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SOCIO-CULTURAL CHALLENGES OF WOMEN LIVING WITH HIV IN MANYATTA INFORMAL SETTLEMENT KISUMU COUNTY, KENYA

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Abstract**:** *The study focused on establishing the socio-cultural challenges of women living with HIV in Manyatta informal settlement (shanties) in Kisumu County. Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) have been in existence for more than twenty years and women account for nearly half of the 40 million People Living with HIV/AIDS (PLWHAs). Earlier studies done in Kenya have largely concentrated on transmission and prevention of HIV/AIDS (NACC, 2015). However, there are limited studies that have been conducted on socio-economic challenges faced by women living with HIV in an informal settlement among communities living in Manyatta informal settlement in Kisumu County. The objective of the study was to determine the socio-cultural challenges of women living with HIV in Manyatta Informal Settlement, in Kisumu County. The study used descriptive research design and 110 respondents were sampled using purposive sampling technique. The respondents including key informants were served with questionnaires for quantitative data, while Focus Group Discussion were used for qualitative data. Data was analysed using descriptive statistics using Statistical Packages for Social Sciences (SPSS). Qualitative data was analysed using thematic content analysis. The analysed data or findings were presented in tables and graphs. The study found statistical significance in understanding socio- cultural and economic factors that impact on WLWHA. The findings of this study illuminate the socio-cultural and economic actions that hinder adherence to ART among WLWHA. The findings of this study would be useful to the guidance and counselling professionals for the improvement of their helping relationship with women living with HIV/AIDS.*

Keywords: *HIV/AIDS, Manyatta, Informal Settlement*

1. Introduction

HIV/AIDS is not an issue to be neglected today. Many people have been affected by HIV/AIDS worldwide. Women are the greatest growing population infected with HIV (Thomas *et al.*, 2009). Women represent half of the people living with HIV around the world (WHO, 2014). The burden of disease on women is even more challenging in many countries due to gender inequality. Women face many difficulties to access reproductive health services upon disclosure about their status. In addition, they might transfer HIV to their children due to mismanagement of their cases or lack of proper services in health care provision during childbirth. According to the centre for disease control and prevention in Granich *et al*., (2015) approximately one in four people living with HIV infection in the United States are women. The study further indicates that, good number new HIV infections in women are from heterosexual contact (84%). An estimated 88% of women who are living with HIV are diagnosed, but only 32% have the virus under control. The lack of a cure has caused an increased

fear of AIDS among many people, which has resulted in serious stigma and discrimination against WLWHA. These facts threaten the psychological well-being of WLWHA. Studies conducted in China revealed that nearly half of WLWHA suffered from anxiety disorders and that 20–32% of WLWHA were affected by depressive disorders (Bain *et al*., 2017). According to a study in Peru, poverty and low socioeconomic status contribute significantly to depression in impoverished women living with HIV (Wu et al., 2009). Dageid and Duckert (2008) found that poverty, gender inequality and the unequal distribution of resources place a heavy burden on women living with HIV.

More socio-cultural challenges facing communities in *Manyatta* settlements in Kisumu County include; Lack of education, information and empowerment amongst women, compounded with cultural beliefs and passive male participation were challenges that required urgent intervention in the region (Karanja, 2013).

In sub-Saharan Africa, 59% of adults with HIV are women (Shors, 2006). For instance, among the reported cases in Egypt, the ratio of females who live with HIV to males is (1:4) (WHO, 2014). This is unexpected as the global ratio is around (1:1). One of the authoritative explanations is that women have less access to testing services. Women living with HIV in Egypt are more likely to face stigma and discrimination due to cultural misconceptions. HIV is misperceived to be indicator for unacceptable sexual activities, women who live with HIV in Upper Egypt struggle to keep their status secret and some of them prefer to die rather than inform their status. In South Africa as well as other sub-Saharan African countries, most HIV- positive women live in poverty, are therefore not regularly employed, and are dependent on others for financial assistance (Amunyunzu-Nyanmongo *et al*., 2007; Gilbert & Walker, 2002). As a result, money and employment remains a great source of concern for many women living with HIV (Nyanzi-Wakoli *et al*., 2009; Olley, 2006).

Ghana, a sub-Saharan African country has about 250,232 women living with the HIV virus with an estimated 11, 356 new infection recorded in 2017; there were about 9, 248 HIV/AIDS related deaths recorded that year (Bain *et al*, 2017; Senard *et al*., 2017). And stigma which is one of the aspect of the socio-psychological perspective of HIV/AIDS is arguably one of the most important components in minimizing the spread of the disease and its impact on the lives of those infected, and most significantly affected.

In Kenya, the number of women infected is twice that of men and women account for 60% of the entire PLWHA (NASCOP, 2016). In the year 2007, 24.5% of people in Kenya tested H1V positive, whereby 34.8% were women whereas 16.5% were men (Musyoki, 2017). This alarming trend is caused by the vulnerability of women to HIV. The rates of HIV infection among women and girls are a cause for deep concern, but when combined with the workload that women take the situation becomes challenging. Poverty and HIV/AIDS have turned the care burden for women into a crisis with far-reaching social, health and economic consequences (NACC, 2006). Low- income earning women are the most hit and the problem is magnified if the woman is the breadwinner and more so in a female- headed household. Absenteeism from work due to poor health makes the affected households poorer than they would have been without HIV/AIDS. Households experience the immediate impact of HIV/ AIDS because families are the main caregivers for the sick and suffer AIDS- related financial hardships (Ashford, 2006).

Gender disparities are also observed with women having higher prevalence (8.7 percent) than men (5.6 percent). This shows that Kenya is one of the four HIV ‘high burden’ countries in Africa. In Kisumu County, the region is among the top 4 counties leading in HIV prevalence in Kenya. According to the Kenya HIV Estimates 2015, HIV prevalence in Kisumu is 3.4 times higher than the national prevalence at 19.9%. The HIV

prevalence among women in the county is higher (21.2%) than that of men (18.3%) indicating that women are more vulnerable to HIV infection than men in the County.

HIV/AIDS has economic implications on the infected woman and her family, and it becomes more challenging if the infected low- income earning woman is staying in an informal settlement area like *Manyatta* informal settlement. *Manyatta* is an informal settlement (shanties) in Kisumu County. It is one of the largest settlement where low income-earners reside and bordering Kondele area. Earlier studies that have been done in Kenya have largely concentrated on transmission and prevention on HIV/AIDS (NACC, 2015). However, there are limited studies that have been conducted on socio-economic challenges faced by women living with HIV in an informal settlement especially those living in *Manyatta* informal settlement. This information is to provide the basis for advocacy, mitigation policies and the design of effective interventions. This study therefore is aimed at establishing the socio-economic challenges facing women living with HIV/ AIDS within *Manyatta* informal settlement in Kisumu County.

The study generally aimed at investigating the Socio-cultural and economic challenges that impact on the well-being of women living with HIV/AIDS in *Manyatta* informal settlement in Kisumu County**.** *Manyatta* is referred to one of the informal settlement located within Kisumu County. Pacifically, the study aimed at determining the socio-cultural challenges of women living with HIV in *Manyatta* Informal Settlement, in Kisumu County. Furthermore, there lacks sufficient studies in Kisumu County conducted to determine the Socio-cultural and economic challenges that impact on the well-being of women living with HIV/AIDS in *Manyatta* informal settlement. This study sought to address the gap and to offer appropriate recommendations.

2. Literature Review

Socio-cultural position of women living with HIV

Life for HIV infected women is never easy; they manifest profound physical and psychological consequences (De Bruyn, 2012). Women bear a 'triple jeopardy' impact of HIV/AIDS: as person infected with HIV, as mothers of child, and as carers of partners, parents, or orphans with AIDS. Women living with HIV/AIDS (WLHA) are at particularly high risk of living a painful, shameful life of exclusion **(**Buzy & Gayle, 2016). Millions have been rejected from their family, friends and partners, thousands have lost their lives and thousands have been unable to live their life. Despite the burden of disease, the world is paying less attention to the issues raised by WLHA. Their voices remain unheard since it was first identified, HIV/AIDS has been linked with 'sexual misbehaviour' and 'promiscuity' contributing to the high level of stigma and Discrimination associated with it. Women are often even more susceptible to the stigma associated with HIV/AIDS and are frequently referred to as 'vectors', 'diseased' and 'prostitutes' (Fletcher & Cullinane, 2017).

Socio-Economic Challenges facing Women Living with HIV

With an estimated number of 40 million, India is the home to the largest number of widows in the world. Widows are often subjected to deep societal, cultural, psychological, and economic deprivation in the name of traditions. Deep seated patriarchal roots and unquestioned customs place widows at a defenceless position. They are often disdained, stigmatized, abused, and marginalized from the mainstream. A diagnosis of HIV further exacerbates the challenges of widowhood as now these HIV positive widows battle dual marginalization: being a widow and suffering from HIV. Diagnosis of HIV coupled with cultural factors which look down upon widows add on to already existing inferior status of widows. Paucity of literature related to HIV positive widows led to the conception of the present study, (Gupte *et al.*, 2007).

HIV/AIDS is a challenge and a problem in Kenya in particular (Kata, 2011). Many people are infected with this disease and most of them are not powerful economically. The available evidence shows that AIDS epidemic is having an enormous effect on household, which come in various forms: increased medical and health expenditures and decreased income. The result is a loss of savings, assets, and property in the affected households because HIV/AIDS imposes significant additional costs. This is magnified when the infected person is the bread winner. Absenteeism from work due to poor health as the disease progresses affects households and they become poorer than they would be without HIV/AIDS (Chuma & Molyneux, 2009).

3. Research methodology

Research Design

The study adopted a cross sectional descriptive survey research design. A cross-sectional survey collects data to make inferences about a population at one point in time. Kothari (2004) described this design as a snapshot of the populations about which they gather data. Cross-sectional surveys may be repeated periodically; however, in a repeated cross-sectional descriptive survey, respondents to the survey at one point in time were not intentionally sampled again, although a respondent to one administration of the survey could be randomly selected for a subsequent one. Therefore, data was collected from the study population at one time to examine the socio- economic challenges faced by women living with HIV in *Manyatta* informal settlement in Kisumu County.

Study Area

The study was carried out in *Manyatta* informal settlement in Kisumu County. The slum is one of the most densely populated slums in Kisumu County with a microcosm of many of the world's most vexing issues: poverty, healthcare, severe water shortage and the spread of HIV/AIDS (Karanja, 2013). Studies revealed that the highest poverty rates in Kisumu city were in Kolwa West and East Kisumu Sub County, where *Manyatta* informal settlement is located (CBS, 2005). *Manyatta* informal settlement occupies a total land area of 1.39 sq. km and with a population density of 6,200 people per sq. km.

The *Manyatta* informal settlement area was chosen since it was in line with the research problem, and it gave the anticipated information. *Manyatta* informal settlement in Kisumu was characterized by habitats who upheld socio cultural believes and myths and the affiliated socio-economic states for the habitants is low. Lack of education, information, and empowerment amongst women, compounded with cultural beliefs and passive male participation were challenges that required urgent intervention in the region (Karanja, 2013). The study area was generally cosmopolitan.

Methods of data collection and analysis

Primary data was collected using structured questionnaires. Burns and Grove (2003) confirmed that questionnaires were considered rich for both quantitative and qualitative research. The questionnaire was mainly composed of closed-type questions. Questionnaires were preferred as the most suitable instruments for the data collection because they allowed researchers to reach many respondents (or large samples) within limited time. Questionnaires were also suitable because they ensured confidentiality and thus helped to gather more candid and objective answers. The questionnaires were developed to address the objectives of the study. Kothari (2004) observes that questionnaires enable the person administering them to explain the purpose of the study and to give meaning of the items that may not be clear. The questionnaires were administered to the

110 women living with HIV. The questionnaires were divided into different categories to address each specific research question in addition to the general question. Questionnaires are deemed suitable for the study as not only did they allow for the collection of standardized information but were also relatively inexpensive to administer and easy to analyse (Creswell, 2014).

Data Analysis and Presentation

Upon completion of the data collection exercise, all completed research data was assembled, coded, summarized, and entered the computer; and analysed using the statistical package for social science (SPSS) version 24.0. Descriptive statistics were used to analyse the data. Descriptive statistics consisted of computation of sums, means, standard deviations, frequencies and percentages. The analyses were further amplified by subjecting selected results by use of graphical and tabular techniques permitting to some of the results to be presented in form of tabular matrices and pie / bar charts for clarity. Qualitative data were analysed using thematic content analysis. Qualitative data analysis provided ways of discerning, examining, comparing, and contrasting, and interpreting meaningful patterns or themes from data. Meaningfulness was determined by the objectives of the research study.

4. Demographic Response

The demographic responses were measured using age and level of education.

Age

Based on the results of the study, the highest number of participants was aged between 26 and 30 years of age, followed by those between 31 and 35 years. The study participants targeted by this research were aged between eighteen to forty years. Young women of between twenty-six and thirty years recorded the majority (43.64%) of the study participants. 20% of the women were in their 30's, 13.64% were below twenty-five year, women aged between thirty five to forty recorded 11.82 % while the list group of women entailed 10.91% those were above forty years. The predominance of majority young women was attributed to aspect of early marriages and high birth rates within *Manyatta* informal settlement. This information is presented in Table 1.

Table 1: Age Response

Age group	Frequency	Percent
18-25	15	13.6
26-30	48	43.6
31-35	22	20.0
36-45	13	11.8
50 and above	12	10.9
Total	110	100.0

Education Level

The highest education level attained by most of the participants was primary school level. Education was a core factor that this research investigated as it influences socio cultural and economic lifestyles of women

living with HIV/AIDS in *Manyatta* informal settlement. Under education the research had five clusters or categories: primary level, high school, college diploma, undergraduate and postgraduate. Majority (80.91%) of the participants were primary level dropouts. 16.55% were high school leavers, 2.73% had college diplomas, and 1.82% had university degrees. There were no study participants with post graduate education. Further discussions with the study respondents indicated that many of them were from extremely poor background and their parents were completely unable to raise funds for their education to further their education and that was the reason for dropouts. This information was presented in Table 2.

Table 2: Education level response

Education Level	Frequency	Percent
Primary	89	80.9
High school	16	14.5
Diploma	3	2.7
Undergraduate	2	1.8
Total	110	100.0

5. Women Diagnosed with HIV

This question focused on the participants who were diagnosed with HIV to determine exactly how many of them were directly affected. More than 90% of the participants were affected by HIV. This was a sensitive question and was asked cautiously. No respondent was forced to answer but they all chose to. The information was tabulated in table 3.

Table 3: Women Diagnosed with HIV Response

Responses	Frequency	Percent
Yes	100	90.9
No	10	9.1
Total	110	100.0

The researcher sought to establish the Cost of Transport to Health Facility as a Challenge Faced by Women Living with HIV in *Manyatta* informal settlement. This section provides analysis on mean and standard deviations regarding participant's response on Cost of Transport to Health Facility as a Challenge Faced by Women Living with HIV. The respondents were required to indicate the extent of their agreement or disagreement with the statements in relationship to challenges faced by *Manyatta* women living with HIV using the Likert scale year by ticking the box that best described their answer. Where Strongly Disagree (SD), mildly disagree (MD), Disagree (D), Agree (A) and strongly agree (SA). The analysis was done using mean and standard deviation and the results were tabulated as shown in Table 4.

6. Cost of Transport to Health Facility

From the results of the frequency tables based on standard deviation, it is easy to point out that most of the responses leaned toward strongly agreeing with the statements. This is shown specifically by the means where they are all above 3.48. Given that the Likert scale was between 1 and 5, with one being strongly disagree and 5 being strongly agreed, most women were agreeing. The individual statements indicate that most women agreed the cost of transport to health facilities was too high. This information is presented in Table 4.

Table 4: Cost of Transport to Health Facility Response

Description	N	Mean	Std. Deviation
Distance to health facility too long and costly	110	3.78	.952
I go Distance to health facility by foot	110	3.58	1.112
I go Distance to health facility on boda-boda	110	3.48	1.232
Transport is unaffordable	110	3.58	1.112

7. Cost of Treatment of Opportunistic Infections

The same trend was realized when the responses for the cost of treating opportunistic disease was analysed. More women leaned towards agreeing and strongly agreeing to the statements based on the means. A good example was when the women mostly agreed that they sometimes were not able to reach their clinics in time or ever because of lack of cash. Some of these women have had to walk on foot and then have no funds for medication. A separate problem that emerged was the lack of medication in the specific hospitals to treat the diseases, and thus they had to buy them from other selling points. The government medication was subsidized and thus it had a lower cost, which could be cost friendly to the women, however, if they were sold by independent pharmacists, the prices are likely uncontrolled and definitely higher, and thus unaffordable. The information is tabulated in Table 5.

Table 5: Cost of Treatment of Opportunistic Infections Response

Description	N	Mean	Std. Deviation
Don't get to clinic because of no money	110	3.39	1.342
Medication is scarce in this facility	110	3.78	.952
costly medication from pharmacy	110	3.58	1.112
Resulting opportunistic diseases is costly	110	3.48	1.232
Cannot afford prescribed drugs	110	3.58	1.112

8. Cost of Nutrition

The means relating to the cost of nutrition was even higher and closer to 5 than 1. Compared to the other two sections, the cost of nutrition scored the highest, indicating that more women strongly agreed that the cost of nutrition was high and that they could not afford it. HIV medication often required one to have good nutrition

and proper dieting. Most of the women were unable to take their medication because of hunger on many occasions. This information is tabulated in Table 6.

Table 6: Cost of Nutrition Response

Description	N	Mean	Std. Deviation
Amount of money to buy medicine has affected my health	110	3.77	1.029
Sometimes I do not take medication because of hunger	110	4.29	1.070
Recommended food is costly	110	4.29	1.120
Cannot afford recommended food	110	4.29	1.070

9. Regression results

The regression analysis is often used to test the hypotheses. The first hypothesis tested in this study was:

H1: the cost of transport to health facilities for women living with HIV in *Manyatta* Informal Settlement was too high.

Based on the ANOVA test, the hypothesis was accepted to prove that many women could not afford the transport costs to clinics. This was presented in Table 7.

Table 7: Coefficients

	Standardized Coefficients				
Description	B	Std. Error	Beta	**T**	**Sig.**
(Constant)	.663	.113		5.877	.000
Distance to health facility too long and costly	.061	.080	.203	.771	.442
Transport to health facility on boda-boda	.019	.114	.083	.170	.865
Transport is unaffordable	.029	.077	.110	.373	.710
Don't get to clinic because of lack money	.008	.095	.035	.079	.937

10. Discussions

The study revealed that young women of between twenty-six and thirty years recorded most of the study participants while older women were fewer. The predominance of majority young women was attributed to aspect of early marriages and high birth rates within informal settlement (*Manyatta*). The demographic alignment of these region to have more young women exposed to risks of HIV were because of poverty and lack of education as the main drivers. The discussions in this section are consistent with what most researchers who looked at HIV prevalence and risk factors in low-income areas found (Thomas *et al.,* 2016).

The highest education level attained by most of the participants was primary school education. Given the condition of the area as a low income earning as well as being an informal settlement, the areas was more likely to experience such levels of education as corresponds to low income. According to Orne-Gliemann *et al.,* (2015), education was an essential aspect that affects socio cultural and economic lifestyles of women living with HIV/AIDS in any region. Having college education and above is a factor that could help people access

better jobs, have higher income, and enhance the quality of life (Poku, 2017). In the case of women from the informal settlement, they would be able to access better clinical services, have access to transport, as well as good nutrition.

More than 90% of the participants were affected by HIV. This was a sensitive question and was asked cautiously even though all respondents chose to answer. A high rate of HIV prevalence among low-income communities is in line with literature results. According to Cluver *et al.,* (2016) people from low-income areas have access to little or no information, lack necessities, and are often marginalized when it comes to access better healthcare. Low-income settlements in areas like India and Soweto in South Africa experience similar demographics due to the mentioned reasons of lacking access to many essentials (Cluver *et al.*, 2015).

11. Conclusion

From the results of the frequency tables based on means, it was easy to point out that most of the responses leaned toward strongly agreeing with the statements. This is shown specifically by the means where many were above the halfway point between 1 and 5. Given that the Likert scale was between 1 and 5, with one being strongly disagree and 5 being strongly agreed, most women were agreeing. The individual statements indicated that most women agreed that the cost of transport to health facilities was too high. The same trend was realized when the responses for the cost of treating opportunistic disease was analysed.

More women leaned towards agreeing and strongly agreeing to the statements based on the means. A good example was when the women mostly agreed that they sometimes were not able to reach their clinics in time or ever because of lack of cash for transport. Some of these women have had to walk on foot since they had no funds for medication. A separate problem that emerged was the lack of medication in the specific hospitals to treat the diseases, and thus they had to buy them from other selling points. The government medication was often subsidized and thus it had a lower cost, which could be cost friendly to the women (Hargreaves *et al,* 2016). However, if they were sold by independent pharmacists, the prices were likely uncontrolled and higher, and thus unaffordable. Medication for HIV was essential, more so, medication to treat opportunistic diseases was highly necessary (O'Laughlin, 2015). Therefore, a lack of access to medication will have consequences on patient (Casale *et al.,* 2015).

The cost of transport to health facilities for women living with HIV in *Manyatta* Informal Settlement is too high showing that many women could not afford the transport costs to clinics. It was also realized that the cost of treating opportunistic diseases for women living with HIV in *Manyatta* Informal Settlement was too high. This along with the cost of nutrition for being a significant challenge further alienated the recovery, management, and access to better lives for women living with HIV.

12. Recommendation

The findings from the research study were a analysed, findings recorded and recommendations by the researcher were as below;

(i) To bring services closer to the women, including having mobile clinics to reach them given the high rate of poverty, increased costs of transport to the ART.

(ii) The availability of mobile clinics or a government facility closer to the *Manyatta* settlement would eliminate the problem of distance.

Competing Interests

Authors declare that no competing interests exists.

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