THE EFFECTS OF HIV/AIDS ON THE SOCIAL, ECONOMIC AND PSYCHOLOGICAL STATUS OF INFECTED WOMEN IN NAKURU MUNICIPALITY

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A Research Project Report Submitted to Graduate School in Partial Fulfillment of the Requirements for the Award of the Degree of Master of Education in Guidance and Counselling of Egerton University

EGERTON UNIVERSITY

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DECLARATION AND RECOMMENDATION

DECLARATION

This research project report is my original work and has not been submitted for the award of a degree or diploma in any other university.

Signature: _____ Date: _____

GRACE NYAERA MOGIRE,

EM16/0583/02

RECOMMENDATION

This research project report has been submitted for examination with my approval as University supervisor.

Signature: _____ Date: _____

Prof. A.M. SINDABI.

DEDICATION

To my children and my husband for their encouragement and inspiration.

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ABSTRACT

HIV/AIDS continues to have social, economic and psychological effects among infected and affected persons and their households. This has been further complicated by the negative perceptions and attitudes toward people living with HIV/AIDS as a result of social stigmatization, isolation and discrimination. Women infected with HIV/AIDS have disproportionately been the main victims of the negative perceptions and attitudes and thus face and shoulder the biggest burden of the effects associated with the disease. This study sought to evaluate the impact of HIV/AIDS on the social, economic and psychological status of women infected with HIV/AIDS in Nakuru Municipality. This study adopted an *ex post facto* research design. The target population included 151 women infected with HIV/AIDS who were members of five counselling associations affiliated to Family Planning Association of Kenya, Nakuru. A proportional random sample of 109 respondents was selected from the five associations. Data acquisition was through administration of a structured questionnaire to the selected respondents. The Data was processed and analysed using Statistical Package for Social Science (SPSS) version 11.5. Findings indicate that negative perceptions and attitudes of the society towards people living with HIV/AIDS have increased social stigmatization, isolation and discrimination of women infected with HIV/AIDS. Lack of adequate access and equity to economic resources has made it difficult for women infected with HIV/AIDS to balance between their medical expenses and family obligations and responsibilities. There is need for vigorous advocacy campaign and awareness in the society to demystify the social stigma of HIV/AIDS among persons infected with the disease, especially women who are the most vulnerable group. There is need to develop appropriate strategies that could address gender-based issues exposing women to the risk of HIV/AIDS infection. These findings will be beneficial to government agencies, policy makers, NGOS and other interested parties in assisting women living with HIV/AIDS cope with their condition.

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LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ARVs	Antiretroviral Drugs
CBO	Community Based Organizations
CSW	Commercial Sex Workers
G.O.K	Government of Kenya
HIV	Human Immuno Deficiency Virus
K.I.E	Kenya Institute of Education
NACC	National Aids Control Council
NASCOP	National AIDS and STI's Control Programme
STD's	Sexually Transmitted Diseases
UNAIDS	United Nations Programme on HIV/AIDS
UNICEF	United Nation Children Education Fund
WLWHA	Women Living with HIV/AIDS

CHAPTER ONE
INTRODUCTION

1.1 Background Information

HIV/AIDS is a worldwide epidemic affecting almost all the countries. It is estimated that there were about 39.5 million people living with HIV/AIDS worldwide in the year 2007, 2.6 million more than in 2004, and the number of new infections reached 4.3 million in 2006. Two-thirds of those infected, 24.7 million people, live in sub-Saharan Africa, which also accounts for almost 72.4 percent of AIDS deaths which is 2.1 million out of the 2.9 million global HIV/AIDS deaths (UNAIDS, 2007; Asiimwe, 2007). The pandemic has become a human, social and economic disaster with far reaching implications for individuals, communities and countries. No other disease has so dramatically highlighted the current disparities and inequalities in health care access, economy and human rights as HIV/AIDS (Murrah, 2001). Globally, there are more than 39.4 million people with HIV/AIDS, 70 percent of these reside in sub-Saharan Africa according to (UNAID, 2005). During 2002, the HIV/AIDS pandemic claimed more than 3 million lives and 5 million people were infected with a half of these occurring among young people under 25 years of age in Kenya.(Republic of Kenya, Ministry of health,2005).

When the epidemic was first reported, men vastly outnumbered women in terms of HIV/AIDS infections. However, the number of women infected grew steadily and by 2002, more women were infected than men (Kipkemboi, 2004). Women are more vulnerable to the disease and its associated effects since they are 2-6 times more likely to get the infection. The number of women with HIV/AIDS infection has increased steadily worldwide. By the end of 2005, according to the World Health Organization (WHO), 17.5 million women worldwide were infected with HIV. Around 76 percent of women living with HIV are in sub-Saharan Africa. Furthermore among young people living with HIV in this region, three in every four are female. Across the region, 57 per cent of adults with HIV are women, and young women aged 15 to 24 are more than three times as likely to be infected than it is with young men .aged between 30-39. The situation is worsened by the fact that women know less than men about how HIV/AIDS is transmitted and how to prevent infection, and whatever little they know is often rendered useless by the discrimination and violence they face (Miranda, 2003; Willis, 2002; Adler, 2001).

Kenya is one of the Sub-Saharan countries worst affected by the disease accounting for more than 7 percent of global HIV /AIDS. It is estimated that 2.2 million people in the country are infected with HIV/AIDS and that approximately 750 people die everyday due to this pandemic (National Aids/STI Control Program of Kenya - NASCOP, 2000). On average, 12,000 new cases of HIV/AIDS are reported in the country each year (NASCOP, 2005) This robs the country of an economically productive and active group of people (NACC, 2006). It is estimated that for every eight adults aged between 15-49 years, one is infected. Although the rate of increase of HIV/AIDS prevalence which had reached a peak of 14% in 2000, had fallen to 7% in 2004, the number of people infected by the disease will continue to grow (NASCOP, *ibid*). Similarly, AIDS related deaths are estimated to be three times the number of deaths caused by all other diseases combined, (Republic of Kenya, Ministry of Health, 2005). However, according to National AIDS Control Council - NACC (2006) the national prevalence rate is placed at 5.8 percent although infection among women remains higher than those of men. The Kenya Demographic and Health Survey (KDHS) Report of 2003 found a prevalence rate of 9 percent in adult women and 5 percent in adult men (CBS, 2003).

HIV/AIDS in Kenya has also shown that gender-based imbalance in power in the economic and social aspects of life affects sexual behaviour. Women have less control over nature and timing of sex and practice of protective behaviour (Berer, 1993). Women infected by HIV/AIDS also undergo considerable psychological distress, anger, fear, depression, stigma, fear, discrimination and denial which are common initial reactions to HIV positive result (Wigley et al 2002, K.I.E, 1999). Beliefs about masculinity and femininity have encouraged men to have multiple sexual partners, while women are encouraged to be passive and ignorant about matters of sexuality and reproduction. The burden of HIV/AIDS related care is often inexplicably distributed between men and women (KANCO, 2000). This has been complicated by the fact that majority of the women depend on men for physical, social and economic security, which makes them more vulnerable to the disease and its associated effects (Ashford, 2001).

Nakuru district has not been spared by the ravages of HIV/AIDS. The District has the highest HIV/AIDS infection rates in Rift Valley Province. In the district, 48 percent of women are

infected with the disease and 4,624 related deaths related to HIV/AIDS have been recorded (NACC, 2005). By the year 2001, the district had an estimated total of 151, 272 people infected by the disease, with 45,587 in the urban areas and 105,685 in the rural areas. This constituted a prevalence rate of 25 percent. These prevalence rates were categorized as high (NACC and NASCOP, 2003). Like the country and the entire Sub-Saharan Africa, women in Nakuru district are also excessively infected and affected by HIV/AIDS, they also carry the burdens of the negative social, economic and psychological effects of HIV/AIDS.. This study aimed at evaluating the level of vulnerability of women to HIV/AIDS; the effects of the epidemic on women, and the role of counselling in assisting them address these challenges.

1.2 Statement of the Problem

HIV/AIDS continues to pose the greatest health challenges to many developing countries. The disease has caused a lot of social, economic and psychological effects among the infected and affected persons in the community. In developing countries like Kenya, little documented information exists on the extent of these effects on women infected by the disease. Therefore a study to investigate the social, economic and psychological effects of HIV/AIDS on infected women and the role of counselling in alleviating their problem in Nakuru Municipality was necessary.

1.3 Purpose of the Study

This study sought to evaluate the effects of HIV/AIDS on the social, economic and psychological status of women infected with HIV/AIDS in Nakuru Municipality.

1.4 Objectives of the Study

The following specific objectives guided the study:

1. To determine the social effects of HIV/AIDS on women infected by the disease.
2. To assess the economic effects of HIV/AIDS on women infected by the disease.
3. To determine the psychological effects of HIV/AIDS on women infected by the disease.
4. To establish the role of counselling in assisting the women infected with HIV/ AIDS cope with the disease.

1.5 Research Questions

The study sought to address the following research questions:

1. What is the social effects of HIV/AIDS on women infected by the disease?
2. What is the economic effects of HIV/AIDS on women infected by the disease?
3. What is the psychological effects of HIV/AIDS on women infected by the disease?
4. What is the role of counselling in assisting the women infected with HIV/ AIDS cope with the disease?

1.6 Significance of the Study

In order to adequately address and reduce the rates of infection and prevalence of HIV/AIDS in the country, there was need for detailed empirical study highlighting the social, economic and psychological effects of the disease on infected women This was important in determining the extent to which women infected with HIV/AIDS had been socially, economically and psychologically affected by the disease. It also highlighted the role of counselling services in addressing the challenges that these women face as a result of their status. This study was critical in providing information that could be useful in developing strategies that would cater for such a vulnerable and marginalized group, to concerned stakeholders including the Ministry of Health, policy makers, decision makers and the entire society. The output of this study is also expected to help to provide input into projects and programmes that seek to address HIV/AIDS, especially among women infected with the disease in the country. The findings of the study would lay a foundation for further research in the same area of concern.

1.7 Assumptions of the Study

This study was based on the following assumptions:

(i) Women infected with HIV/AIDS in the study area were affected by the disease.

(ii) The respondents were willing and honest in talking about the disease and thus their views were a true reflection of the situation at hand.

1.8 Scope of the Study

The study focused on evaluating the effects of HIV/AIDS on the social, economic and psychological status of women infected with HIV/AIDS in Nakuru Municipality which is in

Nakuru District, Rift Valley Province. Nakuru municipality was chosen as a research site due to the available evidence of high disproportionate prevalence and infection rates of HIV/AIDS between men and women (NACC, 2005; NACC & NASCOP, 2003). This pointed out to gender imbalance in the level of vulnerability, infections, prevalence and burden of the disease between men and women. Only women infected with HIV/AIDS and who were members of counselling associations affiliated to Family Planning Association of Kenya were involved in this study. This was because of the stigma surrounding the disease and therefore those women affiliated to FPAK were assumed to have accepted their HIV/AIDS status and thus would be more open in talking about their condition. The study sampled women infected with HIV/AIDS and counselling providers from five counselling associations.

1.9 Limitations of the study

The study encountered a number of limitations which could have impeded answering the research questions. These included:

(i) Women infected with HIV/AIDS were likely to have been stigmatised, discriminated and isolated in the society as a result of the negative perceptions and attitudes towards the disease. This might have made potential respondents apprehensive about other people in the society, especially foreigners, and therefore affect development of a good rapport with the researcher. However, the study targeted only those women affiliated to counselling services who were expected to be more open and truthful about their status and its associated impact.

(ii) There were very many women infected with HIV/AIDS in the country and study area and all of them were expected to have been encountering social, economic and psychological impact as a result of their status. However, due to confidentiality involved in establishing the HIV/AIDS status, only those who had openly come out to admit their status and seek for help were targeted. The findings of this study may therefore be confined to the sampled women in the five selected counselling associations. The findings could also be applicable to infected persons facing similar situations in the country with caution.

1.10 Definition of Terms

In this section, operational definitions are presented as used within the context of this study.

AIDS Acquired Immune Syndrome. A serious disease caused by a virus which destroys the body's natural protection from infection.

Counselling: The process where the infected receive help from professionals to help overcome personal and social problems which may interfere with their behaviour.

Economic Effect: Basically refers to the management of money, opportunities to engage in gainful activities that may have financial implications e.g. access to capital assets. In this study, the researcher sought to investigate how the onset of HIV/AIDS had affected the financial status of the infected women.

HIV: Human Immunodeficiency Virus is a virus that causes AIDS.

Infection: To pass a disease from one person, to another. This is usually caused by a bacteria or virus.

Pandemic: Refers to a situation where a disease affects a large group of subjects or area.

Prevalence: Existing very commonly or happening frequently.

Psychological Effect: This entails the mind of a person where by a person suffers from Psychological stress related to the HIV virus. They experience fear, worry, feeling of helplessness, anxiety, confusion and even depression. This state of the mind ends up weakening the physical body too.

Social Effect: Women are part of the larger human society with which they interact. In this study the researcher found out that the reaction of the community towards women who are HIV positive. The society tends to discriminate against them, blame them and even isolate them. This lowers their self esteem and leads to loneliness.

Status; An individuals position compared with others, in this study the researcher found out that the infected women are looked down upon by others in the society because they are HIV positive

Vulnerability: A situation in which one is physically, mentally or emotionally hurt, influenced or attacked by something.

CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

The study assessed the social, economic and psychological impact of HIV/AIDS on women infected with HIV/AIDS. This chapter therefore reviewed literature on HIV/AIDS concept, HIV/AIDS prevalence, women and vulnerability, economic impact of HIV/AIDS, psychological impact of HIV/AIDS and the role of counselling services. The chapter also outlined the theoretical and conceptual frameworks that guided the study.

2.2 HIV /AIDS

HIV (Human Immuno-Deficiency Virus) is the organism that causes AIDS (Acquired Immuno-Deficiency Syndrome). AIDS is a disease in which natural immunity or resistance to infections is destroyed and those infected become susceptible to serious "opportunistic" infections (Wanyoike, 2003). According to him, those infections ultimately kill those infected and there is no cure or vaccine currently available. When the virus enters the body and infection develops, that person is said to be infected with HIV. The virus starts to multiply and systematically destroys the cells of the immune system. AIDS sets in as the final stage of HIV infection, when the virus has destroyed the immune system to the level whereby the victim can no longer resist commonly occurring infections and other infections that usually do not cause disease in healthy individuals.

AIDS is spread through blood, semen, vaginal secretions and breast milk. The most common method of transmission is through unprotected sexual intercourse with an HIV positive partner (Wigley et al 2002). Other routes include transfusion of HIV infected blood or blood products, tissue or organ transplant, use of contaminated needles and syringes and mother-to-child transmission during pregnancy, birth or breast feeding (MTCT) (Murrah, 2001). HIV/AIDS kills by weakening the body’s immune system until it can no longer fight infections. When the immune system is compromised, opportunistic infections such as pneumonia, meningitis and tuberculosis (TB) easily affect the body (Tarantola, 2000).

The resurgence of TB in many parts of the world is forcing some countries to tackle HIV /AIDS and TB epidemic simultaneously. In Sub-Saharan Africa, TB cases are increasing by an estimated 10 per cent per year of HIV and AIDS (Tarantola,. 2000). In 1992, two million new cases of TB were reported and researchers had the figure at 3.3 million in 2005 .TB is the leading cause of death among people with HIV/AIDS. HIV/AIDS and TB interact destructively each worsening the effects of the other.

2.3 HIV/AIDS Prevalence

The virus that causes AIDS was first identified in the United States of America in the early 1980's,and in Kenya it was identified at Kenyatta hospital in 1984. Researchers soon found evidence of the disease in Europe and Africa and eventually all over the world. UNAIDS estimates show that there were fewer than 200,000 people living with HIV /AIDS in 1980, but the number soared to 3 million by mid 1980's and to nearly 8 million by the end of the decade worldwide. However, it was the 1990's that brought the epidemic to nearly inconceivable growth worldwide, a growth that continues unabated today (Wigley, 2002).An estimated 33.2 million worldwide were living with HIV as of December 2007 and, although the rate of new infections had fallen Globally, the number of people newly infected had increased in a number of countries, including China, Indonesia, Russia and Ukraine. In Africa just like the other countries mentioned there was feminization of the epidemic, with the rate of infection among women increasing compared to men.(UNAIDS, 2007).

When HIV/AIDS was first identified in the 1980's, it was associated with high-risk behaviour like prostitution. However, in the late 1980's the HIV epidemic surged and shifted from groups with high risk behaviour to the general population especially the marginalized and the poor. Health officials thus realized that HIV/AIDS transmission was not only linked to specific risky behaviour, but was also influenced by societal factors that determined people's vulnerability to infection. Therefore, many – political economic, social and cultural factors of life such as poverty and powerlessness increase the vulnerability to HIV /AIDS especially for women, children and young adults (World Bank, 1997).

The understanding of HIV /AIDS pandemic in relation to these determinants has helped look at HIV /AIDS as a universal human rights issue. In USA, the current figures show that 16 percent of people with HIV /AIDS are women, deaths from AIDS declined in men by 15 percent in 1996. It increased among women by 3 percent. In 1985 women accounted for only 7 percent of AIDS cases, while in 1996, the percentage of women diagnosed with the disease rose to 20 percent. The cumulative number of USA women with AIDS reached 114,622 by July 1999. AIDS is the third leading cause of death among women aged 25 to 44 (Cox, 2000).

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Prevalence rates have reached alarming levels in South Africa, Botswana, Zambia and Zimbabwe (UNAIDS, 2000). In Southern Africa, current reports indicate that infected females outnumber the males by two to one. The difference between infection levels is more pronounced in urban areas, with 14 women for every 10 men being infected. In South Africa, it ranges from 20 women for every 10 men, while in Kenya, it is approximated at 45 women for every 10 men, this is the case also in Mali (Kweyu, D. 2004).

While the number of new infections stands at 200,000 each year, the number of hospital beds occupied by AIDS patients is approximately 50 percent, the number of secondary school students infected is estimated at 20 percent, while percentage of GDP lost to the HIV /AIDS scourge was projected at 15 percent by 2005 (Murrah, 2001). Although the rate of increase of HIV prevalence is beginning to slow down, current National AIDS and STDs Control programme, (NASCOP) projections show that the number of infected people will be growing by the year 2010 see (Figure1).

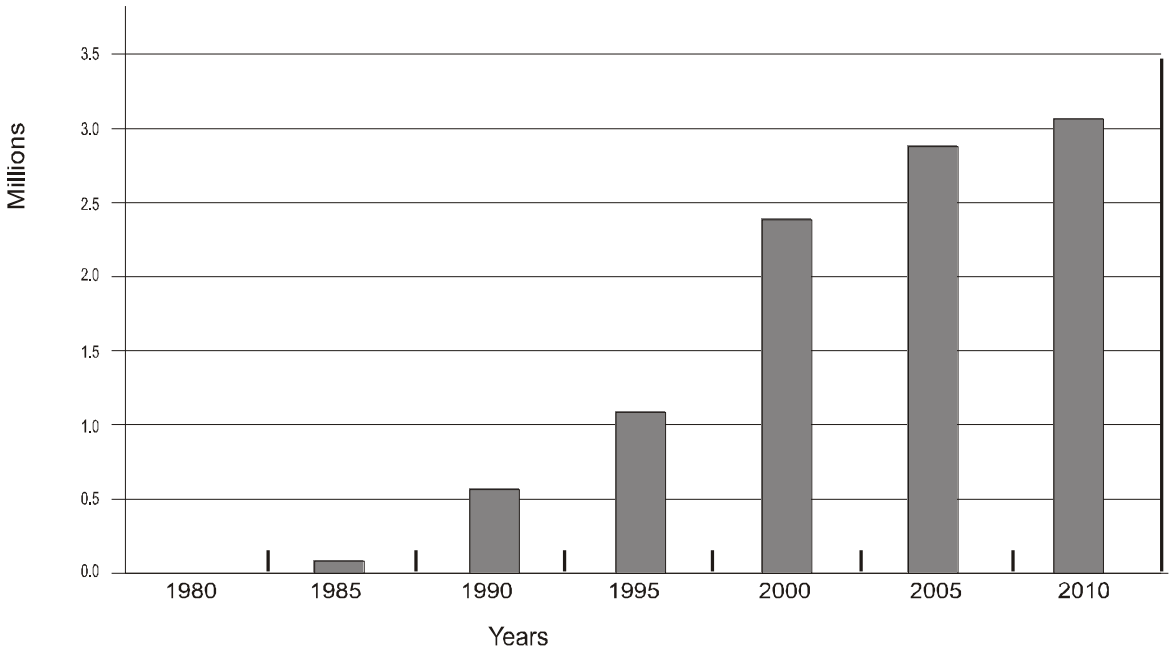

Figure 1: HIV/AIDS Projections in Kenya

Adopted from: HIV and AIDS Facts by Murrah (2002)

Kenya currently has a whooping 6 percent of the world's HIV positive people. It is ranked fifth in the world. Nakuru District on the other hand has an HIV prevalence of 24.7 percent. It is one of the districts with high number of HIV /AIDS cases in the country (Murrah, 2001). As the virus continues to affect mankind, its effect on women are many and varied and since women are part and parcel of the larger community, these effects are thus translated automatically to the community that which affects women affects the community too.(Kenya Institute of Education - K.I.E., 1999). According to the latest statistics the national HIV/AIDS programme has registered significant progress in the past one year. The current data show an estimated adult HIV prevalence of 5.1% in 2006,compared to 5.9% registered in 2005.The current estimate of urban prevalence is about 8.3%,while in the rural the rate is 4.0%.

Table 1

Estimated Prevalence among 15-24 Year Olds by Gender

	Prevalence%			
Year	2003	2004	2005	2006
Male	1.2	0.9	0.8	0.8
Female	5.8	4.9	4.5	4.4
Total	3.5	2.9	2.6	2.6

Source; *National Aids Control Council 2007.*

Table 2

Estimated Adult Prevalence by Province

Province	Number HIV+	Prevalence			
		Total %	Male %	Female %	Male: Female Ratio
Nairobi	197,000	10.1	8.0	12.3	1.5
Central	96,000	4.1	1.7	6.5	3.8
Coast	93,000	5.9	5.0	6.9	1.4
Eastern	72,000	2.8	1.1	4.4	4.0
North Eastern	9,000	1.4	0.9	1.8	2.0
Nyanza	183,000	7.8	6.1	9.6	1.6
Rift Valley	171,000	4.8	2.6	4.9	1.9
Western	112,000	5.3	4.2	6.4	1.5
Total	934,000	5.1	3.5	6.7	1.9

Adopted from National Aids Control Council 2007

The HIV prevalence rate in Nakuru clearly indicate that by 1997 it was at 24.6 percent.

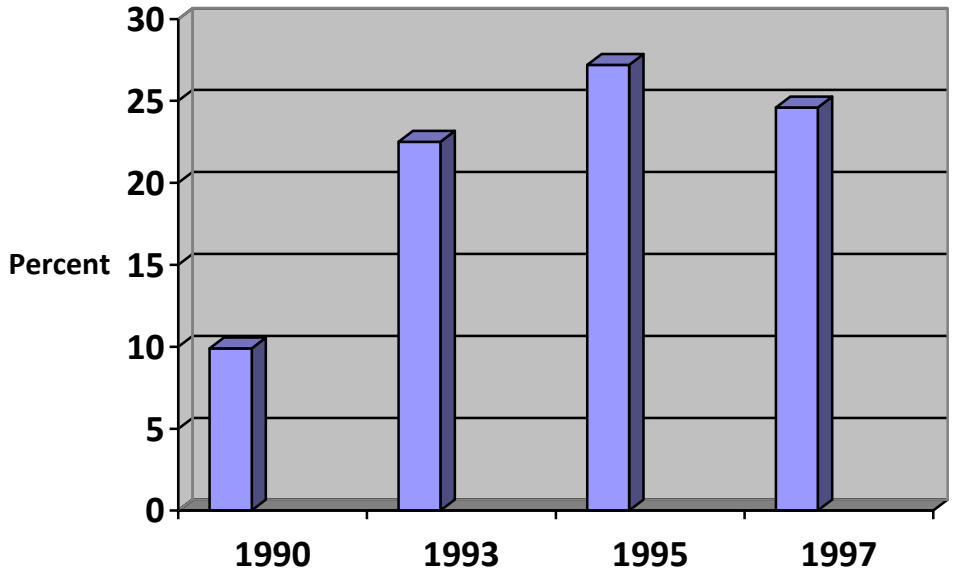

Figure 2: HIV Prevalence in Nakuru, Kenya

Source: Nakuru STI Final Report – 1998

2.4 Women Vulnerability to HIV/AIDS

The effect of the AIDS epidemic on women has changed considerably over the past decade (WHO, 1994). currently women are at the centre of concern. World Health Organization (WHO) estimates that women account for almost half of all newly infected adults. There are 15.7 million women living with the HIV infections worldwide.

Although men were the most affected by HIV /AIDS at the beginning of the epidemic, women's rate of new infections surpasses that of men especially, in countries where women live in poverty and have relatively low status (Murrah, 2001). With HIV /AIDS spreading dramatically among women, AIDS is becoming "a disease of the women" (Kipkemboi, 2004). Elsewhere while addressing an AIDS conference organized by the society for women against AIDS in the year (2002), Kofi Annan, the then secretary general of the United Nations referred to AIDS as having "a women's face" in Africa. (Swaa, 2002). Women are therefore vulnerable to and are more affected by HIV /AIDS for reasons that are beyond their control. These include their physiology,

poverty, economic inequality and influence of culture and traditions among others (UK NGO AIDS consortium, 1999).

HIV/AIDS infection is a gender concern. Infection of a woman by a man is biologically more likely than infection of a man by a woman (Wigley et al., 2002). Women and young girls suffer from biological vulnerability. Research shows that the risk of becoming infected with HIV during unprotected vaginal intercourse is as much as 2-4 times higher for women than for men (Figure 3).

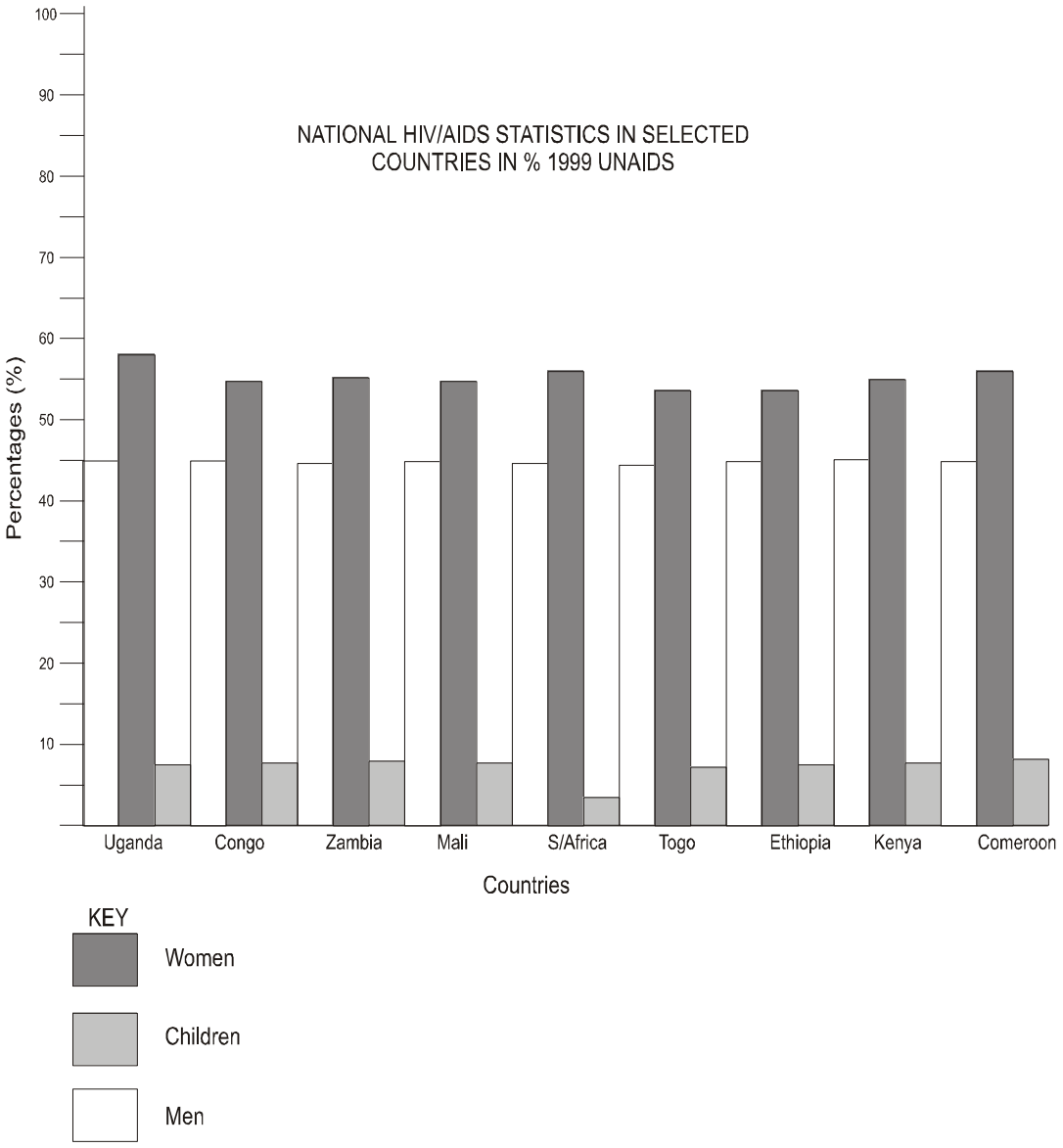

Figure 3: Facts Sheets on HIV /AIDS of 1994

Source: Murrah and Kiarie,(2001)

Male to female transmission during vaginal intercourse is more efficient as men have a higher concentration of HIV than a woman's vaginal secretions. In addition, women are also more vulnerable to other sexually transmitted infections (STIs) that multiply the risk of contracting HIV tenfold (Berer, 1993). Younger women are even more at risk as their immature cervix and scant vaginal secretions make them prone to vaginal mucosal lacerations and tearing and bleeding during intercourse, whether from rough sex, rape, or prior genital mutilation, these increase the risk of HIV infection as does intercourse. Twenty five percent to fifty percent of domestic violence involves forced sex. Coercion also takes place against children and adolescent in both developing and developed countries (Table3).

Table 3

Mode of Transmission of HIV/AIDS and Associated Risks

Mode of transmission	*Risk of infection per Exposure (%)*
Infected man to uninfected women (heterosexual)	0.2
Infected woman to uninfected man (heterosexual)	0.1
Infected man to un infected man (gay sex)	3
Infected mother to child	35
Transmission of contaminated blood	100

According to Ashford (2001), statistics on rape victims around the world indicate that they are younger than 16 years. Since girls and women are often subjected to coerced sex than boys, they risk becoming infected with sexually transmitted infections (STI's) including HIV /AIDS.
Gupta (2002) states that "most of the world's women are poor and most of the world's poor are women". Women make up almost two thirds of the world's illiterate people and are often denied property rights or access to credit. UNAIDS (1999) and Reley (1998) observe that women's jobs are characterized by income insecurity and poor working conditions.

Some national laws reinforce women's economic dependence on men, such as those restricting property ownership and inheritance (WHO, 1994). Also, in some cases, laws limit women's ability to enter into independent contracts or obtain credit under their own names and impede their ability to control income and property. These practices reinforce women's economic dependence on male relatives. This renders them powerless to reject risky behaviour or negotiate preventive actions (Murrah, 2001). Laws regarding marriage, divorce and child custody leads to

children being physically or sexually abused or exposed to the risk of HIV /AIDS infection (WHO, 1994) in the absence of a source of income. This leads some women to engage in commercial sex as their only means of subsistence, increasing their vulnerability to HIV /AIDS and making poverty both " a cause and a consequence of HIV/AIDS' (Tabifor, 2002). Migration as a result of war, famine, political oppression or poverty can increase a woman's vulnerability to HIV infection if she is isolated from community structures and support and does speak or read the local language. For example, female migrant workers, refugees or returnees are often more vulnerable than other women to some kind of sexual barter as they try to negotiate employment, necessary documentation or a place to live (WHO, 1994). In time of war, rape of women is widespread (WHO, 2000). Furthermore, according to UNAIDS (UNICEF, 1999) there are women from traditional families who are caught in a terrible pressure to produce children while unable to admit that they have contracted HIV from a husband who is unfaithful. There are teenage girls from very poor homes whose only way of staying at school is to barter sex with teachers or "sugar daddies" to pay for books, uniforms and fees. Research confirms that non consensual sex is pervasive in the lives of girls and women (Murrah, 2001; UNAIDS 1999).

Cultural practices such as female genital mutilation may also increase the risk of HIV transmission through tearing and other trauma during sexual intercourse (WHO, 2000). Violence against women best illustrates the connection between women's rights, their health and the consequences of their inferior position (UNIFEM, 2000). Violence against women also known as gender based violence occurs in nearly all societies. It includes incest, rape, child prostitution, wife beating and sexual harassment. It also includes harmful traditional practices such as forced early marriages and widow inheritance (Ashford, 2001). Many women tolerate the abuse because they fear retaliation by their spouses. Women's vulnerability to violence is reinforced by not only their economic dependence on men, but also the widespread cultural acceptance of domestic violence and lack of law enforcement mechanisms (Barnett, 1993). In most societies, men are viewed as the principal decision makers and women in their position, cannot determine the terms under which they have sex including whether their partner is sexually faithful, while infidelity is by no means exclusive to men (Barnett, 1993), majority of women tend to be unassertive as taught by the norms of the society that, good women should be loyal, succumb and accept their

husbands. The consequence of being obedient makes them so ignorant and with the onset of the virus, their ignorance leaves them open to the transmission of HIV /AIDS (Moediatta, 1996).

HIV/AIDS is seen as a sign of sexual promiscuity and because of high rates of the infection in women sex workers, it has been assumed that sex infection is concentrated in sex workers, though much of the evidence is on the contrary (Marge, 1993). As a result of this belief, most people consider HIV/AIDS to be a "promiscuous women's disease" along with sexually transmitted diseases. This is particularly with men looking for somebody to blame, Early posters used to warn men "beware of those women; what you see is not what you get ……" (Marge, 1993). The stigma therefore, is more burdensome for women than for men because male promiscuity is saliently permitted in most societies. In Kenya, there are cases reported of women being thrown out of their marital homes by their spouses due to their positive status (KANCO, 2000).

2.5 Economic Effects of HIV/AIDS

HIV/AIDS is one of the most expensive illnesses ever recorded in the history of health in Kenya and in many countries,(World bank,1997) The epidemic has made many rich families experience extreme poverty and lack of resources to purchase the basics of life because they lack purchasing power (Demeke, M.1993).

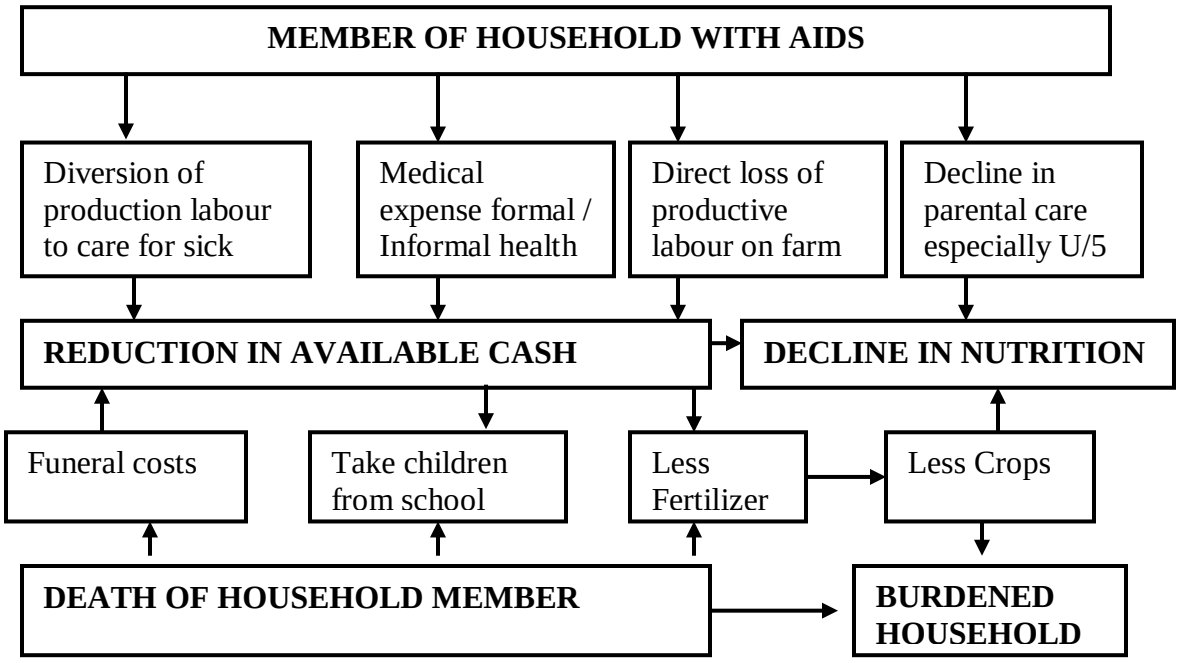

Figure 4: Effects of AIDS on the household

Adopted from Barnett and Blaikie (1993)

The economic consequences of HIV are different from those of other illnesses. The people most likely infected are at the peak of their reproductive and income earning years: they often support spouses and children (Kenya Episcopal Conference, 1999). Families feel the effects of the epidemic as soon as one of their members falls ill with AIDS – related condition (Tarantole, 2000). Income falls, as the family member's ability to work decreases, while the households living costs increase, especially for medical expenses. HIV affects the economy by causing illness and death (Tabifor, 2002) This results in a reduction in overall productivity and increased health costs. The impact on other sectors like education will have a long-term effect on the economic development. In Kenya, HIV/ AIDS had reduced GDP by 15 percent by 2005, than it could have been without AIDS.

HIV/AIDS has a major economic effects on individuals, families, communities and society as a whole,(Caldwell,1997).In Kenya just like other countries in the sub-Saharan Africa, AIDS threatens personal and national wellbeing 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,(Ainsworth, 1998).The net Economic effect of AIDS not only affects individuals but it directly contributes to the reduction of the annual growth rate of GDP of the Nation.

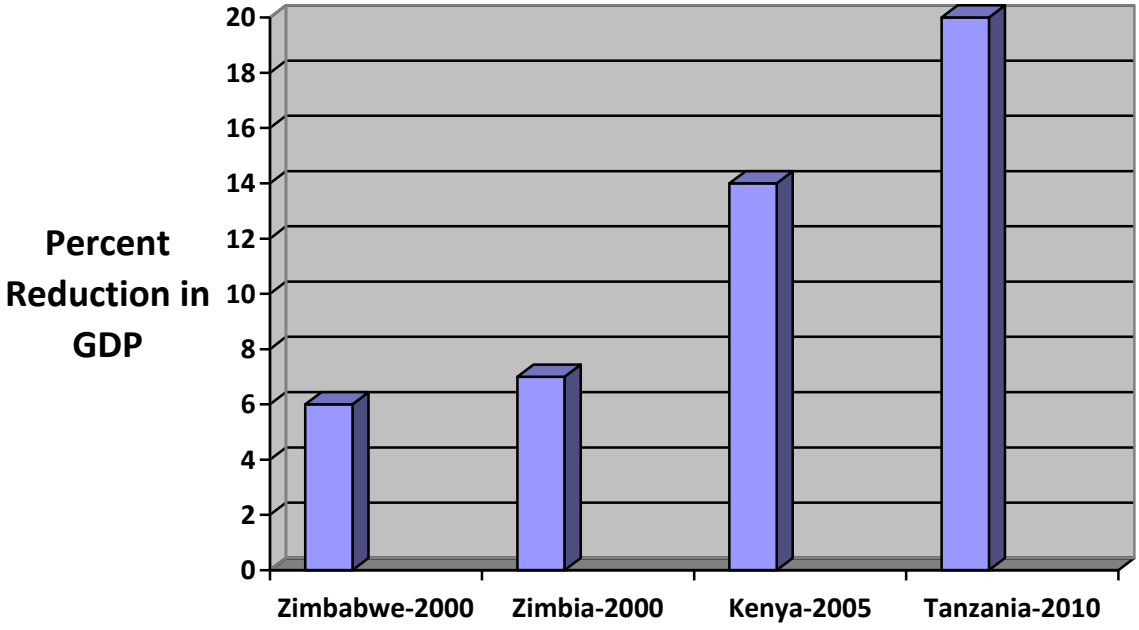

Figure 5: Percent Reduction in Future GDP due to AIDS
Source: Policy Project 1999

The productivity of the agriculture sector, upon which the majority of women depend on for their livelihood and the whole household, is undermined by negative effects on the supply of labour and remittance income. The loss of a few workers at the crucial periods of planting and harvesting can significantly reduce the size of the harvest.(Tibaijuka,1997).The tasks women are responsible for include, weeding, harvesting minor crops and household duties. The death of a woman to AIDS makes it difficult for other household members to carry out these tasks in addition to caring for children. (Reley, 1998).The death of a family member to AIDS also leads to reduction in savings and investment. The stock of food grain is depleted to provide food for mourners and other expenses met most times by sell of available livestock, such loss of productive assets only makes it harder to survive in future.(Kwaramba, 1997).Death therefore results in permanent loss of income, less labour on the farms, and this results in removal of

children from school in order to save on educational expenses and increase household labour, resulting in a severe loss of future earning potential.(WHO,2000)

AIDS affects the education sector in at least three ways; the supply of experienced teachers of whom the majority are women are reduced by AIDS and related illnesses and death.(UNAIDS, 1998).Children mainly girls are kept out of schools if they are needed at home to care for sick family members or to work in fields, (Taylor,1996)

2.6 Psychological Effects of HIV /AIDS

HIV/AIDS pandemic has not only physiological effects, but also major psychological effects on people infected and their caregivers (Wigley et al, 2002). Once one is told that she is HIV positive, there is no such a thing as being asymptomatic. You may not have physical symptoms, but your life is forever changed (Marge, 1993). Anger, fear, depression and denial are common initial reactions to an HIV positive result, leading to profound psychological distress, (UNAIDS, 2000). Feelings of helplessness, withdrawal and isolation, despair and loss of hope for the future, frustration and confusion are other psychological effects that set in (K.I.E, 1999).

The psychological or internal challenges a person with HIV/AIDS faces vary from one individual to another. Not everyone will experience all of the emotional responses, there are individuals who face catastrophic changes not only in their personal and job relationships, but also in their physical bodies and their self-images and self-esteem,(Watstein and Chandler,1998).As a result of these changes the behaviour of the infected may change ,they may become withdrawn, aggressive, and rude to other people. This is so because the infected person may feel (or imagine) being victimized. They experience a decrease in self-esteem as they are no longer confident in themselves or what they can achieve. This is likely caused by stigma within society against the infected.

Infected persons are normally in fear because they have to adjust to a new lifestyle .It is not easy to accept that one is infected and thus shock and disbelief, leading to denial, is a frequent initial response. According to Watstein and Chandler (1998) there are emotional responses that are symptoms of psychological effects that people have when infected with HIV/AIDS, they may be confronted with having to re-examine their sexual identity and the behavioural choices they have

made in support of that identity. When one associates HIV/AIDS with what society has traditionally considered immoral, the infected person then has to work through her feelings in order for her sexual identity to be reaffirmed in a way that will allow for feeling good about oneself.

Persons with HIV/AIDS may be caused to see themselves as undesirable by others who view them as contagious. This in itself is an emotional situation that can cause infected people to withdraw, not disclose their feelings, and become socially isolated. this may in turn lead to emotional breakdown.(UNAIDS, 2000).

Carbello,(1998) explains that another destructive stressor is that of feeling dependent. this occurs when the infected person must rely on family and friends for emotional and financial support, particularly when they have to apply for social services assistance. The final aspect of dependence is the fear of a protracted illness that will drain the family and friends both financially and emotionally.

Studies done in India on the impact of HIV/AIDS on rural women, show that women are affected psychologically by HIV/AIDS in their role as care givers (Taylor 1996) When family members fall ill, it is women who provide nursing care and in the case of illness of the breadwinners, it is the women who usually take over as providers of basic needs for themselves and other family members. Such women face the fear of death of their spouses, and fear of their own infection status. They suffer a feeling of helplessness, and mental stress over the physical and psychological burden of care and sense of despondency and failure about the future (Berer, 1993).

The infected suffer from the feelings of loss; they feel that they have lost everything that is most important and beautiful to them. They experience loss of control, loss of ambition, loss of autonomy, loss of physical strength and attractiveness, sexual relationships, status respect in the community, financially stability and independence. Loss of job, friends and family, Loss of confidence occasioned by rejection of people who were important to them, people who were once friends but have now rejected because of their positive status.(Goss,E.1989)

Most personal testimonies by women describe how much they are affected by learning they have HIV /AIDS and the difficulties of coming to terms with this knowledge. They question their whole lives, worry about the future and wonder what will happen to them, their close relationships and families particularly their children (K.I.E 1999). Since women are particularly susceptible to stress and depression, the rejection and discrimination experienced by many living with HIV/AIDS can exacerbate these problems. Fear of rejection can be worse and often stops women from telling anyone or seeking help.

2.7 The Role of Counselling in Assisting HIV/AIDS Infected Person

Counselling the infected helps to provide for the emotional and psychological needs, counselling, love and attention are essentially useful in providing a sense of security.(Makinde,O.1994)The main function of counselling is to support the infected person, the counsellor listens to the problems of the infected and to empower them to solve their problems and better their lives. Counsellors allow their clients to verbalize their fear, anxiety, anger, sorrow, guilt or shame because this will give counsellors the opportunity to identify possible problem areas that will need to be addressed and processed.(Carbello,1998;,Miller1998, Miller and Bor,1998)

Counsellors empower HIV infected people to make decisions for themselves. They are encouraged to make decisions for as long as possible. The individuals control over everyday life situations and this is encouraged and reinforced by the counsellor,(Egen,G.1998).Counselling helps the infected by assuring them that they can still be productive in economic, intellectual and social spheres for many years. The infected are encouraged to go back to their work and resume normal lives as quickly as possible, the contentions that infected people are unemployable, that they should not be given educational opportunities and that they should not be allowed to be socially active could very well cause collapse of a whole society because treating HIV infected as passive invalids would place intolerable and unsustainable economic, medical and psychological burdens on the community (WHO 1999)

It is also an important approach to use with any person worried about AIDS and wants advice on the best way of re-orienting his or her life style to reduce the risk of becoming infected or re-infected with HIV (Hubley, 1995). Furthermore, counselling is a service designed to help an individual analyse herself by relating to her capacities, achievements,

interests and mode of adjustment to what new decisions she has made or has to make (Makwele, 1994). It is therefore very crucial to apply counselling in helping women cope with the disease and other issues related to the effects of HIV/AIDS. A person diagnosed with HIV infection will undergo considerable distress. The main concern for those testing positive include; the need for social, peer and psychological support, access to medical care and treatment, disclosure and planning for the future (UNAIDS, 2000). Temmerman et al (1995) adds that the aim of counselling HIV infected women is to help them cope with the disease and prepare for the future, reduce the sexual risk behaviours and enable them and possibly their partners to make informed choices about reproductive health. However the vast majority of the literature on counselling and HIV focuses almost exclusively on Voluntary Counselling and Testing (VCT). This literature primarily focuses on the information a woman and a couple needs in order to consider testing, and to promote decision–making in relation to safer, sex practice and behavioural change. The mother to child HIV transmission focusing on the special needs and risks for HIV infected women and infants, still considers the primary focus to be on information sharing, preparation for testing and unforced sex, and informed decision making (UNAIDS 1999, WHO 2000).

In a review of the literature of HIV interventions for at risk, women including risky sexual behaviours and drug abuse. Exner (1997) provides a five-component interpersonal intervention model. This model outlines information on interventions which consider facts about HIV transmission and prevention strategies. It also highlights condom skills which involves teaching of proper use of condoms. It provides relations, actions and skills which includes sexual negotiation, assertiveness and problem solving. The HIV counselling and testing information in this model gives information that promotes safer sexual practices. Conclusively, little is mentioned about the psychological support of the HIV infected women's needs. These women need to be encouraged to tell their story rather than only being given information and advice. Talking out one's fears and problems reduces the psychological load that may otherwise have had negative effects on a person and her significant others.

There is urgent need to support and protect women affected by HIV /AIDS especially in Sub-Sahara Africa, where the majority of the affected live. The needs of the affected women include providing material support, education and job training, medical care, and protecting their legal human rights (Lamptey, et al 2002). Infected women should be trained in women rights, psychosocial care and counselling. These will allow them to deal with stigma and discrimination and be able to support others who experience similar problems. There should be more support groups so that they can share their experiences as this can help enlighten their hearts (International HIV/AIDS Alliance, 2003), In joining support groups, the counsellor is able to put clients in touch with each other on an individual basis these groups help in providing psychosocial support of the infected they learn from each others experience by exchanging practical experience (WHO, 1990).

2.8 Theoretical Framework

The study was based on The Client-Centred Theory by Roger (1996), the Identity Theory by Tajfel (1982) and The social learning theory by Bandura (1996).

2.8.1 The Client—Centred Theory

In an attempt to understand the psychological counselling needs of women infected with HIV/AIDS, client-centred theory has tried to examine its process. The main approach to meeting the counselling needs of infected women is discussed here. The theory presented a lot of reference to the report. In that the basic goal of counselling is to provide a conducive climate to help the individual become a fully functioning person. Roger (1961) states that the goal is setting the client free and creating those conditions that will help engage in meaningful self-exploration. Counselling helps infected women work towards a goal in their infected status; first they put off the mask that they wear and come into contact with themselves that they had lost through the mask. The infected women then become actualized through showing openness to an experience, a trust in themselves and willingness to continue growing. Client-centred therapy is appropriate to women who exhibit of people who are not open to an experience, and have lost most in themselves and are unwilling to grow. According to Combs (1998) Client centred approach is understood is understood as a source of help to discovered new and more satisfying personal meanings about themselves and the world they inhibit. Counselling therefore aids the infected

woman to express their concerns once a conducive climate has been established. This results in locating impasses in their personal growth and making transition from external to internal support. The theory emphasizes on counselling techniques such as unconditional positive regard to clients, being genuine, being an active listener to help them open an experience. The counsellor helps the clients to grow and be able to cope with their challenges as infected women.

2.8.2 Identity Theory

Identity theory as propounded by Tajfel (1982) suggests that those who are stigmatised tend to resist the forces that discriminate against them (Castells, 1997; Hall, 1990). Those who are marginalised generate "resistance identities" and use them to build new identity that re-defines their position in the society and thus seeks the transformation of overall social status. This would include resistance through mobilization and movements, at community, national and international levels, aimed at social change. These ideas offer important insights for reconceptualising HIV/AIDS stigmatization and discrimination within a broader social, cultural, political and economic frame work rather than as individual processes. They offer a framework for understanding stigma and discrimination as social processes that are used to create a social hierarchy by differentiating between stigmatized and the non stigmatized, as well as to produce social inequality and to make these inequalities seem reasonable. Such a framework improves our ability to analyze the causes of stigma and discrimination, the ways in which HIV/AIDS stigma and discrimination interacts with and reinforce pre-existing stigma and discrimination and social exclusion of women infected with HIV/AIDS.

2.8.3 Social Learning Theory

Socialization is a process that occurs over the developmental history of a person and is accomplished by one or more of a set of mechanisms for transforming social influences into changed dispositions of the person (Seidenberg & Snadowsky, 1976). Bandura (1969) in Deaux (1984) argues that in social situations people often learn much more rapidly simply by observing the behaviour of others. Observation teaches the probable consequences of new behaviour. According to Bandura (1971), people do not simply react to environmental events; they actively create their own environments and act to change them. Positive or negative feed back from behaviour in turn influences people's thinking (cognition) and the way they act to change the environment. According to Bandura (1986), in Ryckman (1993), the behaviour of a society is

regulated by anticipated outcome. The anticipated ultimate death of PLHA makes them to be neglected and rejected by their significant others. Like Skinner, Bandura focuses on behaviour rather than on any internal motivating variables that might constitute individual behaviour. Punishment is the most common technique of control of behaviour in modern life. Religious control is exerted through penances, threats of excommunication and consignment to hell fire. Thoughts of punishment create discouragement and depression among women infected with HIV/AIDS especially when they are perceived by the society to be sexually promiscuous. Hence, society views women infected with HIV/AIDS as being punished because of their "sin". Religion is used as a moral justification for homophobic persecution of women infected with HIV/AIDS and the AIDS epidemic has been held as expression of divine anger. There is conflict between religious teachings, values and measures used to control the epidemic. The controversies continue unabated, as religion plays a dominant role in the culture and regulation of society (Schoub, 1995).

Sexual taboo of AIDS infection makes the women infected with HIV/AIDS to be perceived as adulterous, prostitutes, promiscuous and as people who have no control over their sexual appetite. The mechanisms of socialization result in a process by which the individual comes to incorporate, some unique way a set of evaluative possibilities which are displayed to him or taught to him by a social host in which he develops. May (1953), postulated that there is a close association between emptiness and loneliness. When there is general upheaval and confusion about values in the society, people sense danger and turn to people around for an answer and comfort. When people attempt to reach out to others to ease feelings of loneliness, the more lonely and desperate they become. The primary result of the confusion that comes from the disintegration of values is that women infected with HIV/AIDS feel "empty" inside and isolated by significant others. The feelings of emptiness come from feelings of powerlessness and the HIV/AIDS infection seems beyond their control.

2.9 Conceptual Framework

The above theoretical framework based on, identity and social learning theories assisted in developing the conceptual framework of this study. Identity theories emphasized on an understanding that stigma and discrimination are social processes and that stigma and discrimination can be resisted and challenged by social action. Social learning theory on the

other hand explains that behaviour and attitudes towards people infected with HIV/AIDS are learnt through socialization process. These theories thus assisted in highlighting the relationship between independent variables, extraneous variables and dependent variables as summarized in Figure 6.

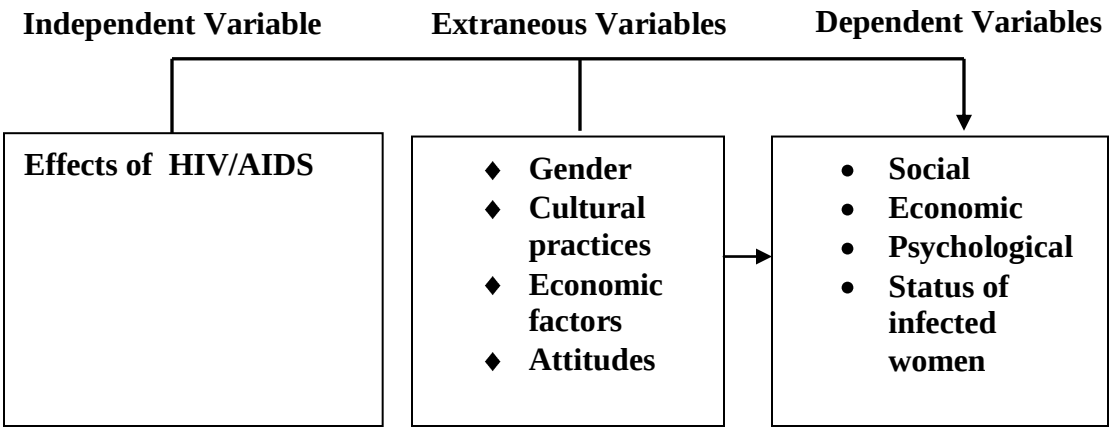

Figure 6: Effects of HIV/AIDS on Women Infected With HIV/AIDS

Figure 6 shows the interrelationships among the variables under study. Persons infected with HIV/AIDS (independent variable) face various social, economic and psychological effects after establishing their status (dependent variables). However, the actual level of effects from HIV/AIDS is in turn influenced by extraneous variables such as gender, cultural practices, socio-economic status, attitudes and beliefs. The extraneous variables facilitate or alter the expected relationship between the independent and dependent variables.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter discusses the research methodology used in data collection and analysis. The discussion includes the research design, location of the study; population of the study, sampling procedure and sample size, instrumentation; data collection, and data analysis.

3.2 Research Design

This study adopted the *ex post facto* research design. This is a causal-comparative research design used to determine reasons or causes of the current status of the phenomenon under study. As a result of the cause-and-effect relationships, this research design does not permit manipulation of the variables (Kerlinger, 1973; Kathuri & Pals, 1993; Mugenda & Mugenda, 1999). The design was adopted in this study because the cause, i.e. the independent variable (HIV/AIDS infection), had exerted effect on the dependent variables (effects of HIV/AIDS). The researcher then proceeded to study the independent variable in retrospect for its possible relationship to, and effects on the dependent variable.

3.3 Location of the Study

The study was conducted on counselling associations affiliated to FPAK situated in Nakuru Municipality in Nakuru District. Nakuru municipality is located 160 kilometres northwest of Nairobi along the Trans-Africa highway and the Kenya –Uganda Railway, both of which link the Mombasa seaport and several East and Central African countries (CBS; Ministry of Planning and National Development,2005).it was chosen as a research site due to the available evidence of high prevalence and infection rate of HIV/AIDS between men and women (NACC, 2005; NACC & NASCOP, 2003). This had pointed out to gender imbalance in the level of vulnerability, infections, prevalence and burden of the disease between men and women.

3.4 Population of the Study

The target population of this study comprised of 151 women infected with HIV/AIDS and were members of five associations affiliated to FPAK situated in Nakuru Municipality of Nakuru District. Table 4 summarizes the distribution of the women in the five associations.

Table 4

Distribution of Target Population in the Selected Associations

Name of Association	*Population size*
Ushuhuda hai	45
Tumaini na fadhili	43
Ambasador of hope	32
Heartshooters	11
Ambasadors of change	20
Total	151

3.5 Sample and Sampling Procedure

In order to determine the sample size of women was drawn from the 151 in the five selected counselling associations in Nakuru municipality, the study adopted a formula by Kathuri and Pals (1993) for estimating a sample size, n, from a known population size, N.

$$n = \frac{\chi^2 NP\ (1-P)}{d^2\ (N - 1) + \chi^2\ P\ (1 - P)}$$

Where:

n = required sample size

N = the given population size of women, 151 in this case

P = Population proportion, assumed to be 0.50

d^2 = the degree of accuracy whose value is 0.05

χ^2 = Table value of chi-square for one degree of freedom, which is 3.841

Substituting these values in the equation, estimated sample size (n) was:

$$n = \frac{3.841 \times 151 \times 0.50\ (1 - 0.5)}{(0.05)^2\ (151 - 1) + 3.841 \times 0.5 \times (1 - 0.5)}$$

$$n = 109$$

Proportionate stratified sampling was used in selecting the 109 women from the five counselling associations. This ensured that the sample was proportionately and adequately distributed among the associations according to the population of each category as shown in Table 5.

Table 5

Distribution of the Sample Size

Name of Association	*Proportionate Sample*
Ushuhuda hai	33
Tumaini na fadhili	31
Ambasador of hope	23
Heartshooters	8
Ambasadors of change	14
Total	109

After proportionately distributing the sample in the five counselling associations, simple random sampling using random numbers table was used to select the specific number of women to be included in the sample from each association. The women corresponding to the number picked were included in the sample. Purposive sampling was then used to select one counselling provider from each association. From the above two sampling procedures, the 109 women and 5 counselling providers formed the sample size for this study.

3.6 Instrumentation

Data was collected through administration of a structured questionnaire for (women infected with HIV/AIDS) and an interview schedule for (counselling providers). Each instrument aimed at collecting specific information from the targeted respondents. The women infected with HIV/AIDS questionnaire elicited information on their HIV/AIDS status and the effects they had encountered as a result of their status. The effects were measured on a 3-point likert range scale. The counselling providers interview schedule sought information on the services offered to women infected with HIV/AIDS by their associations.

The content validity of the research instruments was then established in order to make sure that they reflected the content of the concepts in question (effects of HIV/AIDS among infected women). First, the researcher went through the instruments in relationship with the set objectives

and ensured that they contained all the information that answered the set objectives. Second, experts from the Department of Psychology, Counselling and Educational Foundations were consulted for their opinion on the instruments. The instruments were then taken for piloting on a population that was similar to the target population. The Rift Valley Provincial Hospital VCT Centre was used for this purpose. Piloting included 10 women infected with HIV/AIDS and who sought counselling services and one counselling provider. The objective of piloting was to allow for modifications of various questions in order to rephrase, clarify and clear up any ambiguities in the questionnaire. Piloting also assisted in testing the reliability of the instruments. A Cronbach reliability coefficient of 0.75 was obtained for the women infected with HIV/AIDS questionnaire and assumed to reflect the internal reliability of the instrument. Such a reliability coefficient is considered to be sufficient enough to confirm the internal consistency of the instrument (Fraenkel & Wallen, 2000).

3.7 Data Collection

The researcher proceeded to collect data from the selected respondents after receiving permission from the Department of Psychology, Counselling and Educational Foundations, Egerton University; Provincial Medical Officer of Health, District Gender and Social Development officer, Permission was also sought from the management of Family Planning Association of Kenya in Nakuru and the five affiliated counselling associations. The researcher visited the counselling associations before hand for acquaintance with targeted respondents, especially management and counselling providers. This exercise assisted the researcher in familiarizing herself with the respondents, explaining the essence of the study and booking appointments for the data collection. After familiarization, data was then collected from the respondents using the above mentioned instruments. The counselling providers assisted in the distribution and collection of the questionnaires from the respondents. The completed questionnaires were collected from the subjects within a period of one week.

3.8 Data Analysis Procedures

The data collected were processed and analyzed to facilitate answering the research questions. A computer-based programme - Statistical Package for Social Sciences (SPSS) version 11.5 for windows was used for analysis and yielded information on descriptive statistics. Descriptive

analyses, including frequencies, percentages and means presented in tables, pie charts and bar graphs were used to summarize and organize data and describe the characteristics of the sample population.

CHAPTER FOUR
RESULTS AND DISCUSSION

4.1 Introduction

This chapter presents a discussion of the research results based on the following objectives of the study:

1. To determine the social impact of HIV/AIDS on women infected with the disease.
2. To assess the economic impact of HIV/AIDS on women infected with the disease.
3. To determine the psychological impact of HIV/AIDS on women infected with the disease.
4. To establish the role of counselling in assisting the women infected with HIV/ AIDS cope with the disease.

4.2 Demographic Characteristics of the Respondents

This section focuses on the demographic characteristics of the sampled women infected with HIV/AIDS in the five selected counselling associations offering counselling and support services and affiliated to Family Planning Association of Kenya (FPAK), Rift Valley Province. The demographic characteristics covered in this section include: age, marital status, level of education, number of children, employment status and HIV/AIDS status.

4.2.1 Age, Marital Status and Number of Children

The 109 respondents were aged between 22 and 52 years with a mean age of 35 years. This indicates a group of women who were in their child-bearing ages and still relatively young and economically productive. This means that effects of HIV/AIDS among these women were bound to affect very many people including children and family members. Figure 7 summarizes the marital status of the respondents.

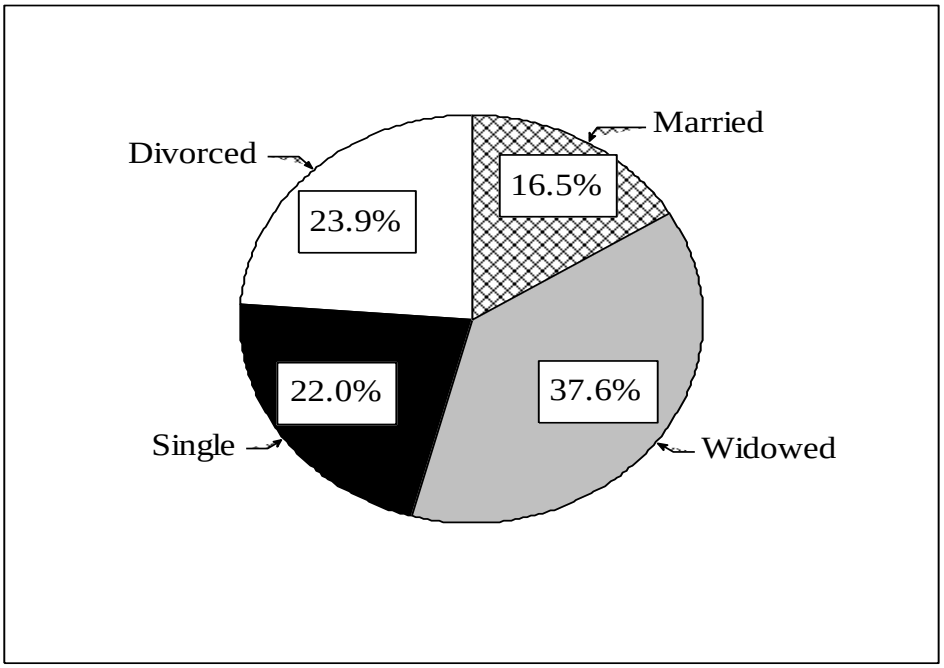

Figure 7: Marital status of women infected with HIV/AIDS

Figure 7 indicates that respondents had different marital status including 37.6% (41) widowed, due to HIV/AIDS 22.0 %(24) single, 23.9 %(26) divorced and 16.5 %(18) married. The type of marital status has a unique influence on the level of impacts of HIV/AIDS on the infected women. This depends on the attitude of the society towards people with HIV/AIDS. It also shows the extent and prevalence of HIV/AIDS in the society where all women were susceptible to HIV/AIDS regardless of their marital status. The study also established that 96 (88.1 %) of the respondents had children while 13 (11.9 %) had none. This shows that the respondents had family obligations to take care of in addition to management of their health conditions. The 96 respondents varied in the number of children that they had as depicted by Table 6.

Table 6

Number of Children of Women Infected with HIV/AIDS

Number of children	*Frequency*	*Percent*
1	12	12.5
2	23	24.0
3	25	26.0
4	20	20.8
5	8	8.3
6	7	7.3
7	1	1.0
Total	96	100.0

Table 6 indicates that 83.4% (80) of the 96 respondents had between one and four children. The number of children that one had was likely to influence her family obligations and responsibilities in terms of resource allocation between HIV/AIDS medication and taking care of the children. This will in turn depend on the amount of resources available to an individual.

4.2.2 Level of Education and Employment Status

The level of education influences the level of knowledge and awareness of HIV/AIDS an individual about issues affecting his/her life. It also indicates the extent to which one is receptive to emerging issues and new ideas. Figure 8 summarizes the distribution of the level of education of the women infected with HIV/AIDS.

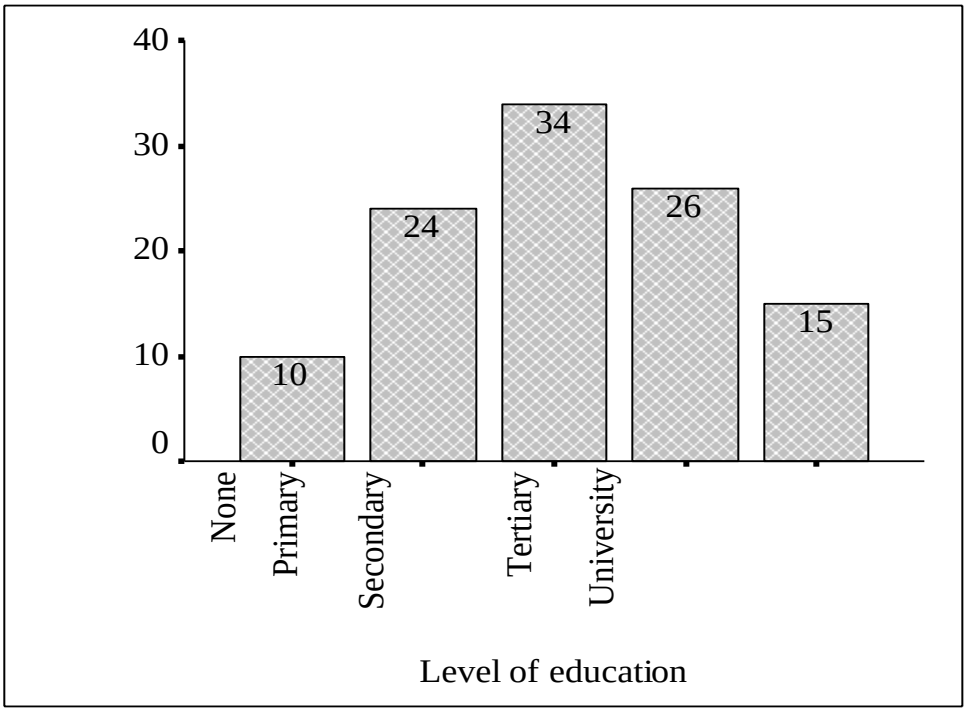

Figure 8: Level of education of women infected with HIV/AIDS

Figure 8 indicates that 75 (68.8 %) respondents had at least secondary school level of education. Out of the 75 respondents, 34 (31.2%) had secondary level of education, 26 (23.9%) had tertiary level of education and 15 (13.8%) had university level of education. The remaining 24 (22.0%) and 10 (9.2%) had primary level and no education respectively. This suggests that majority of the respondents were educated people who were expected to be more aware of HIV/AIDS and the need for counselling for those infected. This may have been the reason as to why the respondents had sought for counselling services after establishing their HIV/AIDS status. The level of education was also expected to make them more receptive to new and emerging approaches of handling HIV/AIDS condition

The level of education determines the kind of employment opportunities that one can access and the income level to earn. In this study, the respondents were asked about their employment status and their responses illustrated in Figure 9.

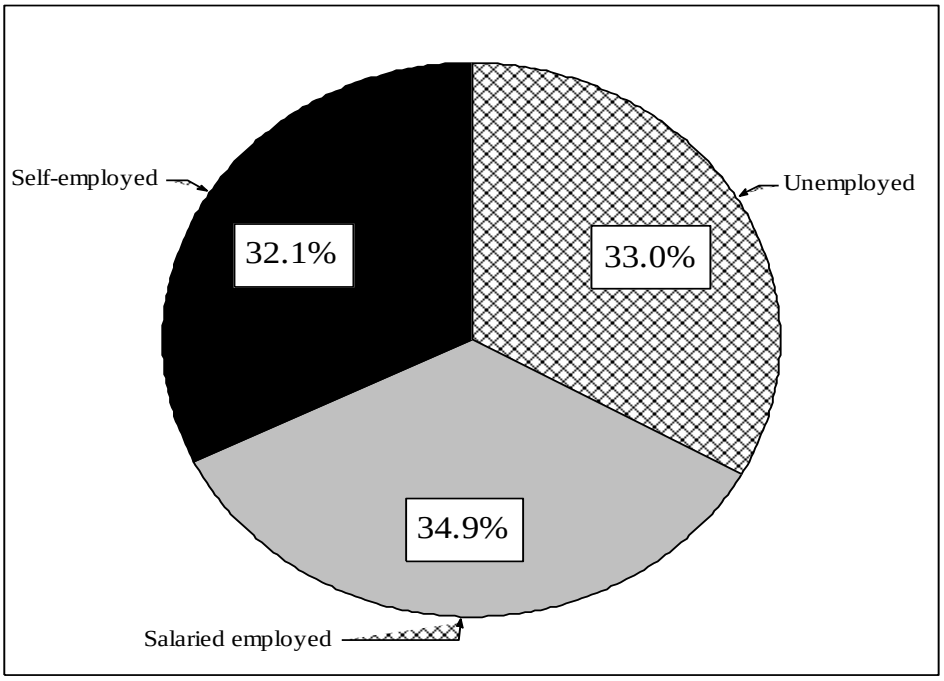

Figure 9: Employment Status of Women Infected with HIV/AIDS

Figure 9 indicates that 67.0 percent (73) of the respondents were employed with 34.9 percent (38) of them being salaried employed, while 32.1 percent (35) were self-employed. The remaining 33 percent (36) were unemployed. This suggests that majority of the respondents had income earning opportunities to enable them access the required medication and nutrition standards to cater for the disease. Such women were more likely to willingly seek for counselling services and abide by what they were required to do as opposed to those unemployed who depended on other people to manage their condition. The 73 respondents had varied average monthly income of between Kshs. 3500 and 35,000, with a mean of Kshs. 14,636.99. The adequacy of these incomes would depend on their levels of family obligations and the requirements for their HIV/AIDS status. The 36 unemployed women infected with HIV/AIDS enumerated their sources of living as illustrated in Table 5.

Table 7

Source of Income for Unemployed Women Infected with HIV/AIDS

Source of income	*Frequency*	*Percent*
Donations	12	33.3
Income remittance	10	27.8
Dependency	11	30.6
None	3	8.3
Total	36	100.0

Table 7 shows that 91.7% (33) of the 36 respondents relied on donations, income remittance from working relatives. The ability of such women to afford the required medication and nutrition for their condition would depend on the amount and sustainability of each source. Only 3 (8.3 %) had no source of income or living despite being unemployed. This was likely to limit their ability to adequately access and afford medication.

4.2.3 HIV/AIDS Status of the infected Women

People establish their HIV/AIDS status in various ways. This study sought to establish how the sampled respondents established that they were HIV/AIDS positive. Table 6 highlights their responses.

Table 8

Knowledge About HIV/AIDS Status

Source	*Frequency*	*Percent*
VCT testing	45	41.3
Partner tested and was positive	23	21.1
Partner died of the disease	18	16.5
Signs and symptoms	16	14.7
A friend told me	7	6.4
Total	109	100.0

Table 8 indicates that 41.3 of the respondents discovered their HIV/AIDS status from the VCT testing. This suggests that majority of the respondents sought professional services in order to establish their status. Such respondents were more likely to have been well counselled and prepared before they knew about their status. This reduces the trauma that accompanies

realization of the HIV/AIDS status. The remaining respondents established their status from a number of sources including: when a partner was tested and discovered to be positive, partner died of the disease, signs and symptoms, and a friend told them. These sources of knowledge about HIV/AIDS status were very traumatizing as the respondents were caught unaware. This was likely to have greatly affected them psychologically. When asked about how they contracted the disease, the respondents enumerated the following modes of infection with HIV/AIDS (Table9).

Table 9

Mode of Infection with HIV/AIDS

Mode of infection	*Frequency*	*Percent*
Willing sexual intercourse	90	82.6
Blood transfusion	10	9.2
Rape	9	8.3
Total	109	100.0

Table 9 shows that 82.6 % of the respondents contracted HIV/AIDS from willing sexual intercourse with an infected person. This shows the level of vulnerability and prevalence of HIV/AIDS in the society as the respondents willingly had sex with someone they knew. The remaining 9.2 % and 8.3 % contracted the disease through blood transfusion and rape, respectively. In blood transfusion, the respondents contracted the disease unknowingly and while undergoing medical treatment. This has high level of psychological effects as one is innocently infected with the virus while undergoing treatment. For rape, this is a violation of human rights as one is violently and sexually assaulted without consent. It therefore also carries high level of psychological effects as the victims is not only physically assaulted but infected with the virus in the process. The respondents were also asked about whether they knew the person who infected them and responded as illustrated in Figure 10.

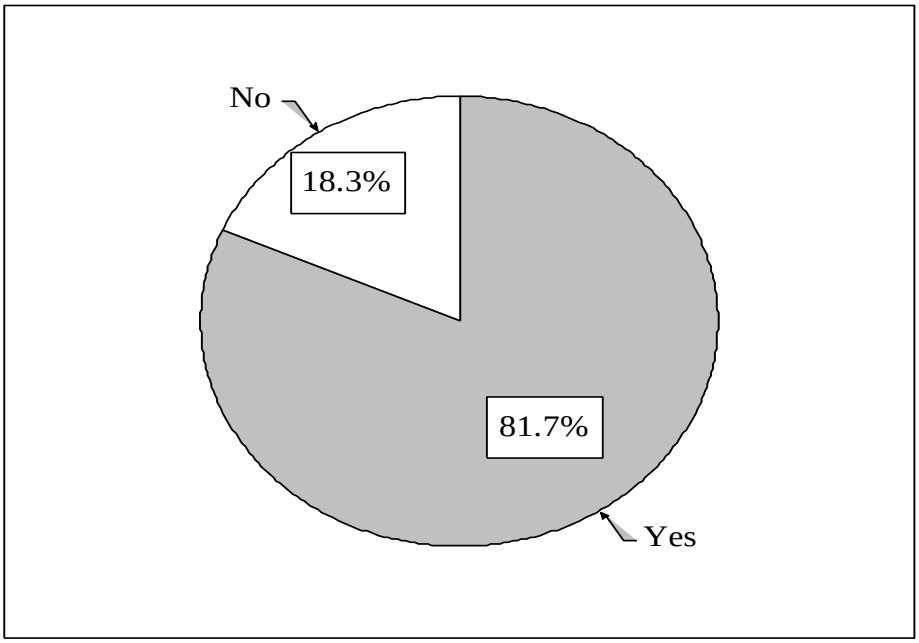

Figure 10: Knowledge of the Person who Infected the Respondents

Figure10, shows that 81.7 % (89) of the respondents reported that they knew the person who infected them with the virus. The 89 respondents were out the 90 who had earlier indicated that they contracted the virus through willing sexual intercourse. Knowing the person who infected them is very traumatizing as the victim is always reminded of her status whenever she thinks about or sees the person. The remaining 18.3 percent did not know the person who infected them and they were the ones who had indicated that they contracted the virus through rape and blood transfusion. The 89 respondents who were aware of the person who infected them with the virus, indicated their relations to the victim as highlighted in Table 8.

Table 10

Relation with the Person who Infected the Respondent with HIV/AIDS

Relation	*Frequency*	*Percent*
Husband	48	53.9
Friend	30	33.7
Relative	10	11.2
Stranger	1	1.1
Total	89	100.0

Table 10 shows that 98.9 percent of the respondents were infected with HIV/AIDS by people who were very close to them including the husbands, friends and relatives. Only one person was infected by a stranger and she knew him being able to identify the person who infected her is very traumatizing as the victim is always reminded of her status whenever she sees or thinks about the person..This continues to indicate the prevalence and vulnerability of HIV/AIDS in the society.

4.3 Social Effects of HIV/AIDS

The first objective sought to determine the social impact of HIV/AIDS on women infected with the disease. To address this objective, the study assessed the level of impact of eight social aspects affecting women infected by HIV/AIDS. The level of impacts of each of these aspects was measured on a 3-point range likert scale ranging from 1 to 3. The higher the score, the greater was the impact of that particular social aspect. Table 9 highlights the distribution of their responses on the statements.

Table 11
Social Effects of HIV/AIDS Among Women Infected with HIV/AIDS

	Response (%)			
Statement	Never	Sometimes	Often	**Mean**
People who know about my status see me as sexually promiscuous	6.4	8.3	85.3	2.79
People do not easily appreciate my contribution in decision making in the society	7.3	10.1	82.6	2.75
My status has not affected my parental/family obligations and responsibilities	78.9	11.9	9.2	2.70
I don't fear associating with other people because of my status	74.3	17.3	8.3	2.66
My family members and friends have isolated me because of my HIV/AIDS status	9.2	18.3	72.5	2.63
My family members do not consider me in any of their future plans	15.6	9.2	75.2	2.60
My children and family members still treat me with respect even after discovering about my status	70.6	10.1	19.3	2.51
I fear to be seen in public	19.3	11.0	69.7	2.50

N = 109

Table 11 indicates that respondents were generally affected in various aspects of their social lives as a result of their HIV/AIDS status. This was demonstrated by them rating all the eight aspects of their social lives above the mean score of 2.00 (between 2.50 and 2.79). This suggests that the above social aspects moderately affected women living with HIV/AIDS. The respondents indicated that people who knew about their status saw them as sexually promiscuous; people did not easily appreciate their contribution in decision making; their status had affected their parental/family obligations and responsibilities; they feared associating with other people; their family members and friends had isolated them; their family did not consider them in any of their future plans; their children and family members still treated them with respect even after discovering their status, and feared to be seen in public. This had affected the social life of women infected with HIV/AIDS. The respondents were stigmatized, discriminated against and isolated from social activities and functions at the family and society levels. Many people blamed the victim of sexual promiscuity and thought that infection with the disease signified physical and economic inability. They also did not understand the mode of transmission and thus avoided socializing with the victims.

It was therefore observed that women infected with HIV/AIDS were affected in various social aspects of their lives as a result of stigmatization, discrimination and isolation from the community and family members. These findings concur with Kusimba et al, (1992) who reported that HIV/AIDS disrupt family and societal relationships between the victim and other people. HIV infection and AIDS has a growing disruptive effect on families of infected women with many unforeseen social consequences. Marge (1993) reports that HIV/AIDS among women in many African societies is seen as a sign of sexual promiscuity. This is attributed to the high rates of the infection among women sex workers. Most people therefore consider HIV/AIDS to be a "promiscuous women's disease". This has increased stigmatization among women infected with the disease more than their men counterparts. The Kenya Demographic and Health Survey (2003) and KANCO (2000) highlights cases reported of women being thrown out of their marital homes by their spouses due to their positive HIV/AIDS status. In some parts of the country, women infected with HIV/AIDS are even disinherited of their property. Most of the women fail in effectively undertaking their parental responsibilities leading to increased poverty levels.

The responses to each constituent social aspect were scored on a scale of 1, indicating no negative impact, to 3, indicating highest level of impacts of HIV/AIDS. The individual social aspect scores were summed up to form a social impact index score for each respondent. The index score varied between 8, indicating no negative impact, and 24, indicating the highest level of impact among women infected with HIV/AIDS. The higher the score, the greater the social impact of HIV/AIDS on infected women. The index score was later collapsed into three ordinal categories in order to differentiate between the levels of social impact of HIV/AIDS on the sampled women infected with the disease. This included a score of 8-13 indicating low impact; a score of 14-18 (average/moderate impact); and a score of 19-24 meaning high social impact of HIV/AIDS. Table 12 summarizes the levels of social effects of HIV/AIDS on women infected by the disease.

Table 12

Level of Social Effects of HIV/AIDS Among Infected Women

Level of social impact	*Frequency*	*Percent*
Average/moderate	15	13.8
High	94	86.2
Total	109	100.0

Table 12 indicates that on the overall, 86.2 percent of the respondents encountered high level of social impact as a result of their infection with HIV/AIDS. The remaining 13.8 percent recorded average level of social impact as a result of their status. This suggests that the society had negative perceptions and attitudes towards people living with HIV/AIDS and therefore, women infected by the disease encountered social impact as a result of their positive status. This may be attributed to the social stigmatization, isolation and discrimination of people living with HIV/AIDS and especially women. The five counselling providers concurred that there was high level of social impact among women infected with HIV/AIDS and attributed it to stigmatization in the society.

4.4 Economic Effects of HIV/AIDS

The second objective sought to determine the economic impact of HIV/AIDS on women infected by the disease. The level of economic impact was assessed from a series of eight statements

seeking respondent's rating of the effects of economic aspects. Responses to these statements were measured on a three-point likert scale ranging from 1 to 3. The higher the score, the greater was the impact of that particular economic aspect. Table 13 highlights the distribution of their responses on the statements.

Table 13

Economic Effects of HIV/AIDS among Women Infected with HIV/AIDS

	Response (%)			
Statement	Never	Sometimes	often	**Mean**
Medical expenses have affected my other family financial obligations and responsibilities	0.9	13.8	85.3	2.84
My income level has deteriorated ever since when I discovered my status	2.8	15.6	81.2	2.79
People still consider me as economically productive	87.2	4.6	8.3	2.79
I no longer care to improve on my future economic status because of HIV/AIDS	6.4	16.5	77.1	2.71
I am always turned away from employment or looked down upon at the place of work	6.4	29.4	64.2	2.58
I am still capable of providing for the needs of my family members even in my present condition	59.2	30.3	10.1	2.50
I spend all available resources on my medical expenses	13.8	32.1	54.1	2.40
I am still physically productive even after contracting HIV/AIDS	24.8	25.7	49.5	1.75

N = 109

Table 13 above indicates that respondents were affected in various aspects of their economic status as a result of their HIV/AIDS status. This was demonstrated by their rating of seven out of the eight aspects of their economic status at least above the mean score of 2.00 (between 2.40 and 2.84). This suggests that the seven economic aspects had more than average impact on women infected with HIV/AIDS. The respondents indicated that medical expenses had affected their family financial obligations and responsibilities; their income level had deteriorated; They were not considered as economically productive; and lacked will to improve on their future economic status; they were also turned away from employment or looked down upon at the place of work; and were not capable of providing for the needs of their family members; because they spent most of available resources on their medical expenses. This may be attributed to the

economic ability and cost of taking care of HIV/AIDS. The disease had high economic cost to the victims in terms of balancing the medical expenses and other family obligations and responsibilities. This had made them to disproportionately allocate more resources to their medication compared to other needs. The respondents were also discriminated and looked down upon at their places of work due to the diseases; and they had despaired and lost hope in investing more in their economic future. However, the respondents were undecided on whether they were still economically productive after contracting the virus. The high economic impact concurs with Kihiko (2000) and UNICEF (2003) who reported that the high economic cost of HIV/AIDS leads to a vicious cycle of poverty as the poor have less access to treatment and care. This affected children as they are more vulnerable to manipulation and even forced to drop out of school, with some taking over household headship at a younger age. In seeking to adapt to the new condition, Cohen (1993) argues that orphans are frequently called upon to provide additional assistance in meeting household needs. Tarantole (2000) points out that the families of people living with HIV/AIDS feel the impact as soon as one of the member's fall sick of the disease. This is through declined income as the affected person is no longer economically active, while the household's cost of living increases due to the cost of medication.. Weinrech and Benn (2004) reports that HIV/AIDS has led to a decline in economic growth in developing countries. The disease reduces overall productivity and increase health costs of people who are economically productive. The effects on other sectors like education will have a long-term effect on the economic development.(UNAIDS 1998).

The economic aspects were interrelated and interacted to cumulatively influence the economic impact of HIV/AIDS on women infected with the virus. Therefore, the responses to each constituent aspect were scored on a scale of 1, indicating no negative impact, to 3, indicating highest level of impacts of HIV/AIDS. The individual economic aspect scores were summed up to form an economic impact index score for each respondent. The index score varied between 8, indicating no negative impact, and 24, indicating the highest level of impact among women infected by HIV/AIDS. The higher the score, the greater the economic impact of HIV/AIDS among infected women, and vice versa. The index score was later collapsed into three ordinal categories in order to differentiate between the levels of economic impact of HIV/AIDS among the sampled women infected with the disease. This included a score of 8-13, indicating low

impact; a score of 14-18 (average/moderate impact); and a score of 19-24 meaning high economic impact of HIV/AIDS. Table 14 summarizes the levels of economic impact of HIV/AIDS among women infected by the disease.

Table 14

Level of Economic Effects of HIV/AIDS Among Infected Women

Level of economic impact	*Frequency*	*Percent*
Average/moderate	11	10.1
High	98	89.9
Total	109	100.0

Table 14 indicates that 89.9 percent of the respondents reported that they were highly affected economically. The remaining 10.1 percent had average economic impact. This suggests that women infected with HIV/AIDS encountered economic impact as they balanced their medical expenses and family obligations and responsibilities.

The five counselling providers noted that low incomes and frequency of opportunistic infections increases the economic cost of HIV/AIDS. They observed that opportunistic infections lowered the economic productivity of the victims. This agrees with Gupta (2002), UNAIDS (1999) and WHO (1994) who observed that most women are poor, illiterate and with limited access to economic resources. For the few who have access to economic resources, there are wide income disparities compared to their male counterparts. Murrah (2001) and Riley (1998) add that this has made many women to rely and depend on men for their economic needs. Reliance and dependency increase further the level of women vulnerability to HIV/AIDS.

4.5 Psychological Effects of HIV/AIDS

The third objective sought to determine the psychological effects of HIV/AIDS on women infected by the disease. The study also assessed the level of impact of seven psychological aspects affecting women infected with HIV/AIDS. The level of impact of each of these aspects was measured on a 3-point likert scale ranging from 1 to 3. The higher the score, the greater the impact of that particular psychological aspect. Table 15 highlights the distribution of their responses on the statements.

Table 15

Psychological Effects of HIV/AIDS Among Women Infected with HIV/AIDS

Statement	Response (%)			Mean
	Never	Sometimes	often	
I was shocked when I learnt about my HIV/AIDS status	5.5	9.2	85.3	2.83
I don't feel that am worthless, helpless and hopeless in life	84.4	9.2	6.4	2.78
I am worried about the future of my children	6.4	12.8	80.7	2.74
I blamed myself for contracting HIV/AIDS	11.0	8.3	80.7	2.70
I no longer trust any male partner in anything since I discovered my status	8.3	14.7	77.1	2.69
I am stressed and whenever I think or am reminded of my HIV/AIDS status	14.7	11.0	74.3	2.60
I am suspicious of what other people say or think about me ever since when I discovered my status	11.9	16.5	71.6	2.60

N = 109

Table 15 indicates that the sampled respondents rated the impact of all the seven psychological aspects highly with a mean score of between M = 2.60 and M = 2.83. This suggests that majority of the women infected with HIV/AIDS suffered from high impact of all the seven psychological aspects. This indicates that the respondents were affected psychologically when they learnt about their HIV/AIDS status; they felt that they were worthless, helpless and hopeless in life. They were also worried about the future of their children and blamed themselves for contracting HIV/AIDS. They no longer trusted any male partner; and were stressed and depressed as a result of their HIV/AIDS status, and suspicious of what other people said and thought about them.

Majority of the respondents 94.5% were shocked and stressed about their HIV/AIDS status. Having been shocked and stressed about their status, the respondents felt that they were worthless, helpless or hopeless in life. The knowledge of being HIV/AIDS positive causes a lot of mental and physical anguish as one struggles to come to terms with the situation. As a result of the consequences of the infection, the respondents blamed themselves for contracting the disease and no longer trusted any male partner. This showed that the respondents contracted the disease through heterosexual intercourse with a male partner. Therefore they were aware of how they contracted that disease and blamed themselves for not being careful and responsible. As a

result of stigmatization, isolation and discrimination, they were always suspicious of what other people said or thought about them. The five counselling providers reported that there were cases of withdrawal, hopelessness, suicidal tendencies, anxiety and depression among women infected with HIV/AIDS. This concurs with UNAIDS (2002), UNAIDS (2000) and KIE (1999) who report that once a person establishes that he/she is HIV/AIDS positive, there is a lot of psychological stress as a result of anger, fear, depression, denial, helplessness, withdrawal, isolation, despair and loss of hope. The findings concur with UNICEF (2003) reports that there is trauma as a result of discovering her HIV/AIDS status and this is worsened by shame and social stigma that accompany the disease. The society finds it hard to assign substitute parents to children orphaned by AIDS than those whose parents die from other causes, and to cover the costs of their needs.

The seven psychological aspects were noted to cumulatively influence the psychological impact of HIV/AIDS on the infected women. Therefore, the responses to each constituent aspect were scored on a scale of 1, indicating no negative impact and 3, indicating highest level of impact of HIV/AIDS. The individual psychological aspect scores were summed up to form a psychological impact index score for each respondent. The index score varied between 7, indicating no negative impact, and 21, indicating the highest level of impact among women infected by HIV/AIDS. The higher the score, the greater the psychological impact of HIV/AIDS among infected women. The index score was later collapsed into three ordinal categories in order to differentiate between the levels of psychological impact of HIV/AIDS among the sampled women infected with the disease. This included a score of 7-11 indicating low impact; a score of 12-16 (average/moderate impact); and a score of 17-21 meaning high psychological impact of HIV/AIDS. Table 16 summarizes the levels of psychological impact of HIV/AIDS among women infected by the disease.

Table 16

Level of psychological Effects of HIV/AIDS among infected women

Level of psychological impact	*Frequency*	*Percent*
Average/moderate	8	7.3
High	101	92.7
Total	109	100.0

Table 16 indicates that 92.7 percent of the respondents cumulatively rated the seven psychological aspects as having had a high effects on them. The remaining 7.3 percent considered them to have a moderate impact. This suggests that psychological factors had a high effect of 92.7 % on women infected with HIV/AIDS. This may be attributed to the fact that psychological effects affects the mental state of the infected and takes time to manifest, identify and heal as they are caused by a combination of very many other factors.

4.6 Role of Counselling in Assisting Women Infected with HIV/ AIDS

The fourth objective sought to establish the role of counselling in assisting the women infected with HIV/AIDS cope with the disease. The HIV/AIDS infected persons encounter social, economic and psychological effects associated with their status. . This assistance comes in form of counselling from professional institutions and persons. There are very many institutions and groups offering counselling to persons infected with HIV/AIDS in terms of care and support services. In the study area, all the sampled respondents had access to professional counselling services through associations affiliated to the Family Planning Association of Kenya (FPAK) Rift Valley Province. FPAK coordinates associations offering care and support services for HIV/AIDS infected persons in the region. These care and support services were divided into two groups that included home-based care and psychosocial support. Table 17 summarizes the distribution of the respondents in the selected associations by the type of services.

Table 17:

Distribution of Respondents in Counselling Service Providers

Type of care and support service	*Name of association*	*Frequency*	*Percent*
Home-based care	Ushuhuda Hai	33	30.3
	Tumaini na Fadhili	31	28.4
Psycho-social support	Ambasador of Hope	23	21.1
	Heartshooters	8	7.3
	Ambasadors of Change	14	12.8
	Total	109	100.0

As indicated in table 17, 64 (58.7 %) of the respondents were receiving home-based care from their associations, while 45 (41.3 %) received psycho-social support services (Table 17). The

five associations were all affiliated to and coordinated by FPAK. This suggests that the respondents had access to counselling services that helped them develop positive attitudes towards their lives. The counselling associations were reported to emphasize more on creating of a sense of security through counselling, love and attention. This concurs with UNAIDS (2000) and Makwele (1994) who observed that counselling is very important in helping persons infected with HIV/AIDS, women in this case, cope with the disease and other issues related to the impact of the disease. A person diagnosed as HIV positive undergoes considerable mental anguish and needs social, peer and psychological support, access to medical care and treatment, disclosure and planning for the future.The aim of counselling for HIV infected women is to help them cope with the disease and prepare for their future, reduce risky sexual behaviours and enable them and possibly their partners to make informed choices about reproductive health. Table 18 below summarizes the counselling services offered by the counselling associations.

Table 18

Counseling Services Offered to Women Infected with HIV/AIDS

Name of association	*Services provided to clients*
Ushuhuda hai	(i) Home-based care services (ii) Income generating activities through merry-go-round (iii) Home visiting of the members by trained people living with HIV/AIDS (iv) Reproductive health (safe sexual behaviours) (v) Nutritional counselling and ARVs medication
Tumaini na fadhili	(i) Group therapy and health care (ii) Home-based care services (iii) Nutritional support (supply and sale of immune boosters) (iv) Home visiting of the members by trained people living with HIV/AIDS (v) Reproductive health (safe sexual behaviours) (vi) Nutritional counselling and ARVs medication
Ambasador of hope	(i) General and positive living counseling (ii) Training in various income generating activities (iii) HIV/AIDS testimonies with outreach (iv) Home visiting of the members by trained people living with HIV/AIDS (v) Reproductive health (safe sexual behaviours)
Heartshooters	(i) General and positive living counseling (ii) Training in various income generating activities (iii) HIV/AIDS testimonies with outreach (iv) Home visiting of the members by trained people living

		with HIV/AIDS
	(v)	Nutritional counselling and ARVs medication
	(vi)	Reproductive health (safe sexual behaviours)
Ambasadors of change	(i)	General and positive living counseling
	(ii)	Training in various income generating activities
	(iii)	HIV/AIDS testimonies with outreach
	(iv)	Home visiting of the members by trained people living with HIV/AIDS
	(v)	Nutritional counselling and ARVs medication
	(vi)	Reproductive health (safe sexual behaviours)

The respondents had access to almost similar counselling services which entailed nutritional counselling, reproductive health (safe sexual behaviours), positive living, group therapy and psychological counselling (Table 18). All these services were reported to assist the respondents to adequately adjust and positively cope with their conditions by encouraging safe sexual behaviours. They were also encouraged not to give up hope but instead invest in their future and that of their children. As a result, all the respondents reported that they were satisfied with the counselling and other support services they received from their associations and FPAK. They enumerated the actual benefits as illustrated in Table 19 below.

Table 19

Benefits of Counselling Services

Benefit	*Frequency*	*% of 109*
Coping with the disease	76	69.7
Making informed decision and choices about reproductive health	68	62.4
Adopting safe sexual behaviours	73	67.0

Table 19 shows that the counselling services had assisted the respondents to cope with the disease; make informed decisions and choices concerning their reproduction; and adopting safe sexual behaviours. They reported that all these services were aimed at assisting them live positively with the virus by avoiding re-infection or infecting innocent people. While supporting the need for counselling among persons with HIV/AIDS, Exner (1997) reports that the services empower women with information that promotes safer sexual practices and positive living with the virus. These findings concur with NACC (2006) and Lamptey, et al. (2002) that adequate

counselling services provide material support, education, job training, medical care, and protect the legal human rights. All this aims at assisting infected women in behaviour change with stigma and discrimination and be able to support others who experience the same problems.

The study revealed that the respondents had been accessing counselling services for varying number of years. They had been going for the services for a period of between 1 and 6 years. Table 20 highlights the distribution of the number of years that the respondents had been accessing the services.

Table 20

Number of Years of Seeking for Counselling Services

Number of years	*Frequency*	*Percent*
1	13	11.9
2	34	31.2
3	27	24.8
4	18	16.5
5	15	13.8
6	2	1.8
Total	109	100.0

Table 20 indicates that the respondents had been accessing counselling services for between one and six years with a mean of 2.94 years. This clearly indicates that the respondents had accessed counselling services for a considerable period of time that could enable them adjust and cope with the disease. However, adequate utilization of these services will depend on the level of attitude of the society towards people living with HIV/AIDS in general, and women in particular.

FPAK had adopted two main approaches of counselling clients seeking for their services on HIV/AIDS. These approaches included group and individual counselling. Each approach is best suited under different conditions depending on the client and the amount of confidentiality required. All associations affiliated to FPAK were therefore encouraged to adopt these approaches and vary their use according to the type of need. In this study, the respondents were asked about how they interacted with counselling service providers. Table 21 summarizes the different types of counselling approaches used in meeting their counselling providers.

Table 21

Approaches of Meeting the Counselling Provider

Counselling approach	*Frequency*	*Percent*
Individually	19	17.4
In a group	33	30.3
Individually and in a group	57	52.3
Total	109	100.0

Table 21 indicates that 52.3 percent of the respondents met their counselling providers both individually and in a group. The remaining 17.4 percent and 30.3 percent met them individually and in a group, respectively. The five counselling providers drawn from the sample institutions confirmed utilizing both individual and group counselling techniques in addressing the counselling needs of their clients. However, the two techniques were used in different situations depending on the counselling need of the client and the amount of confidentiality required. The providers reported that they preferred individual counselling when handling problems/issues that were unique to one particular client or where there is need for maximum privacy and confidentiality. This was common among new women who were joining the organization. New recruits were still very much stigmatized and shocked after learning about their condition. They also harboured negative attitudes of the society towards people infected with HIV/AIDS. Such clients needed enough privacy and confidentiality to open up and admit their situation. Reckless (1967) reports that individual counselling helps clients to open up easily with assurance of confidentiality; the counsellor to understand the client through both verbal and non-verbal communication; the client to come to terms with his/her problem and set achievable goals to solve the problem; and clients to become more self-directing and reasonable persons.

Group counselling was reported to be preferred when dealing with issues that were cutting across a number of clients and required minimum privacy and confidentiality. The providers reported that the approach was commonly used after the clients had bonded well, free with each other and open to talk about their conditions. It therefore targeted women who had been seeking for the services for along period of time and knew each other very well. This kind of approach is in agreement with Reid (1979) who argued that group counselling is designed to change the behaviour of the entire group through the process of socialization. Bandura (1969) compares group counselling to a family and conceptualizes it as a social way of expressing group

dynamics. Wide variety of problem solutions can be elicited by drawing experiences of several people with varying backgrounds.

The study sought the suggestions of the respondents on how women infected by HIV/AIDS should be treated in the society. Table 20 depicts common suggestions by the respondents.

Table 22

Suggestions to Assist Women Infected by HIV/AIDS

Suggestions	*Frequency*	*Percent*
No stigmatization, discrimination or isolation	57	52.3
Economically supported and empowered	28	25.7
HIV/AIDS not to be misconstrued as promiscuity	24	22.0
Total	109	100.0

From Table 22 above, it can be observed that majority of the respondents suggested that there was need not to stigmatize, discriminate or isolate women infected with HIV/AIDS; economically support and empower infected women; and not to misconstrue HIV/AIDS as a sign of promiscuity. The respondents observed that the society had developed negative attitude towards people living with HIV/AIDS and thus stigmatized, discriminated and/or isolated them in social and economic functions. This had demoralized the victims and added to the miseries of the disease. They therefore appealed to the society to change these attitudes and not to misconstrue infected women as sexually promiscuous. The economic burden of HIV/AIDS was too much for the women who were generally poor with little access to productive resources. This had rendered them unable to effectively afford the required medication and nutrition that could allow them live longer.

CHAPTER FIVE: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the summary of the findings of the study, conclusions drawn, and the recommendations made based on the findings. Also included are suggestions for further research on women and HIV/AIDS.

5.2 Summary of the Findings

The following is a summary of the findings based on the research objectives:

(i) Majority of the women infected with HIV/AIDS encountered high level of negative social effect as a result of their infection with HIV/AIDS.

(ii) Majority of the women infected with HIV/AIDS recorded high level of economic effect as a result of their HIV/AIDS status.

(iii) Majority of the women infected with HIV/AIDS faced high level of psychological effect as a result of their infection with HIV/AIDS.

(iv) All the respondents had access to professional counselling services through associations affiliated to the Family Planning Association of Kenya (FPAK) Rift Valley Province. The counselling services aimed at reducing the level of impact of social, economic and psychological effects that the women faced in their day-to day life by creating a sense of security through counselling, love and attention.

5.3 Conclusions

Based on the summary findings, the study makes the following conclusions:

(i) Negative attitudes of the society towards people living with HIV/AIDS had increased social stigmatization, isolation and discrimination of women infected with HIV/AIDS.

(ii) Lack of adequate access and equity to economic resources had made it difficult for women infected with HIV/AIDS to balance between their medical expenses and family obligations and responsibilities.

(iii) Women infected with HIV/AIDS went through a lot of psychological stress as a result of anger, fear, depression, denial, helplessness, withdrawal, isolation, despair and loss of hope after establishing their status.

(iv) Counselling services play a great role in helping women infected by HIV/AIDS to adjust and cope with the disease and its associated impacts.

5.4 Recommendations

In view of the above conclusions, this study makes the following recommendations:

(i) There is need for vigorous advocacy campaign, sensitization and awareness in the society so as to demystify the social stigma of HIV/AIDS among women infected.

(ii) There is need to develop appropriate strategies that could address gender-based issues exposing women to the risks of HIV/AIDS infection.

(iii) There is need for all women infected with HIV/AIDS to have access to counselling services so as to necessitate appropriate behaviour change and reduce the impact of the disease on the households and society at large.

(iv) There should be more support groups so that the infected can share their experiences as this can help lighten their hearts.

(v) Infected women should be trained on women rights, psychological care and counselling.

5.5 Suggestions for Further Research

The study suggests the following areas for further research:

(i) Attitude of women infected with HIV/AIDS toward counselling services.

(ii) Challenges facing women infected with HIV/AIDS in accessing counselling services and managing the disease.

(iii) A similar study could be done in a different locality to confirm the findings.

(iv) Critique the government policies targeting HIV/AIDS among women infected with HIV/AIDS

(v) The role of NASCOP, UNAIDS, and NAC in financial assistance to HIV/AIDS infected women and their success in campaign against HIV/AIDS.

(vi) The success of millennium Development goals no. 6 on combating HIV/AIDS , malaria and others by the year 2015.

REFERENCES

Adler, M.W. (2001). *ABC of AIDS*. (5th Ed.). London: BMJ Publishing Group.

Ashford, L. (2001). New population polices Advancing women's health and rights. *Population Reference Bureau, 56*: 1. Washington DC

Ainsworth, M.(19980. AIDS and Development; The role of Governments, AIDS; Newsletter.

Asiimwe, A. (19th June, 2007). African Aids Crisis. (Reuters). *Daily Nation,* pp 17.

Bandura, A. (1969). *Social Learning theory of identification proceeds*. Chicago: Rand Mcnally.

Bandura, A., (1971). *Social Learning Theory*. Morriston, N.J; General Learning Press.

Bandura,A. (1991).Social cognitive Theory of self-regulation. Organizational behaviour and human Decision processes, Newbury Park; Sage

Bandura, A., (1986). *Social Foundations of Thought and Action. A Social Cognitive Theory*. Englewood Cliffs, N.J; Prentice Hall.

Barnett, T. (1993). *The effects of HIV / AIDS on farming system in Eastern Africa School of Development*

Berer, M., (1993). *Women and HIV / AIDS* . Sinanda: Pandora Press.

Bor, R, (1993). HIV/AIDS and the family: A review research in the first decade. *Journal of Family therapy,* 15: 187-204

Bourdeiu, P. (1985). *The social space and the gensis of groups. Theory and society.* New York: Wiley.

Caldwell,J.(1997) The impact of the African AIDS epidemic,Health Transition Review.

Carbello,M. (1998).Introduction to AIDS Prevention and Control,Oxford;Pergamon.
Central Bureau of statistics (Kenya) Ministry of Health (MOH) and ORC Macro. Kenya demographic and health survey 2003. Calverton, Maryland: CBS and ORC Macro. 2004.

Cohen, M. (1993). Socio-economic Impact of AIDS: Household Resources and Beyond. Research Proposal.

Corey,G.(1991)Theory and practice of Counselling and Psychotherapy. Brook Cole Publishing Company, a division of Wordswork, Inc.

Deaux, K., (1984). *Social Psychology in the 80's*. California; Monterey Press.

Demeke, M.(1993).The Pontential Impact of HIV/AIDS on the Rural Sector of Ethiopia Unpublished Manuscript, January 1993.

Egan,G.(1998)The skilled Helper; A problem management approach to helping 6th Edition Pacific Grove Brooks Cole.

Exner, T., (1997). *A review of HIV Interventions for at risk women AIDS Behaviour*

Frank, D., & Cox ,D. (2000). *The Aids Booklet.* (6th Ed.) Santa Barbara: City college

Frankel, J.N & Wallen, E.N. (2000). How to Design and Evaluate Research in Education (4th Ed.): New York: McGraw-Hill.

Hall, G.S. (1990). *Adolescence*. New York: Appleton.

Health Management Information System report for the period 1996 to 1999

Hubley J., (1995).*The AIDS handbook: A guide to the Understanding of AIDS and HIV.* International HIV/AIDS Alliance, (2003).UK: Briefing notes.

Kerlinger F.N., (2002). *Foundations of Behavioural Research.* (5th Ed.) New Delhi: Holt Rinehart and Winton.

Kanco, (2000). *Information package on Gender and HIV/AIDS.* NGO'S consortium printed by information management consultants(IMC).

Kathuri, J.N. & Pals, D.A,. (1993) *Introduction to Education Research.* Njoro: Education Media Centre, Egerton University, Kenya.

Kerlinger, F. N. (1973). *Foundations of Behavioural Research.* (2nd Edition). New York: Holt Rinehart and Wilson, Inc.

Kenya Episcopal Conference (1999) *Know more about AIDS*. Unpublished.

K.I.E. (1999). *Bloom or Doom.* An Aid resource book for youth in and out of secondary schools. Nairobi: Government printer

Kihiko,F.N (2000) P.C.E.A-HIV/AIDS programme Nairobi: Jitegemee Press.

Kipkemoi, A. (July 4th 2004). Aids now a "Woman's disease". *The Standard*: pp. 11

Kusimba J, Ndinya-Achola JO, Olenja JK, Moses S, Nyange P, Fish D,& Plummer FA. (1992). The impact of HIV-1 infection/AIDS on family structure in Kenya. A paper presented in an International Conference on AIDS. 1992 Jul 19-24; 8: D388. University of Nairobi, Kenya.

Kweyu, D. (July 14th, 2004). Gender bias, "a stumbling block in war on killer virus". *The Standard*, p.14

Kwaramba,P.(1997). The socio-Economic impact of HIV/AIDS on Communal agricultural systems in Zimbabwe. Working paper 19,Harare Zimbabwe.

Lamptey, P, Wigley, M, Carr, D,.& Collymore, Y.(2002). Population Bulletin: Facing HIIV/AIDS Epidemic. *Population Bulletin 57*: 3. Washington, DC: Population Reference Bureau.

Makinde, O. (1984). *Fundamentals of Guidance and Counselling*. London: Macmillan Education Limited.

May, R. (1953). *Man's Search for Himself*. New York; Norton.

Ministry of Health (2005). *AIDS in Kenya, trends interventions and impact*. Nairobi. Government Printer

Miller,R. & Bor R,(1998) A Guide to clinical Counselling, London; Science Press.

Miller, D. (1998) Counselling Persons with AIDS Oxford; Pergamon.

Miranda, D (1983). *Third World, Second sex*: London: Zed books Ltd.

Mugenda, O. M, and Mugenda G. D. (1999). *Research methods: Quantitative and Qualitative Approach.* Nairobi: Acts Press.

Murrah, W.N.& Kiarie, W.(2001). *HIV and AIDS facts that could change your life.* (1st Ed.).Nairobi: English press limited.

National AIDS Control Council NACC – (2005). Rift Valley province HIV prevalence among adults by district. Nairobi: Government Printer: 270-272.

NACC. (2006). United Nation General Assembly Special Session on HIV/AIDS Country Report-Kenya 2006. Nairobi: Government Printer.

NASCOP & NACC (2003).HIV/AIDS in Kenya. (Online).

Reckless, W, C. (1967). *The Crime Problem*. New York: Publishing Company.

Reid, S, T. (1979). *Crime and Criminology*. New York: Holt Reinehort and Winston Inc.

Riley, E.A. ,(1998). The "virus" and its women: using culturally competent empowerment Interventions as a tool of prevention. *Journal of Multicultural nursing and health.*

Ryckman, R.M, (1993). *Theories of Personality.* (5th ed), California; Brooks/Cole Publisher Co.

Schoub, B.D. (1995). *AIDS and HIV Perspective*, Great Britain, Glasgow; Cambridge University Press.

Seidenberg, B. & Snadowsky, A. (1976). *Social Psychology*. New York: The Free Press.

Swaa –Society for woman against AIDS in Africa. December (2002).

Tarantola, D. (2000). *Reducing HIV/AIDS Risk*: impact and vulnerability. *Bulletin of the World Health Organisation, 78*, No. 2: 236-37 Washington D.C.: World Health Organisation (WHO)

Tabifor, H. (2002). *The dignity of human sexuality and the AIDS challenges*. Nairobi: Alpha and Omega publication.

Tajfel, H. (1982). *Social identity and inter-group relationship*. Cambridge England: Cambridge University.

Taylor, L.(1996).Informal Care for illness in rural Southwest Uganda The Central role that Women play Health transition review;

Temmerman, M. (1995) *The right not to know HIVAIDS test results*. Lancer.

Tibaijuka,AK.(1997).AIDS and Economic welfare in peasant Agriculture World Development. Oxford University press.

UNAIDS (1999). *One strong voice on women and AIDS.* Geneva; UNAIDS.

UNAIDS (2000). *Caring for carers: Managing stress in those who care for living with HIV/AIDS*. Geneva; UNAIDS.

UNAIDS (2002). *Report of Global HIV/AIDS Epidemics and Assessment of Epidemiology Situation in Kenya*. Geneva; UNAIDS.

UNAIDS, (2005). *Report on the global HIV/AIDS Epidemic.* UNAIDS

UNAIDS (2007). *Report of Global HIV/AIDS Epidemics and Assessment of Epidemiology*. Geneva; UNAIDS.

UNICEF (1999): *Children Orphaned by AIDS: Frontline Responses from Eastern and Southern Africa*. New York: Holt, Rinehart and Winston.

UNICEF Kenya (2003). *Child workers in The Shadow of AIDS.* Nairobi: UNICEF Kenya

UNIFEM (2000) *Rural Women and HIV.* London: Commonwealth Secretariat.

UK NGO (1999) AIDS Consortium

Wanyoike, S.K. (2003). *Understanding youth and Family Issues.* Nyeri: Published By English Press.

Watstein, K. (1998) The AIDS Dictionary. Facts on file, Inc. New York.

WHO (1994). *Women and AIDS: agenda for action.* Geneva: World Health Organization

World Bank,(1997) Confronting AIDS; Public Priorities in a global Epidemic; New York Oxford University Press.

WHO (1999).Guidelines for Counselling about HIV infection and diseases.(AIDS Series No.8), Geneva; World Health Organization.

WHO(2000).Woman and AIDS: Agenda for action. Geneva World Health organization.

Willis R. The AIDS pandemic Lincolnshire: Stanborough Press. 2002.

Weinreich, S., & Benn, C., (2004). *AIDS meeting the challenge. Data, Facts, Background*. Geneva; World Council of Churches Publications.

Yvonne, S. & Graveisloot (1999). *Care counselling model* a hand book. Harare: M.G. printers.

APPENDICES

APPENDIX A: INFECTED WOMEN QUESTIONNAIRE

My name is Grace Nyaera Mogire, a student at Egerton University undertaking a Masters degree in Guidance and Counselling. As part of the requirements of the course, I am required to undertake a research project in my area of study. My research topic is on "The impact of HIV/AIDS on social, economic and psychological status of women infected with HIV/AIDS in Nakuru Municipality". You have been selected as one of my respondent in this project. Your sincere and correct answers will be important in attaining this goal. All information will be treated with utmost confidentiality.

Section A: Background Information

1. Name of the respondent (optional) _____
2. Age (in complete years) _____
3. Level of education

   None ☐

   Primary ☐

   Secondary ☐

   Tertiary (excluding university) ☐

   University ☐
4. Marital status

   Married ☐

   Widowed ☐

   Single ☐

   Divorced/separated/abandoned ☐
5. Do you have children? Yes ☐ No ☐
6. If yes, how many? _____

7. Employment status

   Unemployed ☐

   Self-employed ☐

   Salaried employed ☐

8. If employed (self and/or salaried), in which sector of the economy is it?

   Public/government sector ☐

   Informal/Jua kali ☐

   Agriculture ☐

   Religious organization ☐

   Private sector/NGO/CBO ☐

9. What is your average monthly income? _____

10. If unemployed, what are your sources of income/living?

    Donations ☐

    Income remittance from relatives/family members ☐

    Dependency ☐

    None ☐

Section B: HIV/AIDS STATUS

1. How did you discover that you have HIV/AIDS?

   VCT testing ☐

   A friend told me ☐

   Signs and symptoms ☐

   Partner tested and discovered to have HIV/AIDS ☐

   Partner died of HIV/AIDS ☐

2. When did you discover about your status? (year) _____
3. For how long have you been living with the virus? (in years) _____
4. How did you contract the disease?

   Willing sexual intercourse ☐

   Rape ☐

   Blood transfusion ☐

5. Do you know the person/partner who infected you with the virus?

   Yes ☐ No ☐

6. If yes, have are/were you related to the person?

   Husband ☐

   Friend ☐

   Stranger ☐

   Son ☐

   Relative ☐

7. Is the partner/person responsible still alive? Yes ☐ No ☐
8. Are you the only person in your family infected with HIV/AIDS?

   Yes ☐ No ☐

9. If No, who else in your family is infected? _____

Section C: Social Effects of HIV/AIDS

1. Please indicate whether you have never, sometimes or often/always encountered the following as a result of your HIV/AIDS status.

Statement	Never	Sometimes	often
My family members and friends have isolated me because of my HIV/AIDS status			
I don't fear associating with other people because of my status			
People who know about my status see me as sexually promiscuous			
My status has not affected my parental/family obligations and responsibilities			
My children and family members still treat me with respect even after discovering about my status			
People do not easily appreciate my contribution in decision making in the society			
My family do not consider me in any of their future plans			
I fear to be seen in public			

Section D: Economic Effects of HIV/AIDS

1. Please indicate whether you have never, sometimes or often/always encountered the following as a result of your HIV/AIDS status.

Statement	Never	Sometimes	often
I am still physically productive even after contracting HIV/AIDS			
I spend all available resources on my medical expenses			
Medical expenses have affected my other family financial obligations and responsibilities			
People still consider me as economically productive			
My income level has deteriorated since when I discovered about my status			
I am always turned away from employment or looked down upon at the place of work due to my status			
I am still capable of providing for the needs of my family members even in my present condition			
I no longer care to improve on my future economic status because of HIV/AIDS			

Section F: Psychological Effects of HIV/AIDS

1. Please indicate whether you have never, sometimes or often/always encountered the following as a result of your HIV/AIDS status.

Statement	Never	Sometimes	often
I was shocked when I learnt about my HIV/AIDS status			
I am worried about the future of my children			
I blamed myself for contracting HIV/AIDS			
I no longer trust any male partner in anything since I discovered my status			
I am stressed and depressed whenever I think or am reminded of my HIV/AIDS status			
I am suspicious of what other people say or think about me since when I discovered my status			
I don't feel that I am worthless, helpless or hopeless in life			

Section G: HIV/AIDS STATUS

1. Have you ever sought for counselling services on how you can live positively with HIV/AIDS? Yes ☐ No ☐
2. Name of the counselling association/provider?

   Ushuhuda Hai ☐

   Tumaini na Fadhili ☐

   Ambasador of Hope ☐

   Heartshooters ☐

   Ambasadors of Change ☐
3. For how long have been going for these counselling services? _____
4. What are the counselling services provided by the counselling association/group? _____

   _____

   _____

   _____

5. How do you meet the person(s) offering the services?

   Individually ☐

   In a group ☐

   Both individually and in a group ☐

6. In your opinion, how have these services helped you?

   Coping with the disease ☐

   Making informed decisions and choices about reproductive health ☐

   Reducing/handling risky sexual behaviours ☐

7. Give any suggestions on how women infected and living with HIV/AIDS should be treated in the society? _____

   _____

   _____

   _____

APPENDIX B: COUNSELLING PROVIDERS

My name is Grace Nyaera Mogire, a student at Egerton University undertaking a Masters degree in Guidance and Counselling. As part of the requirements of the course, I am required to undertake a research project in my area of study. My research topic is on "The impact of HIV/AIDS on social, economic and psychological status of women infected with HIV/AIDS in Nakuru Municipality". You and your organization have been selected as one of my respondent in this project. Your sincere and correct answers will be important in attaining this goal. All information will be treated with utmost confidentiality.

1. Name of the respondent (optional) _____
2. Age (in complete years) _____
3. Level of education

   None ☐

   Primary ☐

   Secondary ☐

   Tertiary (excluding university) ☐

   University ☐
4. Marital status

   Married ☐

   Widowed ☐

   Single ☐

   Divorced/separated/abandoned ☐
5. What is your profession in this organization?

   Counsellor ☐

   Medical doctor ☐

   Nurse ☐

Psychologist ☐

Psychiatrist ☐

Religious leader ☐

6. Name of the counselling organization/group/institution? _____

_____

7. Number of women infected with HIV/AIDS served in your organization? _____
8. Services offered by the organization to women infected with HIV/AIDS? _____

_____

_____

_____

9. What are the common impacts that you have noted among women infected with HIV/AIDS coming for your services?

Psychological impacts _____

_____

_____

_____

_____

Social impacts _____

_____

_____

_____

Economic impacts _____

_____

_____

_____

10. Give any suggestions on how women infected and living with HIV/AIDS should be treated in the society? _____

_____

_____

_____