, by 2005, a total of 16,832 had people died from AIDS related illnesses. Those who had 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 (NASCOP, 2005). This study therefore aimed at establishing the psychological challenges facing women living with HIV/AIDS within Nakuru Municipality.

Statement of the Problem:

HIV/AIDS is a critical concern in Kenya, ever since the HIV/AIDS virus was identified, many campaigns have been put in place, and people have been made aware of the various effects of the virus. However, much emphasis has been on the physiological effects, but little concern has been given to the major psychological effects the virus can have on individuals who contract the HIV virus. Since a greater percentage of the individuals who contract the HIV virus are women, more detailed information is required on the psychological challenges faced by women living with HIV/ AIDS and ways that can be used to mitigate these challenges. This information will be used to provide the basis for advocacy, mitigation policies and the design of effective interventions. This study therefore was aimed at establishing the psychological challenges that face women living with HIV/ AIDS within Nakuru Municipality.

Purpose of the Study:

The purpose of the study was to establish the psychological challenges faced by women living with HIV/AIDS, within Nakuru Municipality.

Objectives of the Study:

The following objectives guided the study:

i. To establish the psychological challenges faced by low-income women living with HIV/AIDS, in Nakuru Municipality.

ii. To compare the psychological challenges faced by married and single women living with HIV /ADS in Nakuru Municipality.

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Research Questions:

The research questions for the study were:-

i. What are the psychological challenges facing low-income earning women living with HIV/AIDS in Nakuru Municipality?

ii. How do the psychological challenges facing married and single women living with HIV/AIDS in Nakuru municipality compare?

Significance of the Study:

The results of the study may be useful to the government of Kenya and Non Governmental Organizations in formulating policies and 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 providing psychological support and the 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 also be useful to the counselling professionals involved with women living with HIV/AIDS.

Conceptual Framework:

This study will be conceptualized as shown in Fig. 1

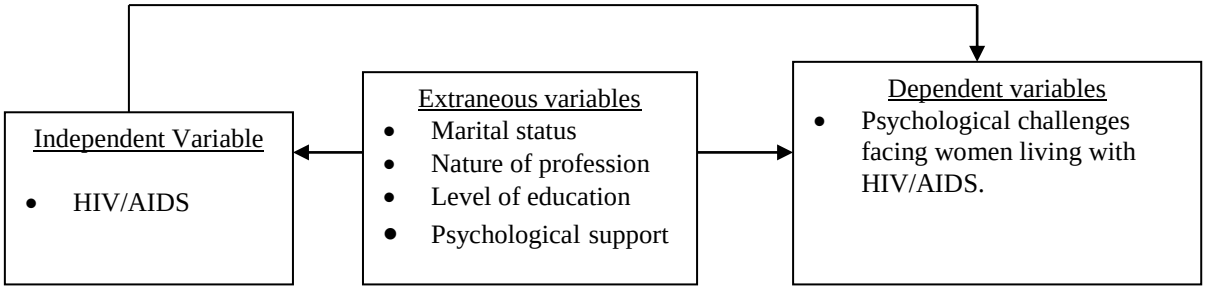

Fig. 1 Conceptual Framework

Fig. 1 is a summary of the psychological challenges facing women living with HIV/AIDS. The independent variable is HIV/AIDS while the dependent variables are the psychological challenges facing women living with HIV/AIDS. HIV/AIDS as the independent variable directly affects the psychological status of women. However, there are extraneous variables like marital status, nature of profession, level of education, and psychological and social support that may have an impact on these women socially. These will be controlled by studying some of them, like marital status and level of education.

2. LITERATURE REVIEW

Psychological Challenges Facing Low-income Earning Women:

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, dominate 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 (Goffman, 1963). 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 is a 'third epidemic" early in the history of HIV (the first two being the hidden but accelerating spread of H1V and the visible rise of AIDS cases). Stigma, discrimination, blame and collective denial were potentially the most difficulty aspects of the HIV and AIDS epidemic to address hut also that addressing them was key to overcoming it (Mann, 1987). Stigma still remains 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 behaviour 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. (Hutchinson et al. 2003). 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 & 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 the 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. Furthermore, the stigma related to HIV infection may lead to social isolation. Often, families do not disclose their HIV status to family members, including the infected child and their community for fear that they and their children will be mistreated, and Herek and Grunt (1998) 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 copying 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. NASCOP (2008) suggests that those factors place these individuals and their family members at risk for mental health disorders, developmental deficits and behavioural problems such as drug or alcohol use, school failure, inability to maintain a job, and criminal behaviour. 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, 2008).

3. RESEARCH METHODOLOGY

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. 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 social challenges facing low-income earning women living with HIV/AIDS.

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.

Population of the Study:

This research targeted 700 HIV/AIDS infected women who live 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 1: 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).

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 samp1e a 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.

Instrumentation:

Questionnaires were used in collecting data from low income women living with HIV/ AIDS regarding the social 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.

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, Counseling 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.

Reliability of the Instruments:

The researcher piloted the research instruments to enhance their validity and reliability in one Home Based Care center 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).

4. RESULTS AND DISCUSSION

Ages of Women Living with HIV/AIDS:

Data about the ages of women living with HIV/AIDS in the areas of Kaptembwa, Free Area and Bondeni in Nakuru Municipality are tabulated in Table 2.

TABLE 2: 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 2 shows that the age distribution of the HIV/AIDS-status women was fairly representative from all the four areas in the Municipality. Table 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 95 (38%) women followed by those aged 20-30 years old as said by 76 (31%) women. The results reveal that in overall the largest proportion of women infected by HIV/AIDS lie in the ages of 20-40 years (who in this case are 171 or 69%), the age during which people are sexually very active. 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 i.e. 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.

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

Objective one 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 3.

TABLE 3: 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**
Does denial affect you due to your status?	91	*36.8*	102	*41.3*	35	*14.2*	19	*7.7*	247	**100**
Does anger affect you due to your status?	115	*46.6*	80	*32.4*	29	*11.7*	23	*9.3*	247	**100**
Does disclosure affect you due to your status?	93	*37.7*	110	*44.5*	23	*9.3*	21	*8.5*	247	**100**
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**

Table 3 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 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.

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

Objective two of the study sought to compare the psychological challenges faced by married and single women living with HIV /ADS in Nakuru Municipality. The variables under comparison were denial, disclosure, being afraid of infecting others and straining family members.

Comparison of Married and Single Women based on Stigma:

The HIV/AIDS-status women were required to respond to the question: Does stigma affect you due to your HIV/AIDS status? The results showed 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. 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 4 presents the reasons as to why they were being stigmatized by HIV/AIDS status.

TABLE 4: 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 4, the proportion of single women (being 50.4%) and married women (being 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 %. The views of the women, who accepted to be stigmatized by the HIV/AIDS pandemic, in verbatim, were as follows:

> 'People did not want to associate with me freely; My family chased me out of the home; They (family members) opened the door and threw the food at me; I was told to be battling in my house; People still associate this disease with immorality so I face a lot of stigma; I am being chased out of the house by the landlord to go home; I don't associate with others because they don't know their status; What will my peer think about me; Will I get a man to marry me; One might be stigmatized by the community which may lead to one not accepting their status; Because I was not supported with food and money for medicine; I was isolated by my husband; Because many people gossip about my status at work and home; How will my husband react when he knew?; Because I was isolated by my husband. I have stigmatized myself because of my status; what will people say?'

Referring to the views of the women above, 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 59 (48.8%) did not give reasons for being stigmatized. May be they regarded HIV/AIDS being a sensitive and personal matter.

Table 5 presents the reasons of the women who were not stigmatized by their HIV status.

TABLE 5: 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 5, 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. The views of the women, who did not accept that they were stigmatized by the HIV/AIDS pandemic, in verbatim, were as follows:

> 'Because I know my status; HIV is not the only disease there are many diseases, e.g. T.B and diabetes; I have agreed to live positively and I know everyone will die one day; Stigma does not affect me because I have accepted my status and even accepted myself; I have been counseled by Love and Hope Centre on HIV/AIDS; I decided to live positively; HIV/AIDS is not the end of living, life has to continue'.

Referring to the cited reasons above, 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.

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? The results showed that 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. Further, 91 (37%) women who accepted to deny their HIV/AIDS status gave out the reasons presented in Table 6.

TABLE 6: 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 6, 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 views of the women, who denied that they are stigmatized by the HIV/AIDS pandemic, in verbatim, were as follows:

> 'Because I had not accepted my status; I was a saved Christian; I knew very well people will refuse to associate with me when they know my status; Because I regarded HIV/AIDS as shame; I believed my partner was clean; People think that they might be affected by being close to me; I was a religious leader; I have not come to terms; My family was afraid to share some of the things in the house like plates'.

The cited views of women mean that 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.

The women who said that they did not deny their HIV/AIDS status gave out the following responses in Table 7.

TABLE 7: 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 makes me bold	-	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 7, 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). In a nutshell the views of the women were captured as follows:

> 'Have gone to many seminars and learnt that denial wouldn't help but just frustrate; I have accepted it so nothing to deny; Because my husband is also infected; I accepted that I was HIV/AIDS through a lot of counselling that made me realize that there is life after HIV/AIDS; Through accepting that I am positive I have conquered denial'.

From the aforementioned findings, 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.

Comparison of Married and Single Women based on Anger:

The HIV/AIDS-status women were required to respond to the question: Does anger affect you due to your HIV/AIDS status? The findings showed 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 by their HIV/AIDS status are presented in Table 8.

TABLE 8: Why the low-income Women were 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 8 indicates that single women (65.2%) were angered more than married women who (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. The women, in general, expressed their views of not being angered by their HIV/AIDS status as follows:

> 'Why did it happen to me; Why me and am still young; Because of stress of food for children and shelter clothes and school fees so I have to be angry when failed; Was the man that was my boyfriend; Why did he infected me; Because I just assume that everyone knows about my status; Did I get through my deceased parents? Because of joblessness and my status; I feel that I should not have been affected; Was it my husband who infected me?'

Referring to the views of the women above 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.

The reasons why the women were not angered by their HIV/AIDS status are presented in Table 9.

TABLE 9: Why the low-income HIV/AIDS-status women were not 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 9, 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 HIV/AIDS is just like any other disease. The women expressed their reasons as follows:

'I am cool. HIV/AIDS is a disease just like any other disease, if one gets malaria or headache that person is never angry, so I am; I have no anger. Life continues whether being HIV positive or negative; I control my emotions, fear and everything that may affect me negatively'.

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. However, a fairly large number of women (33.8%) did not give reasons for not getting angry with their status.

Comparison of Married and Single Women based on Disclosure:

The HIV/AIDS-status women were required to respond to the question: Does the idea of disclosing your HIV/AIDS status affect you? Findings indicated 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 living with HIV/AIDS got affected by the prospect of disclosing their HIV/AIDS status are presented in Table 10.

TABLE 10: Why the HIV/AIDS-status women got 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 10 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.

The reasons why the women living with HIV/AIDS do not get affected by the prospect of disclosing their HIV/AIDS status are presented in Table 11.

TABLE 11: Why the HIV/AIDS-status women don't get 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 11 indicate that most (88%) married women are not affected by disclosure as compared to the single women (25%). This is because most married women (16.4%) have been empowered to cope with their HIV status.

Comparison of Married and Single Women based on Fear of Infecting Other Family Members:

The HIV/AIDS-status women were required to respond to the question: Do you feel afraid of infecting family members with HIV/AIDS? The results indicated that majority of the women (42.1%) were not afraid of infecting their family members with HIV/AIDS against (25.1%) women who were afraid 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 the women were afraid that they would infect their families with HIV/AIDS are presented in Table 12.

TABLE 12: Reasons for HIV/AIDS Women Getting Afraid of Infecting Family Members

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 12 indicate that the largest proportion of low-income 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.

The reasons why the women were not afraid of infecting their family members with HIV/AIDS are presented in Table 13.

TABLE 13: Reasons for HIV/AIDS women were not 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 13 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 55 (42.9%) compared to the singles who were 49 (47.1%) citing reasons such as HIV/AIDS is not contagious, they know how to protect themselves and know how to take precautions. The women's views are quoted as follows:

> 'Because I cannot share objects like toothbrush, razor blades and needles; Because they will not be infected by me while staying with them and somebody cannot get HIV/AIDS by sharing or staying with them; HIV/AIDS is infected through sexual intercourse so I can't have sex any of my family members; I know the prevention measures that I take so as to protect the rest of my family; Because we are educated about HIV/AIDS'.

The cited views of the women indicates 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.

5. CONCLUSIONS

Based on the findings discussed in the study, the researcher concludes that the women living with HIV/AIDS face various psychological challenges such as stigma, denial, anger and fear of disclosure 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 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 and psychological support was also crucial in the management of HIV/AIDS. This implies that more policies and strategies are needed to be put in place so as to provide more client-driven psychological support to help the women living with HIV/AIDS mitigate the challenges facing them.

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