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Social Challenges Facing Low Income Earning Women Living With HIV/AIDS: A Case of Nakuru Municipality, Kenya

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Abstract: **Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) has been in existence for more than twenty years and women account for nearly half the 40 million people living with HIV/AIDS. Women's rate of new infection surpasses men's because biological, cultural, and social economic conditions contribute to women's greater vulnerability to HIV. The challenges that these low-income earning women living with HIV/AIDS face are social, economic, and psychological. When a woman is sick the family's property, the children's education, savings and food security are threatened because women provide the majority of labour and managerial services for their household. The purpose of the study was to establish the social challenges that face low-income earning women living with HIV/AIDS. A sample of 248 out of a population of 700 who were receiving Home Based Care within Nakuru Municipality was selected. The study was a survey where Questionnaire and interviews were used to collect data. The data was analyzed using descriptive statistics. The findings of the study revealed that low income women living with HIV/AIDS faced various social challenges such as shame, discrimination, and causing strain in the family among others. The disparities that existed among the singles and the married revealed that one's marital status determined the extent to which one was ashamed, evoked negative changes in the behaviour of family members and experienced discrimination based on their HIV/AIDS status. The implications of the findings is that the public support for the low-income women living with HIV/AIDS is inadequate and mostly material, and emotional support is also crucial in the management and coping with HIV/AIDS.**

Keywords: **People living with HIV/AIDS, Social challenges, Pandemic, Low income- earning.**

1. INTRODUCTION

Background to the study:

Human Immunodeficiency Virus (HIV) and Acquired Immune Syndrome (AIDS) pandemic has been inexistence in the world for twenty six years and has disproportionately affected women and young girls than men and young boys, women account for nearly half the 40 million people living with HIV/AIDS (PLWHA) worldwide (UNAIDS, 2006). In sub-Saharan Africa, 59 percent of adults with HIV are women (UNAIDS, 2006).

In Kenya, the number of women infected is twice that of men and in Nakuru District women 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 (NASCOP, 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 consequences (NASCOP, 2008). 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 [7.7 million being women (UNAIDS, 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, 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 (NASCOP, 2005). It is also estimated that 1.09 million people in Kenya are living with HIV today with two thirds being women (NASCOP, 2005). 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, 2005). 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 H.IV 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 and STI Control Program (2006).

TABLE 2: Estimated Adult HIV Prevalence by Province in 2006

		Prevalence (%)		
Province	**Number HIV+**	**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 Aids and STI Control Program (2006).

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 (NASCOP, 2008). 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 micro trauma 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 (NASCOP, 2008). 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 social and psychological challenges. The situation becomes more challenging to low- earning women who have social and psychological 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 social challenges facing low-income earning women living with HIV/AIDS within Nakuru Municipality.

Statement of the Problem:

Women living with HIV/AIDS face social a wide range of challenges, and it is worse if the infected woman is a low income earner. Earlier policies of the Kenya National HIV/ AIDS strategic Plan (KNASP) emphasized the provision of prevention and treatment services (NASCOP, 2008). There is need to broaden this scope to include strategies for the mitigation of the social challenges facing PLWAS with particular reference to low income earning women (NASCOP, 2008). Women infected and affected by HIV/AIDS have difficulties accessing basic services and protecting their rights, including access to health, shelter education, and food and land rights. More detailed information is required on the social 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 social challenges that might have faced low- income earning women living with HIV/ AIDS within Nakuru Municipality.

Purpose of the Study:

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

Objectives of the Study:

The following objectives guided the study:

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

Research Questions:

The research questions for the study were:-

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

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

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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 counseling 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.

Conceptual Framework:

This study will be conceptualized as shown in Fig. 1

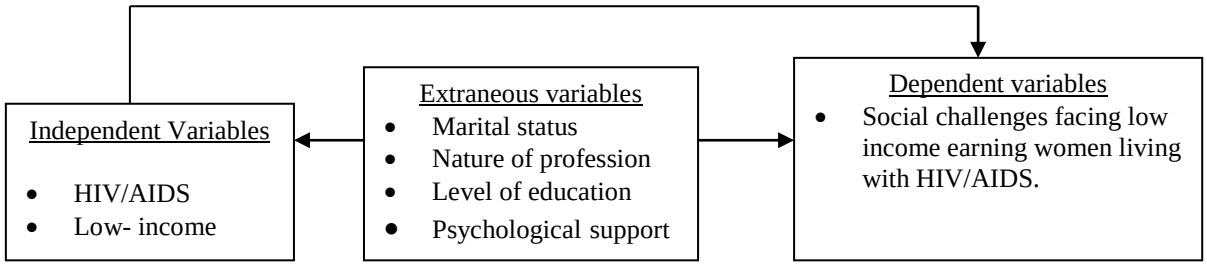

Fig. 1 Conceptual Framework

Fig. 1 is a summary of the social challenges facing low-income earning women living with HIV/AIDS. The independent variables are HIV/AIDS and low income and dependent variables are the social challenges facing low income earning women living with HIV/AIDS. HIV/AIDS and low income as independent variables directly affects the social status of women. After being infected they face social challenges. 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

Social 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 household 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 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 lose their contribution. However, the infected person is likely to lose 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 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 effect of the disease anytime. This may lead to 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, 2005). 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 price for the medicine. Therefore the cripplingly high medical costs plus lost wages, guarantee that the family falls into poverty and destitution. The patient needs plenty and well balanced diet but due lack of money, poor nutrition makes it more likely for a patient's HIV positive status to progress to AIDS sooner than would have been the case if adequate and well balanced meals were available (NASCOP, 2008).

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 to 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, 2008). When a person is diagnosed as HIV positive, she is gripped with fear of publicity due to work, friends, family members and the community will not like to associate with the sick person for fear of infection. Worse still, the sick individual will be judged as promiscuous. This will make her to resign from her job and this worsens 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. Mathu (2004) reveals that another problem an individual has to contend with is the treatment of opportunistic infections such as tuberculosis, pneumonia and thrush for people suffering with 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, 2006). In some cases the breadwinners have to quit their sources of income to take care of the ailing ones and thus reducing the sources 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 (Maman, 2001). Due to the limited resources there is a smaller likelihood that the sick will seek or get treatment for sexually transmitted diseases with which they may be infected.

Managing the 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 this 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 stay 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 (Castro, 1998). This is the 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, counseling 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 (NASCOP, 2006).

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 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)

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, 1995). 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.

4. RESULTS AND DISCUSSION

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. Table 4 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.

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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

	MARITAL STATUS				
Monthly Earnings (KShs)	**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%)**

As shown in Table 5, the monthly earnings ranged from KShs 200 to more than KShs 10,000 though slightly over half of women, being 129 (52%), had an income of less than KShs 2,000. Those who had an income more than KShs 5,000 per month were only 10 (4%). The majority (52%) of the low income women living with HIV/AIDS had an income of less than KShs 2000 and very few (2%) 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 $ 1.9 (about KShs 200 as at 2015 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.

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 indicated that, the majority were widows, who were 88 (35.6%), followed by the married, who were 65 (26.3%) as opposed to the singles, who were 53 (21.5%) and the divorced/separated who were 41 (16.6%). This means that the majority of the infected cases were those within marriage or had one time being 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 (NASCOP, 2005).

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

Objective one of the study sought to document the social 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 Challenge	**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' behaviour?	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' behaviour due to their status. Results in Table 6 show that not all low income 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 104 (42%) women compared to straining families or negative reaction from family members being faced by 75 (30%) and

74 (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.

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

Objective two of the study sought to compare the social challenges faced by married and single low income women living with HIV /AIDS in Nakuru Municipality. The variables under comparison were stigma, shame, anger, and facing negative reaction from family members due to the status.

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? Results indicated that 104 (42.1%) women were ashamed by their HIV/AIDS status vis-à-vis the 89 (36.0%) who were not. A small proportion of them, being 33 (13.4%) did not respond to the question while 21 (8.5%) had no opinion. Table 7 presents the reasons of the women who were ashamed by their HIV/AIDS status.

TABLE 7: Reasons for Being Ashamed By HIV/AIDS Status

	SINGLE	MARRIED	TOTAL
REASON (S)	**f (%)**	**f (%)**	**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 7, 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 views of the women, who were stigmatized by HIV/AIDS in verbatim, were as follows:

'Because I was not going out of the house; I have big children, people will say I am immoral; The face given to the scourge; It is very shameful for my neighbors to know my status ; Because many people in the community only know that people get HIV/AIDS through sex; The disease is of the prostitutes; I was accused of moving with men; Because of growing thin; Still I fear to tell anybody; I don't accept being HIV positive; HIV/AIDS was given a bad face; My face turned black and full of rashes, I felt ashamed to move around; Because many people in the community only know that people get HIV/AIDS trough sex; Because I will be seen as a prostitute; I was ashamed because people will take me as a prostitute; Because HIV people are looked down upon; I have a family how will people think of me'.

It is clear from the reasons above that 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.

Table 8 reveals reasons why the women were not ashamed by their HIV/AIDS status.

TABLE 8: 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 8 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. In summary and in their own words the women said that:

'I have accepted my status, worked hard to restore my self esteem so am not affected by shame; I believe one should not be ashamed of his/her status coz this is just a condition that can be managed; This doesn't affect me because nothing has changed in my life, again life has to continue even if my status is positive; I know my status and hence see no reason for shame'.

The citations of the women above indicate that accepting the situation as well as understanding how the HIV/AIDS can be managed helped the women not to be ashamed about their status. 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.

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? Findings showed that a majority of the women (39%) said that they do not strain their families when in need of support compared to (30%) who accepted that their HIV/AIDS status strained their families. 23% of the women were not sure whether they strain their families while 8% did not respond. The reasons why the women felt that they strain their families in supporting them are presented in Table 9.

TABLE 9: Reasons Why HIV/AIDS women felt that they strained their families

REASON (S)	SINGLE	MARRIED	TOTAL
A lot of money is used on my treatment	29(38.7%)	-	29(38.7%)
Because I am financially handicapped	13(17.3%)	-	13(17.3%)
At times children don't go to school	7 (9.3%)	-	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%)	-	2(2.7%)
No response	**13(13.7%)**	**-**	13(17.3%)
Total	**71(94.7%)**	**4(5.3%)**	**75 (100.0%)**

The findings in Table 9 show that an overwhelming majority (94.7%) of the single respondents accepted that their HIV/AIDS status seriously strained their families compared to only 5.3% married women. 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 taxing as they need drugs, among other things. They further revealed that:

> '…I get sick so many times, they have to take care of me every now and then so I strain them a lot; I have no much input; They see that I am not productive; Because at times one has to depend on them fully i.e. feeding you, bathing you, paying bill and others; Because they have to support me and my kids; There is an organization that usually caters for my health'.

The cited views of the women indicates 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.

The reasons why the women felt that their HIV/AIDS status was not straining their families are presented in Table 10.

TABLE 10: Reason's why HIV/AIDS Women Felt They Were 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%)**

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Table 10 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. A significant number (70.5%) said that they didn't bother their families with anything as they take care of themselves. Moreover, only the singles (though a small number, that is7.4%) depended on well-wishers.

Comparison of Married versus Single Women based on Negative Change in Family Members' Behaviour:

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? Their responses showed that a majority (47%) of the women 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, while 9% did not respond.

The reasons why the women's HIV/AIDS status did evoke negative behavior from their families are presented in Table 11

TABLE 11: Why Women's HIV/AIDS Status Prompted Negative Family Behaviour

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%)**

Results presented in Table 11 show that an overwhelming majority (62.2%) of the married respondents accepted that their HIV/AIDS status evoked negative behavior from family members with most of them (20.3%) saying that they were either being chased away or abandoned by their 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 with them (10.8%) something which married women did not face. However, the two categories of women equally faced discrimination with 5.6% of the singles and 10.8% of the married respondents experiencing discrimination. Further, 5.6% of the singles and 10.8% of the married respondents said that family members did not visit them. With their exact words, they further revealed that:

'The husband's family chased me and/or my children away; My brother did not want to associate with me; Some of my family members live in fear and shame because of my status; Some family or community members think that HIV/AIDS is a disease related to immoral people; They could not want to eat with them; My husband became so wild and decided to marry another lady'.

The cited views of the women indicates 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.

The reasons why the women's HIV/AIDS status did not evoke negative behavior from their families are presented in Table 12.

TABLE 12: Why Women's HIV/AIDS Status did not prompt Negative Family Behaviour

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%)**

Results in Table 12 indicated that 51.3% of the low income married women suffering from HIV/AIDS did not face negative reaction from family members was slightly higher than the 48.7% of the singles who did not face negative reaction from family members. The key reasons for this 'acceptance' among family members were that no one knew their

status as said by 15.4% of the singles and 17.1% of the married respondents, as well as the love from their families as said by a similar number (15.4% of the singles; 17.1% of the married).

How Low-Income Women Living with HIV/AIDS Manage Challenges:

Objective three of the study sought to determine how the low-income women living with HIV/AIDS managed the social challenges they were facing in Nakuru Municipality. To this end, the low income HIV/AIDS-status women were required to reveal the steps they had taken to manage the social challenges facing them due to their HIV/AIDS status.

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

The measures adopted by low income women living with HIV/AIDS in coping with the social challenges facing them are presented in Table 13.

TABLE 13: Measures Adopted by HIV/AIDS Women to Cope With Social Challenges

	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	1.3
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	3.1	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**

Results presented in Table 13 showed that an overwhelming majority 24.7% of single women depended on social support groups (such as Badili Mawazo, Love and Hope Centre, inter alia) as compared to 6.2% of the married women. Whereas it is only the married women who kept poultry (2.1%) as well as got support from micro-financing (2.1%) the singles did not. On the other hand, whereas the singles ensured that they took a balanced diet, identified with people living with HIV/AIDS and sought regular medical attention, the married did not. Counselling also emerged as one of the key steps in managing the HIV/AIDS challenges for both singles (5.2%) and the married women (6.2%). In regard to the steps taken to cope with HI/AIDS, the women said that:

'Support group therapy; I am trying to control my anger/stress and interact with people; Attend support group meetings, visiting friends; By attending any doctor's appointment and all seminars about HIV/AIDS; By doing the right things under medication and taking charge over my life (control); Now I am no staying alone, I went to friends and neighbours; I joined support groups; By being trained on going public; I am so real and try to reach out people and explain myself'.

The aforementioned views of the low income women living with HIV/AIDS indicate that the measures to cope with the scourge cannot be taken by the victims alone but should get financial, material (including food) and emotional support from the entire society.

5. CONCLUSIONS

Based on the aforementioned findings of the study, the researcher concludes that the low income women living with HIV/AIDS face various social challenges such as shame, straining family members and negative changes in family members' behaviour among others. The disparities that existed among the singles and the married reveals that one's marital status determines the extent to which one is ashamed, or discriminated against based on their 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 AIDS scourge.

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