PROBLEMS OF HIV INFECTED WOMEN

A CASE STUDY IN CENTRAL DIVISION OF EMBU DISTRICT

By

KARIUKI JANE WAWIRA
REG. NO. E55/6055/03

A RESEARCH PROJECT SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF EDUCATION (GUIDANCE AND COUNSELLING) KENYATTA UNIVERSITY.

AUGUST 2005

Kariuki, Jane Wawira
Problems of HIV infected women: a case
DECLARATION

This project proposal is my original piece of work and has not been presented for a degree in any other university.

Signature [Signature] Date: 10.10.05

This project proposal has been submitted for examination with my approval as university supervisor.

PROFESSOR A. NWOYE Date 9.11.05
DEDICATION

To all HIV-infected and affected women. May you all live long and achieve your dreams.
ACKNOWLEDGEMENTS

I wish to express my sincere gratitude to all those who contributed to the success of my project. Acknowledgement in this study goes to my supervisor Prof. A. Nwoye for supporting me throughout the course.

Special thanks goes to my family especially my husband for his unlimited support. Not forgetting my son Brian and daughter Brenda. More so to the support Muthoni gave me in typing work in one heart. Lastly but not the least to my loving mother Nancy for the moral support.

May God bless them all.
ABSTRACT

The study focused on problems affecting HIV/AIDS infected women in Central Division of Embu District. The sample population was 100 HIV/AIDS infected women but I was able to work with only 82 women ranging from 15 years – 49 years.

From the findings HIV/AIDS infected women are suffering a lot. The major problems they are experienced are lack of ARV drugs in local dispensaries and hospitals. They are equally expensive for them to afford. Financial difficulties are also noted. Where most women earn very little to sustain their medical bills and attend to other family matters. Children of the single parents often leave school to look for alternative sources of income.

Food is a nightmare in the above families let alone a balanced diet. The very poor who live in the slums relay on well wishers.

Discrimination is featuring at home, hospital, places work and neighbourhood. Women seem to experience the highest level of discrimination from the neighbourhood. This makes them suffer from low self esteem and stress.

Some of the women are rejected and they have no homes. Especially the women who are widowed suffer most. Most women blame their spouses for the virus with a small number blame themselves.
The educated women are able to say no to unprotected sexual practices. While a small number of women are still careless about their sexual behaviour. For some, sex no longer matters to them for fear of re-infections. Those that are still sexually active use methods such as condom, withdrawal, abstainance and being faithful to their partners.

Within the six wards, I visited Majengo ward was highly affected by AID. Most of the residents there are single parents with many children who don't attend school. Christians talks freely about HIV/AIDS while Muslims are abit closed due to religious beliefs.

The majority of women believe that anyone can get HIV/AIDS unlike the primitive ideology that treats HIV/AIDS for the prostitutes, immoral, policeman etc.

Most women are dissatisfied with the effort of the government to arrest the problem. People are still dying and the rate of infection is still high. The poor are the most affected for they cannot avoid ARVs.
1. Table 4.1 (a) and (b) Problems faced since infection
2. Figure 4.1 (c) Problems faced by marital status
3. Table 4.2 (a) Distribution of discrimination against women
4. Figure 4.2 (b) Place of discrimination
5. Table 4.3 (a) Response on whether the government is doing enough
6. Table 4.3 (b) Distribution of respondent by reason for dissatisfaction with the government
7. Figure 4.4 (a) Distribution of respondents by definition of HIV/AIDS
8. Table 4.4 (b) Respondent level of education by anybody can get AIDS
9. Figure 4.5 (a) Distribution of respondents by use of protective methods
10. Table 4.5 (a) Level of education against use of protective measures
11. Figure 4.6 (a) Those who have discussed HIV/AIDS
12. Table 4.6 (a) Religion versus ever discussed HIV/AIDS
13. Table 4.7 Chi-square value for marital status and problems experienced.
14. Table 4.8 Chi-square for place of discrimination
15. **Table 4.9** Chi-square for dissatisfaction with the effort of government by reason. HIV/AIDS

16. **Table 4.10** Chi-square value influence of education by definition of AIDS

17. **Table 4.11** Chi-square for value for influence of education on use of protective methods.

18. **Table 4.12** Chi-square value for influence of religious on discussion of HIV/AIDS
TABLE OF CONTENTS

Declaration i
Dedication ii
Acknowledgement iii
Abstract iv-v
List of tables vi-vii

CHAPTER ONE

INTRODUCTION 1
1.1 Background of the study 1
1.2 Statement of the problem 3
1.3 Objectives of the study 4
1.4 Significance of the study 5
1.5 Purpose of the study 5
1.6 Assumption of the study 6
1.7 Scope and delimitations 6
1.8 Definition of terms 7

CHAPTER TWO

1.0 REVIEW OF RELATED LITERATURE 8
2.1 Introduction 8
2.2 Theoretical framework 8
2.2.1 Abraham Maslow theory of motivation 8
2.2.2 Health belief model 10
2.2.3 The self regulation theory 11
2.2.4 The self efficiency theory 12
CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

2.0 Introduction

3.1 Research design

3.2 Research hypothesis

3.3 Study area

3.4 Population sample

3.5 Data collection instrument

3.5.1 Reliability and variability of research instrument

3.6 Pilot study

3.6.1 Research variables
CHAPTER FOUR

RESULTS OF THE STUDY

4.1.0 Introduction

4.2.0 Disruptive statistics

4.2.1 Major problems faced

4.2.2 Those discriminated

4.2.3 Opinion on effort of the government

4.2.4 Aid by definition

4.2.5 Ways of protection from re-infection

4.2.6 Free to discuss HIV/AIDS

4.3.0 Statistical analysis

CHAPTER FIVE

CONCLUSION

5.0.0 Introduction

5.1.0 Discussion

5.2.0 Summary and conclusion

5.3.0 Counselling implications

5.4.0 Recommendation for counselling

5.5.0 Recommendation for further research
APPENDICES

Questionnaire 68
Budget for the study 75
Plan & schedule of activities 76
References 77-80
CHAPTER ONE
INTRODUCTION

1.1 Background Information

Over the last decade, HIV/AIDS has become the world’s devastating epidemic. Worldwide it is estimated that about 22 million people have died of AIDS-related illness. 36 million people are currently infected with HIV virus. It is also estimated that 40 million people in Southern Africa are living with HIV virus indicating that the virus is not under control. (World Bank report 2000). AIDS is not just a serious threat to our social economic development but it is a real threat to our existence. It has reduced many families to the state of beggars.

About 75% of reported AIDS cases occur among adults between 20-45, on the same 50% are women. This is not only the most economically productive sector of the population, but also the age at which investments into education are beginning to pay off. It is also the age at which many adults are raising children. (Sessional paper 4 of National Development plan 1997-2001).

This suggests dire repercussions as the number of children orphaned by AIDS increases a heavier burden on the lesser productive age group of grandparents, households headed by children, an increased number of children forced to live on the streets. Many women/men are widowed due to the virus. The surviving party may also have the HIV virus hence faces a lot of challenges; for example of becoming the sole breadwinners faces financial constraints, rejection frustration at places of work and at home.
In the past, most affected places were the urban and peri-urban centres with Nyanza, Nairobi and Coast provinces leading. However this trend is changing as high prevalence rates have been reported in Meru, Thika and Embu.

According to National AIDS Control Council (2000), HIV/AIDS spreads rapidly in Kenya and 80-90% of infections are mainly through sexual contacts and mother to child transmission and contact with blood accounts for the other 10%. 80-90% of infections are among young people ages between 15 years and above.

The living conditions of the Urban poor have been made worse by the limited options on the predominantly cash economy whereby they have to engage in small businesses to raise money for their survival. The Newsletter of the Kenya Aids NGO’s consortium March 2000) Partner. Many are not employed, daily needs are a nightmare, women seek favour from men who offer compensation in cash or gifts in exchange for sexual favours. This leads to increasing population of infected women and to problems they face.

AIDS has greatly been called the greatest health threat of the 21st century. In addition to illness disability and death, AIDS has brought fear to the heart of most Kenyans. Fear of the disease and far of the un-known. The incidence of AIDS has been rising rapidly since it was discovered in 1981 (22 million had died and 36 people living with AIDS – (2000, UNAIDS).
In 2002 alone over 5 million new infections occurred 800,000 of them were children. These orphaned survivors both sero-positive and sero-negative, needed to be placed in someone’s care. But in places where there is no institution for them and where the biological relatives are too old or poor a family will have to be created for them.

The virus disrupts the functioning of the body’s immune system rendering the infected person progressively unable to revisit a host of other organisations that would normally be harmless. The end result is death after a long time suffering.

1.2 Statement of the Problem

HIV- infection of the mother in the house threatens the entire family. If the women is infected definitely the man is also sick. The effects of HIV- infection into the parents whether the child is infected or not are likely to include periods of parental hospitalisation and eventually death. Chronic and progressive illness will be associated with severe, emotional and practical pressure on the rest of the family members. Compounding the difficulties of the future care of the orphaned child (Canosa 1991, Sherr, 1991).

Older children shoulder the responsibility of parenting at the expense of their education. This is where their mothers are single parents. They lack enough funds for their basic needs. The situation is even worse in slum areas where the poverty level is high. The children lack extended family support, lack of proper health care and emotional support. They too cannot afford good nutritious food to help them stay healthy and strong against the virus.
The infected woman require proper basic need, food, clothing, shelter, standard medical care, sense of belonging, love, understanding and above all protection from discrimination because of their HIV status. But there may be other problems that confront them that remain unknown.

Hence there is need to find out the extent of their problems and device measures to solve them, to encourage them to live a positive life and accept their status since it’s irreversible and more on. As compared to their men counterparts women are looked down upon and disregarded. A woman is an important entity in the family hence if helped the society will benefit. But this help cannot be effectively offered unless the problems they have are clearly identified. The contract task of the present study is to engage in this process.

1.3 Objectives of the Study

The purpose of the study is to access the problems the HIV-infected women are experiencing in their day to day life and how the diseased has affected their life styles. In specific terms the key objectives of this study are:-

(a) Investigate the problems encountered by HIV infected women.
(b) Find the degree of discrimination
(c) Find the government efforts in taking care of the sick.
(d) Find out the definition of HIV/AIDS.
(e) Investigate the protective measures used
(f) Investigate the role of religion and discussing freely on HIV/AIDS.
1.4 Significance of the Study

It has been established that so far there is no cure for HIV/AIDS and therefore prevention is the key to success.

This research hopes to contribute to the solutions of the felt problems in relation to HIV.

It is also hoped that the study may add to the existing fund of knowledge and also arouse more researchers for more research in this field.

It’s hoped that the findings will enable the stakeholder to establish the age groups that are highly affected and subsequently establish counselling units.

The findings will help the Ministry of Health to ensure that the drugs are available and affordable to all. With the totality of the women’s problems identified, it will be easy for the Ministry of Health and other arms of government to determine the total costs for helping them, and the best strategies for accomplishing this.

1.4.1 Research Questions

The following research questions have been formulated to guide the study:

(a) What problems have you been faced with since you got infected?

(b) Have you ever been discriminated against?
   (i) If yes where?

(c) In your opinion do you think the government is doing enough to take care of HIV/AIDS patients?

(d) Do you think HIV/AIDS is a disease for immoral and unfaithful? Give reasons for your answer.
(e) How do you protect yourself from re-infection?

(f) Would you be free to talk on HIV/AIDS?

1.5 Assumptions of the Study

1. It is assumed in this study that the sample is a representation of the target population of the infected women in central division – Embu District.

2. There will be no extraneous intervening variable with the process of data collection i.e. questionnaires were filled independently.

The Research would make people change their attitudes toward the infected.

It is assumed that many HIV-infected women do not have the basic physical and social requirements like proper food and support.

1.6 Scope And Delimitations of the Study

I focused group discussion with (SEFA) group made up of HIV infected women will be availed of in the study.

Those women represent Central Division in Embu District. This division is made up of 6 wards i.e. Majimbo, Dallas, Itabua, Majengo, Kamiu and Blue Valley.

Only infected women will be involved in the study.
1.7 Definitions of Terms and Ayromes

The following words may have different dictionary definitions but they have the following meaning as used in this particular study.

**HIV**  -  Human Immune Deficiency Virus

The virus weakens and destroys the body defence systems by entering and destroying the white blood cells.

**Human**  -  Found only in humans and can spread from one infected person to another.

**Immune**  -  Deficiency - the virus weakens the body's ability to fight other infections.

**Virus**  -  It's a tiny germ that destroys the body immune system.

The organism works by reducing the ability of the body of defend itself against the infection. The virus can live in a person’s body for several years without causing any ill effects.

**AIDS**  -  Stands for: Acquired Immune Deficiency Syndrome. This a condition in which the person infected with HIV develops signs of repeated, often prolonged illness resulting from the bodies lowered immunity to defend itself against diseases.

**A-Acquired** : It means that its caught from someone else who already had the virus that causes AIDS.

**I-Immune** : Relates to the body’s defence mechanism known as the immune system.

**D-Deficiency** : Means the Immune System is lacking or weakened therefore its deficient.

It fails to do what nature has planned for it to do and that is to protect the body from diseases.

**WHO**  :  World Health Organisation.

**UNICEF** : United Nations Children’s and Educational Fund

**UNAIDS** : United Nations Joint Programme on HIV/AIDS
CHAPTER TWO
REVIEW OF RELATED LITERATURE

2.1 Introduction

This section deals with the systematic study of existing work that is relevant to this study. It attempts to broaden our theoretical understanding of problems of HIV-infected women. In the course of the review both foreign and local studies of interest to the present investigation will be reviewed.

This chapter will also discuss the conceptual framework of the study. The chapter takes the following format

(1) Theoretical framework
(2) Conceptual framework

The study in particular will highlight on four major theories on awareness and what the infected women undergo.

2.2.0 Theoretical Framework

2.2.1 Abraham Maslow Theory of Motivation

Maslow holds that human behaviour is normally driven by motivation in response to our needs. Thus he articulates that, a human being has to pass five stages before he or she can find fulfilment in his or her life.
This stages / hierarchy of needs include:-

5
4
3
2
1

- Self actualisation
- Self esteem needs
- Psychological needs/ love affection and care
- Safety needs- protection from danger feeling secure
- Physiological needs (food, shelter, water, clothing etc)

According to Maslow, every human being requires the above needs. If one is deprived of one of them he/she is not comfortable in life.

Thus according to Maslow's theory, one must fulfil the first needs before he/she can go to the other stage.

HIV - infected people lack the basic necessities due to the fact that medication is very expensive. They drain their family resources in order to meet their medical bills. Some of them die of HIV complications when they have no funds to bring medicine or go for treatment.

Women are also sexually deprived. Especially if people know one has HIV/AIDS. She is isolated and even the husband if married may put the blame on the woman.

HIV-infected woman also have no security. Their lives are in danger. They have nobody to protect them. Some are closed away and they seek for refuge in towns where they rent cheap houses where their security is threatened.
The infected are also deprived of love. Their friends and relatives forsake them due to their sickness. They lead a lonely life. Only few people who may not be related come to assist them. Even those that were initially loved, they are facts away and they are disowned.

HIV-infected suffer from low self-esteem. They look down upon themselves and feel that they are not useful anymore. Counselling is required here so that they don’t suffer from depression. Even those who are talented in different fields their skills go to waste for they have nobody to encourage them.

Most of the HIV-infected women never meet/achieve their goals. They come across so many handles along the way such that they loss hope in life. To them death is close to them hence there is no need of working very hard. They are also weak hence may not even have the strength to work.

2.2.2. Health Belief Model

This model was developed in 1950s by social psychologists in the United States to explain lack of public participation in the health screening and prevention programmes. The model holds that health behaviour is a function of individuals socio-demographic characteristics, knowledge and attitudes.

An individual must perceive the seriousness of bad behaviour e.g. have seen someone very close to him or her dying of HIV/AIDS and perceive benefits of prevention. In this model promoting action the behavioural change beliefs with respect to HIV/AIDS i.e. its
severity and thus upholds good morals. Even though an evaluation of HIV/AIDS campaign providing public education has shown that they have been effective increasing awareness for HIV/AIDS among the general population, there is little evidence that this campaign has been effective among adults in both rural and urban areas. This evidence in their mode of sexual behaviour.

The above is a further indicator that knowing about HIV/AIDS and perceiving it has a threat towards life is not the same. The study therefore uses the principal in this theory in an attempt to look at the extent of infections amongst women. According to this model the family of those affected by HIV/AIDS are mostly likely to react according to the way the society perceives of them.

This mode does not take into consideration other factors such as environmental or economic factors that may influence health behaviour and the model does not incorporate the influence of social norms and peer influence on people’s decision regarding their health behaviour.

2.2.3 The Self Regulation Theory

This theory is credited to Leventhal et al. 1983. The Self Regulation Theory posits that generally people are motivated to regulate their behaviour to avoid health dangers, and that they actively extract information from their environments and previous experiences to formulate plans and actions to cope with health threats.
Applying to the current study the self regulation theory indicates that women faced with the threat of HIV/AIDS, consistently regulate their sex related behaviour by actively utilizing information as provided by HIV/AIDS education programmes and other sources of HIV/AIDS information from their environments. The information enables the women to formulate plans & undertake actions which enabled them to cope with health threats of the HIV/AIDS epidemic.

2.2.4 The Self Efficiency Theory

This theory is attributed to Bandura (1986). The theory of self – Efficacy states that human behaviour is influenced by the extent to which an individual believes that he/she has the ability for competence to undertake the behaviour.

To the current research, the self –efficiency theory indicates that women have to feel capable of engaging in activities that parents HIV/AIDS infection before adopting low risk activities.

2.3 The Size of the Problem – Global Level

The largest number of cases have been reported from the America and especially the USA. However judging the size of the problem in a country only from the number of reported cases can be misleading. The accuracy of reporting can vary from country to country. It is not easy to estimate the number of people with AIDS and infected with the AIDS virus, not all cases are reported. People living in remote rural areas may die without diagnosis by healthy workers. Many symptoms of AIDS such a diarrhoea, weight loss and enlarged lymph nodes are also found with other diseases so cases of AIDS may not be recognised.
The reason HIV/AIDS has become the leading global issue is not just because it is a fatal disease with neither a cure nor a vaccine, but also because of the alarmingly high speed of HIV/AIDS with which it has spread. One reason HIV/AIDS spreads so rapidly is because infected individuals can live for a very long time without exhibiting any symptoms or feeling ill. As a result when HIV starts to infect a population, the epidemic remains silent for years. During this period education campaigns stand to be ineffective as people are largely unaware of the disease and its consequences. After a few years individuals begin to fill ill and a few deaths are reported.

It frequently affects both spouses and it has a major impact on household incomes and also creates a huge orphans problem. Later the number of people who are ill and the number of deaths increases dramatically. At this stage the level of awareness greatly increases.

According to the UNAids report issues in June 2000, Kenya had 2.1 M adults and children living with HIV/AIDS by the end of 1999. Based on the 1990 census report, this is equivalent to the entire population of Nairobi. This is an extremely high number representing 14% of the adults (15 – 49 years) population and 7% of the entire population with less than 0.5% of the global population, Kenya has a whopping 6% of the world’s HIV positive people. This contrasts with the United States, whose population is ten times larger yet has less than half the number of HIV cases.

Other HIV/AIDS statistics just add to the gloom of a truly black picture. The number of deaths (180,000 in ’99 alone equivalent to the population of Eldoret) (the number of orphans 730,000 by end of ’99) the number of new infections (around 200,000 each year);
the number of hospital beds occupied by AIDS patients (appr. 55%), the number of secondary school students infected (20% according to some estimates, percentage of GOP lost to the scourge (estimated at 15% by 2005). It is an endless litany of misery and woe. "Kenya ranks ninth with 14% Adults using HIV prevalence”.

Source UNAIDS, (June 2000)

Date from Peri-urban and rural sentinel sites source NASCOP, 1999.

Embú had 27% of pregnant women testing positive in 1997.

National AIDS & STDs control programme – NASCOP “AIDS is a major public health problem with a negative impact on development the pandemic is here to stay and its effects will be felt in all aspects of human endeavours and for a long time to come”. President Fred Chilumba; Zambia November 2000.

“AIDS has become the host devastating disease human kind has ever faced”. This was sobering statement made by the world health organisation (WHO) in the AIDS Epidemic update (December 2001) statistical provided by the UNAIDS (2002) support this. Since the start of the epidemic, over 60 m people have been infected by HIV/AIDS. Most of them in Southern Africa.

HIV/AIDS is the leading cause of death in this region. World-wide it is world’s largest killer. It is estimated that 40 m people are currently living HIV virus indicating that the virus is not under control. AIDS is an infectious disease caused by a virus that has spread
from person to person through a variety of routes. This makes it different from immune, deficiency, from other causes such as treatment with anticancer drugs given to persons suppressing drugs given to persons receiving transplant operating, Kivanguli, Gregory (2002).

AIDS did not come to the world public attentions until mid 1981, after cluster of deaths from pneumocytisis Carnii pneumonia (PCP) and Kaposi's Sarcoma (KS) were spotted in young, previously healthy homosexual men in New York, Los Angeles and Francisco Milan, Rian (2001). A summary of these early cases was published in a journal called mortality Weekly Report MMWR (1982). This publication elicited subsequent reports of additional cases. Reports from similar findings come quickly form France, Caribbean and Central America.

In the United states the disease was first called Gay Cancer, then labelled gay-related immune deficiency. In some areas in Africa the disease was called "Slim disease" because of the profound wasting and the association on deaths with progressive weight loss, and diarrhoea. It is also widely believed that HIV is the result of animal to human zoorotie transfer of Simon Immuno deficiency virus (SIV) which infects chimpanzees.

In Kenya most people contract HIV through heterosexual contact, while the significant portions of the mothers pass virus to the child during pregnancy, labour and delivery or bread-feeding. It is also estimated that about 5 to 10% of infections in developing countries like Kenya are acquired through blood transfusion Kivanguli (2002).
Current research shows that the urban area, nearly one out of every five adults is infected (CHAK 2002). Former president Daniel Arap Moi (1999) in addressing members of parliament in Mombasa declared AIDS a National Disaster. Stating that AIDS is not just a serious threat to our social and economic development it is red threat to our very existence. No family realises untouched by suffering and death caused by AIDS, the real solutions lie with each and every one of us.

In Africa the situation is particularly serious. The WHO estimates that, by mid 1993 close to 1.5 million AIDS cases had occurred in Africa. Over two thirds of the global total. In the urban centres, between a quarter and one third of adults aged 15 – 49 years are estimated to be infected. While originally concentrated in Urban areas, infection is spreading to rural areas. The early spread of the epidemic followed closely the highways with truck drivers and road side night stops playing a significant role in transmission.

2.4.1 Factors Associated with the Risk of Assurance

A sound knowledge of factors associated with the risk of occurrence of a disease is a prerequisite to development of meaningful interventions for its preventions. It can be noted with some degree of pride that a lot of what is currently know of the risk factors is currently known of the risk factors for the transmission of HIV derives from studies carried out in African with significant participation of Africa scientist.

Several researchers revealed that knowledge and methods of HIV/AIDS control indicated that individuals were still not aware of the methods. For instance a study conducted in Australia by Bernard (1993) revealed that precautions against HIV/AIDS were wrongly thought of in terms of having many but specific partners.
Unpublished thesis by Lidambiza, D.S. (2003) Kenyatta university on sexual risk taking behaviour among adolescents reported that individuals believed that AIDS is a disease of special group of people. Notably commercial sex workers and their clients, barmaids and track drivers. Since individuals believed that they did not belong to this group of people then they assume they are not at risk of contracting AIDS, even for those engaging in sexual risk-taking behaviours. Nzioka (1994) took a similar study and his study revealed that the risk of HIV/AIDS was constructed not as a function of sexual risk-taking behaviours but as having sex with particular groups of people.

Oluoch, (1993) found that people could use condoms as a way of prevention of HIV/AIDS but very few actually did use them. Condoms use increase with level of education. Unpublished Thesis by Solomon C.J. (2003) on knowledge on HIV/AIDS found that people with higher education level and greater or more precise knowledge about HIV/AIDS. But knowledge has been largely unsuccessful in changing attitudes and enhancing favourable attitudes in matters related to HIV/AIDS. Solomon further asserts that HIV/AIDS education without efforts to enhance a positive attitude may do very little in changing people sexual behaviour.

However there is a documented evidence of active HIV transmission among those previously regarded as low risk groups, for example, women attending antenatal and family planning clinics. Infections reaches the low transmitters through their sex partners who at the same time engage in sex with high frequency transmitters. This kind of behaviour is encourages by separations of couples especially where the male partner has to work in the city while the wife remains in the rural areas (absentee husbands).
2.4.2. Risk of HIV – Transmission in Times of Civil Unrest

History shows that in times of civil unrest and during war-like periods women become targets from mass rape, which apart from the immediate pain and humiliation they suffer. It exposes these to risk of STDs and HIV infections. This happens all over the world and it is not just an African peculiarity, as recent events in Europe testify. Women in penal institutions are also frequently molested and exposed to infections. In many African countries the extent of HIV infections among the prison inmates is such that they no longer are the main source of donated blood for transfusion, that they once used to be.

Armed Forces personnel are at special risk for HIV transmission because they are recruited at precisely the age of greatest risk i.e. 15 – 24 years. They are also often away from home for long periods, at an age and in an environment which encourages risk-taking behaviour. Military corps and installation are known to attract CSWS facilitating soldiers to engage in casual sex. Infection rates of STDs as well as HIV-AIDS among the military are generally higher than in comparable civilian population. Such men have multiple sexual partners including their wives who may be very innocent.

2.4.3. Early Sexual Experiences

Young women are not spared either, we cant data from a number of African countries show that 15 – 19 years old girls already have many sex partners, probably for financial gain and therefore at risk of contacting STDs a and HIV. It has also been observed that women are exposed to infection at a younger age than men. Data from Tanzania has shown that HIV infected women had a range of 15 – 34 years, ten years younger than in
the case of men whose age ranged from 25 and 44 years. In Kenya, analysis of the AIDS cases reported between 1986 – 1996 shows that in the age group 15 – 29 years, female cases exceed male cases, while above this age there were more men than women. The peak age for female cases was 25 – 29 while it was 30 – 34 for males cases.


Unpublished Thesis by Sophia (2003) found that sexual debut among Kenyan youth is much earlier than their counterparts in other countries in Africa. The maiden age for first sexual intercourse is twelve years for girls and thirteen years for boy (Rok, 2000). Young people are getting into intimacy with older men and women as the pressure for sex continue to be exerted by regular partners and peer regardless of their danger. A study conducted among unmarried adolescents between 10 – 24 years in Central Kenya indicated that their maiden age for first sexual experience is 14.5 year for girls and 16 years for boys (Erulkar, 1999).

The study further found that in Siaya and some parts of Western Kenya, the situation is exacerbated by the belief among older men that school girls are HIV negative (Onyango, 1999). In most cases young girls are infected by older men whom they engage in sexual relationship in return for financial reward. Due to economic handicaps many parents are not able to provide requirements for their young daughters and sons demanded by them due to social and peer pressure as this is above their means (Tuju, 1996).
The inability of parents to provide such requirements has made young girls to opt for the much older and financial secure men. With the advert of HIV/AIDS the ultimate prices such girls pay for this reward is their lives (Marger Sunanda, 1993). Although most cultures condemn premarital sex there are certain communities where premarital sex among young girls is encourages as it is believed it prepares them for marriage (Tuju, 1996).

2.4.4. Risk of HIV Infection Higher for Women

The social economic disadvantages that women face make them especially vulnerable to HIV infections for example by their exposure to the high risk sexual behaviour of their sexual partners.

The efficiency of HIV transmission from infected men to women is greater than it is from infected women to men and besides, many women are powerless to take steps to protect themselves for example by insisting on condom use. Anatomically women are exposed longer to potentially infections male secretions (Semen) men are exposed to female secretions during sexual intercourse. Vaginal intercourse exposes a large surface area of the vagina and the cervix, to semen, compared to surface area of male genitalia exposed to female secretions.

Traditional/cultural practices also increase risk of women getting infected such as polygamy, wife inheritance and preference of “dry sex” sexual abuse and violence including rape, drug abuse as well as lack of knowledge about the disease.
A study by Herold, (1991) found that changing a woman’s perception of vulnerability to HIV/AIDS significantly increased perceive risk of infection. Unpublished Thesis by Solomon C. J. (2003) found that women were not using condoms in their sexual encounters. He therefore held that they should be taught the risks. Consequently the review of sexual behaviour should remind them that their sexual behaviour increases their risk of HIV infection. According to the scholar great concern should be given to women in urban and rural areas regardless of their sexual orientation or lifestyles are at risk because of frequent sexual contacts and because they may not engage in “safe” sex practices due to low sense of invulnerability or the belief that if any of their partners had HIV/AIDS they would let others know. Additionally they should be informed on how to negotiate safety with potential sexual partners.

2.5 Aids on Population

AIDS will have a large impact on population size. It will cause population growth to stop or become negative. The projection assumes that the total fertility rate (the average number of births per woman during her lifetime) continues to decline, from about 4.5 during 1990 – 1993 by 2000 and 3.5 by 2010. It also assumes that mortality from all causes other than AIDS continues to decline so that life expectancy would increase from about 57 years today to 67 by 2710. If there was no AIDS causing increased deaths, the total population of Kenya would be 1.3 m smaller by 2000 and 2.9 m smaller by 2005.
2.6 Costs of Health Care

AIDS is an expensive disease that will require a considerable amount of resources from the health system. A 1992 study (Forsyle) estimated that the cost of hospital care for AIDS patients averaged about 27,200 Shillings during the course of their illness. If this expenditure rate remains constant then the total hospital cost would increase to 5,400 million shillings by 2005.

AIDS has a significant impact on the provision of services within all statutory and local authority organisations. It has created new demands in housing social services support, primary and secondary health care, formal and non-formal education services.

Most of these medicines are very expensive and very few patients in the developed world where 95% of the HIV positive individuals live currently accesses them. On the same the victims develop resistance to drugs hence they become ineffective.

Some of the proposals made are:

(a) Donation programmes to be extended to the poor.
(b) Reduction of prices by pharmaceutical companies to patients.
(c) Massive global funding to the poor nations.

2.7 Other Problems of HIV/AIDS on Women

In all regions of the world women are getting infected not only because they lack information but because they lack the power to keep themselves safe. If more women and girls had the “right to abstain”; to decide when and with whom to have sex, to negotiate
condom use, to live their lives free from violence to earn an income adequately to feed their families – their ability to protect themselves from HIV would be real. Far too often they don’t.

2.7.1 Lack of food

Food is recognised as a critical challenge brought on by HIV/AIDS has most of the time is spent taking care for the sick. They are rarely involved themselves in activities that would generate income to enable them buy food. The HIV victims hardly have the recommend diet. This is even worse in slum areas where poverty level is high. Further more malnutrition HIV-infected people progress more quickly to AIDS. (Harvey 2003).

2.7.2. Psychological Challenges

The psychological challenges associate with the illness especially the mother who is very important in the family sector has far reaching effects both to the affected and the infected. The society usually stigmatises the family members, the sick lack emotional support from the immediate family members. However it is often traumatising and for the infected and affected who find it difficult to reconcile with their new condition. Making this situation more difficulty is almost universal moral condemnation by the society of people living with HIV.

Unpublished Thesis by Hussein N.A. (2003) holds that HIV/AIDS positive face a lot of discrimination both at home and at their places of work. Solomon C.J. (2003) study found that ordinary people in the society have a negative attitude towards the sick who needs solace. The health ones feel that they are inevenarable hence isolate the sick.
Knowing that one is infected with a disease that does not have a cure takes a heavy psychological toll on the sick. On the other hand, despite the infection and good quality of life depends on a positive mental outlook. A positive mental frame can be achieved through counselling although it is inadequate and in accessible (for immobile patient).

2.7.3 Income

The loss of the ability to earn an income due to illness symbolizes the onset of loss of independence for people living with HIV/AIDS. This is usually a devastating moment leading to loss of self esteem and they (people living with AIDS) begin to depend on parents and relatives for support. AIDS affected households suffer severe poverty than an affected household. (Rugadema 2002).

2.7.4 AIDS Orphans

This is one of the worst impact on AIDS death to young adults. An orphan is a child under the age of 15 who had lost a mother to HIV. Estimates of 26 Africans countries suggest that the number of children loosing a father (paternal orphan) or mother (maternal orphan) from any cause of illness will double between 1990 to 2010. Within the same period the number of children who have lost both parents (double orphans) will increase 8 fold throughout Africa (Levine, 2000). By 2010 15% of this 26 countries will have lost one or both parents. This children may lack the proper care and supervision they need at this critical period of their lives. There will be a tremendous strain on social systems to cope with such a large number of orphans. There is increased burden and stress for the extended family which has the traditional mandate to care for this orphans (Ankrah, 1993, Ntozi, 1997). Many grandparents are left to care for young children.
Some families are headed by children as young as 10 – 12 years. Those who have nobody to guide them results to the streets to make heads meet (Okeyo, 1992).

In particular, poor female headed household lack access to this network (relatives/community support). In general wealthier households have greater access to reciprocal that their poorer counterpart lack (Bayer, 2002).

2.8 Conceptual Framework

Background
Dependent variables
Independent variables

<table>
<thead>
<tr>
<th>Age</th>
<th>Gender</th>
<th>Social/Economic status</th>
<th>Education level</th>
<th>Marital status</th>
<th>Polygamy</th>
<th>Wife inheritance</th>
</tr>
</thead>
</table>

HIV infected

| Loneliness |
| Financial constrains |
| Rejections |
| Discrimination |
| Separation/divorce |

Control variables

Females
Aged 13-49 years
The researchers conceptual framework is based on the premises that HIV-infected women has essential needs irrespective of their HIV status. Their problems are worse if they live in slum areas meaning they are economically deprived. Dallas wars is one slum area in central division of Embu district with the highest number of HIV-infected women where life is a total struggle. Most of the resident are the single parents with many children of different biological fathers. Some are young girls who have left the rural areas to urban in such of jobs and have found themselves in prostitution to make ends meet where jobs are not available. Other residents have small businesses of trade to keep them going.

The researcher ascertains that AIDS threatens entire society for women are the threads that bind fabrics of society holding together families, communities and the country at large. That is if the woman is sick the spouse is definitely sick as well while the children may hang on the balance (positive or negative). These children suffer psychological as they care for their dying parents, drop out of school to help with household work or experience decline access to food and health services.

The researcher feels that the children also are at the risk of exclusion from family inheritance, abuse (physical or sexually), discrimination, stigmatisation while some turn to risky sexual behaviour as a means of survival. Then the researcher holds that HIV-infected women are discriminated, rejected both at home and in places of work. No one wants to be associated with them. For those who are married separation and divorces evidenced where men would not want to bear the blame or go through the suffering together.
Poor health and general weakness of body are evidence amongst the HIV-infected women that is those who cannot afford good medical care and the recommended proper balanced diet suffer a great deal. Other results depression and suicide attempt when they get the end of the road. HIV-infected lead along – illness of suffering and eventually death. Despite all this the HIV-infected women/girls can lead a positive healthy productive life, but it will only be possible if the society change their attitude towards them as well as improve their conditions by actively engaging men/boys and entire community. “After all HIV/AIDS is not a death certificate”.

It is observable from the above literature review that non of the study reviewed specifically investigated on the problems facing persons, HIV/AIDS has variable where women were the sample population. This is because such studies have not been done as such the researcher hopes to investigate on the problems facing women who are living with HIV/AIDS in order to provide further information on how they can be assisted.
CHAPTER 3
RESEARCH DESIGN AND METHODOLOGY

3.0 Introduction

This chapter gives details on the methodology and of the present study.

It covers the following:

- Research design
- Study area
- Population sample
- Data collection tools/instruments
- Data analysis and measurement of variables

3.1 Research Design

Schutt, (1996) defined survey as a kind of research in which the information is obtained through responses that a sample of individual give to questions.

A cross section descriptive survey was used to determine the problems the HIV infected women undergo. This is a method for gathering data through the measurement of some items or through solicitation from other people or documents (Koul, 1990).

Survey deals with phenomena as it exists in nature or society. It involves the systematic collection of data on an entity or group of entities and drawing conclusions from the data. Survey enables the researcher to cover a more representative population and hence obtain credible results on the true and actual problems facing women.

The design yield both qualitative and quantitative data which enables the researcher to get in-depth information which is especially important given the sensitive nature of the study. The study sought to address the variables that will enable us to answer the HIV/AIDS aspects that adversely affect women.
3.2 Research Hypothesis

H01 : There is no significant relationship between problems experienced and marital status.

H02 : There is no significant relationship between discrimination and place of discrimination.

H03 : There is no significant relationship between the efforts of the Government to assist the HIV/AIDS infected women by reason of dissatisfaction.

H04 : There is no significant relationship between level of education and that anyone can get AIDS.

H05 : There is no significant difference between level of education and use of protective measures to prevent re-infection.

H06 : There is no significant relationship between religion and discussing freely on HIV/AIDS.

3.3 Study area

Central division is found in Manyatta Constituency of Embu District. It is bordered by Nembure Division to the East and Manyatta Division to the North. It’s the most populated area in the district with 37% of the total population. It covers an area of 30sq/km.
Central Division is the most populated area in the constituency. It covers Embu town and the surrounding areas. It's made up of 6 wards namely:

1. Majimbo
2. Dallas
3. Majengo
4. Kamiu
5. Blue Valley

Central division is the targeted area for it has one of the highest % of 21.0% of HIV infections in the District compared to other Divisions.

3.4 Population sample

Singleton et al (1998) defines sampling as the process by which a relative small number of individual is selected and analysed in order to find out something about the entire population from which it was selected.

Since everyone is a potential victim the study targeted the population aged between 13 – 49 years.

Records have revealed that the most affected age group in Embu is between 26 – 35 years followed by 13 to 25 years, which is consistent with the national figures.

Other dynamics of HIV in Embu show that women account for about 66% of all the cases while men account for about 30% women should therefore be targeted aggressively while at the same time not neglecting men.

The sample size is 100 women to represent the whole division. For one cannot be able to interview the entire population the sample will have similar features hence generalise the results for the entire population.
Table 4. The sample done to the study area.

<table>
<thead>
<tr>
<th>NO</th>
<th>WARD</th>
<th>NUMBER OF WOMEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Majimbo</td>
<td>25</td>
</tr>
<tr>
<td>2</td>
<td>Dallas</td>
<td>30</td>
</tr>
<tr>
<td>3</td>
<td>Majengo</td>
<td>15</td>
</tr>
<tr>
<td>4</td>
<td>Itabua</td>
<td>15</td>
</tr>
<tr>
<td>5</td>
<td>Kamiu</td>
<td>10</td>
</tr>
<tr>
<td>6</td>
<td>Blue Valley</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>TOTAL</td>
<td>120</td>
</tr>
</tbody>
</table>

3.5 Data Collection Instruments

The research instrument that was used was self-structured questionnaire. The questionnaire was selected to enable the researcher collect a lot of information within a very short time.

The instrument chosen also ensures data validity, reliability and relevance to the study.

All the data collected was in view to the objectives of the study.

The questionnaire consists of both closed-ended and open-ended questionnaires so as to allow for further probing in view of getting indepth responses and structural answers.

3.5.1. Reliability & Validity of Research Instrument

According to Cooling (1994) reliability refers to the measures consistency in producing similar results on different and comparable occasions. On the other hand, validity refers to whether a measure is really measuring what is intended to measure.

Thus pre-testing the instruments was done before the actual study. This was done with the purpose of enhancing the validity and the reliability of the instrument. A pilot study was undertaken where, twenty respondent were selected randomly from each stratum of the already sampled group.
3.6 Pilot Study

The pre-testing will be done before the actual study. This will be done for the purpose of enhancing and the validity and reliability of research instrument. For the pilot study 10 respondents will be selected from the 6 wards at random. The purpose for piloting it to assist the researcher to discover weaknesses in the research instruments. It is also to check the clarity of the items, language level and how well the questions would be understood. It also enlists comments from the respondents that will help in the improvement of the instruments.

3.6.1 Research Variables

According to Claire Bless and Achola (1987) variables are empirical properties that are capable of taking two or more values.

These are independent and dependent variables as described below.

Independent variables

That which influence other variables or causes change in dependent variables.

The dependent variables of the study problems of women with HIV/AIDS.

Independent variables

That will generate women’s problems: HIV infection.

3.7 Data Collection Procedure

The first step was to obtain permission from the relevant authorities i.e. (Do control).

Then the subjects will identified as women aged between 13 – 49 years. It’s here the researcher will identify himself/herself, explain the reasons for the study and request them to kindly fill the questionnaires as accurately as possible. In cases where this is
not possible the researcher will request any other relevant person to assist in filling the questionnaires. In some situations an interview was conducted to those who needed elaborations into the questionnaires and research in general. They are given time to ask questions which are responded to. This is done to maximise their return rate. In addition this is also to assure the respondent that their responses would be treated in strict confidence.

3.8 Data Analysis

Having completed collecting data the questionnaires were scored and data coded for analysis. Data analysis will be analyzed by use of qualitative and quantitative methods. The results will be presented in tables and figures. Frequency distribution figures and % will be used because they are relevant for heightening the problems to be identified. The qualitative analysis will be by content analysis. For the quantitative analysis computer will be used. The statistical package for social science (SPSS) and excel package will employed to analyse data. They superman’s correlation co-efficient and the chi-square will be used to test the relationship between variables. The conclusions will drawn from the findings.
CHAPTER 4

RESULTS OF THE STUDY

4.1.0 Introduction

This chapter deals with the presentation and analysis of data collected from people living with HIV/AIDS (PLWHA). This data was collected through questionnaires and personal interviews with key informants.

The data has been represented by use of frequency tables or by descriptive analysis of the various issues. Bar charts and pie charts have also been used where appropriate, for clarity and easier understanding of the data presented.

The study set out to investigate the problems facing HIV infected women in central division of Embu District. Some of the issues addressed in the study include:

1. The problems they experience in their day-to-day life.
2. Places of discrimination
3. Efforts of the government to eradicate the problems.
4. Free talk about HIV/AIDS.

The items that were directly concerned with the study were selected for analysis. The response rate was good. The target sample population was 100 PLWHA’s. Out of these 82 returned the questionnaires. This represents 82% response rate as shown on table below.
The first section consisting mainly of descriptive statistics deals with answers to the major questions explored in the study as outlined in chapter one, while the second section deals with the results of the tests null hypothesis investigated.

4.2.0 Descriptive statistics

4.2.1 Research question one. What are the major problems you have been faced with since you got infected with HIV/AIDS?

The question explored specific problems experienced by women living with HIV/AIDS and problems faced by marital status and length of stay with the virus. The results are in figure 4.1 (a) (b) and (c).

Table 4.1(a) and (b) shows the distribution of respondents by the problems faced since infection.

<table>
<thead>
<tr>
<th>Problems faced since infection</th>
<th>Number of respondents</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial difficulties</td>
<td>61</td>
<td></td>
</tr>
<tr>
<td>No proper food</td>
<td>61</td>
<td></td>
</tr>
<tr>
<td>Discrimination</td>
<td>57</td>
<td></td>
</tr>
<tr>
<td>Loneliness</td>
<td>54</td>
<td></td>
</tr>
<tr>
<td>Rejection</td>
<td>52</td>
<td></td>
</tr>
<tr>
<td>Inadequate drugs/medication</td>
<td>48</td>
<td></td>
</tr>
</tbody>
</table>
According to figures 4.1 (a) and (b) above most of the women infected with the HIV virus (61%) had financial difficulties and a similar proportion lacked proper food. 54% had the problem of loneliness, 52% faced rejection while 48% lacked access to drugs and medical attention.
Table 4.1.(c) shows problems faced by marital status.

Figure 4.1 above show that the problems of rejection and inadequate access to medical care are almost evenly distributed within the marital status. Loneliness is most prevalent among the single, same to depression or stress and loss of job opportunities. The bars generally indicate that the single women are the most afflicted by the problems.
4.2.2 Research question two. Have you ever been discriminated against?

Table 4.2 (a) and (b) gives information on the response of women discriminated and the respondent place of discrimination.

Figure 4.2 (a) shows distribution of discrimination against women.

Table 1.9: Percentages distribution of women by act of discrimination

Have you ever been discriminated against?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>6</td>
</tr>
<tr>
<td>Yes</td>
<td>75</td>
</tr>
<tr>
<td>Total</td>
<td>81</td>
</tr>
</tbody>
</table>

93% have been discriminated against compared to 7% who have not been discriminated at all.

4.2 (b) shows place of discrimination

![Bar chart showing percentages of women discriminated against in different places]
Figure 4.2 (b) shows 78% of women have been discriminated in their neighborhood, 76% in hospital, 71% at home and 56% at their place of work.

4.2.3 Research question three. In your opinion do you think the government is doing enough to take care of the sick.

This question gives the respondents' point of view on whether the government assists the HIV/AIDS positive women or not. The reasons to support the answer given. The data to this question highlighted in tables 4.3 below.

Responses on whether the government is doing enough.

<table>
<thead>
<tr>
<th>Response</th>
<th>Number</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>33</td>
<td>60%</td>
</tr>
<tr>
<td>No</td>
<td>49</td>
<td>40%</td>
</tr>
</tbody>
</table>

60% of the respondents are dissatisfied with the government with the government intervention in helping and caring for the HIV/AIDS infected while 40% are satisfied.

Table 4.3 (b) Distribution of respondent by reason for dissatisfaction with government.
Reasons for dissatisfaction

<table>
<thead>
<tr>
<th>Reason</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor HIV patients are suffering</td>
<td>2</td>
<td>2.4</td>
</tr>
<tr>
<td>No support to PLWHA groups</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td>Should give free ARVs</td>
<td>13</td>
<td>15.9</td>
</tr>
<tr>
<td>Lack of drugs</td>
<td>10</td>
<td>12.2</td>
</tr>
<tr>
<td>CD4 count machines are poorly maintained</td>
<td>2</td>
<td>2.4</td>
</tr>
<tr>
<td>Real help never reaches the grassroots or never been assisted</td>
<td>9</td>
<td>11.0</td>
</tr>
<tr>
<td>misuse of resources meant to benefit PLWHA</td>
<td>4</td>
<td>4.9</td>
</tr>
<tr>
<td>Infection rate still high</td>
<td>3</td>
<td>3.7</td>
</tr>
<tr>
<td>Should offer free medical attention to PLWHA</td>
<td>4</td>
<td>4.9</td>
</tr>
<tr>
<td>Rampant discrimination at govt hospitals</td>
<td>1</td>
<td>1.2</td>
</tr>
</tbody>
</table>

16% of the respondent had the opinion that the government was not doing enough to help the HIV/AIDS patients because they were not provided with free ARVS. 12% of the women said that government efforts were not enough because there was shortage of drugs, and 11% were of the opinion that grassroots people never got the much deserved support and assistance. Women who expressed concern that resources meant for assisting PWHA were being diverted or misused were 5% and 4% doubted the government efforts on preventive measures because infection rates were still high. A slim minority (1%) said that there was rampant discrimination at government hospitals to people infected with HIV/AIDS.
4.2.4 Research question four. Do you think HIV/AIDS is a disease for the immoral and unfaithful people? (Give reasons for your answer).

The information to this question entails the individuals definition of HIV/AIDS. The results are tabulated in figure 4.4. (a). Table 4.4. (b) tabulates distribution of responses by level of education that anyone can get HIV/AIDS.

Figure 4.4 (a) shows percentage distribution of respondents by definition of HIV

<table>
<thead>
<tr>
<th>Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Truck drivers</td>
<td>18%</td>
</tr>
<tr>
<td>Policemen</td>
<td>16%</td>
</tr>
<tr>
<td>Single women</td>
<td>16%</td>
</tr>
<tr>
<td>The rich</td>
<td>16%</td>
</tr>
<tr>
<td>The prostitutes</td>
<td>15%</td>
</tr>
<tr>
<td>Married women</td>
<td>7%</td>
</tr>
<tr>
<td>The widowed</td>
<td>7%</td>
</tr>
<tr>
<td>The unfaithful</td>
<td>3%</td>
</tr>
<tr>
<td>Anybody</td>
<td>1%</td>
</tr>
</tbody>
</table>

Figure 4.4. (a) above shows that 18% of the women would not define HIV as a disease for truck drivers. 16% would not call it an infliction for Policemen, single women or the rich. 15% would either not call it one from the prostitutes. The lowest percent of 1% is for those that would not call it a disease for anybody.
### Table 4.4. (b) Respondent level of education by anybody can get AIDS.

**HIV/AIDS is the disease of: Anybody can get it * Educational Level Crosstabulation**

<table>
<thead>
<tr>
<th>HIV/AIDS disease of: Anybody can get it</th>
<th>Educational Level</th>
<th></th>
<th></th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>None</td>
<td>Primary</td>
<td>Secondary</td>
<td>College</td>
<td></td>
</tr>
<tr>
<td>Missing</td>
<td>9</td>
<td>15</td>
<td>36</td>
<td>17</td>
<td>77</td>
</tr>
<tr>
<td></td>
<td>11.7%</td>
<td>19.5%</td>
<td>46.8%</td>
<td>22.1%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Anybody can get it</td>
<td>4</td>
<td>1</td>
<td></td>
<td></td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>80.0%</td>
<td>20.0%</td>
<td></td>
<td></td>
<td>100.0%</td>
</tr>
<tr>
<td>Total</td>
<td>9</td>
<td>19</td>
<td>37</td>
<td>17</td>
<td>82</td>
</tr>
<tr>
<td></td>
<td>11.0%</td>
<td>23.2%</td>
<td>45.1%</td>
<td>20.7%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

The table above shows 80% of the women who thought that HIV is a disease that anybody can get, have primary level education while 20% are educated up to secondary level.
4.2.5 Research question five. How do you protect yourself from re-infection?

The respondent states the protective measures she uses to prevent re-infection.

The data to this question is found on figure 4.5 (a).

Figure 4.5. (a) Percentage distribution of respondents by use of preventive method

In order to prevent further infection on HIV/AIDS, most women 81% would abstain from sex. 68% would use a condom and 49% prefer remaining faithful to their sexual partners. While 18% would use the withdrawal method, 11% saw prayer as the ideal method of preventing further infections.
Table 4.5 (b) tabulates level of education against use of protective measures.

<table>
<thead>
<tr>
<th>Level of education</th>
<th>Use of protective measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>9</td>
</tr>
<tr>
<td>Primary</td>
<td>17</td>
</tr>
<tr>
<td>Secondary</td>
<td>19</td>
</tr>
<tr>
<td>College</td>
<td>37</td>
</tr>
</tbody>
</table>
4.2.6 Research questions six. Would be free to talk about HIV/AIDS.

The information to this question gives the respondent who would be free to talk about HIV/AIDS. Figure 4.6. (a) gives the percentage distribution of those who talk freely about HIV/AIDS.

4.2.4 Ever discussed HIV/AIDS

![Ever Discussed HIV/AIDS](image)

Table 4.6 (b) Percentage distribution of respondent’s religion by ever discussed HIV.

<table>
<thead>
<tr>
<th>Whats your religion?</th>
<th>Have you ever discussed HIV/AIDS</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Christian</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>28</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>50.9%</td>
<td>49.1%</td>
</tr>
<tr>
<td>Muslim</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>44.4%</td>
<td>55.6%</td>
</tr>
<tr>
<td>Traditional</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>25.0%</td>
<td>75.0%</td>
</tr>
<tr>
<td>None of the above</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>50.0%</td>
<td>50.0%</td>
</tr>
<tr>
<td>Total</td>
<td>38</td>
<td>41</td>
</tr>
<tr>
<td></td>
<td>48.1%</td>
<td>51.9%</td>
</tr>
</tbody>
</table>

It is seen that 51% of Christian women have discussed HIV with their spouses, while 44% of Muslims have. For women subscribing to traditional religion only 25% of them have discussed the virus with their spouses.
4.3.0. Statistical analysis

Statistical analysis was done to test if there were any significant differences in the various variables. Chi-square was used to anlayse the relationship between variables.

4.3.1. Major problems experienced by women living with HIV/AIDS.

\( H_0 \) There is no significant relationship between problems experienced and marital status.

The results of testing this hypothesis are shown in table 4.7 below.

**Table 4.7 Chi-square value for marital status and problems experienced**

<table>
<thead>
<tr>
<th>Observed N</th>
<th>Expected N</th>
<th>( x^2 )</th>
<th>df</th>
<th>Asymp.sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>82</td>
<td>20.3</td>
<td>48.4</td>
<td>3</td>
<td>0.000</td>
</tr>
</tbody>
</table>

Table 4.7 analysis reviews that \( P<0.05 \) where \( x^2 \) is (48.4, df= 3) the difference was significant meaning that the single women experience more problems compared to the married they have no one to take care of them. The tabulated chi-square value is 8.3. Therefore the null hypothesis is accepted.

4.3.2 Women discriminated against

\( H_0 \) There is no significant difference between discrimination and place of discrimination.

The results of testing this hypothesis are in table 4.8

**Table 4.8 Chi-square for place of discrimination.**

<table>
<thead>
<tr>
<th>Observed N</th>
<th>Expected N</th>
<th>( x^2 )</th>
<th>df</th>
<th>Asymp.sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>82</td>
<td>75</td>
<td>58.7</td>
<td>4</td>
<td>0.000</td>
</tr>
</tbody>
</table>
Table 4.8 analysis reviews that P<0.05 where $x^2$ is (58.7, df= 4) the difference was not significant meaning that discrimination was same at home, work place, neighborhood and hospital. Therefore the chi-square value was 10.5. The null hypothesis was accepted.

**4.3.3 Dissatisfaction with the effort of the government**

$H_{03}$ There is no significant relationship between the efforts of the government to assist the HIV infected women and by reason of dissatisfaction. The results of the analysis can be seen in the table 4.9.

**Table 4.9 Chi-square for dissatisfaction with the effort of the government by reason**

<table>
<thead>
<tr>
<th>Observed N</th>
<th>Expected N</th>
<th>$x^2$</th>
<th>df</th>
<th>Asymp.sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>82</td>
<td>41</td>
<td>78.7</td>
<td>4</td>
<td>0.000</td>
</tr>
</tbody>
</table>

Table 4.9 analysis reviews that P<0.05 where $x^2$ is (78.7, df= 4) the difference was not significant. The tabulated chi-square value was 13.2. The null hypothesis was rejected.

**4.3.4 HIV/AIDS by definition**

$H_{04}$ There is no significant relationship between level of education that anybody can get HIV/AID. The results of the analysis can be seen in the table 4.10 below.

**Table 4.10 Chi-square value for influence of education by definition of AIDS**

<table>
<thead>
<tr>
<th>Observed N</th>
<th>Expected N</th>
<th>$x^2$</th>
<th>df</th>
<th>Asymp.sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>82</td>
<td>20.5</td>
<td>16.5</td>
<td>3</td>
<td>0.000</td>
</tr>
</tbody>
</table>
Table 4.10 analysis reviews that $P<0.05$ where $x^2$ is $16.5$, df $= 3$. The tabulated chi-square value was 11.5. The null hypothesis was rejected.

### 4.3.5 Women who use protective measures to prevent further re-infection

$H_{05}$ There is no significant difference between level of education and use of protective measures to prevent further re-infection. The results of the analysis can be seen in the table 4.11 below.

**Table 4.11 Chi-square for value for influence of education on use of protective methods**

<table>
<thead>
<tr>
<th>Observed N</th>
<th>Expected N</th>
<th>$x^2$</th>
<th>df</th>
<th>Asymp.sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>82</td>
<td>20.5</td>
<td>20.4</td>
<td>6</td>
<td>0.000</td>
</tr>
</tbody>
</table>

Table 4.11 analysis reviews that $P<0.05$ where $x^2$ is $20.4$, df $= 6$ the difference was not significant. The tabulated chi-square value was 16.4. The null hypothesis was rejected.

### 4.3.6 Women who discuss freely about HIV/AIDS.

$H_{06}$ There is no significant relationship between religion and discussing freely on HIV/AIDS. The results of the analysis can be seen in the table 4.12

**Table 4.12 Chi-square value for influence of religion on discussion of HIV/AIDS**

<table>
<thead>
<tr>
<th>Observed N</th>
<th>Expected N</th>
<th>$x^2$</th>
<th>df</th>
<th>Asymp.sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>82</td>
<td>40.0</td>
<td>95.1</td>
<td>5</td>
<td>0.000</td>
</tr>
</tbody>
</table>
Table 4.12 analysis reviews that $P<0.05$ where $x^2$ is $(95.1, \text{df}=5)$ the difference was statistically significant meaning that there are other factors in play. The tabulated chi-square value was 11.25. The null hypothesis was rejected.
5.0.0. Introduction

In this chapter the findings of the study are discussed and interpreted. It also includes the recommendations to the stakeholders and other arms of government on what they should do to eliminate the problems facing women infected by HIV/AIDS virus.

5.1.0. Discussion

Discussions of the findings of the study follow the major research questions in the order presented in chapter one and chapter four.

Research question one: what are the major problems you have been faced with since you got infected with HIV/AIDS?

Figure 4.1 (a & b) summarises the women’s response to this question, while figure 4.1. (c) summarises the problems faced by marital status.

This question aimed at exploring the major problems experienced by HIV/AIDS infected women. The results show that there were relatively many problems women undergo figure 4.1 a and (b) showed that 61% of HIV infected women had financial difficulties while a similar proportion lack proper food. 54% experienced loneliness while 52% faced rejection and 48% lacked access to drugs and medical attention.
Financial constraints is the leading which brings other implications such as lack of food, lack of drugs and dropout of school for the children of the sick.

A 1992 study (forsyle) estimated that the cost of hospital care for AIDS patients averaged about Kshs. 272,000/= during the course of their illness. If this expenditure rate remains constant then the total hospital cost would increase to 5,400,000 million shillings by 2005. Most of these drugs required for the infected are too expensive for the common man.

More so 35% of the women had health problems. 17% lost their jobs and 10% had depression and stress related problems. Women who had problems of low esteem and lacked shelter were 9% in each category. 6% had broken marriages. Women who said that they lost hope in life and pitied themselves were 4%.

The chi-square value 13.2 is showing that marital status influences discriminating hence a significant relationship.

Figure 4.1 (c) revealed that the problem of reflection and inadequate access to medical care evenly distributed within the marital status. The bars generally indicate that single women are mostly hit by depression, loneliness, discrimination and loss of jobs.
Other findings indicated in figure 4.1 (d) show that problems of rejection, loneliness and financial were most prevalent amongst the women that have lived with the virus for more than 3 years. 65% of women who lacked basic needs have lived with the virus for more than 3 years. Poor health sets in as from the second year. It's evidenced from the figure 4.1 (d) that people in their first year have for less problems. Majority of women feel that they should be provided with nutritious food as well as be educated on nutrition. They should be empowered to grow crops or do business instead of relying on food handouts. Provisions of freed drugs as a form of health assistance is a priority. These drugs should be available and affordable for all.
Research question two: Have you ever been discriminated against?

Table 4.2(a) gives the response on women discriminated against.

Table 4.2 (b) gives the response of women on discrimination by age group. While figure 4.2 (b) presents place of discrimination.

The question aimed at determining whether HIV infected women have been discriminated against. The results show that 93% of women have been discriminated against because of living with the virus while 7% have not been discriminated at all.

Unpublished thesis by Hussein W.A. (2003) found that HIV/AIDS positive people faces a lot of discrimination. Further research by Solomon C.J. 2003 found that ordinary people in the society have a negative attitude towards the sick. This brings a lot of psychological distress.

The single women feel that they are discriminated most and called names. Discrimination is most felt in the neighbourhood where one is isolated and loses most friends.

The findings are that younger respondents feel more discriminated. However all age groups reported high percentage of discrimination. Further information is revealed by fig. 4.2 (b). It shows the percentage distribution of respondents by place of discrimination.
Figure 4.2 (b) show that 78% of women feel most discriminated in the neighbourhood while 76% are those discriminated in the hospital surprising a high percentage of 71% was reported to take place at home and 56% faced discrimination at their work places.

The chi-square is 8.3 that shows there is no significant relationship between discrimination and place of discrimination.
Research question three. In your opinion do you think the government is doing enough to take care of the sick?

Table 4.3 a shows the responses by on women on whether the government is doing enough.

The results show that 60% of HIV infected women are dissatisfied with the government's efforts in assisting the sick while 40% are satisfied.

Further information is given on Table 4.3 (b) on reasons for dissatisfaction with the government. 16% of the respondent had the opinion that the government was not doing enough to help the HIV/AIDS patients because they were not provided with free ARVS. 12% of the women said that government efforts were not enough because there was a shortage of drugs, and 11% were of the opinion that grassroots people never got the much deserved support and assistance. Women who expressed concern that resources meant for assisting PWHA were being diverted or misused were 5%, and 4% doubted the government efforts on preventive measures because infection rates were still high. A slim minority (1%) said that there was rampant discrimination at government hospitals to people infected with HIV/AIDS.

The chi-square test table 4.9 reveals that there was no significant difference between people's dissatisfaction with the efforts of the government in eradicating HIV/AIDS. It is important to note that people are suffering silently with no one to turn to. HIV/AIDS has become an individual problem where change of behaviour is of paramount important. The donors may do very little.
Research question four. Do you think HIV/AIDS is a disease for the immoral and unfaithful people? Give reasons for your answer.

Table 4.4 (a) responses to this question while table 4.4 (b) presents the distribution of responses by level of Education that anyone can get HIV/AIDS.

It is evidenced from figure 4.4 (a) that 18% of the women would not define HIV as a disease of truck drivers, 15% would also not call it one for the prostitutes. 16% would not call it an infection for policemen, single women or the rich. The lowest percent of 1% is for those that would not call it a disease for anybody. Further information is tabulated on table 4.4 (b) that gives the respondents’ level of education by anyone can get AIDS.

The table showed 80% of the women who thought that HIV is a disease that anybody can get have primary level education while 20% are educated up to secondary level.

The chi-square value of 11.5 signifies a very significant relationship between Educational level and the belief that HIV/AIDS is a disease that anybody can get.

Those who are ignorant may have the belief that the disease is for the unfaithful and immoral but there are a number of women who are faithful to their spouse and get infected in one way or another. It is no wonder that the sick are looked down upon and humiliated by the healthy population.
Education enables one to relate well with others hence harmony in the society. There are others who are educated but behave in a primitive manner. The sick need to be loved, cared for, counselling and treated as human beings. This will make them live longer.

Those that are humiliated suffer low self esteem. They go to a state of denial and some even attempt committing suicide. Many homes have broken as a result of the virus. The couples blame one another and differ a great deal. Some become so frustrated that they are never seen home again. Marital problems may make one become unfaithful hence bring problems to the innocent spouse. The secret is to try and strengthen the marriage bond. By so doing each party will fulfil the others' needs hence no need to have extramarital affairs.
Research question five. How do you protect yourself from re-infection.

Figure 4.5 (a) (b) shows the women's protective measures that they use to prevent re-infection.

In order to prevent further infection women use different techniques. Most women 82% would use condom and 49% prefer remaining faithful to their sexual partners while 18% would use withdrawal method, 11% say prayers as ideal method of preventing further infections.

The chi-square value of 16.4 signifies that education level is significant as far as deciding on what method to use.

Majority of women are very sorry about their illness and would do anything possible within their reach to avoid re-infection.

The educated will stand firm and say no to dangerous sexual demands. Indeed many marriage are breaking up as mentioned earlier especially where one party is continuously unfaithful women have run away for their dear lives where marriage is not workable. Women and girls are endangered species and needs to be protected. They should be educated on how to protect their rights.

A majority of women are still sexually active either with their spouses, boyfriends. A great number who do not know the status of their partners use
protection. But there is also an unfortunate lot that engage in unprotected sex with partners whose status they don’t know. This is the unfortunate lot that could knowingly infected other people. Condom is the most popular protection method used by women who engage in sex. However other lost value of sex due to frustrations and have chosen to refrain from it. Others don’t even want risk infecting other people hence keep off. There is a group of women too whose health cannot allow therefore they forget about sex all together. They become very cold and withdrawn.
Research questions six. Would you be free to talk on HIV/AIDS?

Figure 4.6 (a) shows the percentage distribution of those who talk freely about HIV/AIDS?

Further information tabulated on table 4.6 (b) showing the respondents religion by discussion on HIV/AIDS. It is evidenced on figure 4.6 (a) that 52% of women talk freely about HIV/AIDS while 48% would rather not discuss it.

Table 4.6 (b) showed that 51% of Christians have discussed HIV/AIDS. 44% of Muslims have and 25% of traditional believers have also discussed AIDS. Table 4.1.2 chi-square value is 11.25 shows that religion plays a key role in enabling people to talk freely. The Muslims are silent while the Christians speak without fear.
5.2.0. **Summary and conclusions**

This study was aimed at exploring the problems facing HIV infected women and to discuss the implications for counselling.

The key issues explored are:-

(i) Major problems experienced by women living with HIV/AIDS.
(ii) Women discriminated against.
(iii) The effort of the government to assist the HIV positive women.
(iv) The true definition of HIV/AIDS.
(v) The true definition of HIV/AIDS.
(vi) Protective measures from re-infections.
(vii) Free talk on HIV/AIDS.

The study has found out that:-

(i) Financial constrains is the major problems the HIV infected women experience.
(ii) Discrimination is highest among the single women and most felt in the neighbourhood.
(iii) The majority of women are dissatisfied with the government's effort to help the infected.
(iv) HIV/AIDS is a disease anyone can have.
(v) Most women use protective measures from the re-infections.
(vi) A group of women would be free to discuss AIDS.
Based on the study the researcher therefore arrived at the following conclusions.

(i) That the rate of women being infected with HIV/AIDS virus is high. They experience many problems despite the talk on HIV/AIDS.

(ii) That discrimination is highest in the neighbourhood. This results to a lot of stress amongst the infected.

(iii) The government is doing very little as far as arresting the deadly disease is concern. Many people are dissatisfied with the government effort.

(iv) That the women feel that they should be taken care of medically, provided with basic needs and accepted in the society.

(v) The educated women feel that HIV/AIDS is a disease like any other.

(vi) That most women use protective measures to prevent infection.

(vii) That the majority of women would be free to talk about HIV/AIDS.
5.3.0. Counselling implications

Important implications arise from the findings of this study. It's clear that HIV/AIDS is on the increase. The infected are suffering economically, psychologically as well as physically. The infected need medication which is a nightmare to the poor and have no source of income. From the study it is evidenced that the majority of women rely on well wishers to finance the medical bills others are small scale business women. The little they earn cannot sustain all the projects. Instead something should be done pretty first to arrest the HIV/AIDS pandemic. The sick should be done the necessary assistance so that they don't feel neglected.

The infected should be assisted to start up sustainable projects so that they can meet their medical bills and other basic needs.

Furthermore, people should be counselled on how to treat the sick. The infected and affected are discriminated upon even by their blood relatives. They should be shown love and appreciation so that they don't suffer from low self esteem.

They should be made to understand that HIV/AIDS is a National disaster that affects all citizens directly or indirectly. It is our responsibility therefore to try and arrest the pandemic.
It is of great significance to educate the masses on good morals. People should change the behaviour and practice safe sex. Women should also be advised to negotiate for safe sex with their spouses. Condom use should be advocated for even for sick to prevent further infection. The married should be faithful to the partners in order to avoid many sexual partners.

It is clear that the young teenagers engage in sex very early hence risk to HIV/AIDS infection. They should be advised to practice abstinence as they say, “The love waits.” Early sex experience will risk one being infected with sexual transmitted disease hence become vulnerably to HIV/AIDS infections. Peer counselling should be strengthened in schools youth seminars and churches on the moral ways of living. Hence we shall have a healthy nation.

The government and other stakeholders should ensure that the funds meant for HIV/AIDS victims is well utilised. Those given the responsibility to handle the funds should be trust worth people. They should be educated on how to manage the resources and be accountable to every shilling they receive. The funds should not be given discriminatly. Every person should be recognised depending on the needs. A part from the sick, many children are orphaned with no one to take care of them.
These children lack the proper care and supervision they need at this critical period of their lives. Many grandparents are left to care for the young children. Those who have nobody to guide them results to the streets to make heads meet (Okeyo, 1992).

Parents should be free to talk about AIDS to their children as early as possible. They should guide the children towards the right direction. Moreso they should set good examples to their children so that the young can learn from them. Where the parents have an unstable relationship the children are likely to fall astray. Its advisable therefore for the parents to be role models to their children. Guide/counsel them on boy/girl relationship so that they learn to respect their bodies.

The gospel on HIV/AIDS should be extended to the rural and slum areas where people are ignorant. They should be advised on how to promote safe sex and avoid wife inheritance. Women should be able to say no to primitive traditional demands that would risk their lives. Cultural practices should be upheld but not that those that threaten human race.

The study found out that the HIV/AIDS infections are higher in the slum areas. This is because there is a lot of commercial sex in practice. Poverty has made things worse for the women seek sexual favours in exchange of gifts or other...
vulnerable. Counselling should be doubled to the slums where poverty is rampered. Most of the slum dwellers are single women with many children who do not attend school due to illness financial difficulties or family responsibility. If attention is not given to the slums the battle is far from over.

The HIV positive women should be advised to accept their status and live positively. They should be urged to join PLWHA organisations, also engage in economic activities.

They need also be educated on eating balanced diet in order to improve their immune system. Its also important to attend seminars and workshops to share ones experience with others.

5.4.0 Recommendations for counselling

In view of the foregoing findings and conclusions, it is recommended that:-

(i) Addressing the problems affecting the HIV/AIDS victims in a more serious manner. This would reduce their stress and depression. They problems are financed problems, rejection, poor health and discrimination.

(ii) The community should be advised not to reject the sick instead shown them love and appreciation.

(iii) Women used to educated on how to negotiate for safe sex. For example use of condom, abstinence and faithfulness. This would lower the HIV infection cases.
(iv) The young girls should be guided on abstinence and avoid early sex experiences.

(v) The HIV infected women should be encouraged to live positive lives and be productive.

(vi) Knowledge on HIV/AIDS should be given to all, extended to the rural areas and slums where HIV/AIDS is rampered.

(vii) ARV drugs should be made available in local dispensaries and district hospitals for all people.

(viii) People should be encouraged to talk freely about HIV/AIDS. These go beyond the traditional and religious bonds.

5.5.0 Recommendations for further research

1. Further research on knowledge on home based care of HIV/AIDS patient could be of great importance.

2. This study was done on problems facing HIV positive women further research is necessary on problems facing HIV infected men to compare the facts with the current study.
APPENDIX 1

QUESTIONNAIRE

I would like to investigate on problems of HIV infected women. Please go through all the statements carefully and give your frank and honest response. I assure you that the information given by you will be kept confidential and shall be used for research purpose only.

SECTION A
Answer the following questionnaires to the best of your knowledge circle the alphabet where you fit best.

Q1. How old are you?
   A. 13 - 15
   B. 19 - 21
   C. 22 - 29
   D. Above 29

2. How far did you go in terms of Education?
   A. None
   B. Primary
   C. Secondary
   D. College

3. What is your marital status?
   A. Married
   B. Single
   C. Windowed
   D. Divorced

4. Where do you live?
   A. Dallas
   B. Majengo
   C. Blue valley
   D. Itabua

5. How long have you lived with HIV?
   A. 1 year
   B. 2 years
   C. 3 years
   D. above 3 years
6. What is your religion?
   A. Christian
   B. Muslim
   C. Traditionalist
   D. None of the above

7. How often do visitors come to visit you?

<table>
<thead>
<tr>
<th>Visitors</th>
<th>Daily</th>
<th>Weekly</th>
<th>Monthly</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relatives</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friends</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neighbours</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religious groups</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical personnel</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Volunteers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others (specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
SECTION B
Read the statement below and decide how much you agree or disagree with the statement. You can express your opinion where necessary.

Q1. Do you have children?
Yes ( )
No ( )

Q2 (a) Have you ever been discriminated against?
Yes ( )
No ( )

(b) If so, where? (Tick as many as appropriate)
(i) Working place
(ii) Home
(iii) Hospital
(iv) Neighbourhood

Q3(a) Do you have school going children who don’t attend school?
Yes ( )
No ( )

(b) How many are they?
Boys ( )
Girls ( )

(c) Reasons they don’t attend school, if so.
(i) Medical problem ( )
(ii) Financial problem ( )
(iii) Responsibility ( )
(iv) Distance from the school ( )
(v) Other reasons (specify)

Q4(a) Are there any children in the household who work as a form of earning income?
Yes ( )
No ( )

(b) If yes, what kind of occupation

<table>
<thead>
<tr>
<th>Child</th>
<th>Gender</th>
<th>Age</th>
<th>Occupation</th>
</tr>
</thead>
</table>

Q5 What do you think should be done to help HIV-infected women in terms of the following
1. Food
2. Health

3. Social

4. Others

Q6 Have you ever discussed HIV/AIDS with your spouse?
Yes ( )
No ( )

If yes, what did you discuss

Q7 Would you be free to talk about AIDS?
Yes ( )
No ( )

Give reasons to your answer

Q8 State the key problems you have been faced with since you got infected.
1.
2.
3.
4.
5.
6.
7.

Q9 What do you do for a living?
(1) Business ( )
(2) Peasant farmer ( )
(3) Any other, please specify
Q10. Do you do your day chores throughout the week or yearly without a break?


Q11. In your opinion do you thin the government is doing enough to take care of the sick (HIV/AIDS)?


If no, give reasons.


Q12. Have religious leaders, politicians and other opinion leaders done something to AIDS patients?


Q13. In your opinion should women be tested for HIV/AIDS before marriage.
   Yes (   )
   No (   )

Q14. How do you prevent yourself from further infections? Tick as many as possible.
   1. Use of condom
   2. Abstinence
   3. Being faithful to my partner
   4. Praying
   5. Withdrawal method
   6. None of the above
Q15. What did you do when you realized you are HIV positive

Q16. Who takes care of you when you are in bad shape?
(a) Children (  )
(b) Neighbours (  )
(c) Spouses (  )
(d) Relatives (  )
(e) Friends (  )

Q17. Do you blame anybody for your illness?
Yes (  )
No (  )
If yes whom and why?

Q18. Do you have sexual relationship with anybody today?
Yes (  )
No (  )
If yes (i) who? (ii) How often?

(iii) Is he HIV positive or not

(iv) Do you use preventive measures
Yes (  )
No (  )
If yes which one,
Q19. What advice could you give to the following group of people
1. Widowed
2. Orphaned children
3. HIV patients
4. Rejected
5. Those with multiple partners
6. Those intending to marry
7. Single women
8. HIV carriers

Q20. HIV/AIDS is the disease for the following
(Tick only five incorrect answers)
1. The rich
2. The prostitutes
3. Track drivers
4. Policemen
5. Single women
6. Married women
7. Anybody can contact it
8. The unfaithful
9. The widowed
## APPENDIX 2

### BUDGET FOR THE STUDY

1. **STATIONERY**
   - Printing papers: 2,000 Kshs.
   - Pens: 100 Kshs.
   - Writing materials: 1,000 Kshs.

2. **SECRETARIAL SERVICES**
   - Typing of proposal: 2,000 Kshs.
   - Typing of final report: 4,000 Kshs.
   - Photocopying: 1,000 Kshs.

3. **TRAVELLING EXPENSES**
   - Piloting: 5,000 Kshs.
   - Actual survey: 15,000 Kshs.

4. **BINDING EXPENSES**
   - Binding proposal: 1,000 Kshs.
   - Binding final report: 4,000 Kshs.

5. **Computer services**: 10,000 Kshs.

6. **Miscellaneous**: 10,000 Kshs.
   - **TOTAL**: 55,100 Kshs.
### APPENDIX 3

#### PLAN AND SCHEDULE OF ACTIVITIES

<table>
<thead>
<tr>
<th>ACTIVITIES</th>
<th>Jan</th>
<th>Feb</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proposal writing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proposal submission</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plot study</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Actual field study</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data analysis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compilation of the report</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Submission of the report</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
REFERENCES


Government report


AIDSCAP, (1997). Women’s initiative: The female condom, from research to the market place. FHIAIDS CAP.


Unpublished Thesis

Unpublished Thesis

Unpublished Thesis

Journal article

Journal article

Newspaper article


Government report


Government report