

**IMPEDIMENTS TO WOMEN'S ECONOMIC EMPOWERMENT
IN MITIGATING THEIR VULNERABILITY TO HIV/AIDS IN
LOWER NYAKACH DIVISION, KISUMU COUNTY**


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**A RESEARCH PROJECT REPORT SUBMITTED IN PARTIAL FULFILLMENT FOR
THE REQUIREMENTS OF A MASTER OF ARTS DEGREE IN PROJECT PLANNING
AND MANAGEMENT OF THE UNIVERSITY OF NAIROBI**

2012

DECLARATION

This research project is my original work and it has never been submitted for a degree or any award at any university.

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DEDICATION

I dedicate this research project to my late father Paul. It would have been my utmost joy to have you share this pride of furthering my education with me. Thanks for making me know the importance of education. I also dedicate this research project proposal to my husband Moses, thank you for your unselfish support throughout.

ACKNOWLEDGEMENT

The work done here would not have been successful without the assistance of The University of Nairobi academic department. I am deeply indebted to my lecturers in the department of Extra mural Studies at Kisumu campus including Prof. Omolo Ongati, Dr. Charles Rambo, Dr Paul Odundo, Dr. Raphael Nyonje, Dr. Maria Onyango, Dr. Ouru Nyaega, Mr. William Nyaoro and Mr. Michael Ochieng for their academic lectures while undertaking this course. My profound gratitude goes to my supervisors Prof. Omolo Ongati and Ms. Lena Kirop for their unselfish time, support and guidance they offered me during the formulation and development of this Research Project.

Other very special and profound gratitude go to my husband Moses and my Children Anita and Leona, who have been very supportive and patient throughout the development of this document. To my dear friends Percilla, Joyce and Vivian, I say thanks for always taking your time to support me morally. To my mother, brothers and sisters, thank you so much for making me see the light and realize the importance of education. I also say thanks to my baby nurse Rose who ensured the babies were comfortable when I was studying.

I would also wish to acknowledge the support received from the National Centre for Science and Technology for authorization to undertake the research in Lower Nyakach Division. I would also wish to acknowledge the District Commissioner and the District Education Officer for giving me the green light to undertake the research in Lower Nyakach Division. Lastly, but certainly not least, I would also like to thank the 201 Lower Nyakach women who were involved in the questionnaire response. I also thank the 10 opinion leaders and 10 CBO leaders for taking their time to participate in their depth interview. Lastly, I would like to thank everyone who may have taken part in this Research Project in one way or another. All your efforts are highly appreciated.

TABLE OF CONTENT

	Page
DECLARATION.....	ii
DEDICATION.....	iii
ACKNOWLEDGEMENT.....	iv
TABLE OF CONTENT.....	v
LIST OF FIGURES.....	x
LIST OF TABLES.....	xi
ACRONYMS AND ABBREVIATION.....	xiii
ABSTRACT.....	xv
CHAPTER ONE	
INTRODUCTION.....	1
1.1 Background of the study.....	1
1.2 Statement of the Problem.....	5
1.3 Purpose of the study.....	5
1.4 Objectives of the study.....	7
1.5 Research questions.....	7
1.6 Significance of the study.....	8
1.7 Basic assumptions of the study.....	9
1.8 Limitations of the study.....	9
1.9 Delimitations of the study.....	9
1.10 Definition of significant terms used in the study.....	10
1.11 Organization of the study.....	10

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CHAPTER TWO

LITERATUREREVIEW.....	12
2.1 Introduction.....	12
2.2 Family status and women’s economic empowerment and vulnerability.....	12
2.3 Women’s economic status and vulnerability to HIV/AIDS.....	15
2.4 Culture and women’s economic empowerment and vulnerability to HIV/AIDS...	19
2.5 Sensitization, training and women’s economic empowerment and Vulnerability to HIV/AIDS.....	24
2.6 Theoretical Framework.....	27
2.7 Conceptual Framework.....	29
2.8 Existing knowledge gap.....	32
2.9 Summary of Literature Review.....	32

CHAPTER THREE

RESEARCHMETHODOLOGY.....	34
3.1 Introduction.....	34
3.2 Research Design.....	34
3.3 Target Population.....	34
3.4 Sample Size and Sample Technique.....	35
3.4.1 Sample Size.....	35
3.4.2 Sampling Technique.....	35
3.5 Research Instrument.....	39
3.5.1 Piloting of the Study.....	39
3.5.2 Validity of the Research Instrument.....	40

3.5.3 Reliability of the Research Instrument.....	40
3.6 Data Collection Procedure.....	41
3.7 Data Analysis Technique.....	41
3.8 Ethical Consideration.....	42

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION, INTERPRETATION AND DISCUSSION

4.1 Introduction	43
4.2 Questionnaire return rate	43
4.3 Demographic characteristics of the respondents	43
4.3.1 Distribution of women respondents by age.....	44
4.3.2 Distribution of women respondents by level of education	45
4.3.3 Distribution of women respondents by marital status	46
4.4 Family status and economic empowerment in mitigating vulnerability to HIV/AIDS..	48
4.4.1 Household leadership and vulnerability to HIV/AIDS.....	48
4.4.2 Number of dependents and vulnerability to HIV/AIDS.....	49
4.4.3 Gender duties and vulnerability to HIV/AIDS.....	51
4.4.4 Women with HIV and how they are treated in the family	52
4.5 Economic status and empowerment in mitigating vulnerability to HIV/ AIDS.....	53
4.5.1 Occupation and vulnerability to HIV/AIDS.....	54
4.5.2 Monthly average income and vulnerability to HIV/AIDS.....	56
4.5.3. Provision of household basic needs and vulnerability to HIV/AIDS.....	57
4.5.4 Control of income and vulnerability to HIV/AIDS.....	58

4.5.5 The age group and vulnerability to HIV/AIDS	59
4.5.6 Availability of credit and vulnerability to HIV/AIDS.....	60
4.6 Cultural factors and economic empowerment in mitigating vulnerability to HIV/AIDS..	61
4.6.1 Ownership of property and vulnerability to HIV/AIDS.....	62
4.6.2 Decision making and vulnerability to HIV/AIDS.....	63
4.6.3 Negative cultural practices and vulnerability to HIV/AIDS.....	66
4.6.3.1 Polygamy and vulnerability to HIV/AIDS.....	67
4.6.3.2 Early Marriage and vulnerability to HIV/AIDS.....	68
4.6.3.3 Widow inheritance and vulnerability to HIV/AIDS.....	68
4.6.3.4 Taboos and vulnerability to HIV/AIDS.....	69
4.6.4 Gender roles and vulnerability to HIV/AIDS.....	70
4.7 Sensitization and training and economic empowerment in mitigating vulnerability to HIV/AIDS	71
4.7.1 Knowledge and vulnerability to HIV/AIDS.....	71
4.7.2 Sources of information and vulnerability to HIV/AIDS.....	72
4.7.2.1 Media and vulnerability to HIV/AIDS.....	73
4.7.2.2 Schools / Church and vulnerability to HIV/AIDS.....	74
4.7.2.3 Health facilities and vulnerability to HIV/AIDS.....	75
4.7.2.4 Friends and vulnerability to HIV/AIDS.....	75
4.7.3 Knowledge on ways of acquiring HIV/ AIDS.....	76
4.7.4 HIV/AIDS preventive measures and vulnerability.....	78
4.7.5 Female Condoms and vulnerability to HIV/AIDS.....	81
4.7.6 Level of knowledge of women on their vulnerability to HIV/AIDS	82

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATION

5.1. Introduction.....	84
5.2 Summary of findings	84
5.3 Conclusions	88
5.4 Recommendation for policy actions	91
5.5 Suggestions for further studies	93
5.6 Contribution to the body of knowledge.....	94
REFERENCES.....	95

APPENDICES

Appendix I: Letter of Transmittal	101
Appendix II: Letter Seeking Authority.....	102
Appendix III: Questionnaire for women.....	103
Appendix IV: Interview Guide for CBO Leaders.....	108
Appendix V: Interview Guide for Opinion Leaders.....	110
Appendix VI: Research Permit	112
Appendix VII: Research Authorization	113

LIST OF FIGURES

	Page
Figure 2.1 Conceptual Framework.....	29
.....	30
.....	31
.....	32
.....	33
.....	34
.....	35
.....	36
.....	37
.....	38
.....	39
.....	40
.....	41
.....	42
.....	43
.....	44
.....	45
.....	46
.....	47
.....	48
.....	49
.....	50
.....	51
.....	52
.....	53
.....	54
.....	55
.....	56
.....	57
.....	58
.....	59
.....	60
.....	61
.....	62
.....	63
.....	64
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.....	74
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.....	77
.....	78
.....	79
.....	80
.....	81
.....	82
.....	83
.....	84
.....	85
.....	86
.....	87
.....	88
.....	89
.....	90
.....	91
.....	92
.....	93
.....	94
.....	95
.....	96
.....	97
.....	98
.....	99
.....	100

LIST OF TABLES

	Page
3.1 Number of households sample size.....	38
4.1 Age brackets of the respondents	44
4.2 Highest level of education and vulnerability to HIV/AIDS	45
4.3 Distribution of women by marital status and vulnerability to HIV/AIDS	47
4.4 Household leadership and vulnerability to HIV/AIDS.....	49
4.5 Dependents per household and vulnerability to HIV/AIDS.....	50
4.6 Preparation of meals in households and vulnerability to HIV/AIDS	51
4.7 How women with HIV/AIDS are treated in the family	52
4.8 Occupation of the respondents and vulnerability to HIV/AIDS	54
4.9 Type of self-employment and vulnerability to HIV/AIDS	55
4.10 Monthly average income and vulnerability to HIV/AIDS	56
4.11 Provision of household basic needs and vulnerability to HIV/AIDS	57
4.12 Control of income and vulnerability to HIV/AIDS	58
4.13 Age group and vulnerability to HIV/AIDS.....	59
4.14 Availability of credit to women and vulnerability to HIV/AIDS	61
4.15 Ownership of property and herding of cattle and vulnerability to HIV/AIDS	62

4.16 Main decision maker in the household and vulnerability to HIV/AIDS	64
4.17 Autonomous decision making and vulnerability to HIV/AIDS	65
4.18 Negative cultural practices and vulnerability to HIV/AIDS	66
4.19 Gender roles and vulnerability to HIV/AIDS	70
4.20 Knowledge and vulnerability to HIV/AIDS	71
4.21 Sources of information and vulnerability to HIV/AIDS.....	73
4.22 Knowledge on transmission and vulnerability to HIV/AIDS	76
4.23 Knowledge on preventive measures and vulnerability to HIV/AIDS	78
4.24 Knowledge on female condoms and vulnerability to HIV/AIDS.....	81
4.25 Level of knowledge of women and their vulnerability to HIV/AIDS.....	82
5.1 Contribution to the body of knowledge	94

ABBREVIATIONS AND ACRONYMS

MDGs:	Millennium Development Goals
HIV:	Human Immunodeficiency Syndrome
AIDS:	Acquired Immune Deficiency Syndrome
UNAIDS:	Joint United Nations Programme on HIV/AIDS
UNIFEM:	United Nations Entity for Gender Equality
IFAD:	International Fund for Agricultural Development
UNDP:	United Nations Development Programme
NGOs:	Nongovernmental Organizations
KIHBS:	Kenya Integrated Household Budget Survey
USAID:	United States Agency for International Development
STI:	Sexually Transmitted Infections
ARV:	Antiretroviral Therapy
NASCOP:	National AIDS and STDs Control Programme
KDHS:	Kenya Demographic Health Survey
KNBS:	Kenya National Bureau of Statistics
CBO:	Community Based Organization
NACC:	National AIDS Control Council

VCT: Voluntary Counseling and Testing

PEP: Post Exposure Prophylaxis Therapy

ABSTRACT

Economic powerlessness poses major threats to mitigation of HIV/AIDS vulnerability among women in the world. As such, exploration of the relationship between economic powerlessness and HIV/AIDS vulnerability will be the focal point of this study. Through mainly the use of literature based research, studies have indicated how low economic status and disease, most specifically HIV/AIDS are related. Researchers globally have argued that there is ample evidence that the high and increasing vulnerability of women to HIV/AIDS is due to gender-based social and economic inequalities; sexual violence and inequality in access to prevention, education and training. Low economic status among women and dependence on men contribute to their inability to control the conditions such as condom use and multiple sexual partners. This shapes their risk of HIV infection and their high infection rates compared to men. The purpose of this study therefore was to investigate the impediments of women's economic empowerment in mitigating their vulnerability to HIV/AIDS in Lower Nyakach Division, Kisumu County. The study was carried out to fulfill four objectives, to establish extent to which family status impedes women's economic empowerment in mitigating vulnerability to HIV/AIDS; to investigate how economic status impedes women's economic empowerment in mitigating women's vulnerability to HIV/AIDS; to examine extent to which cultural factors impedes women's economic empowerment in mitigating vulnerability to HIV/AIDS and finally to assess how lack of sensitization and training impedes women's economic empowerment in mitigating vulnerability to HIV/AIDS. The study was limited by the fact that diversity of cultural background made it difficult to generalize findings to women in other parts of the country. The study was delimited by being confined to women in Lower Nyakach division. Literature was reviewed under the following sub themes: Family status and women's economic empowerment and vulnerability to HIV/AIDS, Economic status and vulnerability to HIV/AIDS, Cultural factors and economic empowerment and vulnerability to HIV/AIDS and lastly sensitization and training and economic empowerment and vulnerability to HIV/AIDS. The study adopted the relevant theoretical and conceptual frameworks which guided the researcher in determining variables. The descriptive design which involved qualitative and quantitative strategies to data collection was employed. 13,018 households were targeted for the study; a sample of 208 was identified using multi stage sampling method. Key informants were sampled purposively. Data was collected through focus group discussions and questionnaires as the main research instruments. The data was analyzed through frequencies and percentages presented in tables and discussed as per the literature reviewed in chapter two. A cross sectional research design was used to establish the findings and revealed that impediments to women's economic empowerment have contributed to vulnerability to HIV/AIDS. From the findings, 63.7% of the respondents reported that men are the household leaders hence key decision makers. Low economic status was very critical as it led to low level of education and knowledge. It was revealed that 51.7% of the respondents earned below kshs 5,000 while only 11.9% earned above kshs 15,000. Such low income rendered women powerless in negotiations for safe sex. 49.8% of the respondents reported that men solely owned property while 17.4% reported that women owned property. The study also revealed that negative cultural practices have subjected women to unsafe sexual behaviours. For instance, 58.7% reported that men were the main decision makers in households. 60.2% reported that condoms prevent HIV infection though they lack the final say on their use. The study concluded that low economic status impedes economic empowerment hence vulnerability to HIV/AIDS. Negative cultural practices subjected women to unsafe sexual practices. Low level of training and sensitization contributed to women's vulnerability to HIV/AIDS. The study recommended that women should be economically empowered through income generating schemes, a participatory approach to fight HIV/AIDS should be adopted and there is need for greater awareness regarding the need of knowing ones HIV status.

CHAPTER ONE

INTRODUCTION

1.1 Background of the study

Women's economic empowerment is a key development goal in itself, as asserted in international conventions and in the Millennium Development Goals (MDGs). There is also evidence that promoting women's economic empowerment can make a positive impact on the response to HIV/AIDS. In some regions, obstacles posed by unequal access to market information for example drive women into the informal economy with little access to social protection. This situation in turn increases the vulnerability to HIV/AIDS and hampers mitigation impacts (UNAIDS, 2010).

More than 30 million people are today living with HIV. Globally, women now account for half of all infections. Young women aged 15-25 are up to six times more likely to be HIV positive than young men of the same age. This is because women and girls often have less information about HIV and fewer resources to take preventive measures (Omutoko and Wambugu, 2010).

Women economic empowerment is a prerequisite for sustainable development, pro-poor growth and the achievement of all the MDGs. Economic empowerment increases women's access to economic resources and opportunities including jobs, financial services, property and other reproductive assets, skills development and market information. Women's economic empowerment is fundamental to strengthening women's rights and enabling women to have control over their lives and exert influence in society (Zoellick, 2010).

Ownership of land and property empowers women and provides income and security. Without resources such as land, women have limited say in household decision making, and no recourse to the assets during crises. This often relates to other vulnerabilities such as

HIV/AIDS. When women can find decent jobs, they earn incomes and accumulate savings to help themselves and their families. The pool of human resources, talents, and economic contributions expand, spurring productivity and growth (UNIFEM, 2008).

The HIV/AIDS epidemic is often described as “feminized epidemic”. The term refers to some features of the epidemiology, in that in many countries which are experiencing generalized epidemics, the numbers of women infected are significantly higher than the numbers of men. In most parts of Europe, North America, South America and Asia, the greatest burden of infection is among men. However in Sub-Saharan African countries, women now make up 57% of infections, with some 17 million women living with HIV at the end of 2003(UNAIDS, 2007).

In the United States, CDC (2009) statistics estimated that more than one million people were living with HIV, and more shockingly, one in five (21%) of those people living with HIV is unaware of their infection. However, despite increases in the total number of people living with HIV in the US in the recent years, the annual number of new infections has remained relatively stable. Though, new infections continue at far too high a level, with an estimated 56,300 Americans becoming infected with HIV every year. It is estimated that around 2.2 million people were living with HIV in Europe at the end of 2009. According to the report, adult HIV prevalence was estimated to vary below 0.1% in parts of Central Europe to above 1% in parts of the former Soviet Union(UNAIDS, 2010).

Most households in developing countries remain dependent on primitive agriculture. The typical fate of women is a demanding combination of unpaid subsistence farming and caring for an extended family. Beyond the rural economy, women’s livelihoods are predominantly in low paid, temporary and informal sectors. In Asia, there is a concentration of women’s labor at the bottom of the production chain in factories, many offering poor conditions of work. This pattern of occupational inequality stems from a culture of

discrimination which denies women access to the basic ingredients of economic status-education, land and decent work (IFAD, 2003).

According to the UNDP Human Development Report, women in Sub-Saharan Africa represent 52% of the total population, contribute approximately 75% of the agricultural work, and produce 60 to 80% of the food. Yet they earn only 10% of African incomes and own just 1% of the continent's assets. These numbers indicate the tremendous challenges women face on their road to equality. Despite efforts made by governments, NGOs and multilateral development agencies, the majority of women in developing world are still relegated to micro enterprises and informal tasks. Consequently, these women working in informal economies are likely to have less access to basic health care services, financial capital, employee rights and land ownership. However, there is wide consensus that investment in the economic empowerment of women can and will help reverse these trends (UNDP, 2001)

The impact of socio-economic conditions in Africa such as poverty, poor health services, ignorance, sexual violence and sexual conditioning on HIV exposure have spurred the spread of the pandemic. The United Nations AIDS Control Programme (2010) observes that there is a direct link between poverty and HIV and it forms a vicious circle in the national response to the pandemic and increasing poverty levels continue to fuel the spread of HIV. The pandemic itself exacerbates those levels in households and families with people living with HIV/AIDS. Those who can afford costly anti-AIDS drugs treatment prolong their lives, while the world's majority who are women, die in overwhelming numbers (Population Bureau, 2000).

In Southern Africa, young women are almost an endangered species of AIDS due to reasons such as lack of access to jobs and economic dependence on men and many may not have the power to resist sex. Among girls and young women, aged 12 to 24, low wealth is associated with earlier sexual debut, more sexual partners, lower likelihood of condom use, as

well as odds of non-consensual first female sexual experience and of having to trade sex for money, goods and services. Where the woman controlled her own income, HIV/AIDS prevalence rates were lower; but where her husband (or, infrequently, others) controlled her income, HIV/AIDS prevalence rates were higher (UNAIDS, 2009.)

In Northern Uganda, Circumstances of extreme poverty or conflict unquestionably fan the flames of violence against women and other forms of vulnerability. For example, sex trafficking flourishes in the region, where hardship weakens the natural bonds of family life, already eroded by traditional attitudes towards women. Rape has been rampant and the extent of such abuse may never be known, and perpetrators rarely called to account (IFAD, 2003)

There is no denying that Kenya has made great strides in fighting HIV/AIDS since the first case was diagnosed in 1984. Still the World's AIDS Day in 2011 comes with some disturbing data. The disease continues to have a hugely feminine face. Today, HIV/AIDS prevalence among females aged 15-49 stands at 8%, compared to 5% for males in the same age bracket. One of the reasons behind this is, female condom remains inaccessible due to its high cost and limited number available for free in government hospitals (Odinga, 2011).

The Human Development Report for Kenya 2001 indicates that women in Kenya are more likely to be unemployed than men and even when they are employed; they earn less than men on average. Thus a combination of high level of poverty and the HIV/AIDS pandemic exerts an immeasurable toll on women. Nyanza region in particular records the highest number of women infected with HIV/AIDS. Some of the reasons behind this include cultural practices such as widow inheritance and the denial of their fundamental rights to property ownership which make women suffer adversely from poverty, violence and disease (National Aids Control Council, 2010). Lower Nyakach, one of the Divisions in Nyanza province may not be an exception. Women have less access than men to resources and limited enjoyment of socially valued goods, opportunities and rewards. The inferior position of

women in society especially within marriage is a major issue of concern in the Division. Traditional ownership and inheritance patterns continue to marginalize women and girls and prevent them from having access to and gaining control of productive resources such as land. In addition, the traditional division of labor overburdens women and blocks them from positions of power and influence (Nyando District Development Plan, 2010).

It is against this backdrop that this research endeavors to contribute to an intellectual understanding of impediments to women's economic empowerment in mitigating their vulnerability to HIV/AIDS in Lower Nyakach Division.

1.2 Statement of the problem

Women's economic status and HIV/AIDS have been linked in a cause and effect relationship (UNAIDS, 2010), which leads to the assumption that by improving women's economic status, it is possible to reduce HIV/AIDS. While this is a reasonable assumption, this may not have been studied in Lower Nyakach Division, especially in relation to economic development initiatives directed towards reducing vulnerability among women. The Kenya Integrated Household Budget Survey (KIHBS, 2008) collected detailed information, revealed higher incidences of illness among female in Western and Nyanza regions which leads to low income generation since few women would engage in productive activities.

Families headed by females may use sexual networking in order to satisfy family needs and this exposes them to the risk of contracting HIV/AIDS. Number of dependents in a family may increase vulnerability to HIV/AIDS because if the number is so big that the family cannot take care of then it calls for sending others to other relatives and in cases where they are school going then they are forced to drop out of school and this contributes negatively on the children especially girls who may be subjected to early marriage hence exposure to the risky environment. Women who are not economically empowered may not determine the number of children that they wish to have because of their low bargaining

power in the family. In terms of division of labor, women in rural areas have the burden of fetching water, cutting firewood, going to the farm, taking care of the children and preparing family meals. This leaves them with very little time to take part in productive activities.

Low economic status increases vulnerability to HIV/AIDS because women, who are not economically empowered, suffer the greatest burden of sexual ill health. When they depend on men for their economic security, they are less able to demand safer sex fearing abandonment and violence. Cultural factors also influence women's vulnerability to HIV/AIDS because women's property rights are limited by norms and customs, hampering their economic empowerment. Cultural practices such as widow inheritance have increased women's vulnerability because widows have no rights to choose whether they want to be inherited or not. Roles and responsibilities are also determined traditionally and in many cases, women are assigned roles that confine them to their homes and are not economically productive. This contributes to the risk of HIV infection since economic powerlessness motivates their participation in risky sexual practices.

Sensitization and training increases women's knowledge and awareness concerning preventive measures against HIV related infections. Lack of awareness has made women remain behind in anti AIDS campaigns. Further, stigma and fear of discrimination as a result of misconceptions has also increased women's vulnerability.

Evaluations of economic empowerment programs have tended to focus on measuring conventional financial indicators such as poverty targets or financial sustainability measures (USAIDS, 2008). However, up to date not much has been done in evaluating impediments to women's economic empowerment. There may be other indicators other than low economic status that contribute to women's vulnerability. Therefore, it was necessary to investigate and determine impediments to women's economic empowerment to reduce their vulnerability to HIV/AIDS in Lower Nyakach Division, Kisumu County.

1.3 Purpose of the study

The purpose of this study was to establish impediments to women's economic empowerment to reduce their vulnerability to HIV/AIDS in Lower Nyakach Division, Kisumu County.

1.4 Objectives of the study

The objectives of this study were:

1. To establish the extent to which family status impedes women's economic empowerment in mitigating vulnerability to HIV/AIDS in Lower Nyakach Division.
2. To investigate how economic status impedes women's economic empowerment in mitigating vulnerability to HIV/AIDS in Lower Nyakach Division.
3. To examine the extent to which cultural factors impede women's economic empowerment in mitigating vulnerability to HIV/AIDS Lower Nyakach Division.
4. To assess how sensitization and training impede women's economic empowerment in mitigating vulnerability to HIV/AIDS in Lower Nyakach Division.

1.5 Research questions

The study sought to establish answers to the following questions concerning impediments to women's economic empowerment in mitigating vulnerability to HIV/AIDS.

1. To what extent does family status impede women's economic empowerment in mitigating vulnerability to HIV/AIDS in Lower Nyakach Division?
2. Does economic status of women impede economic empowerment in mitigating vulnerability to HIV/AIDS in Lower Nyakach Division?

3. To what extent do cultural factors impede women's economic empowerment in mitigating vulnerability to HIV/AIDS in Lower Nyakach Division?
4. How does sensitization and training impede women's economic empowerment in mitigating vulnerability to HIV/AIDS in Lower Nyakach Division?

1.6 Significance of the study

The study was to generate data and information that may be useful for planning and decision making at the levels of government, financial institutions, NGOs and community to bring about improved strategy for promoting women's economic empowerment that may contribute to positive impact on the response to HIV/AIDS.

Secondly, the findings and recommendations of the study may be useful to the government and community to base their decisions and actions on knowledge on issues of improved economic empowerment of women; this would be attributed to the fact that the economic empowerment of women has been low hence high vulnerability to HIV/AIDS.

Thirdly the study would open gaps for further research on how lower economic status is a dimension of women's vulnerability to HIV/AIDS.

Lastly, the findings from the study may add to existing knowledge on factors that hinder women's economic empowerment in alleviating their vulnerability to HIV/AIDS. Again, the research findings may benefit both the ministries of Gender, Children and Social Development and Public Health on what guidelines and practices are appropriate for the women in Lower Nyakach Division.

1.7 Basic assumptions of the study

In this study, the researcher assumed that the sample size chosen was a representative of the target population of the study. It was assumed that the chosen respondents were willing

to participate in the study and responses given were also assumed to be to the best of their knowledge.

1.8 Limitations of the study

The diversity of cultural background made it difficult to generalize findings of the research to other women in other parts of the country. Secondly, given that not all women were literate enough to understand English language, comprehending and answering the questions in the questionnaire posed a challenge to them. However, when such a case arose, the researcher translated the questions from English to the local language (Luo) and also translated the responses to English. The other limitation arose from the spouses of the respondents. Given that women were the main respondents of the study; their spouses looked at the process with suspicion due to the fact that some of the questions in the questionnaire touched on control of household resources and decision making. However, the researcher made clear the intention of the research and did not force anyone into taking part.

1.9 Delimitations of the study

The study was carried out in Lower Nyakach Division in Kisumu County. This is a rural area in Kenya located 40 kilometers South West of Kisumu town. The rationale of choosing this Division was because some of the locations found within it neighbor Miriu and Nyando Rivers and hydropower generating company which was an indication of economic activities taking place.

The study was delimited to women as the main target group since women have less access than men to resources and limited enjoyment of socially valued goods, opportunities and rewards. Traditional ownership and inheritance patterns continue to marginalize women and girls and prevent them from having access to and gaining control of productive resources such as land (Nyando District development plan 2010). Since this is a social science study, it

was restricted to the descriptive survey design appropriate in collecting information on opinions, perception and experience of the respondents. The study was also delimited to questionnaires and focus group discussions to address possible cases of semi-literate respondents who were encountered in the field.

1.10 Definition of significant terms used in the study

Impediments: refers to the factors that cause hindrance towards achievement of a particular goal

Women's economic empowerment: refers to the recognition that women legitimately have the ability to and should individually and collectively have access to economic resources.

Vulnerability: refers to the exposure or being at risk of contracting HIV.

Cultural factors: refers to a community's lifestyle which involves elements of tradition, taboos, roles and responsibilities.

Family status: refers to the composition of the household in terms of marital status, head of household and number of dependents.

1.11 Organization of the study

The study was organized into five chapters. Chapter one divided into the following sections: Background of the study, statement of the problem, purpose of the study, objectives of the study, research questions, the significance of the study, basic assumptions, limitations, delimitations, definition of significant terms used in the study and the last part of chapter one was organization of the study. Chapter two contains literature review: the general literature and empirical literature related to the area of study. Chapter three presented a detailed research methodology that were to be used in conducting the study and this includes: area of the study, target population, sample and sampling procedure, research design, research instruments, pilot testing of research instruments, validity of research instruments, reliability

of the instruments, data collection procedures, data analysis techniques and ethical considerations. Chapter four presented data analysis, presentation, interpretation and discussion by objective which included demographic characteristics of respondents which was blended with the first objective of family status and women economic empowerment in mitigating vulnerability to HIV/AIDS, economic status and women's economic empowerment in mitigating vulnerability to HIV/AIDS, cultural factors and women's economic empowerment in mitigating vulnerability to HIV/AIDS and lastly, training and sensitization and women's economic empowerment in mitigating vulnerability to HIV/AIDS. Finally chapter five presented the summary of major findings, conclusion, recommendations pre objective, recommendations for further research and contribution to the existing knowledge.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

In this chapter, the researcher reviewed literature related to impediments to women's economic empowerment to mitigate their vulnerability to HIV/AIDS in Lower Nyakach Division. The review was conceptualized under the objectives of the study and focused mainly on: family status and women's economic empowerment in mitigating vulnerability to HIV/AIDS, economic status and women's economic empowerment in mitigating vulnerability to HIV/AIDS, cultural factors and women's economic empowerment in mitigating vulnerability to HIV/AIDS and lastly training and sensitization and economic empowerment in mitigating vulnerability to HIV/AIDS.

2.2 Family status and women's economic empowerment and vulnerability to HIV/AIDS

It is estimated that up to one third of households in developing countries have women as sole providers. Breaking this cycle will require not only greatly increased investments and more effective HIV prevention and care but also effective measures to combat poverty (Population Reference Bureau, 2000).

Female-headed families use sexual networking as an economic strategy as these women lack other avenues of earning income they could use to sustain themselves and their families. The women usually have multiple partners to gain access to resources that they do not command themselves because of entrenched gender discrimination in gaining access to education, to credit, and to the formal economy. Women living in poverty may adopt behaviors that expose them to HIV infection, including the exchange of sexual favours for food, shelter, or money or support for themselves and their families. Sexual networking is not seen as a pleasure-seeking experience and reducing the number of one's partners is not only a question of exerting self-control (Heise & Elias, 1995).

Most often when a poor household is faced with chronic HIV/ AIDS morbidity, their pre-emptive strategies include: seeking employment locally or to migrate in search of greener pastures; changing farming methods; adopting labor saving techniques or leaning on family or the community for support. However as time passes and this range of coping strategies is exhausted, families are forced to adopt other coping strategies which not only carry a higher impact (negative) on household resources but also provide temporary or inadequate relief and prove to be unsustainable. Such include spending less on children's education or de-registering them from school; using up of savings to cover the cost of treatment and care; breaking down of household cohesion as some family members may be sent to live with relatives or borrowing from formal or informal sources of credit. In due course, families forced to either depend on charity or distress migration to ensure survival (Sonia, 2000).

Families affected with HIV/AIDS suffer loss of assets, decreased income and productive capacity, labor shortages, increased healthcare costs, and changing expenditure patterns. The social impact involves increased food insecurity, decreased school access, increased work burden on children as well as changes in household structure and composition, life expectancy, increased burden of care, losses and shifts in community support, and social isolation. Rural households, poor households, the elderly, women and children suffer the most from the impact, particularly in terms of loss of assets, decreased nutrition and education. The emergence of HIV/AIDS orphans has an effect on other households in the community or extended family as well; straining household income and productive capacity of the extended families who suffer some of the impact of the death of parents. Elderly relatives tend to serve as surrogate parents and, according to evidence from Asia and southern Africa, care givers as adult persons with AIDS often move back to their families and communities of origin, which impacts negatively on their welfare and health (Agyarko & Kowal, 2000).

Traditional community and extended family resources are stretched beyond their capacity by rapidly growing HIV/AIDS orphans, whilst at the same time the labor supply shrinks and fewer teachers and health workers are available. Extended families that are overstretched by a large number of HIV/AIDS orphans have led to the emergence of child-headed households. Increasingly therefore, orphans are cared for by the elderly or the very young. These child-headed households are characterised by high mortality rates of AIDS orphans, food insecurity and low school enrolment, as well as malnutrition, lack of immunizations or health care, increased demands for labor, lack of schooling, loss of inheritance, forced migration, homelessness, vagrancy, starvation, crime and exposure to HIV/AIDS infection. Maternal orphans are particularly affected, although in rural areas where widows often lose their land, paternal orphans are also at risk of rapid impoverishment. Generally, rural children living on farms suffer most acutely from HIV/AIDS in the community, due to higher labor migration, greater involvement in production, diminished skill transfer from the parents, reduced schooling opportunities and higher food insecurity. Evidence from Southern Africa shows that the impact of the HIV/AIDS pandemic is also not gender-neutral, as women suffer disproportionate amount. Elderly women are the main foster parents of maternal orphans. AIDS widows in rural areas often lose their access to land, labor, inputs, credit and support services; stigmatization of widows can alienate them from the extended family and the community and female commercial sex workers are particularly vulnerable to HIV/AIDS (Ayieko, 1997).

Households with adult female infections experience lower birth rates and higher infant and child mortality rates. In households where a parent or both parents have AIDS, the likelihood is that fewer children will be born and a significant proportion of those who are will die very young. Inevitably this means that the personnel of the household are not reproduced and neither are the life-ways and traditions of that household (Barnet and Whiteside, 2002).

Deaths in individual households have implications for other households because of their interdependence. Rugalema (1999) shows how coping mechanisms become increasingly weakened as more households in a community are affected and communal support networks are less and less able to cope. It has been argued by some that an entity called "the extended family" will absorb the orphans and destitute created through AIDS related mortality. This view has been heard from people ranging through senior policy makers in international agencies to politicians in Africa and Asia and people in local communities. It is now heard less as the full effects of the epidemic become apparent. The reasons for this are the extended family is variable; it is dynamic and can become more or less extended depending on resource availability. Affected households will try to adapt. One way in which they do this is by changing their composition. Family status determines how women reduce their vulnerability to HIV/AIDS. This research therefore attempted to fill the gap of establishing the family based factors and women's vulnerability to HIV/AIDS in Lower Nyakach.

2.3. Economic status and women's empowerment and vulnerability to HIV/AIDS.

Studies by Whiteside (2002) have linked HIV/AIDS and low economic status, suggesting that HIV infection is concentrated within sections of society with the lowest economic status. Many reasons have been given for this link, including lack of access to education, healthcare and income. It is possible to conceptualize the direct effects of these deficiencies as it relates to HIV infection: without education, there is less knowledge about HIV transmission and protection, without healthcare, there is no way to know one's status, and without income it is difficult to purchase contraceptives. But understanding the impact of low economic status on these proximal factors related directly to individual behaviour does not provide the entire picture. Economic status affects and reflects where one lives, what one does for a living, and the power one has in relationships (Kate, 2007).

Mabala (2006), in his discussion of vulnerability to HIV infection, shows that low economic status can make it difficult to avoid, mitigate the effects of, or live unsafe relationships, and can cause individuals to feel unsafe in their communities. As well, statistics have shown that people (especially women) of low economic status are more likely to experience coerced sex, or exchange sex for money, gifts, food and shelter. The increased economic burdens on AIDS-affected households can often force girls to provide for themselves and their families by engaging in relationships that might heighten their risk of HIV infection. The economic pressures that lead to vulnerability is felt still more acutely among adolescents, especially those without parents.

A lot of women's economic work is not accounted for by the national economic statistics since a great deal of women's work does not take place in large market oriented formal sector establishments. Majority of women's economic activities are mainly in the informal sector. More women are involved in food processing and clothing industries as well as in agro-processing, weaving, embroidery and street hawking at the bottom levels (Blackden and Bhanu, 1999).

Women who are vulnerable to HIV/AIDS are the world's poorest. Low economic status is a key ally in the spread of HIV/AIDS. The UNAIDS report asserts that despite women's higher biological vulnerability, other factors such as the legal, social and economic disadvantages faced by women in most societies greatly increase their HIV vulnerability (UNAIDS, 2004).

Though HIV is not confined to the economically disadvantaged only, economic instability has contributed to its spread by creating yet another situation of vulnerability. The overwhelming majority of about 94 percent of all people living with HIV/AIDS at the end of 2000 were found in the less developed regions where a large proportion of the populations were women. Sub-Saharan Africa bears a disproportionate burden of the epidemic. The

region is home to 70% of the world's adults living with HIV/ AIDS. In what has emerged as a vicious cycle, HIV/ AIDS deepen the instability of households and nations, and this favours the spread of the virus. With few financial assets, the poor are often politically and socially marginalized and often have limited access to healthcare information and services (Population Reference Bureau, 2000).

Despite numerous policies since independence, economic inequality still remains widespread in Kenya, afflicting proportionately more women than men. The national Poverty rate estimated at 52.3% in 1997 had increased to 56.8% by 2000 with wide regional disparities. The most affected regions are Nyanza and North Eastern. Female headed households constitute a higher proportion of the poor both in the rural (54.1% vis-à-vis 52.5% for male heads) and urban areas (63.0% vis-à-vis 45.9%). In general, the female headed households are economically disadvantaged than the male headed households (Welfare Monitoring Survey, 1997).

When women have economic power—defined as control of income and capital—they gain more equality and control over their own lives. The high and growing incidence of AIDS highlights women's lack of power over their own sexuality. Because of economic reasons, many women feel unable to refuse the sexual advances of partners even if they know they risk infection. This has also pushed some young women between the ages of 15 and 25 into sex work, and many new cases are being reported from this group. In 1992, HIV prevalence rates of 15 to 20% were reported for female sex workers in Nigeria (Takyiwaa, 1998). Women in Kenya are more likely to be unemployed than men and even when they are employed; they earn less than men on average. Women are mainly found in the rural and informal sectors of the economy and other low-income occupations such as basket weaving and dress making. Lack of opportunity is typified by lack of access to labor markets, employment opportunities and lack of access to productive resources. In the formal labor

market in Kenya, women constitute only 29% of total labor force. The majority of women employed in the modern sector (about 58%) work in the service industry. Further analysis also shows that even in the service industry, especially in the public sector, it is 'men heavy' at the top, whereas women occupy the lower cadres (Human Development Report for Kenya, 2001). Women employment in Kenya is still characterized by low productivity, low pay and long hours of work. This is partly due to disproportionate high amount of time spent on unpaid work and inadequate access to economic opportunities. Unemployment is also higher for women than for men. Estimates for the late 1990s show that the overall urban unemployment was about 25 percent, with female being 38 percent (Manda, 2002).

A combination of low levels of income and cost sharing in the provision of healthcare means that majority of Kenyans have no access to Medicare, thus shifting the burden of care to women who take over from hospitals and other healthcare providers. Therefore, while cost sharing in the healthcare sector may have succeeded in reducing the cost to the government, the burden has simply been passed over to women. This combination exerts an immeasurable toll on women in two ways. First, women have to take time off from other productive work to take care of the sick. Secondly, this increases their vulnerability to the scourge through their reproductive function. The increasing number of HIV/AIDS cases and the resultant number of widows and orphans has increased women's workload and their financial responsibilities significantly (USAID, 2000).

Women's lack of access to basic health care are symptomatic of greater susceptibility to HIV exposure. From this perspective, HIV becomes not only a particularly harsh sexually transmitted disease but also an economically determined one (Heise and Elias, 1995). Their economic status also increases the likelihood of marrying early and to older men so as to uplift their standard of living. They may see this as an avenue of improving their lot or what is referred to as social mobility. Young women (14-24 years) from low-income families are

particularly vulnerable to the men called —Sugar daddies who offer money and gifts. These younger women are documented as the most infected compared to older women -50 year olds (UNAIDS, 2004).

Overall, the neglect of women's needs and rights undermines the potential of entire communities to grow and develop. Economic powerlessness is therefore deeply rooted in the glaring imbalance between what women do and what they have – in terms of both assets and rights. As women's status increases, so do the benefits to society. Studies have shown, for instance, that the major contributing factor to improved child nutrition is women's economic status, particularly their educational levels. In addition, the countries that have closed the gender gap in education the fastest have experienced the fastest economic growth(IFAD, 2003).

From the literature, it is evident that low economic status factor is connected to women's vulnerability to HIV/AIDS. The researcher therefore carried out a research in Lower Nyakach Division to determine whether low economic status hinders women's fight against HIV/AIDS pandemic.

2.4. Culture and women's economic empowerment and vulnerability to HIV/AIDS

Some cultural practices are perceived to be the main causes of the spread of HIV especially where women are concerned and the main challenge in prevention is the limited understanding of the social context of HIV. Cultural beliefs and practices relating to fertility and sexuality may represent significant barriers to the adoption of HIV prevention strategies by women. Cultural values undoubtedly shape behaviour central to the AIDS epidemic. It is also important to note that there are positive attributes of culture that can be identified and harnessed. Some values and beliefs regarding the sexual behaviour of women and men influence the balance of power in sexual decision making - many cultural factors enhance women's vulnerability to STIs and HIV and are incompatible with attitudes, knowledge,

skills and a sense of efficacy necessary for women to negotiate and practice safe sexualbehaviour (Weiss&Gupta,1993).

There are a number of factors that make culture a key ally to the spread of HIV/AIDS where women are concerned. There is a cultural expectation that —good women don't know about sex. Gender determines how and what men and women are expected to know about sexual matters and sexual behaviours. These norms prevent women from being knowledgeable about their bodies, sexuality, STI and HIV prevention. This then constrains women from making informed decisions about their sexual behaviour and sexual health (UNAIDS, 1999).

In many cultures women accept itching, burning, discharge, discomfort, and abdominal and back pain as an inevitable part of womanhood. Also some traditional norms of virginity elevate ignorance about sex to being a sign of purity, yet boys are expected to be more knowledgeable and experienced. Young girls have no forum (except probably school) where they can inquire about sexuality. The assumption is that if they were given information they would definitely indulge in the sexual act. Virgins are even more in danger today because of the myth that prevails that if a man is HIV positive and have sexual relations with virgin changes his HIV status to being negative from positive (Weiss and Gupta, 1993).

The sexual communication taboo inhibits open discussion about sexual issues both between partners and between parents and children. Openly discussing sexuality is seen as encouraging promiscuity and is viewed as a violation of traditional values and cultural practices. The inability of families to discuss sexual behaviour within the family may lead to discomfort and inability to discuss sexual histories with prospective partners. Family patterns laid down within the family during childhood work to the disadvantage of women who may not know what questions to ask prospective partners or the most effective methods of protection against HIV/AIDS (Rankin, 2005).

Attitudes and practices relating to sexuality may make women more vulnerable to HIV infection. This is because it is culturally acceptable for a man to have pre-marital sexual relationships and extramarital relationships that are socially sanctioned and common for men. A recent study done in Kenya to determine the modes of HIV transmission confirms that the determinants of HIV epidemic are strongly associated with culture mainly male circumcision and societal acceptance of concurrent/multiple partners. Even when there are calls for monogamy, they do not make sense because many women are monogamous but their sexual partners are not (National AIDS Control Council, 2009: V). Heise and Elias (1995) point out that a number of campaigns tell women to stick to their partners and to love faithfully give women a mistaken impression that if they remain monogamous, they will be safe from HIV/AIDS.

Many cultures allow for double standards that give men the license to be sexually adventurous while restricting female sexuality. The call for monogamy is unlikely to be heeded because polygamy is widely accepted in many African societies. HIV prevalence in those who are in polygamous unions in Kenya is also said to be high at 13 percent compared to those who are in non-polygamous unions at 6 percent. AIDS prevention programmes do not address this aspect of double standards but leave women in this situation without adequate information or skills to protect themselves from infection (Susser, 2000). There is also the tendency for young women between the ages 15-24 to be partnered with older men and this increases the likelihood that they will be exposed to HIV/AIDS. This age gap is likely to increase as older men seek out younger and younger partners in the hope of avoiding AIDS (Heise & Elias, 1995). These older men are likely to have had other partners and may be infected themselves. Practices such as, body tattooing and piercing, use of unsterilized instruments in child birth, female genital cutting, male circumcision, surgery, wife sharing, wife inheritance, ritual cleansing, early marriages and also nutritional taboos are known to fuel the spread of HIV (Futures Group Europe, 2005: V).

It has been documented that Female genital cutting is particularly widespread in sub-Saharan Africa and is associated with infections, complications in pregnancy and urination and psychological problems (Futures group, 2005: v). The preference for male children and preferential treatment of the male child often results in the female child being undernourished, overworked and being subjected to early marriage. If a young woman is exposed to HIV before genital maturation she may face a greatly augmented likelihood of HIV infection. This dynamic may account for the very high incidence of clinical AIDS among young women that are found in areas where sexual initiation with older men occurs at a very early age (Heise and Elias, 1995). It was observed in a 2006 study by UNAIDS in Kisumu, Kenya, an area that is documented as the epicentre of HIV/AIDS in Kenya, that the fact that girls having early sex with older men correlated strongly with a higher risk of HIV, and traditional early sexual initiation and early marriages was seen to contribute to the dramatic spread of the virus. Girls who married early were sexually active by the age of 15 and it is reported that 50% girls in Kenya according to the UNAIDS study have had sex by 18 years of age, 20% premarital and 25% are pregnant by the time they are 18 years. The prevalence rate of HIV for girls in the Kisumu region is as high as 30 percent. Young girls face a number of problems where their reproductive health is concerned; they are disadvantaged because they are deliberately given limited knowledge about modern contraceptives and minimal information about the use of condoms and lack parental guidance. They may also not get access to STI/ARV therapy in health centres because they are ridiculed by health workers since they are purported to know too much and that is why they are in trouble. The expectation is that they should not be knowledgeable (UNAIDS, 2006a).

Children are also viewed as a source of labour for the family and also a source of security for the parents in their old age. To provide women exclusively with HIV prevention methods that contradict the fertility norm of most societies is to provide women with no

options at all (Weiss&Gupta, 1993). A childless woman faces the risk of rejection from her husband, family and kin. The choice of women is in a dilemma because it is the choice between disease prevention and fulfillment of their reproductive role and also how to handle the mother-to-child prevention of HIV. Women are known to bear the brunt of HIV transmission even when it is universally known that it is men who are likely to have multiple partners. Mothers tend to suffer blame and stigma when their infants or young adults become HIV infected. Many women do not want to be tested because of the stigma and the difficulties they would face such as partner rejection and psychological stress as a result of the diagnosis. Men and women experience stigma differently. In most cultures women are usually seen as the infectors as opposed to men who may be HIV positive and not diagnosed yet. The woman may have been discovered to have HIV before the man because of antenatal clinics, where mothers to be are tested for HIV (UNAIDS, 2004a).

Though women have the potential to be more efficient, they lack the complementary inputs (capital) that would increase their productivity. Furthermore, women have insecure tenancy rights; they cultivate the land that they do not own and in the event of divorce or the death of spouse women become extremely vulnerable. The inaccessibility to a land title limits women's access to credit in the formal markets. This leaves them trapped in a vicious circle of poverty thus increasing their vulnerability to HIV/AIDS as they try to fend for themselves (Were, 2003). Other studies have concluded that when women farmers have direct access to knowledge and technologies, crop yields increase significantly. A World Bank review found that 74 per cent of 54 completed agricultural projects with gender-related action were rated satisfactory for overall outcome, compared with 65 per cent for the 81 projects with no gender-related action. An often-quoted study estimated that a specific project focus on gender increased agricultural productivity and output by more than 20 per cent. Data also reveal that HIV infection rates are higher where gender gaps in literacy are larger (IFAD, 2003).

Belief is an element of culture. There is a widespread belief that African traditional healers have the ability to cure HIV/AIDS. A belief that is deeply entrenched is the actively propagated message by the traditional healers in which they claim to have the ability to cure AIDS. A study found that some respondents believed that the African potato is a cure for AIDS. As mentioned earlier, the most debilitating of all is the belief that sleeping with virgin cures AIDS (Van Rensburg, 2002).

While the scale of these myths and beliefs has not been established, their contribution to the spread of the HIV pandemic, however big or small, cannot be ignored. Therefore there was need to carry out the research in Lower Nyakach to find out if the same traditions, taboos and myths prevail in the area and suggest recommendations that may help women alleviate HIV/AIDS vulnerability.

2.5 Sensitization, training and women's economic empowerment and vulnerability to HIV/AIDS.

Women's lack of general education and access to information also applies to sexuality. Women have scanty information about their bodies, pregnancy, contraception and STIs. The lack of knowledge is supported by cultural norms that dictate that good women should not know anything about sex or the functioning of their sexual reproductive organs. Lack of information also limits the women's ability to identify abnormal gynaecological symptoms that could signify sexually transmitted infections (Futures group, 2005).

In much of sub-Saharan Africa, knowledge about HIV transmission is still sparse and women are generally less informed about HIV than men. This is more so in the in rural areas than in urban areas. Young women in surveys carried out lacked comprehensive knowledge about HIV and young men were likely to have correct information about HIV. There is a need for knowledge, communication and interventions about HIV/AIDS to go beyond raising general awareness (NASCOP, 2009).

It has been noted that there is lack of access to clear, factual HIV prevention information and to HIV testing, counseling and related services, in an environment that is safe for confidential testing and voluntary disclosure of HIV status. It is common knowledge that few women are even aware that prevention technologies such as the female condom exists and even if they knew that they existed they would not be able to afford them and neither would they be available. Female condoms are said to be effective in preventing pregnancy and STI including HIV prevention. Very few women are even aware that microbicides are being developed as a prevention technology that they could control so that they are not at the mercy of their partners at all times especially when they know that their partners have multiple partners. The Intensifying HIV Prevention Policy Position Paper states that: —HIV prevention programmes must be differentiated and locally adapted to the relevant epidemiological, economic, social and cultural contexts in which they are implemented. Adapting messages to the specific group under study is vital because if messages are not targeted, chances of the messages being fruitless are high (UNAIDS, 2005a).

Research has shown that many HIV/AIDS messages usually designed to change behaviour and reduce the risk of HIV transmission have been aimed generally at the whole population of male and female alike. In other words these —messages are —gender-neutral. These messages have failed to take into account the specific needs of women and girls and the often difficult reality of their daily lives. The result is that we have targeted the symptoms of the pandemic rather than the underlying causes and the consequences of this failure have been catastrophic (UNAIDS, 2004a).

The UNAIDS (2006) report notes that 25 years after the epidemic was first recognized most people at high risk of HIV infection have yet to be reached by HIV prevention, as many policy makers are not implementing approaches that have been shown to work. Due to the fact that women have a secondary status, their educational levels and

literacy rates are low and therefore they are reached less effectively by anti-AIDS campaigns relying on printed materials such as pamphlets, posters, and brochures. Women have less access to radio and TV. The Kenya National HIV/AIDS Strategic Plan (2005/6-2009/10) has observed that there is a need to use prevention strategies that adapt to the language and situation of a given group. There are misconceptions that it's not worth investing in educating a girl child because she will soon (14-18 years) be married off and educating her would be wasting resources which should rather be invested in a boy child who culture dictates will remain with the family. Keeping girls at school for a longer period is one of the strategies that are viable as this raises the status of the girl child and protects her from early marriage. When young women go to school they become more knowledgeable about their bodies and sexuality since this is taught in schools and they also become more economically empowered later on by getting employment in the job sector (UNAIDS, 2004). Studies done in Kenya and other sub-Saharan regions indicate that educational attainment has a strong effect on health behaviours and attitudes. Data reveal that in Kenya the proportion of illiterate women is double that of men. 14 percent of Kenyan women age 15-49 cannot read at all compared to 7 percent of men in the same age group. This also implies that information access increases with educational attainment and wealth quintile for both men and women (KDHS, 2010).

HIV stigma and the resulting actual or feared discrimination based on lack of enough knowledge and misconceptions have proven to be the most difficult obstacles to effective HIV prevention. It has been observed that both stigma and discrimination reduce the efforts to control the global epidemic and create an ideal climate for further spread of HIV. HIV stigma emanates from fears and associations of AIDS with sex, disease, death and taboo behaviours that may be illegal, forbidden such as pre and extramarital sex and sex work. Stigma also accrues from inadequate awareness and knowledge about HIV that can lead to violence and abuse against certain people and groups. Stigma is further ameliorated by

existing prejudices and patterns of exclusion further marginalizes people who are already vulnerable to HIV infection (UNAIDS, 2005a).

Gender sensitive approaches are key to designing prevention programmes that seek to increase women's access to information and services. Gender sensitive approaches recognize: That women and men have different prevention, care and support needs and therefore approaches that are suitable should be explored. Examples of possible approaches are diagnosing, and treating sexually transmitted infections that should be integrated with family planning/reproductive health clinics, and promoting female-controlled preventive tools such as female condoms and microbicides. That AIDS literature is characterised by the invisibility of women and women have been ignored for a long time by AIDS education and prevention campaigns and the absence of —awareness and/or concern for women as potential sufferers of AIDS (Cline and McKenzie, 1996).

Since knowledge is power and empowerment means having a good information base, there was need to investigate the level of sensitization and training of women in lower Nyakach division and how they influence their vulnerability to HIV/AIDS.

2.6 Theoretical Framework

The study employed economic empowerment theory as propounded by Blumberg which states that enhancing women's economic empowerment comes close to being a 'magic potion' that boosts gender equality and the wealth and well-being of nations (Blumberg, 1984). This argument flows from Blumberg's general theory of gender and stratification (Blumberg, 2004b) and his theory of gender and development (Blumberg, 1988). In both theories, he posits that women's economic power relative to men is the most important of the many factors affecting the level of gender stratification in a given society at a point in history. He makes a theory-guided case that women with economic power—defined as control of income and other key economic resources like land and animals gain more equality and

control over their own lives while also contributing directly to their children's nutrition, health, education and thereby indirectly to their nation's wealth and income growth (Blumberg, 1984). With control of income, women also gain self-confidence which helps them to obtain 'voice and vote' in household decisions such as domestic well-being decisions. Women tend to use income clout for more equitable decisions about sons and daughters' diet, education and health; economic decisions such as acquiring, allocating and selling assets and facility decisions. They also gain freedom of movement. Further, economic power also leads to influence by women in community affairs and ultimately, more protection from male violence. Women who control their own income have fewer children and the fertility rate is inversely related to national income growth (Hess, 1998).

In adopting economic empowerment theory for this study, the researcher did not fail to recognize the limitation of this theory. The theory does not take into consideration the external factors that impede the economic empowerment of women such cultural beliefs and family status. These impediments are rarely discussed because there is an assumption that people are equal.

2.7 Conceptual Framework

This section describes the perceived conceptual framework:

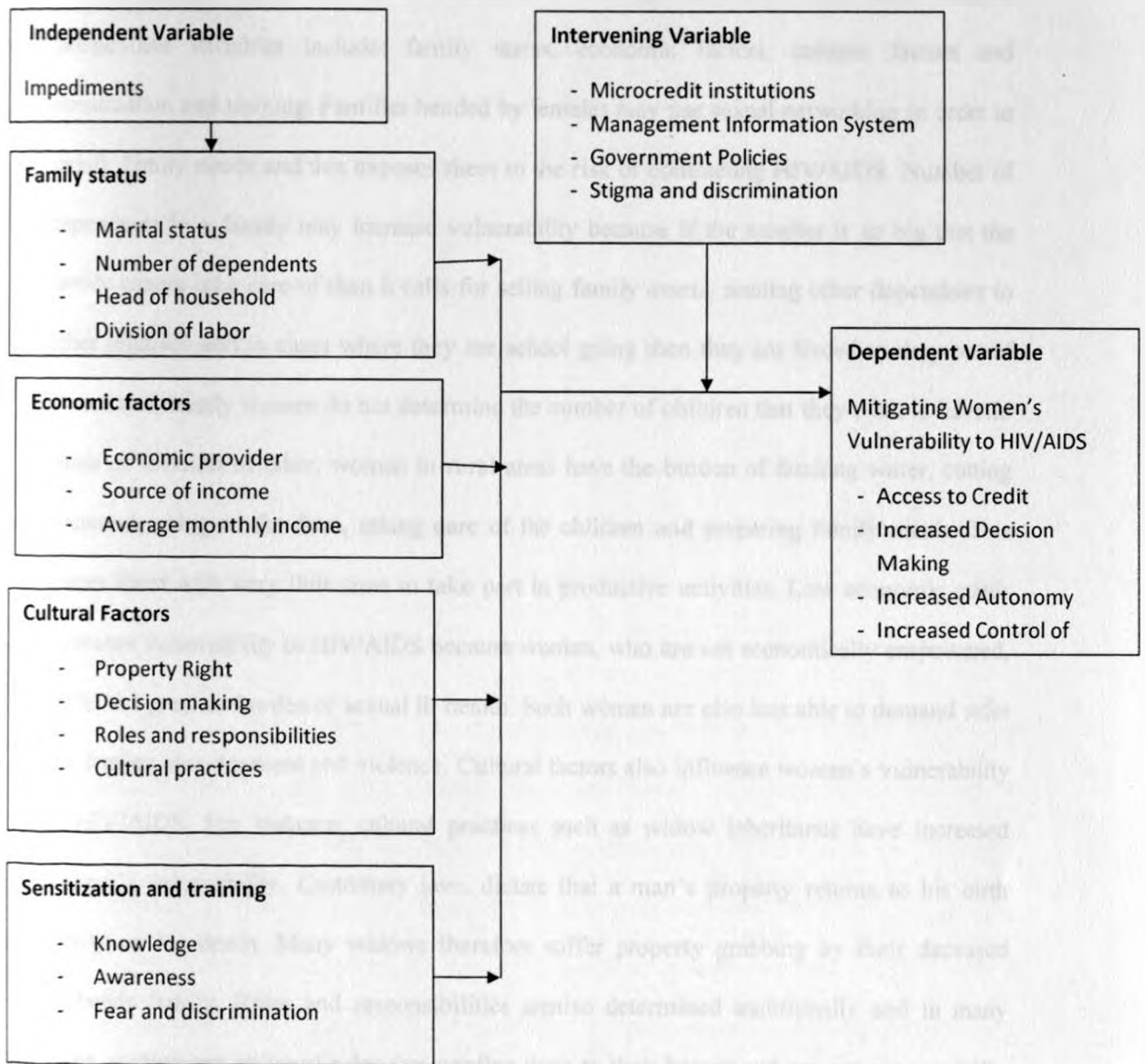


Fig 1.1 Conceptual Framework

From the framework, the independent variable is the factor that is measured, manipulated or selected by the researcher to determine its influence on women's vulnerability to HIV/AIDS; it may be called factor and its variation levels. It is presumed to cause changes to occur in another variable hence it is a causal variable (Kenny and Baron, 1986). Therefore independent variables include: family status, economic factors, cultural factors and sensitization and training. Families headed by females may use sexual networking in order to satisfy family needs and this exposes them to the risk of contracting HIV/AIDS. Number of dependents in a family may increase vulnerability because if the number is so big that the family cannot take care of then it calls for selling family assets, sending other dependents to other relatives and in cases where they are school going then they are forced to drop out of school and mostly women do not determine the number of children that they wish to have. In terms of division of labor, women in rural areas have the burden of fetching water, cutting firewood, going to the farm, taking care of the children and preparing family meals. This leaves them with very little time to take part in productive activities. Low economic status increases vulnerability to HIV/AIDS because women, who are not economically empowered, suffer the greatest burden of sexual ill health. Such women are also less able to demand safer sex fearing abandonment and violence. Cultural factors also influence women's vulnerability to HIV/AIDS. For instance, cultural practices such as widow inheritance have increased women's vulnerability. Customary laws dictate that a man's property returns to his birth family on his death. Many widows therefore suffer property grabbing by their deceased husbands family. Roles and responsibilities are also determined traditionally and in many cases, women are assigned roles that confine them to their homes and are not economically productive. Due to lack of sensitization and training, women are oblivious of for example, female condoms that may protect them from contracting HIV. Lack of awareness has made women remain behind in anti AIDS campaigns, stigma and fear of discrimination as a result of misconceptions has also increased women's vulnerability.

The intervening variable is a variable which comes in between other variables. It helps to delineate the process through which variables affect each other hence it is one that links between the independent variable and dependent variable (Kenny and Baron, 1986). These include micro-credit institutions that extend loans to women for various purposes which include investment in own generating enterprises, asset creation or even consumption. This improves the women's outlook, reduces their vulnerability to HIV/AIDS and improve HIV related knowledge and behaviour among women. Management Information System is another variable which enables reporting on the progress to take place and therefore it determines whether work is on or not if well managed. Stigma and discrimination from the surrounding make it difficult for women to speak openly about their HIV status thus lowers their ability to resist HIV infection. Government policy of a nation play a critical role in programmes aimed at controlling HIV/AIDS. In Kenya, the government policy zeros on the ethical, legal and financial considerations that must be taken into account when discussing and planning communication interventions. This highly affects vulnerable groups like women.

The dependent variable is a variable that changes because of another variable hence it is the effect or the outcome of the variable (Kenny and Baron, 1986). These include increased control of household resources that allows women self-esteem which is normally accompanied by greater respect from the family hence reduces their vulnerability to HIV/AIDS. Increased autonomy gives women ability to control their own lives. Women's degree of control of options such as marriage, divorce, sexuality, fertility patterns and freedom of movement is increased when they are autonomous. Another dependent variable is increased decision making which gives women a voice and vote in decisions concerning domestic well-being, economic decisions such as acquiring, allocating and selling assets. Lastly, access to credit will allow women to improve in terms of economic well-being. They

can improve their small scale farming and business. This will then reduce their vulnerability to HIV/AIDS as they will manage to control their own lives and make own decisions.

2.8 Existing Gap of Knowledge

This study is in line with Akinyi's report (2011) that observes that economic empowerment is a strategy on women's HIV/AIDS risk behaviour change. However, not much has been reported on the factors that hinder women's economic empowerment. Thus this study aims to unearth impediments to women's economic empowerment in mitigating their vulnerability to HIV/AIDS.

2.9 Summary of Literature Review

It is advocated for women's economic empowerment in order to mitigate the vulnerability to HIV/AIDS. Economic empowerment has been cited as a promising strategy for overcoming HIV/AIDS vulnerability among women. This may be achieved through improving income stability and ownership of labor, increasing independence and abandonment of retrogressive cultural practices. However the combination of family status, economic factors cultural factors and lack of sensitization and training have fuelled the spread of HIV/AIDS in the lives of women especially in Sub-Saharan region.

Given that women do not have the choice of marriage partner and the timing of marriage make women who marry young to have older husbands and in polygamous societies, they are junior wives. Both these factors increase the probability that their husband is infected with HIV. Low economic status exacerbates the impact of HIV/AIDS vulnerability among women. They earn less than men on average and are mainly found in the informal sectors of the economy and other low income occupations such as basket weaving and dress making. Cultural practices such widow inheritance, female genital mutilation, wife sharing, ritual cleansing and early marriages have also fuelled the spread of HIV/AIDS. These

practices are associated with, complications in pregnancy and urination and psychological problems. Women do not have property rights; they cultivate land that does not belong to them. This has increased the vulnerability of women since they have no access to essential property like land. Training and sensitization is power and therefore for women to mitigate their vulnerability, they should have adequate sensitization and training on HIV/AIDS related issues. However, many women have not had adequate information regarding HIV preventive measures.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter presents a detailed description of the selected research methodology. It describes the research design, target population, sample size and sample procedure, research instruments, validity and reliability, data collection procedure, data analysis techniques and ethical considerations.

3.2 Research Design

The research design for this study was descriptive survey. The descriptive survey describes the state of affairs and facts as it is (Kerlinge, 1969). It also results in the formulation of important principles and solutions to significant problems.

The study used both qualitative and quantitative sources. Qualitative methods were used to capture the experience of women and also established what the community perceived as the underlying reasons for women's vulnerability to HIV/AIDS. Quantitative method was used to give insights of the magnitude and extent of the problem.

3.3 Target population

The study was done in Lower Nyakach division, a rural division in Nyanza province located 40 km south of Kisumu town, covering an area of approximately 186.3 sq kms. The division constituted 8 locations namely: East Nyakach, Nyalunya, Rang'ul, Pap-Onditi, Asao, Central Nyakach, North Nyakach and North East Nyakach. It has a total of 13,081 households (KNBS, 2009). In this study households will be targeted because the study focuses on residents who can be best found in households as opposed to meeting people on the street.

3.4 sample size and sampling technique

This section described the sample size and sampling techniques which were used during the actual research.

3.4.1 Sample size

A sample size of about 208 households took part in the study. At each of these households, a woman was voluntarily asked to participate in the study. 8 chiefs, 8 opinion leaders and 8 Community Based Organization (CBO) leaders dealing with HIV/AIDS in Lower Nyakach division also formed part of the study. This gave a total sample size of 232.

3.4.2 Sample Procedure

Multi-stage random sampling method was used mainly to sample the women in the chosen households. Mugenda (2008) describes multi-stage sampling as a complex form of cluster sampling in which instead of using the entire selected cluster, the researcher randomly selects elements from each cluster at different stages. This method of sampling was preferred by the researcher because sampling the entire division would have been expensive and time consuming. The chiefs, CBO leaders and opinion were purposefully sampled using convenient sampling.

Out of 13,081 households in Lower Nyakach division, 208 were sampled to be used in the study. This number was arrived at through multi stage random sampling process. According to Mugenda (2008), 30% sample size is sufficient to represent a population to be used in a social science study. Based on this, 30% of the total 8 locations in Lower Nyakach division were sampled to determine the number of locations to be used in the study. From this (30% of 8), 2 locations were randomly selected through a ruffle method containing names of the above locations of which the first 2 locations picked represented the others. The ruffle

method was preferred because it was simple to use. When this was done, Rang'ul and North East Nyakach locations were selected to represent the others.

In the second stage sampling, sub-locations were sampled from the already chosen locations. Two sub-locations were then picked randomly, one from each location, using ruffle method. From this, Kasaye sub-location in Rang'ul location and Agoro West sub-location in North East Nyakach location determined the number of households to be used in the study. According to KNBS Lower Nyakach division (2009), these sub-locations had 225 and 1852 respectively. Given the large number of households, the third stage of sampling used 10% of households in each of the selected sub-locations to get the number of households to participate in the study, that was, (10% of 225=23 and 10% of 1852=185) totaling to about 208 households.

One woman from each household was asked to voluntarily give response to the study. In a case where there was more than one woman, simple random technique was employed to select one for the study. Thus a total of 208 women were sampled as the main target group but since other key respondents' opinions were sought regarding impediments to women's economic empowerment, the researcher sampled 20 key informants to give response to the study. This summed up the number of respondents to approximately 228. In a case where there was no woman in a household, the researcher skipped it.

To choose the first sub-location with which to start the survey from the two sub-locations, the researcher again used the ruffle method containing the names of the two sub-locations. The one which was picked first was chosen to start the survey. The actual survey started by the researcher going at the centre of the first randomly selected sub-location after which the researcher tossed one side of the shoes to determine the starting household. This was arrived at following the direction that the front part of the shoe faced. After this, the

Table 1.1 Showing multi stage sampling method used to determine number of households sample size.

Location	1 st stage	Sub locations	2 nd stage	Number of households	3 rd stage	Number of Households in the study
	30% randomly selected		Randomly selected		10% randomly selected	
East Nyakach						208
Nyalunya						
Rang'ul	Rang'ul	Kasaye, Jimo Middle	Kasaye	225	23	
Pap-Onditi						
Asao						
Central Nyakach						
North Nyakach						
North East Nyakach	North East Nyakach	Agoro West, Agoro East, Awach	Agoro West	1852	185	

Source: KNBS Lower Nyakach Division, 2009

3.5 Research instruments

The study used questionnaires as the main research instruments. The selection was guided by time available as well as the objectives of the study. The research was concerned with collecting opinions, views, perceptions, feelings, practices and attitudes and such information were best collected through the use of questionnaires and interview techniques. Semi-structured questionnaires were used to capture both qualitative and quantitative data. The questions were structured into five sections in line with the objectives: section one dealt with demographic information and establishing the level at which family status and economic empowerment impedes mitigating vulnerability to HIV/AIDS, section two gathered data establishing the extent to which economic status and women's economic empowerment impedes mitigating vulnerability to HIV/AIDS, section three sought to investigate the level at which cultural factors and economic empowerment impedes mitigating HIV/AIDS vulnerability, section four sought to examine the level at which sensitization and training and economic empowerment impedes mitigating vulnerability to HIV/AIDS. An interview schedule that captured the study objectives was developed for the focus group discussion. In this study, structured interviews which involved the use of a set of questions were used to collect data from opinion leaders. The interview schedule was made up of three sections and included questions on how the opinion leaders, chiefs and CBOs helped the women reduce their vulnerability and also questions on follow ups conducted. These measurement tools were drafted in English and were translated into vernacular language (Luo) in case of need.

3.5.1 Piloting the study

Piloting was done in Kochogo East location which presented respondents with similar characteristics. According to Mugenda and Mugenda (1999), a pretest sample of a tenth of the sample respondent with homogeneous characteristics is appropriate for the pilot study. Therefore a sample of 20 women participated in the study. The respondents were not part of

the selected sample which was used in the main study but had the same characteristics. The pilot study adopted procedures and sampling techniques outlined in the main study. Pretesting of the research instruments to the respondents with the same characteristics helped in eliminating errors which were made during the administration and scoring. It also helped in reframing questions which were misunderstood.

3.5.2 Validity of instrument

Validity is a measurement characteristic that describes the ability of a research instrument or tool to measure what it is intended to measure (Kothari, 1990) and the extent to which the results of the study could be accurately interpreted and generalized to other populations. The research instruments were given to two experts in the area to evaluate the relevance of each item in relation to study objectives. The university supervisors as well reviewed the instrument to see if the instrument was relevant.

3.5.3 Reliability of instrument

Reliability is the extent to which a measurement instrument gives consistent results after repeated trials or the extent to which the test scores are free from measurement errors (Mugenda, 1999). In research, reliability is influenced by random error, which is a deviation from a true measurement. Hence research instrument was pretested under similar conditions to different individuals who voluntarily accepted. Reliability was checked from the consistency and uniformity of test results that came out of this testing. According to Copper and Schindler (2000), test retest enables the study to compare research instruments over time. The technique involved administering the same questionnaires and interview schedule guides twice to the same group of subjects, but after an interval of two weeks. Scoring was done to ascertain the number of items answered the same and this was correlated using spearson's coefficient correlation.

3.6 Data collection procedure

The researcher was given a letter of approval by the University College of Education and External Studies, School of Continuing Studies and Distant Education (Kisumu Campus). The researcher then presented the letter to the Ministry of Education, science and technology for the authority to go ahead and carry out the study. Authority was again sought from the District Commissioner and the District Education Officer both of Nyakach District. A thorough training for the research assistants on the instruments was conducted, appointment was made with the key informants and the target group was informed of the exercise by their respective chiefs. The researcher and the assistants proceeded to collect both qualitative and quantitative data using the already design research instruments. After the data collection process the researcher collected the questionnaires from the research assistants for analysis, all the interview schedules and questionnaire forms were reviewed by the researcher to check whether all the questions were responded to.

3.7 Data Analysis Technique

Since data was in qualitative and quantitative form, organization, presentation and analysis took different forms depending on the nature of the data. The data entry process started immediately after collection from the field. The data was entered into the computer for quantitative analysis. Gay (1992) noted that the most commonly used method of reporting descriptive survey research is by developing frequency distribution, calculating percentages and tabulating them appropriately. Inferential statistics were used to make deductions from the data collected, to the sample or population. Qualitative data were descriptively presented, explaining the variables to be investigated. Such data consisted of words; therefore qualitative mode of data analysis provided ways of examining and interpreting themes hence thematic analysis was used.

3.8 Ethical consideration

As a way of making sure that the research analysis was based on an honest reflection of the beliefs of the respondents, and that the respondents were protected in this research, the researcher's way of working required adherence to ethical considerations. Since knowledge cannot be pursued at the expense of human dignity, the researcher ensured informed consent of the respondents and the interviewees. The researcher did personal identification thereafter the respondents were fully informed about the aim of the study, thus avoiding problems of deception or preventing participants from reporting negative feelings their participation. The respondents were assured of the confidential nature of their participation and procedure to be followed. Again the respondents were not obliged to write their names on either the questionnaires or focus group discussions. The respondents had the freedom to ignore items that they do not wish to respond to.

CHAPTER FOUR

4.0 DATA ANALYSIS, PRESENTATION, INTERPRETATION AND DISCUSSION

4.1 Introduction

This chapter presents the study findings which have been analyzed, presented, interpreted and discussed under thematic and sub- thematic areas in line with research objectives. The thematic areas include questionnaire response return rate, demographic characteristics of the respondents, family status and economic empowerment in mitigating vulnerability to HIV/AIDS, economic status and women's economic empowerment in mitigating vulnerability to HIV/AIDS, cultural factors and women's economic empowerment in mitigating vulnerability to HIV/AIDS and lastly sensitization and training and economic empowerment in mitigating vulnerability to HIV/AIDS in Lower Nyakach Division, Kisumu county.

4.2 Questionnaire Return Rate

A total of 208 questionnaires were administered to the respondents to the women and an interview schedule was done with 10 CBO leaders and 10 opinion leaders and chiefs. Of the 208 questionnaires administered for women, 201 were returned representing 96.6% return rate. Whereas 100% response rate for CBO leaders, opinion leaders and chiefs was realized meaning that all the opinion leaders and CBO leaders were available and accepted to respond to the questions. The remaining 3.4% of the questionnaires not returned was due to unwillingness to participate. This is a very good response rate as in line with Mugenda and Mugenda. (1999) who noted that a response rate of 60% is good and a response of 70% and over is very good.

4.3 Demographic characteristics of the respondents

This section provided personal data which helped in contextualizing the findings and how they impede economic empowerment in mitigating vulnerability to HIV/AIDS. To

gather more information, the interview and the questionnaires sought details on the following areas: age, level of education and marital status.

4.3.1 Demographic characteristics of women respondents by Age

In this section, the study sought to focus on age of the women respondents. This variable was included here to allow an observation of the distribution of respondents according to age group. Although it is beyond scope of research to assess the influence of age on sexual behaviour, its importance is worth noting. The respondents' age greatly influences their knowledge and sexual behaviour and should be included as an explanatory variable. To analyze this, the respondents were asked to state their age bracket and the responses presented in table 4.1.

Table 4. 1

Age of the Respondents

Age	Frequency	Percentage
18-25	32	15.9
26-35	90	44.8
Above 35	79	39.3
Total	201	100.0

Out of 201 respondents who participated in the study, 32 (15.9%) fell in age bracket 18-25 years, 90 (44.8%) were in age bracket 26-35 years, while 79 (39.3%) were above 35 years old. The impact of these findings of age distribution in the study in relation to vulnerability to HIV/AIDS is that young women of ages 26-35 from low income families are particularly vulnerable to the men called sugar daddies who offer money and gifts. This age group is also characterised by a number of sexual partners and high frequency of sexual intercourse. All these factors are very important in assessing the risk of acquiring HIV as they indicate the number of potential exposures to the virus. These younger women, who may be

most productive, are therefore the most vulnerable compared to older women of 35 years and above. This concurs with Tladi (2005) report on 'Establishing and Explaining the link between Poverty and HIV/AIDS' which reported young women are likely to behave very differently from older women and vice versa.

4.3.2 Distribution of women respondents by level of education

The study focused on the level of education of the women and how it impedes economic empowerment in mitigating vulnerability to HIV/AIDS. Education has an indispensable role in both knowledge of HIV and sexual behavioural practices and is therefore worth examining. In most instances, education level varies according to economic status with those with low economic status accounting for the majority of those with low education levels. In recognition of this and in allowing for the assessment of the importance of economic power in educational attainment and consequently in reducing the risk of HIV infection and transmission, the respondents highest level of education provided a background characteristic used during data analysis. To analyze this, the respondents were asked to state their level of education and the responses were presented in table 4.2.

Table 4.2

Highest level of education of the Respondents

Level of education	Frequency	Percentage
College/University	48	23.9
Never attended School	14	7.0
Primary	78	38.8
Secondary	61	30.3
Total	201	100.0

Out of 201 respondents who participated in the study, 48(23.9%) were college/university graduates, 14 (14%) never attended school at all, 78 (38.8%) had attained education up to primary school level, 61 (30.3%) had attained education up to secondary level. Even though majority of the respondents had attained primary level of education and a good number had attained secondary education, it can be said that women's lack of higher education applies to limited knowledge of sexuality thus vulnerability to HIV/AIDS. Qualitative data collected from the CBO leaders who were among the key informants reported that, "Women have scanty information about their bodies and STIs. Again, if the education level is low, then the chances of acquiring employment in the formal sector diminish thus economic disempowerment which further leads to risky sexual behaviour and vulnerability to HIV/AIDS". It could be interpreted that sensitization increases with higher level of education. High education is also linked with high level of income which safeguards women who are the majority hence contributes positively to the economy of the nation at large. This concurs with NASCOP (2009) report on 'Kenya AIDS Indicator Survey' which reported that there is a need for knowledge about HIV/AIDS to go beyond raising general awareness.

4.3.3 Distribution of women respondents by marital status

The study sought to know the marital status of the respondents so that it can determine whether difference in marital status leads to difference in sexual behaviour and vulnerability. To analyze this, the respondents were asked to state their marital status and the responses were presented in table 4.3.

Table 4.3

Distribution of women by marital status

Marital status	Frequency	Percentage
Single	31	15.4
Married	128	63.7
Divorced	1	.5
Separated	8	4.0
Widowed	33	16.4
Total	201	100.0

Out of 201 respondents who participated in the study, 128 (63.7%) were married, 31 (15.4%) were single, 1 (0.5%) was divorced, 8 (4%) were separated while 33 (16.4%) were widowed. The importance of this variable lies in the fact that a person's marital status often influences their sexual behaviours, that is, the type of sexual partners (regular vs. non-regular) and the number thereof. Therefore it is important that this variable be provided firstly as a background variable and secondly as a predictor when assessing the impediments to economic empowerment in mitigating vulnerability to HIV/AIDS since marital status influences one's sexual behaviour by influencing the type of sexual partners one has as well as whether a condom is used during sex.

From the study, majority of the respondents were married thus it can be argued that they are in stable relationships with one regular sexual partner. It is expected that this should reduce their vulnerability to HIV/AIDS. However, such women are more at risk to get infected by their spouses with whom they cannot insist on the use of condoms. The qualitative data which was collected from the CBO leaders who were among the key

respondents also confirmed that women who are married are more vulnerable to HIV/AIDS.

One respondent reported that:

“Many men do not accept to use condoms with their wives and when their wives insist, the men tell them that may be they are the ones who are infected and that is why they insist on condoms and when the women suggest they go for HIV test together, the men refuse saying that they are not women to go to clinic.”

Therefore the women's vulnerability is determined by the heterosexual behaviour of their steady male partners. This concurs with UNAIDS (2005) report on 'Intensifying HIV Prevention' which documented that more than 85% of women with HIV are currently married or were previously married. Women's vulnerability to infection within marriage is underlined by the fact that most men with multiple partners are married; indeed 45% of married men had multiple partners compared with just 5% of women.

4.4 Family status and economic empowerment in mitigating vulnerability to HIV/AIDS.

In this section, the researcher wanted to establish the extent to which family status impedes women's economic empowerment in mitigating vulnerability to HIV/AIDS. To generate more information, the following sub sections were explored: household leadership, number of dependents, gender duties in households, how women with HIV/AIDS are treated.

4.4.1 Household Leadership and vulnerability to HIV/AIDS

The study sought to know whether the households had leaders or not. To analyze this, the respondents were asked to state the leader of their households and the responses were presented in table 4.4.

Table 4.4

Household leadership and vulnerability to HIV/AIDS.

Leadership	Frequency	Percentage
Myself	67	33.3
Husband	128	63.7
Both	6	3.0
Total	201	100.0

Out of 201 respondents, 128 (63.7%) agreed that their husbands are the leaders in their households. Husbands make critical decisions including influencing the actions in certain directions in the families. Women remain to be followers and or implementers of these decisions and have to abide by them under all circumstances. 67 (33.3%) of the respondents revealed that they were the leaders of their households while 6 (3%) revealed that both man and woman were leaders of households. It can be interpreted that the imbalance in power that exists between men and women encourages male sexual freedom thereby increases women's vulnerability to HIV/AIDS. This further controls women's sexual independence and encourages male sexual freedom, thereby increasing women's risk and vulnerability to HIV/AIDS. This concurs with Gupta (2000) report on 'Gender, Sexuality and HIV/AIDS: The What, The Why and The How' which stated that the glaring lack of power of women over their life coupled with inequalities make them easy prey for contracting HIV.

4.4.2 Number of dependents and vulnerability to HIV/AIDS

In this question, the researcher wanted to find out if there were dependents in the households. When asked whether there were dependents in the household, 100 % of the respondents reported that there were dependents in their households. The researcher further

sought to establish how many dependents were available in each household. The following question was asked: If yes, how many? The responses were presented in table 4.5.

Table 4.5

Dependents per household and vulnerability to HIV/AIDS

No. of dependents per household	Frequency	Percentage
1	10	5.0
2	17	8.5
3	25	12.4
4	32	15.9
5	68	33.8
6	39	19.4
7	10	5.0
Total	201	100.0

Out of the 201 respondents who participated in the study, 117 (58.2%) of the respondents reported that there were five and above dependents in their households. 10 (5.0%) reported that they had 1 dependent each, 17 (8.5%) reported that they had 2 dependents each, 25 (12.4%) reported that each of them had 3 dependents while 32 (15.9%) reported that each of them had 4 dependents. From the responses, it can be argued that families with high number of dependents require adequate resources to sustain them. Qualitative data collected from the opinion leaders who were the key informants reported that, "When a household does not meet the demands of the dependents, the girls especially become vulnerable as they may also involve themselves in sex trade to meet their demands. When the number of dependents in a household is high, then all the income is spent on their education and food leaving almost nothing to save for an income generating scheme." It can be interpreted that women living in poverty may adopt behaviors that expose them to HIV infection, including the exchange of

sexual favours for food, shelter, or money or support for themselves and their families. On the same note, as earlier on reported, most of the respondents had low levels of education which did not favour them in the job market. This incapacitated them in providing for their dependents since they concentrated most in the informal sectors with low income. Therefore when the family, particularly the female headed ones, is not able to meet the demands of the dependents because of low income, they are likely to engage in unsafe sexual practices in exchange of material gifts such as money. This concurs with Heiss and Elias (1995) report on 'Transforming AIDS Prevention to Meet Women's Needs' which reported that women usually have multiple partners to gain access to resources that they do not command themselves.

4.4.3 Gender Duties in households and vulnerability to HIV/AIDS

The study also sought to know how gender roles are allocated in families. When asked whether there are different gender duties in their household, all the respondents, 201 (100%) said yes. The respondents were further asked to specify the duties that were assigned to different sexes and the responses were presented in table 4.6.

Table 4.6

Preparation of meals and vulnerability to HIV/AIDS.

Preparation of meals	Frequency	Percentage
Man	1	0.6
Woman	165	82.0
Both	2	1.0
Others(specify)	33	16.4
Total	201	100.0

Out of the 201 respondents who participated in the study, 165 (82.2%) reported that women are concerned with the preparation of the meals, 1 (0.6%) reported that men prepare meals, 2

(1%) reported that both men and women prepare meals while 33 (16.4%) reported that other people in the household prepare meals.

It can be interpreted that a lot of women's work is not accounted for because it is unpaid work. Women tend to spend more time on children and household chores. Such duties consume the better part of the women's time consequently have little time to engage in productive activities. This is in line with the study conducted by Quisumbing and Benedicte (2000) on 'Women Economic Empowerment' where the study revealed that women work two-thirds of the world's working hours, and that the overwhelming majority of the labour that sustains life in the households - such as farming, cooking food, caring for children and the elderly, the maintenance of the house, fetching water - is done by women; universally this work is accorded low status and no pay.

4.4.4 Women with HIV/AIDS and how they are treated by the family

The study also sought to know how women with HIV/AIDS are treated by other family members. The responses are illustrated in table 4.7.

Table 4.7

How women with HIV/ AIDS are treated in the family

How women with HIV/AIDS are treated	Frequency	Percentage
Caring	39	19.4
Abandoned	108	53.7
Forced out of family	21	10.4
Immoral	33	16.4
Total	201	100.0

Out of 201 respondents, 108 (53.7%) reported that women who suffer from HIV/AIDS are abandoned by other members of the family, 21 (10.4%), reported that such women are forced out of the family, 33 (16.4%) reported that such women are said to be immoral. Only 39

(19.4%) reported that women suffering from HIV/AIDS are cared for by the members of the family.

Most families abandon the women who suffer from HIV/AIDS. This may lead to social isolation which is associated with exploitative working conditions which put individuals at higher risk. This concurs with a survey conducted by Malaba (2003) on 'Addressing Vulnerability of Girls and Young Women in Urban Areas' which revealed that negative perceptions can lead to social isolation and make it difficult to seek material or social support from the family when it is most needed.

Women who are abandoned by their families may have been infected by their husbands because naturally men are known to have multiple partners. They may be innocent but will be accused falsely. Mothers tend to suffer blame and stigma when their infants become HIV infected. Many women therefore do not want to be tested because of the stigma and the difficulties they would face such as partner rejection and psychological stress as a result of the diagnosis. In most cultures women are usually seen as the infectors as opposed to men who may be HIV positive and not diagnosed yet. The woman may have been discovered to have HIV before the man because of antenatal clinics, where mothers to be are tested for HIV. This therefore means that women who have not known their HIV status shy off from doing so because of fear of abandonment by the family members particularly spouses on whom they depend economically. This concurs with a study carried out by Eka (2000) on 'Establishing the Link between Poverty and HIV/AIDS' which reported that women are known to bear the brunt of HIV transmission even when it is universally known that it is men who are likely to have multiple partners.

4.5 Economic Status and economic empowerment in Mitigating Vulnerability to HIV/AIDS

In this section, the researcher wanted to find out how economic status of women impedes economic empowerment in mitigating vulnerability to HIV/AIDS. To generate more

information, the following sub sections were explored including occupation of the respondents, monthly average income of the respondents, provision of household basic needs, age group mostly affected by HIV/AIDS and lastly, availability of credit to women in Lower Nyakach.

4.5.1 Occupation and vulnerability to HIV/AIDS

The study sought to know the occupation of the respondents and the responses are illustrated in table 4.8.

Table 4.8

Occupation and vulnerability to HIV/AIDS

Occupation	Frequency	Percentage
Formally Employed	43	21.4
Self-employed	105	52.2
Unemployed	53	26.4
Total	201	100.0

Out of the 201 respondents, 105 (52.2%), were self-employed, 53 (26.4%) were unemployed while 43 (21.4%) were formally employed. When asked to specify the type of self-employment the responses revealed that most of the respondents were in the informal sector and the responses are illustrated in table 4.9.

Table 4.9

Type of self-employment and vulnerability to HIV/AIDS

Type of self-employment	Frequency	Percentage
Peasant farming	91	45.3
Hair Dressing	3	1.5
Herbalist	2	1.0
Basket weaving	30	14.9
Small Business	62	30.8
Tailoring	13	6.5
Total	201	100.0

Out of 201 respondents, 91 (45.3%) were peasant farmers, 62 (30.8%) were involved in small businesses, 30 (14.9%) were engaged in basket weaving, 13 (6.5%) were tailors, 3 (1.5%) were hair dressers and 2 (1.0%) were herbalists. It can be interpreted that majority of the respondents were engaged in the informal sector which is associated with low income. It can therefore be argued that the informal sectors subject women to low incomes thus making them powerless economically and vulnerable to HIV/AIDS since such women are likely to involve themselves in risky sexual behaviours to meet their demands. This was confirmed by qualitative data which was collected from CBO leaders who were among the key informants and they were asked to briefly describe educational background of Lower Nyakach women. One leader reported that, "Most of the women in Lower Nyakach have education up to primary school level thus cannot secure jobs in the formal sector which requires high level of education." Therefore it can be interpreted that the respondents are economically powerless and vulnerable to HIV/AIDS because behaviour change does not simply come through the dissemination of information: It comes through empowerment – providing opportunities to enable them to secure respectable livelihoods. This is not realized because of the low levels

of education. This concurs with the study conducted by Kalipeni (2000) on 'Health and Disease in South Africa' which reported that women lack or have limited opportunities in regard to formal employment, training and more resources and income generating projects are unavailable to them.

4.5.2 Monthly Average Income and vulnerability to HIV/AIDS

The researcher sought to know monthly average income of the respondents. The respondents were asked to state their monthly average income and the responses were illustrated on table 4.10.

Table 4.10

Monthly average income and vulnerability to HIV/AIDS

Monthly average income	Frequency	Percentage
10,000-15,000	26	12.9
5,000-10,000	47	23.4
Above 15,000	24	11.9
Below 5,000	104	51.7
Total	201	100.0

Out of 201 respondents, 104 (51.7%) earn below Ksh 5,000 per month, 24 (11.9 %) earn above Ksh 15,000 per month, 26 (12.9%) earn between Kshs 10000- 15000 while 47 (23.4%) earn between Kshs 5000- 10000. Given family obligations, the low income among the respondents leads to harsh circumstances that force them to resort to unsafe sexual practices for survival. The high price associated with unsafe sex also serves as a disincentive against condom use. The qualitative data which was collected from the opinion leaders who were among the key respondents also confirmed that women with low income are likely to engage in unsafe sex to meet their demands. A participant illustrated that:

"Because of handouts, women accept to be used by men. This may be due to low income or neglect by their husbands. When a husband fails to meet the needs of the wife, the woman will definitely go out to look for these things from other men. The men who do not provide for their wives expose them to risks."

Since this type of sexual activity is often characterised by unequal power relations, it renders women powerless in negotiating safe sex, thereby increasing their risk of infection.

This is in line with observations by Webb (1997) in his study on 'Establishing the Link between Poverty and HIV/AIDS' which reported that often women with low incomes would have a string of boyfriends who provided for their needs, such as food, clothing and money for their children's school fees

4.5.3 Provision of Household basic needs and vulnerability to HIV/AIDS

The researcher was interested in establishing the provider of the basic needs of a household. This was to help in determining who is actually concerned with the provision of daily needs such as meals, clothing and even water for domestic purposes. The responses were presented in table 4.11.

Table 4.11

Provision of Household basic needs and vulnerability to HIV/AIDS

Provision of basic needs	Frequency	Percentage
Man	44	21.9
Woman	93	46.3
Both	64	31.8
Total	201	100.0

Out of 201 respondents who participated in the study, 93 (46.3%) reported that women provide for their families' basic needs, 44 (21.9%) reported that men provided for the basic needs while 64 (31.8%) reported that both men and women provided for the family basic

needs. Nevertheless as reported earlier, majority of the women earn below Kshs 5,000 as indicated in table 4.11. It can therefore be argued that women who fall prey of men because of hand outs are overburdened with family obligations beyond their ability. They must therefore look for means of meeting those obligations however risky they may be. These women use sexual networking as an economic strategy as these women lack other avenues of earning income they could use to sustain themselves and their families. Sexual networking is not seen as a pleasure-seeking experience and reducing the number of one's partners is not only a question of exerting self-control. This concurs with Heiss and Elias (1995) study on 'Transforming AIDS Prevention to Meet Women's Need' which reported that women living in poverty may adopt behaviours that expose them to HIV infection, including the exchange of sexual favours for food, shelter, or money or support for themselves and their families.

4.5.4 Control of income and vulnerability to HIV/AIDS

The study sought to know whether the respondents have control over their income and the responses were illustrated in table 4.12.

Table 4.12

Control of income vulnerability to HIV/AIDS

Control of income	Frequency	Percentage
Yes	67	33.3
No	134	66.7
Total	201	100.0

Out of 201 respondents who participated in the study, 67 (33.3 %) who earn their own income still do not have control over those earnings while 134 (66.7%) reported that they control their own income. Although majority of the respondents reported that they had control over their income, the number of those who do not have autonomy over their income is very significant. Lack of control of income contributes to economic powerlessness because

one may not use her income as she wishes. The women cannot purchase their personal effects that they may not want their spouses to know. Women lack economic autonomy thereby rendering them powerless to reject risky behaviour or to negotiate the most basic precaution against the disease. This concurs with the study carried out by Copeland (2006) on 'Women's Empowerment vs. Disempowerment' which reported that women's economic empowerment and, in a sub-Saharan African sample, was inversely associated with HIV/AIDS rates. He used surveys which included a variable of whether married women had earned cash income in the previous year, and if so, who controlled how it was spent. Where the woman controlled her own income, HIV/AIDS prevalence rates were lower; but where her husband (or, infrequently, others) controlled her income, HIV/AIDS prevalence rates were higher.

4.5.5 The age group and vulnerability to HIV/AIDS

The researcher also sought to find out the age group that is mostly affected by HIV/AIDS. The responses were illustrated in table 4.13.

Table 4.13

Age group and vulnerability to HIV/AIDS

Age group mostly affected with HIV/AIDS	Frequency	Percentage
15-24	41	20.4
25-34	125	62.2
35 and above.	35	17.4
Total	201	100.0

Out of the 201 respondents who participated in the study, 125 (62.2%) reported that those affected by HIV/AIDS fall within the age bracket of 25-34 years. 41 (20.4%) reported that the most affected group falls within the age bracket of 15-24 years while 35 (17.4%) reported that those affected by HIV/AIDS fall within the age bracket of 35 and above. From this it can be argued that HIV/AIDS affect the most active group of individuals. This may

have a very negative impact on economy both at community and national levels since the productivity of such individuals will definitely go down. People who are infected with or affected by HIV/AIDS may be unable to contribute to economic production. The common thread that runs through this study is based on the argument that because in most instances HIV/AIDS claims the lives of those aged between 25 and 35 years, the very people that work to support families, their ailment and later death can have a very negative impact not only on the economy but also on the household as funds become depleted as they are diverted from saving to paying for the care of the sick and later for funeral costs.

Qualitative data which was collected from one of the opinion leaders who were among the key informants and were asked to say how HIV/AIDS has affected their community. It was reported that, "In cases where the affected or the infected was employed, prolonged illness might result in the loss of employment, thus depriving families of their source of income. HIV/AIDS also poses a threat among subsistence and small-scale farmers and their families as they are too ill to carry out farming activities." This then implies that farmers can only farm small portions of land thus compromising household food consumption which then increases the likelihood of hunger and famine in the community. This concurs with the study by Ford et al (2002) on 'The Microeconomic Impact of HIV/AIDS' which reported that the majority of those affected are the economically active youth which affects both the supply and demand side of the economy, thus carrying very negative consequences for the economy at all levels.

4.5.6 Availability of credit and vulnerability to HIV/AIDS

The researcher sought to find out if Lower Nyakach women have accessibility to credit. The respondents were asked to describe availability of credit to them and the responses were illustrated in table 4.14.

Table 4.14

Availability of Credit and vulnerability to HIV/AIDS

Availability of credit	Frequency	Percentage
Not Available	53	26.4
Averagely available	114	56.7
Very available	34	16.9
Total	201	100.0

Out of 201 respondents who took part in the study, 34 (16.9%) agreed that credit facilities are very available, 114 (56.7%) reported that availability of credit is average while 53 (26.4%) reported that credit is not available to them at all. Qualitative data collected from the CBO leaders who were part of the key informants and were asked to describe accessibility of credit to women in Lower Nyakach reported that, "Credit is available but women cannot access them since they lack collateral. This is because women lack ownership of valuable property such as land and real estate thus reduces their ability to acquire such credit." It can therefore be interpreted that women are economically disempowered and are therefore vulnerable to HIV/AIDS because of lack of collateral. Men are the sole owners of property. Again, men are the key decision makers in most cases and when they say no to lending, the women cannot go against it. This concurs with Omutoko and Wambugu (2000) on 'Gender Issues in Development' that ownership of land and property empowers women and provides income and security. Without resources such as land, women have limited say in household decision making.

4.6 Cultural factors and economic empowerment in mitigating vulnerability to HIV/AIDS

In this objective three, the researcher sought to establish the level at which cultural factors impede economic empowerment in mitigating vulnerability to HIV/AIDS. In this

regard, the following were tested from the respondents, the opinion leaders and the CBO leaders interviewed on ownership of property, decision making, negative cultural practices and gender roles.

4.6.1 Ownership of property and vulnerability to HIV/AIDS

The researcher wanted to find out how property ownership differs between men and women. Further, the researcher wanted to find out who was responsible for herding cattle. The responses were illustrated in table 4.15.

Table 4.15

Ownership of property, herding of cattle and vulnerability to HIV/AIDS

Who owns land, cattle, and estate?						
Who herds the cattle	Man	Woman	Both	Others	Total	Percent (%)
Man	4	3	22	1	30	14.9%
Woman	58	11	29	2	100	49.8%
Both	4	0	5	0	9	4.5%
Others(specify)	12	21	10	19	62	30.8%
Total	78	35	66	22	201	
Percent	38.8%	17.4%	32.8%	10.9%		100.0%

Out of the 201 respondents, 78(38.8%) agreed that higher percentage of men own the property.35 (17.4%) reported that women own property, 66 (32.8%) reported that both man and woman have equal rights in ownership of property while 22 (10.9%) reported that other people such as in laws have the right of ownership to property. On the other hand, 30 (14.9%) reported that men take the role of herding cattle, while 100 (49.8%) reported that women take the leading role of herding for their husbands, 9 (4.5%) reported that both men and women herd cattle while 62 (30.8%) reported that other people such as children and herds boys herd the cattle. This is evident in the cross-tabulation between who owns property and who herds

the cattle as indicated in the table 4.15. These are the valued property yet women do not have the ownership. They have no right to make productive use of this property and this reduces their economic power and decision making thus increase their vulnerability. Qualitative data collected from one of the opinion leaders who were among the key informants reported that *"The reality is that women have less personal autonomy, fewer resources at their disposal, and limited influence over the decision-making processes that shape their societies and their own lives. Additionally, there is little opportunity for a woman to acquire a piece of land. Indeed, even when the husband dies, the customary law still does not acknowledge the wife as having full rights to that land left by her deceased husband. In that context, widows and divorced women have virtually no tenure or inheritance rights with which to ensure food security for themselves or their children; it is only through their male children, or male relatives from their husband's lineage, that women have land tenure rights."*

It can be interpreted that a landless situation keeps women in a vulnerable context, given the fact that they are not free to use the land still called the property of their husbands or even their male children. They cannot utilize the land optimally to the extent of raising their levels of income. This is in line with the study carried out by Wanyoike (2011) on 'Perception of Samburu Rural Women in Kenya with Regard to HIV/AIDS' which reported that the main drivers of the AIDS epidemic in women are the social norms and values that relegate women to a lower status, where she is looked upon as a social minor or a second class citizen who cannot inherit or own property or make independent financial decisions.

4.6.2 Decision making and vulnerability to HIV/AIDS

The researcher in this question, wanted to find out the main decision maker in the house household. The respondents were asked who the main decision maker in the household is. The responses were illustrated in table 4.16.

Table 4.16

Decision making and vulnerability to HIV/AIDS

Decision maker	Frequency	Percentage
Woman	59	29.4
Man	118	58.7
Both	24	11.9
Total	201	100.0

Out of 201 respondents, 118 (58.7%) reported that men are the main decision makers. 59 (29.4%) reported that women are the decision makers while 24 (11.9%) reported that both man and woman are decision makers in the household. From the analysis it could be noted that women have few chances of making decisions in households. Unequal power relationships between men and women in sexual decision making, for instance results in fear of disrupting a relationship by bringing up sex issues such as condom use. This may make women passive sexually and in many other ways hence vulnerability to HIV/AIDS. One of the CBO leaders who were among the key informants illustrated that:

"Women have no right to decide on an income generating project, how many children to have, which schools to take the children to, and even the kind of clothing to own. They cannot decide on the kind of farming activities for the family. Widows are most disadvantaged, they cannot decide on whether to be inherited or not, they are forced into it and they can even be ejected out of the families should they resist inheritance."

This statement clearly shows that women are economically disempowered because they have to seek authority from their male partners whenever they want to engage in an income generating activities and even their reproductive health. This is in line with studies done by Family Health International (1998) on 'Family Planning and Women's Lives' which reported

that decisions regarding to sexual and reproductive health information and services are often made by male partners or parents in law.

On a further analysis, the researcher sought to know if there are certain times when women can make decisions without consulting other people. The responses were illustrated in table 4.17.

Table 4.17

Autonomous Decision Making and vulnerability to HIV/AIDS

Autonomous Decision making	Frequency	Percentage
Yes	133	66.2
No	68	33.8
Total	201	100.0

Out of 201 respondents who participated in the study, 133 (66.2%) reported that there are certain times when they make decisions without consulting other people while 68 (33.8%) reported that there are no chances of making decisions without consultation. The researcher further wanted to find out when the respondents can make decisions without consulting another person. Thus the respondents were asked to give examples of cases when they can make decisions. Out of 201 respondents, 97 (48.3%) reported that they made decisions on the kind of meals to prepare, 22 (10.9%) reported that they could make decision on when to go to the market, 10 (5.0%) reported that they could only make decision on farming activities, 2 (1.0%) reported that they could make decisions on the company to work for and other 2 (1.0%) of the respondents reported that they could make decisions on when to go for further studies. Quite a significant number, 68 (33.8%) however reported that they were not aware of cases when they could make their decision. From this finding, it could be noted that majority of women could make decision on very less productive things such as preparing meals and going to the market. This still confirms that women occupy a very low position in decision

making. This therefore reduces their economic empowerment since they don't take part in making decisions in areas that concern productivity thus they are unstable economically hence vulnerable to HIV/AIDS. It can be argued that women were not key decision makes because they had no rights to own property. Ownership of property such as land empowers women economically and thus they could have a bargaining power in matters that concern their lives. This concurs with Omutoko and Wambugu (2000) on 'Gender Issues in Development' reported that ownership of land and property empowers women and provides income and security. Without resources such as land, women have limited say in household decision making and this often relates to vulnerabilities such as HIV/AIDS.

4.6.3 Negative cultural practices and vulnerability to HIV/AIDS

In this question, the researcher was interested in finding out whether there were cultural practices that affected women negatively. The respondents were asked if they were aware of such practices and the responses were illustrated in table 4.18.

Table 4.18

Negative cultural practices and vulnerability to HIV/AIDS

Negative cultural practices	Frequency	Percentage
Yes	161	80.1
No	40	19.9
Total	201	100.0

Out of 201 respondents, 161 (80.1%) reported that they were aware of negative cultural practices while 40 (19.9%) reported that they were not aware and the responses were presented in table 4.18. From the analysis, it can be noted that there are negative cultural practices that disadvantage women. Culture refers to a people's way of life and every person is expected to conform to the cultural practices. Some cultural practices are perceived to be the main causes of the spread of HIV especially where women are concerned. This concurs

with Mill & Anarfi (2002) in a study on 'Poverty and HIV/AIDS' which reported that cultural beliefs and practices relating to fertility and sexuality may represent significant barriers to the adoption of HIV prevention strategies by women.

To explore further, the respondents were asked to mention three examples of such negative cultural practices and the responses included the following: widow inheritance, polygamy, early forced marriage, taboos such as women can't own property, once married a woman can't go back to the parents despite the hardships experienced, a woman without a man is not supposed to build a house.

4.6.3.1 Polygamy and vulnerability to HIV/AIDS

Polygamy is accepted in Luo community in which Lower Nyakach division is found. Men are known to have up to ten wives. Polygamy is a cultural indicator of one's economic status. The women among the opinion leaders who were among the key respondents were asked if they saw any connection between HIV/AIDS and polygamy and one of them gave the following illustration:

"It is the worst since the wives are mostly not in terms and so if one gets the virus then it spreads to the rest. If the man is infected it gets to infect the women so easily because they had no control of the situation and the fact that they had other sexual partners apart from their wives."

A CBO leader who was among the key informants pointed out that, 'Polygamy continues and even if men are aware of the dangers they do not want to change. The older women felt that it was the younger women who were spreading HIV/AIDS because they had other sexual partners in addition to their husbands. The women do have an idea how HIV can spread in a polygamous setting especially through the young brides who are married off to older men without their consent but by their parents.' This finding concurs with Susser (2000) on his study on 'Culture and Sexuality' who reported that the call for monogamy is unlikely to

be heeded because polygamy is widely accepted in many African societies. HIV prevalence is high in those who are in polygamous unions in Kenya.

4.6.3.2 Early Marriage and vulnerability to HIV/AIDS

The age difference between men and women was also pointed out. The community does not see the link between early marriage and vulnerability to HIV/AIDS. Qualitative data collected from one of the opinion leaders, the key informants reported that, "Early marriage has created a problem for the empowerment of women because they had little or no education as they did not have a chance to go to school because they had been married early." It can be interpreted that the fact that young girls are married off to older men gives them an impetus to go out and seek younger men and the fact that they have multiple partners increases the risk of getting HIV. Young girls are especially vulnerable to HIV/AIDS because they are introduced to the world of adult sex when they are prematurely married off as children. This concurs with UNAIDS (2008) report on 'Global HIV/AIDS' which observed that promoting universal education has shown that higher educational levels have lower HIV prevalence. Taking girls to school reduces girls HIV risk and vulnerability. Girls who complete primary education are more than twice as likely to use condoms; while girls who finish secondary school education are between 4 and 7 times less likely to be infected with HIV.

4.6.3.3 Widow inheritance and vulnerability to HIV/AIDS

The study revealed that wife inheritance is a cultural practice which the people of Lower Nyakach still hold on to very strongly. Wife inheritance is a cultural aspect that is a possible conduit for the spread of HIV/AIDS. Qualitative data was collected from the opinion leaders who were among the key informants where they were asked to state whether there was a link between HIV/AIDS and widow inheritance. It was reported that, "Widow inheritance has played a major role in the spread of HIV/AIDS because somebody can be inherited when the husband had all the signs of the disease but still they will follow the

culture. The community still believes in the culture.” One of the CBO leaders who were among the key informants reported that, “A widow’s privileges are taken away from her with the demise of her husband to the extent that she cannot be a functional member of the community unless she gets a male companion from the clan. She does not own any livestock, which is an economic strength. The widow becomes vulnerable to HIV infection either through inheritance or through sexual relations with other men in the community to support herself.” This finding concurs with Wanyoike (2010) in his study on ‘Perception of Samburu Women in Kenya with Regard to HIV/AIDS’ which reported that the widow cannot transact any business regarding the sale of cows and goats even if her husband had many cows and goats, it is the inheritor to sell on her behalf.

4.6.3.4 Taboos and vulnerability to HIV/AIDS

The study revealed that taboos such as once a woman is married, she cannot go back to her parents despite hardships experienced, women can’t own property, and that issues of sexuality should not be discussed openly had exposed women to HIV/AIDS. Qualitative data collected from the opinion leaders revealed that, “Married women must live with their husbands even when they are undergoing some form of violence.” This makes women endure abusive marriages that sometimes deny the chances of economic empowerment. Additionally, when women have no right to own property, they become vulnerable because this forces them to exchange sexual favours to meet their demands as it has been discussed in objective two. This concurs with Mill and Anarfi (2002) on his report on ‘HIV Risk Environment for Ghanaian Women’ reported that the sexual communication taboo inhibits open discussion about sexual issues both between partners and between parents and children. Openly discussing sexuality is seen as encouraging promiscuity and is viewed as a violation of traditional values and cultural practices.

4.6.4 Gender Roles and vulnerability to HIV/AIDS

In this section, the study sought to find out how gender roles were determined in the community and the responses were illustrated in table 4.19.

Table 4.19

Gender roles and vulnerability to HIV/AIDS

Gender roles	Frequency	Percentage
Family Unit	51	25.4
Society	150	74.6
Total	201	100.0

Out of the 201 respondents, 150 (74.6%) reported that society determined gender roles while 50 (25.4%) reported that family unit determined gender roles. From the analysis, it could be noted that roles are assigned to men and women by the society thus cannot be changed at individual levels. Qualitative data collected from the opinion leaders who were part of the key informants were asked to state some of the factors that may hinder women's participation in community affairs. It was reported that, "Women are expected to be submissive to their husbands and remain in the home to take care of the children." It could therefore be interpreted that the society is unfair to women because these roles that are assigned to them confine them to the extent that they cannot take part in the income generating activities thus they become vulnerable to HIV/AIDS should their spouses die. These limited women's effort and lag behind in economic empowerment. This is in line with Wambugu and Omutoko (2000) in 'Gender Issues in Development' which reported that roles influence relationship between men and women. For example, women were expected to get married and stay home to raise a family. The men were expected to go out to work to support his family.

4.7 Sensitization and training and economic empowerment in mitigating vulnerability to HIV/AIDS

In this objective four, the researcher sought to examine the level at which sensitization and training impedes economic empowerment in mitigating vulnerability to HIV/AIDS. In this regard, the following were tested from the respondents, the opinion leaders and the CBO leaders interviewed on: Knowledge on STIs, sources of information, HIV preventive measures and level of knowledge on vulnerability.

4.7.1 Knowledge on STIs and vulnerability to HIV/AIDS

The researcher sought to know the respondents' level of knowledge on sexually transmitted diseases. When asked whether they knew any sexually transmitted diseases, all the respondents reported that they were aware that there are diseases transmitted through sexual intercourse. 201 (100%) respondents knew sexually transmitted diseases.

To verify this information, the respondents were asked to give examples of the STIs they know and the responses were illustrated in table 4.20.

Table 4.20

Knowledge on STIs and vulnerability to HIV/AIDS.

Sexually Transmitted Diseases	Frequency	Percentage
Syphilis	1	0.5
HIV/AIDS	5	2.5
All the above	16	8.0
1st three	179	89.0
Total	201	100.0

Out of the 201 respondents, 1 (0.5%) reported that she knew syphilis only, 5 (2.5%) reported that they knew HIV/AIDS only, 16 (8.0%) reported they knew all the above while 179 (89.0%) reported that they knew the first three only. While Lower Nyakach women were aware that there was HIV/AIDS, their knowledge level about its details was very low and many misconceptions existed. This was confirmed by qualitative data from opinion leaders who were the key informants of the study. It was reported that, 'Women have very scanty knowledge on HIV/AIDS. This is ascribed to various factors such as illiteracy.' It was also reported by the CBO leaders who were part of the key informants that, 'Most women have low levels of education and therefore cannot access more information on HIV.' Another CBO leader reported that, 'Lower Nyakach women have scanty information about HIV/AIDS because they were preoccupied with problems of lack of enough food thus they did not want to involve themselves in matters pertaining to sensitization given that they spent much of their time trying to fend for their families.' It can therefore be concluded that women respondents did not have adequate knowledge as a result of the low levels of education. This therefore put them at risk of contracting HIV/AIDS. This is in line with KDHS (2010) report that information access increases with educational attainment for both men and women.

4.7.2 Sources of information and vulnerability to HIV/AIDS

In this question, the researcher sought to further investigate on the sources of information that Lower Nyakach women relied on. The respondents were asked to mention their sources of information and the responses were illustrated in table 4.21.

Table 4.21

Sources of information and vulnerability to HIV/AIDS

Sources of information	Frequency	Percentage
Media	133	66.1
School/Church	20	10.0
Health Facilities	28	13.9
Friends	20	10.0
Total	201	100.0

According to table 4.21, out of 201 respondents who participated in the study, 133 (66.1%) reported that they relied on electronic media for information on HIV/AIDS, 20 (10.0%) reported that they relied on school and churches for more information on HIV/AIDS, 28 (13.9%) reported that they relied on health facilities for more information on HIV/AIDS while 20 (10.0%) reported that they relied on friends for more information on HIV/AIDS.

4.7.2.1 Media and vulnerability to HIV/AIDS

From this analysis, it could be concluded that majority of the Lower Nyakach women relied on electronic media for more information on HIV/AIDS. Qualitative data collected from the opinion leaders who were key informants reported that, "Radios are the main electronic media that most households own. This is because of low levels of income among most women; they can only afford to purchase small radios to listen to announcements. Additionally, radios are the only means through which information is relayed in their local language." It can be argued that ordinarily, certain aspects of language would be missed when information is not passed in its original language. This means that women missed certain important pieces of information that could have been of great help to them. Qualitative data from the CBO leaders who were among the key informants also reported that, "Low levels of education also play a role in limiting sensitization among Lower

Nyakach women.” As had been earlier analyzed, majority of the respondents had low levels of education. This meant that they could not rely on information in print media. Even though the respondents could read and write, it was reported by the key informants that, “Reading is one thing that the women do not like.” A CBO leader reported that, “Women, when issued with booklets that contain information on HIV/AIDS, are reluctant to receive them. They often complained, ‘I will not be able to read the small letters. I will also not get time to read them’.” From such complaints, it could be interpreted that women were not well educated hence lacked interest in reading. This stems from the fact that women have a secondary status, their educational levels and literacy rates are low and therefore they are reached less effectively by anti-AIDS campaigns relying on printed materials such as pamphlets, posters, and brochures. This is in line with The Kenya National HIV/AIDS Strategic Plan (2005) which also observed that there is a need to use prevention strategies that adapt to the language and situation of a given group.

4.7.2.2 School/ church and vulnerability to HIV/AIDS

It was also recognized that a section of the respondents relied on church or schools for more information on HIV/AIDS. This could be probably because those women could not afford to buy radios, TVs and even magazines due to their low income. Qualitative data from the opinion leaders who were part of the key informants reported that, “Because of low economic status of women, they only rely on information they get from schools and churches.” Thus religious leaders play a very powerful role as opinion leaders in their respective communities. They can appeal to the moral code of their followers and also provide a supportive environment for people and families of people living with HIV/AIDS. However, some of the religious leaders have been in the forefront in the fight against HIV prevention tools such as the condoms thus failed to inform their audience on the importance of condoms. This has therefore increased the vulnerability of the women. This concurs with Agha (2003) on his study on ‘The impact of a mass media campaign on Personal Risk

Perception' which reported that the church in Kenya has fought against the use of condoms to fight against HIV as well as the introduction of sex education in the Kenyan curriculum.

4.7.2.3 Health Facilities and vulnerability to HIV/AIDS

It was recognized that other respondents relied on health facilities for more information on HIV/AIDS. However, as reported by opinion leaders who were the key informants of the study, "Health facilities are charging levies on the clients. The services are not offered for free. This therefore deters some women from visiting the health facilities if they consider their cases not so serious." A female opinion leader reported that, "Some women prefer to deliver their babies at home due to lack of money. They seek the services of the Traditional Birth Attendants who have been sanctioned and trained previously." This practice has been discontinued by the government of Kenya but it still goes on unabated. The Traditional Birth Attendants are in danger themselves of getting infected and so are the women because they do not know the status of the attendants, and chances of a baby getting infected from a HIV/AIDS positive mother are high. It is therefore concluded that they risk their lives so much by delivering at home since most of the precautions are not taken into consideration. This is opposed to when a woman delivers in the health facility where she would get better services and will also be taught health issues. This is in line with Wanyoike (2011) in the study on Perception of Samburu Rural Women in Kenya with Regard to HIV/AIDS reported that very few women attend ante-natal clinics where information about mother-to-child transmission is available, because they do not think it necessary.

4.7.2.4 Friends and vulnerability to HIV/AIDS

According to table 4.21, out of 201 respondents who participated in the study, 20 (10%) reported that they relied on friends for more information on HIV/AIDS. However, given that most women in Lower Nyakach have low levels of education, it could be argued that they may not have the knowledge necessary to adopt safer sexual behaviours. Qualitative data collected from CBO leaders who were among the key respondents reported

that, "Women are shy to discuss HIV/AIDS issues with other people other than their peers. They therefore feel freer to discuss with their friends but not any other." This implied that the respondents who relied on friends for more information on HIV/AIDS could only receive very scanty information. This is in line with UNAIDS (2004) which reported that rural women have been observed to be the least informed about transmission of HIV/AIDS.

4.7.3 Knowledge on ways of acquiring HIV/AIDS and vulnerability

In this question, the researcher wanted to find out if the women were aware of ways through which HIV/AIDS is acquired. The following question was asked: in what ways can one acquire HIV/AIDS? The options provided included blood transfusion, mother-to-child, sharing body piercing/cutting instruments, all the above and lastly, don't know. The responses were presented in table 4.22.

Table 4.22

Knowledge on ways of acquiring HIV/AIDS and vulnerability

Ways of acquiring HIV/AIDS	Frequency	Percentage
Sexual Intercourse	49	24.4
All the above	152	74.6
Total	201	100.0

Out of the 201 respondents who participated in the study, 49 (24.45%) reported that HIV/AIDS can only be acquired through sexual intercourse while 152 (74.6%) reported that HIV/AIDS could be acquired through all the options provided. From this analysis, it is clear that all the respondents (100.0%) knew that HIV/AIDS is acquired through sexual intercourse. Despite the awareness, most of the respondents still are the most vulnerable group. This could be due to the fact that the women do not have adequate knowledge concerning the disease. Qualitative data collected from the opinion leaders who were among the key respondents reported that, "In as much as women were aware that HIV/AIDS is

acquired through sexual intercourse, there are some knowledge gaps associated with it because of lack of sensitization and training. It is reported that majority of women do not know how to read the symptoms of HIV/AIDS. It is therefore hard for them to discover that their spouses are infected or not. They will continue engaging in unprotected sexual behaviour. Lack of knowledge on the symptoms of the scourge is as a result of low levels of education that the women had." This is a knowledge gap that has continued to put women at risk. Additionally, a CBO leader that deals with HIV/AIDS and was part of the key informants reported that, Women do not know their HIV status and their spouse's status and that is why they are at risk." It was reported that when a woman was asked why she did not know her status, she illustrated that:

"I don't like VCTs because of the stigma associated with the disease if you are diagnosed and you are positive, you don't have friends, you have no company. VCT is not something that has been embraced."

It is clear from the above sentiments that VCT as a concept is not well understood and is not accepted because of the fear, stigma and discrimination that it created for the community.

Qualitative data from the CBO leaders who were part of the key informants reported that, "Women in Lower Nyakach Division do not know about Post Exposure Prophylaxis therapy (PEP)." When asked to describe the knowledge level of women regarding PEP, it was reported that, "Women are not aware that rape or forced sex could make them vulnerable to HIV/AIDS infection. They are not aware of the existence of PEP and so even after forced sexual intercourse or rape; they remain quiet and not discuss it with anyone."

Even though, Lower Nyakach women were aware of the ways through which HIV/AIDS is acquired, there were deadly myths regarding the transmission that put women at risk. It was reported by the opinion leaders who was part of the key informants that, "Myths are very profound to the extent that they have been considered as crucial reasons for therapid spread of the pandemic. The most common is witchcraft instigated by a jealous neighbour.

These myths are provided as reasons for not adopting safer sexual practices especially condom use. It is common belief among some people that condoms, most especially government condoms, carry germs that spread HIV/AIDS.” These reports recognized that women were aware of the ways of acquiring HIV, however lack of knowledge, training and sensitization which was as a result of low levels of education left women vulnerable. This finding is in line with UNAIDS (2004) report on ‘Facing the Future Together’ which observed that basic AIDS education remains fundamental. Rural women have been observed to be the least informed about transmission of HIV/AIDS.

4.7.4 Knowledge on HIV/AIDS Preventive measures and vulnerability

In this question, the researcher wanted to find out whether the respondents were aware of HIV/AIDS preventive measures. To respond to this, women were asked the following question: List at least two HIV/AIDS preventive measures that you know of. The responses were presented in table 4.23.

Table 4.23

Knowledge on HIV/ AIDS preventive measures and vulnerability

HIV/AIDS preventive measures	Frequency	Percentage
Abstinence	15	7.5
Faithfulness	50	24.9
Screen blood	3	1.5
No share sharp objects	12	5.9
Condom use	121	60.2
Total	201	100.0

Out of the 201 respondents who participated in the study, 15 (7.5%) reported that HIV/AIDS is prevented through abstinence, 50 (24.9%) reported that HIV/AIDS is prevented through faithfulness, 3 (1.5%) reported that HIV/AIDS could be prevented through screening

blood before transfusion, 12 (5.9%) reported that by not sharing sharp objects, HIV/AIDS could be prevented whereas 121 (60.2%) reported that HIV/AIDS is prevented through the use of condoms. It can therefore be noted that women were aware of the preventive measures especially the condom use. However, one of the CBO leaders who provided qualitative data reported that, "HIV stigma and the resulting actual or feared discrimination based on lack of enough knowledge and misconceptions have proven to be the most difficult obstacles to effective HIV prevention." It could therefore be interpreted that both stigma and discrimination reduce the efforts to control the global epidemic and create an ideal climate for further spread of HIV. HIV stigma emanates from fears and associations of AIDS with sex, disease, death and taboo behaviours that may be illegal or forbidden such as pre and extramarital sex and sex work. This concurs with UNAIDS (2005) report on 'Intensifying HIV Prevention UNAIDS Policy Paper' which reported that Stigma accrues from inadequate awareness and knowledge about HIV that can lead to violence and abuse against certain people and groups.

From the analysis, it can further be noted that majority of the women only recognized use of condoms as the only way of preventing HIV/AIDS. There are other means through which HIV could be prevented. Therefore this implies that women lacked comprehensive knowledge about HIV preventive measures. Qualitative data collected from opinion leaders who were among the key informants and were asked: what do Lower Nyakach women identify as ways of preventing HIV/AIDS among themselves? It was reported that women had a narrow knowledge on the preventive measures. It was illustrated that:

"Due to the fact that women have a secondary status, their educational levels and literacy rates are low and therefore they are reached less effectively by anti-AIDS campaigns relying on printed materials such as pamphlets, posters, and brochures. Therefore keeping girls at school for a longer period raises the status of the girl child and they become more knowledgeable about their bodies and sexuality since this is

taught in schools and they also become more economically empowered later on by getting employment in the job sector".

The above statement clearly sum up the main reason behind the scanty knowledge that the women have in HIV/AIDS prevention- low levels of education which results in economic powerlessness. Closely connected to this are the HIV stigma and the resulting actual or feared discrimination based on lack of enough knowledge and misconceptions have also proven to be the most difficult obstacles to effective HIV prevention. In addition, condom use that majority of women were aware of has a number of limitations. Qualitative data from the opinion leaders illustrated the perception below:

"Condoms are a technology that women may influence but cannot control because it hinges on a male decision. Condom use is also based on the fact that a woman must negotiate the use of the same with an often-unwilling partner. This is because of Social, economic, cultural, and emotional forces that limit a woman's ability to negotiate the use of condoms. For the condom strategy to work, women must be able to discuss their use and sex with their partners, which is not the norm. The women also believe that when they are married, there is no need of using condoms because condoms deny them the pleasure derived from sex."

It can therefore be argued that there are also strong emotional barriers that may prevent a woman from discussing condoms because it hinges on matters of fidelity and trust. In many communities the use of condoms signifies distrust among partners rather than care and concern. When a couple does not use condoms it is a sign of intimacy. Women themselves have not warmed up to condom use because they find condoms unpleasant because they reduce sensation and they interfere with natural sex thus vulnerability to HIV/AIDS. The above illustration concurs with the study conducted by Heiss and Elias (1995) on 'Transforming AIDS Prevention to Meet Women's Needs' who reported that Psychological

factors may also prevent a woman from raising the topic of condom use because they feel that they are immune to infection and that it cannot happen to them.

4.7.4 Female condoms and vulnerability of HIV/AIDS

To explore the level of training and sensitization, the women were asked the following question: Are you aware that there are female condoms? The responses were presented in table 4.24.

Table 4.24

Female condoms and vulnerability to HIV/AIDS

Female condoms	Frequency	Percentage
Yes	66	32.8
No	135	67.2
Total	201	100.0

Out of 201 respondents who participated in the study, 66 (32.8%) were aware that there are female condoms while 135 (67.2%) were not aware that there are female condoms. From this finding, it could be noted that the level of training and sensitization was low. Qualitative data collected from the CBO leaders who were part of the key informants reported that, "Many women in Lower Nyakach are not aware that female condoms are available and it is because they have not been widely advertised. Female condoms are so expensive that women who are economically disempowered cannot afford them." This could be attributed to low levels of education among the women, especially those who live in the village. It is no wonder few women are even aware that prevention technologies such as the female condom exist and even if they knew that they existed they would not be able to afford them because of their low level of income, however female condoms help in preventing HIV. This is in line with UNAIDS (2005) report on 'Intensifying HIV Prevention UNAIDS Policy

Paper' which reported that female condoms are said to be effective in preventing pregnancy and STI including HIV prevention.

4.7.5 Level of knowledge of women on their vulnerability to HIV/AIDS.

In this section the researcher wanted to find out the level of knowledge of women on their vulnerability to HIV/AIDS. The women were therefore asked the following question: To what extent do you rate level of knowledge of women on their vulnerability to HIV/AIDS? The responses were illustrated in table 4.25.

Table 4.25

Level of knowledge of women on their vulnerability to HIV/AIDS

Level of knowledge	Frequency	Percentage
Excellent	05	2.5
Fair	68	33.8
Good	10	5.0
Very Good	07	3.5
Worse	111	55.2
Total	201	100.0

Out of 201 respondents who participated in the study, 5 (2.5%) reported that the level of knowledge of women on their vulnerability to HIV/AIDS was excellent, 68 (33.8%) reported that the knowledge of women on their vulnerability to HIV/AIDS was fair, 10 (5.0%) reported that the knowledge of women on their vulnerability was good, 7 (3.5%) reported that the level of knowledge of women on their vulnerability was very good whereas 111 (55.2%) reported that the level of knowledge of women on their vulnerability to HIV/AIDS was worse. From the analysis, it could be noted that majority of the women were not aware of the fact that they were vulnerable. As been explained in earlier sections, there

are salient factors that have caused the increase in numbers of vulnerability. Such factors include limited access to education, economic factors and cultural factors. However, women were still not aware that they were the ones most vulnerable and their vulnerability still increases due to low levels of sensitization and training. This concurs with UNAIDS (2004) report on 'Facing the Future Together' which reported that although women account for the majority of new HIV infections, this has not been reflected in the policies or the material resources committed to fight the disease and legal structures, instead of protecting women further expose them to HIV vulnerability.

CHAPTER FIVE

5.0 SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATION

5.1 Introduction:

This chapter summarizes the findings of the study. This is followed by conclusions arising from the findings, and the recommendations for policy action aimed at mitigating women's vulnerability to HIV/AIDS through economic empowerment. The chapter further explores areas of further research envisaged in contributing towards the reduction of women's economic powerlessness.

5.2 Summary of Findings:

The summary of the findings were represented as per the objectives of the study. It was found that majority of the women interviewed representing over 44% were of the ages between 26-35 years. This meant that they were within the productive ages. This could be translated into highly economically powerful lot: however, these women were economically powerless due to factors such as economic, cultural and education level. The women, due to their low levels of education, have not secured chances in the formal employment sector. A cross section of the study showed that despite the fact that most of the respondents were married, they were still the most vulnerable.

The first objective of the study was to establish the extent to which family status impedes women's economic empowerment in mitigating vulnerability to HIV/AIDS. Data analysis and interpretation revealed that the psychological consolation that when one is in a monogamous marriage then she is safe, and should not bother about preventive measures, have played a role in endangering the lives of women. More often than not, there are extra marital affairs for different reasons. The men get involved in extra marital affairs because it is believed that men are naturally polygamous. Women on the other hand engage in extra marital affairs because handouts that they get from the secret lovers. Female-headed families use sexual networking as an economic strategy as these women lack other avenues of earning

income they could use to sustain themselves and their families. The women usually have multiple partners to gain access to resources that —they do not command themselves.

In most households, men were the leaders and were charged with the responsibility of decision making. The women are considered second class citizens who cannot make useful decisions. Single and widowed women were the only ones who could make decisions on their own. The women were therefore left behind in most affairs of the family and community at large. In connection to this, most of the household duties are performed by the women. For instance, it was revealed that duties such as preparation of meals, general cleaning, cutting firewood, fetching water, herding cattle, going to the farm and going to the market were majorly performed by women. However a cross sectional study reveals that the women carried the burden of herding cattle and going to the farm that they were not entitled to. Women do not own valued property such as land and cattle. From this it is clear that most of the duties carried out by the women were not paying thus they remained economically disempowered. If women owned the land they cultivate and the cattle they look after, they would be economically empowered, gain financial independence hence lower vulnerability.

The study also revealed that women suffering from HIV/AIDS were treated with a lot of prejudice. Mothers tend to suffer blame and stigma when their infants or young adults become HIV infected. Many women do not want to be tested because of the stigma and the difficulties they would face such as partner rejection and psychological stress as a result of the diagnosis. In most cultures women are usually seen as the infectors as opposed to men who may be HIV positive and not diagnosed yet. The woman may have been discovered to have HIV before the man because of antenatal clinics, where mothers to be are tested for HIV as it has been pointed out by Eka (2000).

The second objective of the study was to establish how economic status impedes economic empowerment in mitigating vulnerability to HIV/AIDS. Data analysis and interpretation revealed that majority of the women in Lower Nyakach is self-employed.

Never the less, they were mostly working in low paying economic activities such as hair dressing, peasant farming, domestic workers and basket weaving. This was revealed when they were asked to state their monthly average income. Majority of the women earned between Kshs 5,000-10,000. Such meager income is not enough to sustain families. This is what may push such women into exchange of sex with handouts. The core reason behind the women's concentration in the informal sector with very low pay is the low levels of education that women possess. The research further revealed that women were the providers of basic household needs. It is ironical that the women who have very low income are the same ones expected to provide for the family basic needs. If women gain high level of education, they will access well-paying job opportunities in the formal sector leading to economic empowerment which in the end will lower their vulnerability to HIV/AIDS.

It was also revealed that women did not have control of the little income generated from the micro-economic activities they were involved in. This implies that women decision making powers are low to the extent that they cannot even control their own income that they have sweated for. This is a major impediment to economic empowerment which leads to vulnerability to HIV/AIDS within marriage. This is also connected to provision of household basic needs. It has been earlier discussed that women are the providers of household basic needs. Unfortunately, the same women do not have the ability to control the little income they generate. This leaves the women with only one option: look for whichever means to access the basic needs and that would imply offering sexual favours in exchange with money.

The study further revealed that HIV/AIDS mostly affected those who are between 25-34 years. Although it is beyond scope of research to assess the influence of age on sexual behaviour, its importance is worthnoting. The respondent's age greatly influences their knowledge and sexual behavior and should be included as an explanatory variable. Women in the teens are likely to behave very differently from those aged 20 and above and vice versa. The women who are between 25-34 years are still very active sexually and are in the

reproduction age bracket. While these women are active sexually, their level of knowledge is low due to low level of education. They are not well equipped with information on transmission and prevention of HIV/AIDS. This leads to susceptibility to HIV from either regular or irregular sexual partners.

Concerning credit availability, it was revealed that credit availability to Lower Nyakach was averagely available. In further analysis, it was revealed that credit was available but accessing was the problem. This was because the women lacked collateral. Given that women did not have the right to own property, accessibility to credit which is tied to collateral such as land is not within their reach. When women have the ability to access credit, then it would be possible for them to expand on their income generating activities and so will be able to have autonomy in decision making hence lower their chances of getting infected with HIV/AIDS.

The third objective of the study was to examine the extent to which cultural factors impedes women's economic empowerment in mitigating vulnerability to HIV/AIDS. Data analysis and interpretation revealed that cultural factors have impeded economic empowerment of women. Women's vulnerability is compounded by a male dominated society. Many cultural aspects of Lower Nyakach stand out as the main conduits facilitating the spread HIV/AIDS. Readily identifiable cultural aspects that predispose Lower Nyakach women to HIV/AIDS include polygamy, early marriages, wife inheritance and numerous taboos. Polygamy is accepted in the area and men are known to have more than one wife. The study revealed that wife inheritance is a central cultural practice and any widow trying to resist it may be subjected to rejection. Early marriages were as a result of drop out from school due to lack of economic resources. Although gender is considered culture specific, there is consistency across cultures in difference between women's and men's roles, access to resources and decision making authority. The findings revealed that because of cultural norms, women were not entitled to ownership of property such as land because they were

viewed as foreigners. They could only make decisions on very small issues such meals to prepare.

The fourth objective was to assess how sensitization and training impedes women's economic empowerment in mitigating vulnerability to HIV/AIDS. The information from data analysis and interpretation is that most women in Lower Nyakach had very little training and sensitization pertaining to transmission and prevention of HIV/AIDS. It was further revealed that the women themselves had little knowledge that they were the most vulnerable. It was revealed that even though women were aware HIV/AIDS is transmitted through sexual intercourse, they had little knowledge on their partners HIV status. The women do not know how to read the signs and symptoms of HIV/AIDS. It was also revealed that in as much as women are aware of condoms as a preventive measure against HIV/AIDS, they do not have the higher bargain. The man decides on whether to use it or not. This was as a result of low level of education which leads to women's lack of bargain for safe. Additionally women are not even aware of the existence devices such as female condoms.

5.3 Conclusions

The study investigated impediments to women's economic empowerment in mitigating vulnerability to HIV/AIDS in Lower Nyakach Division. This was in relation to Akinyi's report (2011) that observed that economic empowerment is a strategy on women's HIV/AIDS risk behaviour change. The study therefore sought to investigate impediments to economic empowerment. To achieve this, the researcher, sought to establish the extent to which family status impedes women's economic empowerment in mitigating vulnerability to HIV/AIDS in Lower Nyakach and concludes that female headed households with low income use sexual networking as an economic strategy as these women lack other avenues of earning income they could use to sustain themselves and their families. Women have multiple partners and offer them sexual favours in exchange of money and food items. Women spend much of their time to perform most of the household duties which are not paying. This leaves them with

very little time left to try and engage in paying duties. Stigma and discrimination from family members have also made women face rejection and this has hindered many women from knowing their HIV status so that they can change their sexual behaviours. Therefore it can be concluded that family status is an impediment to women's economic empowerment in mitigating vulnerability to HIV/AIDS.

The study sought to establish how economic status impedes women's economic empowerment in mitigating vulnerability to HIV/AIDS in Lower Nyakach Division and concludes that majority of the women in lower Nyakach are not formally employed. Most of them are in the informal sectors where the income is very low. This is due to the fact that their level of education is low. Findings indicate that due to the low levels of income, these women are not able to fend for their families thus resort to live unsafe relationships, and can cause individuals to feel unsafe in their communities. Women of low economic status are more likely to experience coerced sex, or exchange sex for money, gifts, food and shelter. It was also revealed that women were the main providers of the household basic needs despite their low monthly average income. From this finding it can be concluded that women engaged in unsafe sexual behaviours in order to provide for the household. The study also revealed that majority of those infected with HIV/AIDS are those falling between 25-34 years thus it can be concluded this has contributed a great deal to the economic powerlessness of the women given that this is the most active age group. Even though 56.7% of the women interviewed reported that availability of credit to women is average, its accessibility is very low due to lack of collateral. It can be concluded that women cannot access credit because they do not own property that can act as collateral.

In seeking to understand the extent to which cultural factors impede women's economic empowerment in mitigating vulnerability to HIV/AIDS in Lower Nyakach Division, the study concludes that vulnerability of women is as a result of gender inequalities that are evident in the lives of women. These gender factors that fuel the spread of HIV as a

result of cultural oppression of women resulting in the greatest number of new infections; millions of women sexually subjugated to forced sex without protection, women without the power to say no to risky sex and without the right to negotiate safe sex. The combination of cultural and economic factors has fuelled the spread of HIV/AIDS in the lives of women. Culture has it that good women don't discuss sexual matters. Women have therefore been left behind in knowledge concerning their sexuality. It can therefore be concluded that these norms prevent women from being knowledgeable about their bodies, sexuality and STI and HIV prevention. This then constrains women from making informed decisions about their sexual behaviour and sexual health. Lack of information also limits the women's ability to identify abnormal gynecological symptoms of sexually transmitted infections. It can also be concluded that the Lower Nyakach women are greatly disadvantaged due to cultural practices that expose them to high chances of contracting HIV/AIDS. The practices that make the women susceptible to HIV/AIDS infection range from early marriage, multiple partners in marriage in terms of polygamy and widow inheritance.

The study sought to establish how training and sensitization impedes women's economic empowerment in mitigating vulnerability to HIV/AIDS and concludes that the messages that the women have received have not led to behaviour change due to impediments such as the low status of women, low literacy levels and cultural barriers. Women have very scanty knowledge on transmission and preventive measures of HIV/AIDS. For example, women are aware that condoms help prevent HIV/AIDS but they don't know that female condoms exist. It implies that such women have very low levels of knowledge which is as a result of low level of education. Lower Nyakach women have not received training and sensitization on the importance of condom use. Qualitative data revealed that women themselves do not prefer to use condoms as it denies them pleasure. They also oppose the use of condoms because they believe that once in a marriage, then they are safe from HIV/AIDS. Additionally, women do not have training and sensitization on the importance on knowing their HIV status. It is

important to know one's status as it will help them change their behaviour accordingly. . In conclusion, low level of training and sensitization is as a result of low level of education that women have.

The limited knowledge they have is distorted and mediated by cultural beliefs and understandings. The subservient position of women renders them powerless to make any decisions regarding their sexuality. Lack of education further disadvantages the women as they become resistant to change with regard to cultural practices which put their health at risk.

5.4 Recommendations for Policy Action

These recommendations are based on the findings of this study.

The study has shown that family status impedes women's economic empowerment in mitigating vulnerability to HIV/AIDS and therefore the study recommends that programmes aimed at economic empowerment range from income-generating schemes to enhanced legal protection for female headed households. Micro-credit or finance programmes aimed at investing in self-employment include credit, savings and capacity-building programmes particularly beneficial to women. Credit programmes to maintain household expenditure and schooling or benefit packages including food, schooling and clothing can provide immediate relief. Prevention efforts need to work at reducing HIV related stigma among the low income groups and high income groups alike for failure to do as such might result in the breeding of a silent epidemic among the vulnerable group, whose impacts will not only be isolated among this population group but will affect the whole family. This could be done by broadcasting more documentaries on HIV/ AIDS and ensuring a balance between the population groups.

The study also recommends that women have to be economically empowered so that they can provide for themselves and also have bargaining power. This can be done through women's projects and small enterprises where they are able to generate their own money which will give them a degree of independence. To achieve this, the government should

reinforce its policies and work with the community leaders and elders to put an end to early marriages and to reduce the high school dropout rate of girls. The fact that the government has not taken serious steps on early marriages has encouraged the community to continue to expose the girl child and women to harmful practices that make them susceptible to HIV/AIDS. Allowing girls to get an education, and keeping girls in school longer, ideally until they are eighteen, is one way of keeping them out of early marriages. In this way they could receive primary and secondary education which would give them more economic opportunities.

The study further recommends a participatory approach to the fight of HIV/AIDS is recommended instead of a comprehensive approach that is not sensitive to people's cultures. Cultural sensitivity is paramount. Ways within the cultures should be explored so as to stop the spread of HIV/AIDS. It is important to engage respected and accepted people in the community such as pastors and religious leaders, as well as the elders in effecting behaviour change within the locality. There is a need to create more awareness about the risk of wife inheritance which is a major pathway of the spread of HIV/AIDS and to encourage HIV testing before those unions. The elders should also be educated about the dangers of wife inheritance and encourage HIV testing to ascertain the status of both the inheritor and the widow as a way of controlling the spread of HIV/AIDS.

Lastly, the study recommends that there is a need for greater awareness regarding the need and importance for knowing ones HIV status. Outreaches are required for women who do not visit VCTs in order to explain the dangers of not doing so and the necessary follow up for pregnant mothers. These outreaches must also be directed at men, political leaders and decision makers to acknowledge the importance of safe motherhood. The use of condoms as a protective tool could be a viable option but it is the sole decision of the man whether to use condoms or not. The men should be sensitized to first accept the condom as a way of

protecting their families. More awareness campaigns using the community health workers and involving men as well as the elders should be encouraged so that the community is sensitized.

5.5 Suggestions for Further Studies

1. Further research needs to be carried out more on quantitative research with men themselves as respondents to establish what can bring about behaviour change in men regarding HIV/AIDS.
2. Further research also needs to be carried out to determine role of economic empowerment in reducing vulnerability to HIV/AIDS.
3. A study should be carried out to assess effectiveness of HIV/AIDS messages that will fill the knowledge gaps in the HIV preventive measures.

5.6 Contribution to the body of knowledge

Table 5.1 highlights the major contribution to the already existing body of knowledge in promoting women's economic empowerment. It highlights the gains to be realized from the study which could be added to the present situation.

Table 5.1 Contribution to the Body of Knowledge

Objective	Contribution to knowledge
1. To establish the extent to which family status impedes economic empowerment in mitigating vulnerability to HIV/AIDS.	Female headed households with low income resorted to sexual networking in exchange of handouts. Men were the leaders and final decision makers in families.
2. To investigate how economic status impedes women's economic empowerment in mitigating vulnerability to HIV/AIDS.	Women with low levels of education find themselves in the informal job sector with very low pay. They have low bargaining powers to safe sexual behaviours thus vulnerability to HIV/AIDS.
3. To examine the extent to which cultural factors impede economic empowerment in mitigating vulnerability to HIV/AIDS.	Cultural practices such as widow inheritance and polygamy have subjected women to HIV infection.
4. To assess how training and sensitization impede women's economic empowerment in mitigating vulnerability to HIV/AIDS.	Low levels of training and sensitization as a result of economic powerlessness has increased women's vulnerability to HIV/AIDS.

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APPENDIX I

Letter of transmittal

P.O. BOX 1691

KISUMU

3RD FEBRUARY, 2012.

Dear sir/madam,

RE: RESEARCH

I am a post graduate student at The University of Nairobi currently carrying out a research study on Impediments of women's economic empowerment to mitigate their vulnerability to HIV/AIDS in Lower Nyakach Division, Kisumu County.

You have been chosen to participate in this study. I would be grateful if you could fill the questionnaires delivered to you for the purpose of this research study. The schedule given is to assist me get unbiased information. The information you give will be treated with confidentiality and for the purpose of the research only.

Your cooperation will be highly appreciated.

Yours faithfully,

ELIZABETH AKINYI ORUKO.

APPENDIX II

Letter seeking authority

P.O. BOX 1691

KISUMU

3RD FEBRUARY, 2012

THE DISTRICT OFFICER

LOWER NYAKACH DIVISION

PAP-ONDITI

Dear sir/madam,

RE: RESEARCH

I am a post graduate student at The University of Nairobi interested in studying Impediments of women's economic empowerment in mitigating their vulnerability to HIV/AIDS in Lower Nyakach Division. I therefore intend to administer questionnaires to 208 women and interview schedules to 10 opinion leaders and 10 CBO leaders. The findings will be confidential and I would be grateful if you could give me chance to carry out the research.

I am looking forward for your assistance.

Thank you.

Yours faithfully,

ELIZABETH AKINYI ORUKO.

APPENDIX III

Questionnaire for women

This questionnaire is designed for use to determine impediments to women's economic empowerment in mitigating vulnerability to HIV/AIDS. Do not write your name anywhere on this questionnaire since all responses is confidential. Thank you for your cooperation.

Date of interview _____

Code _____

SECTION A: DEMOGRAPHIC INFORMATION

1. Age. 18-25 26-35 above 35

2. Highest level of education

Primary Secondary College/university Never attended school

3. Marital status Single Married Divorced Separated Widowed

4. Are there dependents in this household? Yes No

5. If yes, how many? Girls Boys

6. Does this household have a leader?

Yes No

If yes, who?

Myself Husband Others (specify) _____

7. Do gender duties vary in your household differ? Yes No

If yes, who does the following duties?

Activities	Man	Woman	Both	Others(specify)
Preparing meals				
Washing clothes				
Cutting firewood				
Fetching water				
Herding cattle				
Going to the farm				
Going to the market				

8. Are you aware of your HIV/AIDS status? Yes No

9. How does a family treat a woman who is suffering from AIDS?

10. How do you as a family decide on the number of children you would wish to have?

Man Woman Both Others (specify) _____

SECTION B: ECONOMIC STATUS

1. What is your main occupation? Employed Self-employed
Unemployed

2. If self-employed, specify _____

3. What is your monthly average income? Belowkshs5,000 5,000-10,000
10,000-15,000 Above 15,000

4. Who mainly provides for the household basic needs? Man Woman Both

5. In what ways do you use your income? Household expenditure personal effects

6. Apart from yourself, is there another person who controls your income?

Yes No

7. If yes, who? Spouse In-laws others (specify) _____

8. From your own understanding, what age group is mostly affected by HIV/AIDS?

15 - 24 yrs. 25 - 34yrs 35 - 44yrs 45yrs and above

9. How would you describe the availability of credit to women like you? Not available

Averagely available Very available

C: CULTURAL FACTORS

1. Does your household own property? Yes No

If yes, kindly tick appropriately as per ownership.

Property	Ownership			
	Man	Woman	Both	Other
Land				
House				
Bicycle				
Poultry				
Cattle				
Estate				

2. In your household, who is the main decision maker?

Woman Man Both Others

3. As a woman, are there times when you can make certain decisions without consulting another person? Yes No If yes, kindly give an example.

4. Are you aware of certain negative cultural practices which affect women in your community? Yes No

5. If yes, mention a few

i. _____

ii. _____

iii. _____

6. How are gender roles determined in your community?

Family unit Society

SECTION D: SENSITIZATION AND TRAINING

1. Do you know of any sexually transmitted disease? Yes No

2. If yes which ones do you know? Tick the ones you know

Gonorrhoea Syphilis HIV/AIDS Candidiasis

Others (specify) _____

3. How did you get to know about the sexually transmitted diseases?

Friend Relative Peer Media

Seminar/meeting Health facility Others _____

4. What sources of information do you usually rely on when seeking understanding in HIV/AIDS?

- Print and electronic media Local leaders Church
 Seminar and workshops Internet Health facilities
 Sharing among friends Others _____

5. In which ways can one acquire HIV/AIDS? Sexual intercourse

- Blood transfusion Mother to child
 Sharing body piercing/cutting instrument All the above
 don't know

6. List at least two HIV /AIDS preventive measures that you know of.

- i. _____
ii. _____

7. Are you aware that there are female condoms? Yes No

8. To what extent do you rate level of knowledge of women on their vulnerability to HIV/AIDS? Worst Fair Good Very good Excellent

APPENDIXIV

Interview Guide for CBO leaders

This interview guide is designed for use to determine impediments to women's economic empowerment in mitigating HIV/AIDS vulnerability in Lower Nyakach Division. All responses will be treated confidentially. Thank you for your corporation.

Date of Interview _____

Target population: CBO leaders.

1. Gender: Number of male and female CBO leaders interviewed

Male Female

2. How long have you worked in Lower Nyakach Division
3. What objectives does your organization have in regard to HIV prevention in Lower Nyakach Division?
4. Does your organization have a specific programme for women?
 - a) If yes, describe the programme.
 - b) If no, explain why women are not given a programme of their own.
5. How would you describe economic status of women in Lower Nyakach Division?
6. In your opinion, what are some of the factors that hinder women's economic empowerment?
7. What is the knowledge level of Lower Nyakach women regarding how HIV is transmitted?
8. In your opinion, what do you think can be done to improve women's economic empowerment?
9. What possible missing information do Lower Nyakach women have regarding prevention of HIV/AIDS?

10. Could you identify some of the problems you have encountered in relaying information about HIV/AIDS to Lower Nyakach women?
11. What level of knowledge do Lower Nyakach Women have regarding PEP (Post Exposure Prophylaxis) therapy?
12. What mode of communication does your organization use to pass information about HIV/AIDS?
13. What are some of the communication challenges that you have encountered?
14. What, in your view, is the most effective way of having behaviour change in regard to risky sexual behaviour in Lower Nyakach Division?
15. In what ways, in your opinion, do men get involved in HIV/AIDS activities?

APPENDIX V

Interview Guide for opinion leaders

This interview guide is designed for use to determine impediments to women's economic empowerment in mitigating HIV/AIDS vulnerability in Lower Nyakach Division. All responses will be treated confidentially. Thank you for your cooperation.

Date of Interview _____

Target population: Chiefs and opinion leaders.

1. Gender: Male Female
2. Briefly describe the background of your community in terms of education, health and economic status for both men and women.
3. In your own opinion do Lower Nyakach women get entitled to economic resources such as land?
4. In your view, what are some of the factors that may hinder women's participation in family/community affairs?
5. How has HIV/AIDS affected in your community?
6. Between men and women, who is most at risk of contracting HIV/AIDS and why?
7. How do you get involved in HIV/AIDS activities?
8. How do the following groups regard a woman who is HIV positive:
a) Family b) Community
9. What do Lower Nyakach women identify as ways of preventing HIV/AIDS among themselves?
10. What is the role of men in the spread of HIV/AIDS among women?
11. What do Lower Nyakach women see as a link between the following and the spread of HIV/AIDS?

- a) Wife inheritance
- b) Multiple partners
- c) Early marriages
- d) Education level.

12. In your opinion, what are the possible connections between economic status of women and HIV/AIDS?

13. What are the knowledge gaps among women in regard to HIV/AIDS?

THIS IS TO CERTIFY THAT:

Prof./Dr./Mr./Mrs./Miss/Institution
Elizabeth Oruko
of (Address) University of Nairobi
P.O.Box 30197-00100, Nairobi.
has been permitted to conduct resca.ch in

Nyakach
Nyanza

Location
District
Province

on the topic: Impediments to women's
economic empowerment to mitigate their
vulnerability to HIV/AIDS in lower Nyakach
Division, Kisumu County.

for a period ending: 30th June, 2012.

Research Permit No. NCST/RCD/12A/012/74
Date of issue 22ND May, 2012
Fee received KSH. 1,000



[Signature]
Applicant's
Signature

[Signature]
Secretary
National Council for
Science & Technology

CONDITIONS

1. You must report to the District Commissioner and the District Education Officer of the area before embarking on your research. Failure to do that may lead to the cancellation of your permit
2. Government Officers will not be interviewed with-out prior appointment.
3. No questionnaire will be used unless it has been approved.
4. Excavation, filming and collection of biological specimens are subject to further permission from the relevant Government Ministries.
5. You are required to submit at least two(2)/four(4) bound copies of your final report for Kenyans and non-Kenyans respectively.
6. The Government of Kenya reserves the right to modify the conditions of this permit including its cancellation without notice



REPUBLIC OF KENYA

RESEARCH CLEARANCE PERMIT

G:PK605543mt10/2011

(CONDITIONS—see back page)

REPUBLIC OF KENYA



NATIONAL COUNCIL FOR SCIENCE AND TECHNOLOGY

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NAIROBI-KENYA
Website: www.ncst.go.ke

Our Ref:

NCST/RCD/12A/012/74

22nd May 2012

Date:

Elizabeth Oruko
University of Nairobi
P.O.Box 30197-00100
Nairobi.



RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on "*Impediments to women's economic empowerment to mitigate their vulnerability to HIV/AIDS in Lower Nyakach Division, Kisumu County,*" I am pleased to inform you that you have been authorized to undertake research in Nyakach District for a period ending 30th June, 2012.

You are advised to report to the District Commissioner and the District Education Officer, Nyakach District before embarking on the research project.

On completion of the research, you are expected to submit two hard copies and one soft copy in pdf of the research report/thesis to our office.

DR. M. K. RUGUTI, PhD) HSC.
DEPUTY COUNCIL SECRETARY

Copy to:

The District Commissioner
The District Education Officer
Nyakach District.