PSYCHOSOCIAL CHALLENGES AND ADJUSTMENT OF WIDOWS OF HIV AND AIDS PARTNERS: A CASE STUDY OF MUGUNDA LOCATION, NYERI COUNTY, KENYA

Sr. Rose Njoki Mwangi

A Thesis Submitted to the Faculty of Education in Partial Fulfillment of the Requirements for the Award of a Degree of Master of Education in Counseling Psychology

The Catholic University of Eastern Africa

FEBRUARY 2014

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DECLARATION

This master thesis is my original work and has not been presented in any other college or university for the award of any degree. Information obtained from other sources has been appropriately acknowledged.

Sr. Rose N. Mwangi
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Sign

Date 24th MARCH 2014

This thesis has been submitted for examination with our approval as university supervisors.

Professor Belainesh Araya
Head of Department Psychology

Sign

Date

Dr. Peter Aloka
Lecturer, Masters in Educational Psychology

Sign

Date 24th MARCH 2014
DEDICATION

This work is dedicated to the Franciscan Elizabethan sisters who gave me the opportunity to study and invaluable financial and moral support: To my sister Elizabeth Wangari Mwangi who became a widow at a very tender age and also my mother Mary Wanjiku Mwangi who was left widowed after her husband was shot dead. To my late father William Mwangi Macharia who believed in diligence and pursuit of academic excellence and to all widows bereaved by husbands due to HIV virus, who through their experiences acquire a positive transition in life.
ACKNOWLEDGEMENT

I am grateful to God for the opportunity He has given me, for His love, care and graces in guiding my academic work. My very special thanks go to Mother Margherita the former superior general of the Franciscan Elizabethan Sisters for her love, encouragement and trust in me.

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Further, I extend my appreciation to my community members, Sisters Rosaugusta the intercessor, Adri, Catherine and Susan for their great love and support. A word of thanks also goes to the Elizabethan Sisters of Karen community who accommodated and provided me with transportation during my studies.

Again, I thank Sr. Esther, Sr. Ann Macharia, Sr. Linet, Sr. Erika, Sr. Demetria, Brother Michael, Catherine Wamuyu, Naomi, Mr. Mwangi, Mrs. Macharia and Mr. Nyingi the principal, St Regina mixed day secondary school for their invaluable support and understanding.

Special acknowledgement goes to all my colleagues with whom we shared experiences that have seen the realization of this study. Lastly, my sincere gratitude and appreciation goes to all the widows who participated in this study. God bless all of you abundantly. Amen
ABSTRACT
The study explored the psychosocial challenges and adjustment of widows of HIV and AIDS partners in Mugunda Location, Nyeri County, Kenya. Four research questions guided the study: What are the psychosocial challenges faced by widows bereaved by AIDS partners in Mugunda Location, Nyeri County? In what ways do widows in Mugunda location, Nyeri County adjust to widowhood? Which alternative support systems could be used to assist widows in their experiences? The study employed a qualitative research paradigm and a case study research design. Worden’s grief task model theory informed the study. Targeted populations were the widows bereaved of AIDS partners in Mugunda Location, Nyeri County and professional staffs of MUFOA. Purposive sampling was used to select the 15 respondents that comprised of 9 widows who lost partners due to AIDS and 6 professionals. Interview guides instruments for both widows and professionals were used for data collection. Qualitatively data was analyzed using the thematic framework. The major study findings were that: the death of the spouse due to HIV virus is a painful and a difficult reality for the bereaved, since many widows were faced with numerous psychosocial challenges as they struggled to survive with HIV and AIDS diagnosis; many lived in poverty due to lack of resources, skills and education and with no access to the justice. Others had few support systems that assisted them in their efforts to cope with grief and loss. Also the bereaved experienced similar grief emotions, but the grieving process was unique to each individual. However, the lives of many widows were gradually improving depending on different factors. The study recommended that, widows bereaved of AIDS partners should be reinforced in their sense of self-worth, resilience, spiritual growth and ability to handle adolescent behavior problems of their children. Family members, friends and professionals should provide support systems to widows to help in coping with loss. The community should be educated on HIV and AIDS and the plight of widows as a way of helping them change the negative attitude towards people living with AIDS. Governments, NGOs, churches should empower widows by enacting laws and policies that would assist them in accessing services and resources as preparation for widowhood challenges.
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**ABBREVIATION/ACRONYMS**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>ARV</td>
<td>Antiretroviral</td>
</tr>
<tr>
<td>CUEA</td>
<td>Catholic University of Eastern Africa</td>
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<tr>
<td>DEO</td>
<td>District Education Officer</td>
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<td>GTMT</td>
<td>Grief Task Model Theory</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>KNASP</td>
<td>Kenya National Aids Strategic Plan</td>
</tr>
<tr>
<td>MUFOA</td>
<td>Mugunda Fighters of Aids</td>
</tr>
<tr>
<td>NACC</td>
<td>National AIDS Control Council</td>
</tr>
<tr>
<td>NEN (PLWHA)</td>
<td>National Empowerment Network of People Living With HIV/AIDS.</td>
</tr>
<tr>
<td>PLWHA</td>
<td>People Living with HIV/AIDS</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>United Nations Acquired Deficiency Syndrome</td>
</tr>
<tr>
<td>UNGASS</td>
<td>United Nations General Assembly Special Session</td>
</tr>
<tr>
<td>USA</td>
<td>United States of America</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>NGOs</td>
<td>Non Governmental Organizations</td>
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<tr>
<td>DSM-5</td>
<td>Diagnostic and Statistical Manual of Mental Disorder 5th Ed</td>
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CHAPTER ONE

INTRODUCTION

1.1 Background to the Problem

Widowhood is a reality as long as people are born, marry and die (Akujobi, 2006). On the day the spouse dies due to HIV virus, the status of widowhood starts and it causes shock, trauma and grief to the bereaved. As confirmed by Owen (2011) whether death is as a result of chronic illnesses like AIDS or is sudden and violent, it is an awesome event and a challenge to one’s emotional and spiritual understanding of life. For many women the death of a husband because of AIDS has an extra significance because it represents not simply the departure of a partner, protector and breadwinner but also heralds a radical change in their social status with a likelihood of a HIV positive diagnosis (Owen, 2011).

Uzo (2006) concurs with Owen (2011) in that, the loss of a spouse due to AIDS is considered as one of the life’s most stressful experiences and a moment of sadness due to the loss of love, care, company and livelihood. Apart from just losing a partner the widow loses many other things that were related to the departed such as income, social status, and family leadership. For the widows it may seem insurmountable and overwhelming due to the many losses they experience and the fact that they have to resume their normal routines by also assuming responsibilities their partners had done over the years.

Though widows are found in every society in the world, Sub Saharan Africa as the part of the continent that carries the greatest burden of AIDS epidemic has greatly contributed to the big numbers of young widows even in Kenya. Some of the widows, after the loss of a HIV partner go through a lot of sufferings, sometimes inflicted to them by the society, their families or some oppressive cultural practices. Moreover, AIDS is a highly stigmatized disease and often related
to immorality. Further, widows respond differently to the loss and grief in their own time though, on average the hardest time for new and young widows are after the burial of the partner, since many do not have peer groups and are generally less prepared emotionally and practically than older widows in coping with the loss (Kessy, Kweka, Makaramba & Kira, 2010).

Nevertheless, young widows when they lose spouses due HIV virus, have to cope with issues facing all widows especially the sense of losing their womanhood according to the eyes of the society, of being seen as sexless and above all, being suspected by other women as capable of grabbing other people’s husbands (Kessy et al, 2010).

According to World Health Organization (WHO) (2011) psychosocial support systems are necessary to be put in place in assisting the widows of HIV partners. The loss of a husband affects all dimensions of the widow’s life such as physical, psychological, spiritual and social. Counseling, social support provided by friends, families, churches, NGO and the community could assist widows in coping better with bereavement and the related challenges. Again, many men leave widower status by remarrying even when they are HIV positive, whereas many women do not, thereby adding to the surplus of female survivors (Lopata, 2010).

Lester (2012) asserts that, life was precarious and often frightening for widows in the ancient Hebrew, with the lucky ones having families to care for them as they grew old and infirm. The widows without families found themselves in situations that forced them to depend upon the mercy and the generosity of others. Furthermore, the concern for widows up to date is deeply embedded in the scriptural tradition. The Law of Moses prohibited the Jews from taking advantage of widows and orphans. ‘Do not take advantage of the widow or orphan. If you do, and they cry to me, I will certainly hear their cry. My anger will be aroused and I will kill you
with the sword, your wives will become widows and your children fatherless” (Exodus 22:22-24.). This law safeguarded the welfare of widows in the Jewish culture.

For many African cultures, widows were also taken care by their families. Today the closely knit family whom the widow could depend on has virtually disappeared leaving many widows to suffer stigma and discrimination from their own families especially if their partners died of HIV virus (Rachuonyo, 2012). Under the law of succession Act in the Kenyan constitution (2010) women’s rights are well defined, but few widows bereaved of AIDS partners both in the rural and urban areas are aware of their rights to own property or to live dignified life’s (Otieno, 2006). However, the implementation of the constitution by all the stake holders, gradually will bring progress in ensuring widows who lose partners of AIDS are not stigmatized and discriminated.

According to US Bureau of Census (2011), worldwide there are 245 million widows, women who are in the prime of life, young and sole carers for their children’s basic and psychological needs. Many of these women are particularly vulnerable and subjected to a lot of stigma, discrimination and prejudice both in the family and society especially if their partners died of HIV virus.

The situation of widows in developing countries perhaps is tougher than in the developed countries. For instance, in India the land of the 42 million widows, as revealed by Russ and Butts (2013) widows represent the most unreached group in India, due to the many Indian cultures. If the death of a husband was due to HIV virus or any other cause, whether the wife was bereaved at the age of 16 or 100 years, the woman was not allowed to remarry.

Culture and religion in India tends to describe the death of the husband as a curse that came upon the family because of the wife. Such widows often are thrown out of their
community, losing their children and the few possessions. As confirmed by Punnose (2013) 75% of the widows in India experience incredible suffering due to starvation and lack of the basic needs. Further, the same widows are forced to wear either white or gray clothing, meant to take all color and sense of beauty from them. Many Indian younger widows are forced to engage in prostitution or begging on the streets just to survive. In addition, the pathetic situation of many widows in India, contributes to the high suicide rates among the population of widows, because they have virtually no hope in life.

According to UN (2011) many African widows remain victims of harmful traditional practices associated with the passing on of their beloved husbands due to AIDS. Even where death occurs under circumstances that are well known like in cases of AIDS or natural death, many Africans tend to attribute it to witchcraft or sorcery brought about by widows who are accused and blamed for the deaths of their partners (Muchunguzi, 2008). The awareness of the current situation of many widows grieving loss of partners due to AIDS through the reviewed literature, personal experience as a counselor and educator prompted the researcher to carry out an empirical study on the psychosocial challenges and adjustment of widows. The study also explored the alternative support systems that if put in place would assist the widows in coping with the challenges of life.

1.1.1 Widows in Kenya

According to the human rights watch (2010) Kenya is home of the world’s harshest HIV and AIDS epidemic since an estimated 1.6 million people live with HIV virus. According to UNAIDS (2012) the Global Report on AIDS epidemic, many of the widows who lose partners due to AIDS in Kenya, reported having felt suicidal, excluded from the family events, being gossiped about by members of their community, were afraid to disclose their status, avoided
health facilities that provide HIV services for the fear of being seen by neighbors or community members.

Many widows in Kenya suffer a lot of economic hardships. If the husband was the sole bread winner, the nucleus family may be deprived of their husband’s income. For many widows who are illiterate, untrained, without land and those who do not abide to the demands of male relatives of widow inheritances, cleansing, remarriage, household slavery and traditional burial rites, often are violently evicted from their marital homes (Human Right Watch, 2010). In some incidences the widows land rights are further threatened as a result of AIDS in situations where the husband may have used land rights as loans in order to pay for AIDS related health problems and thus upon the husband’s death the family may be left with a debt that is beyond the widow’s financial capabilities (Aliber & Walker 2006).

However women are becoming more educated, economically independent and aware of their rights, factors contributing to a growing trend of widow’s refusal to continue in abusive and unsatisfying family relationships (UN women, 2011).

Nyeri County has 20,800 people living with HIV virus (Daily Nation, 2013). According to Kenya’s population census report (2009), the area had 33,242 persons who were widowed, with a prediction that the high number was as a result of the HIV virus (Daily Nation, 2013). In Mugunda Location, as confirmed from MUFOA register (2012) there were 835 adult people living with AIDS whose age ranged between 15-60 years, 560 out of the group were females and the rest males. Sixty out of the 560 females were widows bereaved because of AIDS (MUFOA, 2012).

There are painful situations in Mugunda Location, encountered by some widows, where during the burial of their husbands, other women unknown to the widow presented themselves
with their children, claiming that they were also widows to the deceased. The co-widows and co-habitees demand the rights of having a share of the deceased property (MUFOA, 2012). Such confrontations are distressing and difficult to resolve. In addition, MUFOA bulletin (2012) reported well known court cases in Mugunda Location, of widows fired from their jobs when they were discovered to be HIV positive. Those were widows denied their right to work because of their HIV status and now are languishing in poverty and untold suffering because the law is taking a long time to make a verdict on their cases. Their cases illustrates that, AIDS in Kenya is more than a health crisis for widows and their families but also a human right issue that needs to be addressed (Mwali, 2013).

1.1.2 Widows Adjustment Strategies to their New Status

Gallagher (2011) studied 212 women for thirty months after they lost spouses in United Kingdom. She found that, widows who did not recover well included women who had previous history of depression, women whose marriages were tumultuous, those who depended on their husbands for most social contacts, the ones whose husband’s had died unexpectedly and the death of the partners which after the death of other close relatives. But healthy older adults tend to grief for a long time, with most of them adjusting within two to four years as widows. However, when the period of grief and mourning had passed or lessened some widow’s found that they enjoyed their new independence, free time and reduced house work (Epstein, 2013).

In many developing countries widows coping strategies with loss, involve exploitative informal sector work, putting children into child labour, begging and engagement with sex commercial works and illicit liquor brewing (Punnose, 2013). However, some widows despite the loss of partners due to AIDS have been able to use determination and courage in the face of the death tragedy, others individually or in collaboration with other widow recovery support
groups have become self-supporting, entreprenuering, ran small businesses, farmed and supported their children were actively contributing to nation building (Mwali, 2013).

Kubler-Ross (2012) in her grief studies asserts that, mourning time depends on the nature of loss experienced and differs from person to person and therefore no fixed amount of time for grieving. Bonanno (2004) conducted a study at Columbia University on resilience in bereaved persons. His findings revealed that, a natural resilience is the main component of grief and traumatic reactions. Again, grief responses can take many forms including what Bonanno coined as the “coping ugly”. The current study also investigated the different coping modalities used by widows who lost husbands in Mugunda due to the AIDS, since the information about coping with bereavement is scanty.

1.1.3 Description of the Study Site

The study area was Mugunda Location in Kieni West District in Nyeri County, which is in the central province of Kenya. Mugunda Catholic Dispensary is a health facility that collaborates with Mugunda Fighters of AIDS (MUFOA) a community based Organization under Mugunda Catholic Parish. MUFOA was established in the year 2000 and has been fighting the HIV/AIDS scourge in the Kieni West District.

Currently MUFOA has a cumulative record of 835 of people living with AIDS ranging between 15-60 years. About 60 women members of MUFOA have been widowed due to HIV and AIDS and many children orphaned. The study focused on those widows bereaved by AIDS partners and have been members of MUFOA therapy group (MUFOA, 2012). The researcher investigated the psychosocial challenges and adjustment of widows who lost partners due to HIV virus. Though the widows belong to MUFOA therapy group, they live in different sub locations within Mugunda Location. They visit the catholic dispensary individually once a month for
therapy. The rationale of selecting the widows from MUFOA therapy group is because no other study in the area has focused on their psychosocial challenges and adjustment after loss of a HIV partner.

1.2 Statement of the Problem

Women whose husbands died of AIDS in Kenya had more psychosocial challenges, as compared to other widows since they had to deal with the fears that stemmed from their likely AIDS diagnosis. The loss of a partner due to HIV virus had direct consequences on the widows who were often stigmatized and discriminated by both family and society. Sometimes those widows could not remarry because of their HIV status. The same widows were deprived of support from, the government and other service providers such as care, provision of basic needs, and sense of belonging to the society and their rights to own property. Bereavement also made widows to experience all kinds of difficult and painful emotions such as shock/denial, sadness, loneliness, insecurity and depression on top of their economic hardships since many had an added burden of raising a family.

Failure of widows to adjust to loss of their AIDS partners was problematic in the sense that, it worked against them since they developed their own helplessness instead of using their natural resilience and development of skills they needed to face the world (Litsa, 2013). In line with Litsa’s arguments, widows who lost partners due to AIDS were vulnerable people, who needed some support systems that would assist them in adjusting to their new experiences. Again, the helps given would create a better society for widows and everyone else.

A number of studies have been done on widowhood. For example Agot, Vander, Tracy, Obare and Bukusi (2010) in Bondo Kenya, conducted a qualitative cross sectional analysis investigating on widow inheritance as a risky practice for HIVvirus infection. Findings showed
that, AIDS prevalence among inherited widows depended on the HIV status of the inheritor. Amasun (2007) in South Africa conducted a qualitative study on perception of risks of AIDS among widows. Findings revealed that, the perception of the risks of HIV among widows was influenced by social economic factors and access to resources. Olayinka and Abalulrazzaq (2008) adopted a qualitative descriptive survey examining widowhood practices and support systems available to widows in Nigeria. They found that widowhood practices generally were traumatic to widows and posed a great challenge to counseling them.

The above mentioned studies revealed that, little empirical research has actually been conducted on the current topic under investigation. In addition, the reviewed studies did not fully address the issue of psychosocial challenges and adjustment of widows who lost partners due to AIDS. Hence, this study was appropriate and explored the psychosocial challenges and adjustment of widows bereaved by AIDS partners in Mugunda Location, Nyeri County, Kenya.

1.3 Research Questions

This study was guided by the following research questions:

1) What are the sociological challenges faced by widows bereaved by HIV and AIDS partners in Mugunda Location, Nyeri County?

2) What are the psychological challenges experienced by widows bereaved by HIV and AIDS partners in Mugunda Location, Nyeri County?

3) In what ways do widows in Mugunda location, Nyeri County, adjust to widowhood?

4) Which alternative support systems could be used to assist widows in their experiences?

1.4 Significance of the Study

Dealing with widowhood has remained largely in the private domain, so the study has potential contribution to widows who lost partners due to HIV virus and their families who are
usually left to cope with loss as best as they can. Since very little attention is given to them from
the government or other service providers, it was imperative to find out the psychosocial
challenges and adjustment of widows who lost partners due to AIDS, in order for the current
Kenyan constitution to reinforce them in exercising their rights without any form of political,
social and religious discrimination or stigma. The findings would enable widows and other
people in the society to identify alternative support systems that may help the bereaved in
adjusting to widowhood.

Further, the study findings could enlighten husbands on the importance of empowering
their wives, by allowing them to be emotionally, financially stable and in building social net
works with other people in order for them to learn the skill of self reliance. The study findings
would influence the counseling Institutions, Churches and the Government in establishing
guidance and counseling programs that would specifically offer grief therapy in the society. The
study findings may also contribute to government policies on widowhood in addressing the
plight of widows who lose partners due to AIDS endemic.

1.5 Theoretical Framework

This study was informed by the Grief Task Model theory (GTMT) of William Worden a
psychologist and a grief specialist, who in 1981 published his book in America on “Counseling
and Grief Therapy”. In the year 2008 he revised the theory. Wordens (2008) theory asserts that,
the bereaved need to engage with their loss and work through it, so that life can be re-ordered
and meaningful once again. The theory was appropriate to this study since widows who lost
husbands due to the AIDS virus suffered untold psychosocial challenges. Hence, many of them
required strategies adopted from GTMT to help them work through grief and loss. This way,
many widows would be able to enjoy a meaningful life once more.
The GTMT involves four psychological tasks namely: (1) recognizing and accepting the reality of the loss of a partner; (2) working through the pain of grief; (3) adjusting to the world without the deceased; (4) finding enduring connections with the deceased and embarking on a new life, (Worden 1991, 2008). GTMT recognizes grieving as a challenging process that is accompanied by feelings and emotions that are an essential part of an individual’s life. Again, the widows using GTMT would be helped to come into terms with loss of their beloved partners by learning to integrate their emotions into their individual lives, seemingly tough without all the other things that were related to the departed.

Worden (2008) acknowledges that each person and each loss will mean working through a range of different emotions ranging from, sadness, fear, loneliness, hopelessness, anger, guilt, blame, shame, depression, and relief. His third grief task involves adjusting to the world without the deceased. This would imply both the internal, external and spiritual adjustment of the widows by gradually starting to resume their normal routines and those their partners had done over the years. Finding new ways of coping with loss could be a time of independence, self discovery and resourcefulness to the widows, who are resilient in continuing to face the challenges of life (Kathleen, 2008). The widow would find appropriate and enduring connections with the deceased and begin to realize that any new relationships established would be simply different from the previous one with the deceased and cannot be replaced.

The strength of the GTMT is that, the four psychological tasks would help in providing a framework for the process of grieving. Widows would be helped in working through the pain of loss and the emotions that accompany it. The GTMT is flexible in that it can be adapted to describe each widow’s unique grieving process, since there is no right or wrong way to experience grief. In addition, it would promote personal wholeness in grief and that the
individual widow would use the model according to their personality type focusing on their most preferred coping resources such as their families, friends, counselors, psychologists and others who would assist them in integrating loss with the widowhood experiences. Moreover, grief is viewed as having a transformational experience.

GTMT has its shortcomings in that it is just one of the grief theories that do not possess the absolute truth about the process of mourning. Again, it is not possible to capture grief by only one simple model. Moreover, the model might not assist all the widows bereaved of AIDS partners. The GTMT may not necessary reflect the experiences of every widow. Wordens assumption that once the four tasks have been completed, grief is assumed to have been resolved and completed, overlooks the fact that re-adjustment happens over an extended period of time. The bereaved does not just relocate the deceased and move on with life but rather, their relationships get transformed in a Continuing Bonds Rando (2003). It is impossible for widows to just abandon the memories of the deceased. Neither do they need to forget nor leave their gone partners behind, but can integrate them into their present and future lives by means of continuing bonds.

Despite the GTMT shortcomings, it was chosen for this study because of its relevance to the life of widows bereaved of AIDS partner since it describes adequate, appropriate strategies and identification of support systems that would assist widows in adjusting to their experiences.
1.6 Conceptual Framework

Figure 1


Source: Synthesis of literature reviewed
The conceptual framework according to Miles and Huberman (1994) is the system of concepts, assumptions, expectations, beliefs and theories that support and inform the research. It also explains either graphically or in narrative form the main themes to be studied, the key factors, concepts or variables and the presumed relationships among them. Figure 1 is a summary of the psychosocial challenges that widows who lost partners due to AIDS undergo. Also captured are the support systems that if put in place would assist widows to readjust and live a meaningful life.

The independent variables were the psychosocial challenges of widows after they lost partners. The widows also struggled with their HIV positive diagnosis. For many widows, the moment they lost a husband due to HIV virus, a number of social factors such as stigma/discrimination, conflicts with in-laws, cruel accusations, denial of their right to own property by family members, their educational and social economic levels, right to work violation, and their religious faiths to some extent multiplied the pain of loss by leaving widows in untold suffering. Again, the Psychological factors such as grief, denial, shock, insecurity, anger, trauma loneliness, self-esteem, resilience, depression, anxiety, the different range of emotions, vulnerability of having AIDS and the fear of death that each widow had to go through sometimes forced them to grief in silence with an added burden of providing for their families.

The intervening variables were the support systems, if available to the widows, such as self-concept, creating awareness in community, engagement in different social roles, building relationships and change in lifestyle. Churches, NGOs, government policies providing widows with legal protection and widow organizations, would assist them to cope with bereavement and assume a normal life.
Widows would adjust to their loss if they used strategies such as remarriage, joining recovery support groups, being in treatment for AIDS, engagement in community services, spiritual activities like prayer/meditation. Psychosocial support from family/friends, agricultural activities embarking on small businesses, advancement in careers, acquisition of life skills, would empower widowhood as a time of self-discovery, independence, resourcefulness, resilience and Using determination and courage to face the death tragedy of their husbands would also enable widows to contribute to the nation building fully

1.7 Scope and Delimitations of the Study

Due to time, resources and the fact that the area of widowhood is very broad, this study was delimited to widows bereaved by partners who suffered from AIDS in Mugunda location, Nyeri County of Kenya. Such widows experienced a number of psychosocial challenges that often hindered them from living a meaningful life. Therefore, the study focused on the psychosocial challenges of widows after the loss of their partners. Discussed were also support systems that would be put in place to assist them in adjusting to widowhood as a time of self-discovery, independence, resourcefulness and resilience (Mwali, 2013).

The study respondents were widows bereaved by HIV partners and members of the MUFOA therapy group. The widows were knowledgeable and provided valid information on the study under investigation. Further, the study respondents included a priest, a HIV and AIDS counselor, a social worker a community based health workers and a clinical officer and the manager of MUFOA. These were considered to be very knowledgeable about the situation of widows who lost partners because of HIV virus since they interacted with them in different capacities. The study was confined to Mugunda Location of Nyeri County because of the accessibility to the widows who had lost partners because of AIDS endemic.
1.8 Operational Definition of Terms

The following terms have been operationally defined:

**Adjustment** – is the going through the grieving process for each individual widow, with an aim of beginning to function normally and reorganizing their lives without the husband.

**Depression** - is primarily a mental health condition manifesting itself with different symptoms like stomachaches, headaches, and back pain, could lead to suicide, drug addiction and death of a widow bereaved by AIDS partners if not handled properly.

**Grief** – is the response to loss, particularly to the loss of a married partner. It is more focused on the emotional response to loss and its physical, cognitive, behavioral and social dimensions.

**Husband**- refers to a male legal marriage partner having died due to the HIV virus.

**Partner** – refers to the husband having died of AIDS.

**Psychosocial** - are psychological and social aspects that affect the life of the widow such as the thoughts, emotions behavior patterns, friends, familial support, cultural and religious background, social economic status, interpersonal relationships and other aspects that help to shape personality influencing their entire lives.

**Psychosocial support** – refers to the process of providing for the emotional social, mental and spiritual needs of widows who lose husbands due to HIV virus in order to promote their integral development.

**Resilience** - Means the ability of some widows who lost husbands due to AIDS despite the stigma and discrimination suffered from relatives or society they manage to maintain stable, healthy levels of psychological and physical functioning as well as the capacity for generative experiences and proper handling of grief emotions.
**Stigma** – is the condition of widows who lose husbands due to AIDS a stigmatized disease by the society, making them to be considered unworthy or devalued as compared to other widows of none HIV partners.

**Widow** – she is a woman married to a man under the statute, customary or religious law, who has the misfortune of losing her husband through death due to AIDS and has not remarried.

**Widowhood** – is a period of time lived after losing a partner, state of having lost ones’ husband through death and was also considered as a personal loss, encompassed everything from the immediate psychological impact of the loss of a partner to the material deprivation of an income among many other things.
CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.1 Introduction

This section presents the review of related literature on the psychosocial challenges and adjustment by widows of AIDS partners. The review examined theoretical and empirical sources relevant to this study discussed under the following subtopics: Social and psychological challenges faced by widows of AIDS partners, ways in which widows adjust to widowhood, alternative support systems that could be used in assisting widows and the research gaps from literature reviewed.

2.2 Sociological Challenges Faced by Widows Bereaved by AIDS Partners.

Amirkhanian, Kelly and McAuliffe (2008) conducted a study on psychosocial needs, mental health and HIV transmission risk behavior among people living with HIV/AIDS in St Petersburg, Russia. Study Sample consisted of 470 persons with HIV/AIDS at St Petersburg HIV care and service agencies. Participants completed anonymous self administered questionnaires on social and psychological characteristics of HIV, where status disclosure, discrimination experience and risk practices. The study found that HIV infected persons in Russia experienced a wide range of social, psychological and care access problems.

Although the study of Amirkhanian and Kelly (2008) and others were interested on psychosocial needs, mental health and support services of PLWHA in Russia, the current study was interested in finding out the psychosocial challenges on widows and how they adjust after losing partners due to AIDS in Mugunda Location, Nyeri County, Kenya. Moreover, the study carried out in Russia fails to specify whether, persons with AIDS were males or female, children or adults, unlike the current study which particularly sampled widows who lost spouses due to
HIV virus and professionals who interacted with the same widows. The study done in Russia had anonymous self administered questionnaires as instruments, unlike this study which employed the interview guides to get a wealth of detailed information and deep insights about the widows who lost partners of AIDS.

In another study, Fasoranti and Aruna (2007) did a Cross-Cultural comparison of practices relating to widowhood and widow-inheritance among the Igbo and Yoruba in Nigeria. It was an explorative study for the differences and similarities in the issues relating to the death of a woman’s husband among two cultures in Nigeria. Purposive sampling was employed to choose respondents both widows and non widows. Age, sex and knowledge, experience of the widowhood was considered.

Data was collected and recorded through interview method. The findings were that most of the rites have found their way to the modern day, some being practiced only nominally. Religious needs and practices, modernization, education and ownership of personal properties and gainful employment by women, the mass media in the outcry against dehumanizing treatment of widows, voluntary associations that support and defend the widows among others have brought about changes in the lives of widows in Nigeria.

While the above studies focused on a cross-cultural comparison of practices relating to widowhood and widow inheritance among two cultures in Nigeria. The current research was a case study which focused on psychosocial challenges faced by widows and adjustment after they lost partners due to HIV virus in Mugunda, Kenya which had very different psychosocial and social economic contexts. But Fasoranti and Arunas findings could inform the present study to some extent on the social challenges experienced by widows such as property ownership,
education, employment and dehumanizing treatment of widows under investigation. Again, there was the similarity in the purposive sampling of both widows and non widows in the two studies.

Yoshihiko (2010) studied widow discrimination and family care giving in India. The Purpose of the research was to address the lack of a region-wide view of widow discrimination in India, the home of 42 million widows, a group that represents the most unreached persons in the world (Russ & Butts, 2013). Moreover, those widows lived in an incredible suffering due to starvation and lack basic needs (Punose, 2013). The study analyzed the household data collected through in depth interviews of individuals and households in six major Indian cities including Delhi, Mumbai, Bangalore, Chennai, Kolkata and Hyderabad.

The target populations were adults aged 20 to 70 years old. Multi-stage Sampling was applied. Responses were randomly collected within each stratum. From the data set, the research chose 794 observations from interviewers who had married. The results from the six cities indicated that overall, there was no evidence that widow discrimination prevailed nationally. There were some regional differences, but most of them were not significant.

A critical look at the above reviewed study, focus was on widow discrimination and family care giving in six Indian cities but not in any of the Kenyan cities. In addition, the research analyzed the household data through interviewing adults between 20 to 70 years, unlike the current study which investigated the psychosocial challenges on widows and how they adjust when their husbands die of AIDS endemic in Mugunda Location, Nyeri County, Kenya. Moreover, the above reviewed study applied the multi-stage and sampling procedures. Whereas, the current case study employed non purposive sampling procedures, with 15 respondents, widows and 6 professionals who provided the most credible information to the study.
Amasun (2011) conducted a study on perception of risks of HIV/AIDS among widows who visited the Ndlovu medical centre, in South Africa. Data was collected from 30 widows, a number which was selected by convenient sampling. The study used the theories of symbolic interactionism and response effect to accurately and comprehensively understand the participant’s perception of the risk of HIV/AIDS among widows. Measuring instruments employed was a semi structured questionnaire and data analyzed quantitatively using the Microsoft Office Excel. The study findings showed that, the perception of the risk of HIV and AIDS among widows was influenced by social and economic factors such as relationships, community expectations and access to resources.

The reviewed study above addressed the perception of risks of HIV and AIDS among widows in South Africa. Findings showed that, social, economic, relationships, community expectations and access to resources influences the perception of the risk of HIV among widows. However, the research findings informed the present study on some of the social challenges faced by widows of HIV partners such as access to economic resources. Moreover, this study was carried out in South Africa and not in Kenya which had a different context. In addition, the above study reviewed was quantitative, and employed interactionism and response effect theories, unlike the current study which was qualitative, employing a case study research design and the grief task model theory GTMT of Worden in order to accurately, comprehensively understand the participants perception.

Agot et al (2010) performed a cross-sectional analysis study to investigate if widow inheritance was a risky practice for HIV infection in Bondo, Kenya. Study participants were 1987 widows who were interviewed regarding their inheritance status and all of them tested for HIV. Of these, 56.5% were inherited. HIV prevalence at 63% was similar among non-inherited
and inherited widows. Exposure status was stratified by the relationship of the widow to the inheritor and the reason for inheritance. Findings were that, widows who were inherited by relatives for sexual rituals, had an elevated level of HIV infection. Widows who were inherited by relatives for companionship had less levels of HIV infection. HIV prevalence among inherited widows varied depending upon why and by whom they were inherited.

The above reviewed study was a cross-sectional analysis that investigated widow inheritance as a risky practice for HIV infection in Bondo, Kenya. The current research was a case study, on the psychosocial challenges on widows and how they adjusted after losing spouses due to HIV virus in Mugunda Location, Nyeri County. Agot and colleagues conducted a quantitative study and tested the widow’s inheritance status, sexual behavior profile and HIV virus, unlike the present research which was a qualitative case study that addressed the research questions adequately in order to obtain in-depth understanding of widows. However, the findings of the study to some extent, would inform the current study on the issue of widow inheritance.

2.3 Psychological Challenges Experienced by Widows Bereaved by AIDS Partners

Reddy (2004) studied widowhood in America and found that the loss of a life partner had great adverse impact on psychological well being of women. Fasoranti and Aruna (2007) asserts in his cross-cultural studies in Nigeria that widowhood was a significantly distressing event in the life of any individual partner who is bereaved as it was associated with psychological ramifications. The studies done by Reddy and Fasoranti showed that, widowhood had great impact on the psychological wellbeing of the bereaved. However, their studies did not focus on widows who lost partners due to AIDS neither did they examine the psychological challenges experienced by such widows which was the interest of the current study.
Haskings (2012) on his widowhood studies, done in America affirmed that, there was consensus about some common grief reactions when the death of a spouse occurs, such as fear of the future, the loss of security, self-esteem being affected, shock, numbness, denial, mental confusion, inability to think, plan and make decisions, disorganization and detachment from reality. The mentioned emotional reactions could occur separately or simultaneously to the bereaved. In addition, the widows experienced anger towards everybody, even the spouse for dying and also God which led many widows to suffer from guilt feelings for being angry towards God and the dead spouse. Some widows tend to blame themselves for not being able to prevent their partner’s death (Hastings, 2012). Hasting’s finding could be similar to what was happening to widows in Mugunda after they lost partners due to AIDS, but such emotions were to be confirmed by the widows themselves who were the study respondents.

The study done by Network Africa (2013) with widows in South Africa, reported the common characteristics experienced by widows during their first three months of bereavement. Nearly half of the widows’ interviewed claimed difficulties in concentration, crying a lot, depression, difficulty in sleeping, lack of appetite, reliance on sleeping pills, loneliness, trauma and shock. Another half reported of having a tendency of rejecting their depressive symptoms because they felt that expression of their feelings and emotions was something socially and culturally unacceptable. The study which was done in South Africa with widows as they grieved for the first three months after bereavement, did not generalize to the present study that was carried out in Kenya. The researcher investigated the psychological challenges faced by widows bereaved by HIV partners in Mugunda location. Moreover, Network Africa studies did not indicate how the widows adjust to their new situation, neither die they sample widows bereaved of AIDS partners, which was the case for the current study.
Holden, JenngKunki and Novak (2010) carried out a longitudinal survey in the America to examine the relationship between psychological well being and financial well being of older men and women, with specific interests in differences by marital status and duration of widowhood. The study had interviewed a representative sample of those who were over 50 years old and were widowed for at least two decades. Basic assumption underlying this analysis was that two major traumas that occurred upon the death of the spouse was the loss of companionship and resources the spouse brought to the household distinguished effects on Psychological well being. Over time widows adjusted to both effects, financial resources and formed new relationships.

The basic assumptions underlying the above reviewed study implied that, two major traumas occur upon the death of spouses, the loss of companionship and resources that distinguished the effects on psychological wellbeing. Overtime, widows adjust to both financial resources and may form new friendships and relationships. The research of the longitudinal survey was done in Wisconsin university but not in Kenya where the current study took place. The survey carried out in Wisconsin considered a representative sample of respondents who were over 50 years both males and females. The current study was a case study that sampled 9 widows bereaved of AIDS partners and 5 professionals interacting with the same widows and a priest. Holden and colleagues study examined the relationship between psychological well being and financial well being of older men and women, who were over 50 years, differentiated by marital status and duration of widowhood. The present qualitative case study addressed the psychosocial challenges and adjustment of widows and the modalities they use in adjusting to widowhood in Mugunda Location. Financial resources and building of new relationships by widows were variables under examination for this study.
A Quantitative research by Asonibare, Oniye and Abdulrazaq (2012) examined the stress levels of Nigerian widows on the basis of the three variables, age, duration of bereavement, and educational levels. The sample consisted of 865 widows purposively drawn from the three major ethnic groups of Nigeria namely: Hawa, Yoruba and Igbo. The stress rating scale for widows (SRSW) developed by the researchers was administered to the widows in their offices, meeting places, religious gathering and their homes respectively. Frequency counts, simple percentages and Analysis of variance (ANOVA) statistics were used for data analysis. The results showed that, majority of the widows had moderate level experiences of stress, (59.9%) while only 29.9% and 10.3% of them experienced low and high levels of stress respectively. No significance differences in stress levels on the basis of age, educational level and duration of bereavement was found in the reviewed study. From the findings, the conclusion was that, widowhood practices in Nigeria result in stress for the widows.

Asonibare et al (2012), in their quantitative research examined the stress levels of Nigerian widows on the bases of three variables, found that majority of widows had moderate experiences of stress 59.9%. However, there was no significant difference in the stress levels on the basis of the three variables. Moreover, what really caused stress for the Nigerian widows were widowhood practices.

The current study was qualitative and interested on the psychosocial challenges and adjustment of widows who lost partner due to HIV virus. Unlike the quantitative studies done by Asonibare and others which focused only on stress levels of widows. Hence, the current study produced participant’s feelings and expressions on the topic under investigation.
2.4 Ways How Widows Adjusted to Widowhood

Colette (2013) argued that dealing with widowhood has remained largely in the private domain. Many widows and their families were usually left to cope as best as they can, with little attention from governments or other service providers. Further, widowhood could also be experienced by the affected as a positive transition, and may even come as a relief if a marriage was unhappy or burdensome as expressed by widows who experienced less strain and greater capacity to make plans and implementing them after the loss (Colette, 2013). According to Owen (2012) widows adjust better if they were involved in physical activities, got support from the family members and friends and when they developed new interests. None of the two studies on how widows adjusted to widowhood focused on widows after bereavement of their HIV partners. The widows under study will be the ones to say exactly how they adjusted to the loss of a partner.

Janalee and Weaver (2010) carried out the qualitative study in America that examined the unique and personal experiences of individuals that had experienced grief and loss through bereavement. It was a historical perspective of the research on theories of grief and interventions of recovery. The narratives stories of bereaved individuals were shared and common themes identified. The major themes of experiences, coping strategies and successful interventions were identified by the participants. Recommendations for counseling bereaved individuals were made based on the experiences of the bereaved participants. Implications and recommendations for counselors working with bereaved individuals were made especially a need for a continued research in the area of bereavement theories and grief counseling.

Weaver’s qualitative study that examined individual experiences of grief through theories and interventions of recovery was done in America but not in Kenya the place of the current
study. Weaver’s study focused on individuals who experienced grief through bereavement without specifying whether they were adults or children, males or females. In addition, the present study focused on the psychosocial challenges faced by widows and how they adjustment. Moreover, as a qualitative case study, the researcher systematically analyzed and organized data in forms of narratives, direct quotes and excerpts (Greg, 2012). The study findings could enrich the area of bereavement and grief counseling of widows who lose partners due to HIV virus.

Further, Boyle, Zhejiang and Raab, (2009) did the longitudinal studies in Scotland considering the effects of spousal bereavement on mortality by different types of spousal death. Some deaths were correlated with social economic characteristics and others not. Data was on 58,685 married men and 58418 married women drawn from the Scotland. Data analysis took three set of analyses, separating causes of the spouse’s death into “informative”, “preventable” and “unpreventable” deaths and “risk” and “unisky” deaths. Mortality was modeled using Cox model’s comparing outcomes for men and women by the different causes of death of the spouse. Results indicated that the effect of widowhood on mortality is substantial for both men and women and the relationship varies little by the cause of the death of a spouse.

The participants of the above reviewed quantitative longitudinal study were a large number of both married men and women from Scotland. The study considered the effects of spousal betterment on mortality by different types of spousal death. Unlike the current qualitative research, a case study which focused on the psychosocial challenges experienced by widows and adjustment when they lost husbands due to AIDS in Mugunda location, Nyeri County, Kenya. In addition, the data took three sets of statistical analysis, whereas analyzes of data in this study will major on thematic analysis through the coding of data in six phases and finally organizing reports in forms of narratives, direct quotes and excerpts (Greg, 2012). Moreover, the study
findings revealed that the effects of widowhood on mortality were substantial for both men and women, with the relationship varying little by the cause of the death of the husband. Again the current study was not tailored on widowhood effects on mortality.

In another investigation, Akpabio, Idongesit, Akpan, Uyanah and Osuchukusu (2008) adopted a comparative descriptive research design to study 280 subjects selected from two health facilities within the study area in Nigeria. The purpose of the study was health and adjustment to chronic conditions often affected by various social demographic variables. The study assessed the influence of gender, age and psychosocial adjustment of people living with HIV and AIDS in Calabar, Nigeria. A validated questionnaire was the instrument for data collection while stratified random sampling was employed. Findings showed a significant influence of gender on the respondents’ psychosocial and spiritual adjustment. The males adjusted better than the females. Similarly, age of the respondents exerted significant influence on psychosocial adjustment.

The above comparative descriptive research assessed the influence of gender and psychosocial adjustment of people living with AIDS in Calabar, Nigeria. The above reviewed study to some extent informed the current study on the widows who could be infected with the HIV virus and their adjustment. Nevertheless, the current research employed a case study research design, using the in-depth interviews and purposive sampling. The reviewed study used questionnaires for data collection and stratified random sampling. However, the present study focused on the psychosocial challenges and adjustment of widows who lost partners due to AIDS in Mugunda Location, Nyeri County, Kenya.

2.5 Support Systems that Could be Used to Assist Widows

According to WHO (2011) psychosocial supports addressed the ongoing concerns and social problems of HIV infected individuals, their partners and caregivers WHO stressed that
HIV infection affects all dimensions of the victim’s life such as physical, psychological and social. For WHO’s observations, counseling, social support provided by friends, families, church NGO and the community could assist widows in coping better with bereavement and related challenges. The respondents under investigation in the current study were be the best in proposing the support systems considered appropriate in assisting widows to cope with loss and grief.

Bonanno, George, Moskowitz, Judith, Papa, Antony and Susan (2012) in their research done in America, examined resilience and loss in bereaved spouses. The sampled populations were the bereaved parents and bereaved Gay Men. Their study had indicated that, many people faced with highly aversive events suffer only minor, transient disruptions and retained capacity for positive effect and experiences in bereavement. The study used a range of self-reports and objective measures of adjustment. Resilience was evidenced in half of each bereaved sample when compared with matched, horrible reared counterparts and 36% of the caregiver sample in more conservative, repeated measures imperative comparisons. Results indicated that resilient individuals were not distinguished by the quality of their relationship with spouse/partner or care giver burden, but were rated more positively and better adjusted by close friends.

Resilience was investigated in the current study as a psychological aspect experienced by grieving widows, but not like the approach of Bonanno et al (2012) who investigated resilience to loss in bereaved parents and gay men. Further, their studies used a range of self-reports and objective measures of adjustment whereas the current study employed in-depth interviews. In addition, their findings indicated that, the resilient individuals were not distinguished by the quality of relationship with the partner or care givers burden but more rated positively and better adjusted by close friends.
Alabi, Yahaya and Jimoh (2010) conducted a descriptive survey, in determining the challenges faced by HIV and AIDS patients in meeting psychosocial needs and accessing support services. The study employed a mixed method paradigm to obtain data from respondents. An estimated 2,365 patients living with HIV and AIDS at the University of Ilorin Teaching Hospital in Nigeria consulted the study population while all the literate HIV and AIDS patients constituted the target population. The sample for the study comprised 125 HIV and AIDS patients. Instruments for the study were questionnaires and in depth interviews. Randomly respondents were sampled.

The study findings showed that, AIDS patients at the hospital were facing some challenges in terms of meeting their psychosocial needs and accessing support services. There were no doubts that if the needs of PLWHA were met, they would be better equipped to adjust and contribute to the development of the society. Again, the study revealed that, AIDS patients in Ilorin teaching hospital in Nigeria faced some challenges in terms of meeting their psychosocial needs and access to support services. Instead, the present study sought to find out the actual support systems that can be put in place in Kenya. Thus, equip widows suffering the loss of partners due to AIDS endemic in Mugunda Location to adjust and contribute to the development of the society. The target populations for the two studies differed in that, the current study focused on widows bereaved of AIDS partners while Alabi and others studied PLWHA without specifying whether they were males or females young or old.

Sandler, Irwin, Shelene, Ayers and Tims (2008) conducted a study in America on Resilience rather than Recovery’s contextual Framework on Adaptation following bereavement. Authors examined the process whereby bereaved persons changed over time. Rather than the concept recovery, the purpose that the concept adaptation best captured the process of change.
following bereavement and the desired outcome of such adaption denoted by the term resilience. Findings were that adaptation occurred over time and was shaped by environmental and individual protective factors like education and interactions with other people.

The current study drew information from the findings of the research done by Sandle and colleagues even though it was carried out in America. The findings that bereaved persons change or adjust with time and that their lives shaped by environmental and the individual protective factors like education and interaction with other people could inform this study. However, the current study investigated the support systems that could assist widows who lost husbands because of the HIV disease in Mugunda, thereby filling in gaps in literature.

Olayinka and Abalulrazaq (2008) adopted a descriptive survey design for their study. They focused on people their beliefs and opinions, in order to understand the Nigerian widows on the nature and amount of support systems received. The pair examined the widowhood practices and support systems available to widows from the major ethnic groups of Nigeria, Hausa, Igbo and Yoruba. The support systems received were compared on the basis of three variables namely age at bereavement, religious affiliation and duration of bereavement. The sample for the study consisted of 865 widows purposively drawn from three ethnic groups mentioned above. The widow’s Network Support Rating Scale questionnaire was administered on the sampled widows. Statistical measures were used to analyze the data collected of frequency count, simple percentages and analysis of variable (ANOVA).

The results showed that, almost all the widows received the four broad support systems available thus economic, service, social and emotional (98.6, 98.2, 97.7, 99.0) support systems respectively. The results of the data analysis revealed that, there was significant difference in the support system enjoyed by widows on the basis of their age at bereavement and religious
affiliation while there is no significant difference in their support system on the basis of bereavement.

Olayinka and Abulalrazaq study adopted a descriptive survey design in Nigeria to understand widowhood practices, the nature and the amount of support systems widows’ received. The current study was a case which explored the support systems that could be put in place in assisting widows in adjusting to widowhood after the loss of AIDS partner. Sample for the current study was 15 respondents purposively selected. Interview guides were the instruments that were used in the current study to get in depth information from the participants. Qualitative data was analyzed thematically. Olayinka study used 865 respondents who were purposively sampled and employed applied quantitative technique for data analysis. Hence, the current research provided richer findings than the quantitative ones of the reviewed study.

2.6 Research Gaps from Literature Reviewed

The research synthesis showed that, widows all over the world were faced with various psychosocial challenges after losing their husbands. Most of the reviewed studies were conducted in other parts of the world other than Kenya. This dearth of literature therefore prompted this current study. Moreover, many of those studies did not sample or fully address the issues of widows who specifically lost partners due to HIV virus. Neither did they indicate clearly how widows adjusted to their new experiences, nor was much attention given to them by governments or other service providers as special populations (Collette, 2013). A number of the reviewed studies either used cross sectional survey or descriptive survey designs, thus failed to make use of qualitative case study design as in the current study. Therefore, many of the reviewed empirical studies were quantitative in nature and did not take an in-depth exploration of
the phenomenon under study. Further, the contexts of the reviewed studies majorly focused on different aspects other than the reality of widows grieving loss of husbands because of AIDS.

There was a consensus about some common emotional reactions after bereavement by widows in some grief studies. However, the similarity of emotions and how they coped was confirmed by widows who were under investigation. The study respondents also proposed the alternative support systems they considered appropriate to assist widows adjust to their experiences in Mugunda Location.

According to the Republic of Kenya (2009) Census report, there was only the mention of the number of widows in Nyeri County, thus failed to specify the number of widows who were bereaved by AIDS partners. Moreover, the current topic has been scantly researched on especially in Kenya. Therefore, the current study filled the missing gap of knowledge by focusing on the psychosocial challenges and adjustment of widows who lost husbands because of HIV virus in Mugunda location, Nyeri County, Kenya. In addition, the current study will provide more support systems to widows that would reinforce and empower them in handling widowhood challenges.
CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter presents the methodology that guided this study. This includes; the research design, target population, description of sample and sampling procedures, research instruments, trustworthiness of qualitative data, description of data collection procedures, data analysis procedures and ethical considerations.

3.2 Research Design

The study adopted a qualitative paradigm within which a case study research design was used. Case study is one of the most widely applied methods of research that concentrates on a phenomenon looking at it in details, from many angles and within its real life context, again not seeking to generalize from it (Gary, 2011). Case study allows the investigation to retain holistic and meaningful characteristics of real life events such as individual life cycles, organizational and neighborhood change, (Turner, 2010). Case studies are also interested in contextual conditions in which something unique has occurred from the perspective of the people who experience the phenomenon, with the researcher considering the voices, perspectives and the relevant groups of actors and the interaction between them (Yin, 2009).

The researcher adopted a case study research design as the most appropriate to solicit important insights about the psychosocial challenges and adjustment of widows who lost husbands due to AIDS in Mugunda location, Nyeri County. This was because they could have unique experiences different from what other widows experienced.
3.3 Target Population

Kombo and Tromp (2009) define target population as any group of people, items, objects or institutions that have at least one or more characteristics in common that are of interest to the researcher and from which samples are taken for measurements. Ogula (2009) argues that population refers to all members, groups or elements that the researcher hopes to gain information to present in the study and from which an individual draws conclusions.

Therefore, the target population for this study comprised of all the sixty widows who lost partners because of AIDS and were members of Mugunda Fighters of Aids (MUFOA) therapy group. The study also targeted all the twenty professionals working at MUFOA and a priest. These were the people who often interacted with widows who had lost partners because of HIV virus. This target population was considered to posses valid information about the phenomenon under investigation.

3.4 Description of the Sample Size

According to Kombo and Tromp (2009), a sample can be defined as a set of respondents selected from a larger population for the purpose of the research study. Gary (2011) contends that, a sample can be a choice of restricted small numbers, representative of the bigger population in trying to understand the phenomenon to be studied in greater detail. (Guest, 2006) asserts that, a sample of 6-9 interviews for qualitative case studies may be sufficient to enable development of meaningful themes and useful interpretations especially for studies with a high level of homogeneity among the populations. The sample sizes for this study were 15 respondents, comprised of nine widows bereaved of AIDS partners, five professionals and a priest, because they interacted with widows regularly. The sample size used for this research was considered to be appropriate, because it was a qualitative case study.
3.4.1 Sampling Methods

Kombo a Tromp, (2009), defined sampling as the act, process or technique of selecting a suitable sample or a representative part of the population for the purpose of determining parameters or characteristics of the whole population. Purposive sampling was employed to select the 15 participants the sample size that was satisfactorily to the specific needs for the study. Purposive sampling procedure was adopted for the study because the researcher obtained information from particular sources, the widows who lost partners due to HIV virus in Mugunda and other professionals and a priest, who interacted with the same widows. The sampled widows were drawn from MUFOA therapy group to facilitate the identification and location of respondents.

3.4.2 Sampling for Widows, Professionals and the Priest

Sampling of the widows who lost partners due to AIDS and the Professionals were purposively selected from the MUFOA therapy group because they were considered to possess the in-depth information with respect to the objectives of this study. Specifically, maximum variation sampling was employed due to their focus on cases that were rich in information special in some way. Purposive sampling captured participant’s variations, in aspects like age, religious faiths, education, social economic levels, occupations, number of dependants one had and the widowhood period and experiences for the widows under investigation.

The professionals interviewed were: a manager, a community based care worker, a clinical officer, an AIDS counselor and a social worker due to their expertise on widowhood issues. The priest was purposively selected because of his role as a spiritual director to MUFOA therapy group.
3.5 Research instruments

The instruments used in this study were in depth interview guides for widows because most of them were semi illiterate and from a rural setup. For the professionals in depth interview guides were used because of the sensitivity of the studied topic. The instruments were employed due to their flexibility and content of both open ended nature that facilitated obtaining of in-depth information. The same instruments provided rich and detailed information about feelings, thoughts, understanding, perceptions and impressions of people under study in their own words (Hancock, 2006). Different Interview questions were administered to both the widows, professionals and the priest whose experiences were probed deeper in obtaining additional information.

3.5.1 Interview Guide for Widows, Professionals and Priest

According to Cohen, Manion, and Morison (2007), the interview guide is a flexible tool for data collection, enabling multisensory channels to be used; verbal, non-verbal, spoken and heard. Moreover, the interview may be controlled while still giving space for spontaneity, and the interviewer can ask for responses about deep and complex issues. Probing is used to get deeper information from the respondents and good rapport with participant being a prerequisite for obtaining maximum cooperation and accurate information (Pickard, 2007).

Therefore, the interview guides were employed in soliciting information from the purposively sampled widows, professionals and the priest. A friendly relationship with prospective respondents prior to the actual interview was a prerequisite for obtaining maximum cooperation and accurate information. Unstructured and open ended questions were administered to elicit views and opinions from the participants. Probing was used by the researcher to obtain potentially important information from the widows, professionals and the priest. The flexibility
of the Interview guide yielded high response rates, offering opportunity to collect in-depth information.

The interview guide had five sections that helped to obtain demographic information, the psychosocial challenges faced by widows, how widows adjusted to their new experiences and support systems that could be put in place to assist widows who lost partners due to HIV/AIDS in Mugunda Location. Interviews were audio taped with the consent of the respondents. The personal in-depth interviews were carried out for duration of about one hour for each respondent.

3.6 Trustworthiness of Qualitative Data

According to Cohen, Manion and Morison (2007) and Creswell (2009) the reliability of research instruments in qualitative data, focuses on the researcher since he or she is the primary instrument. Both validity and reliability of research instruments in qualitative studies are treated together in what is referred to as trustworthiness. Lincoln and Guba (1985) assert that, trustworthiness of qualitative research is done through developing standards of quality which involves four criteria. First, is the credibility the (true value) accuracy, established confidence in the truth of the findings from the informants, the context in which the study was undertaken and the authenticity of the information collected. This was ensured by use of member check in which the respondents were asked to corroborate findings and made segments of raw data available for other readers who analyzed it.

Transferability or applicability is a criterion of the fittingness, showing that findings could be applied to other contexts and settings depending on the degree of similarity between the original situations to which it was transferred (Penland, 2010). This was ensured by researcher presentation of reports that provided sufficient details to other readers for assessment. In the
current study, the findings could be applied to other widows bereaved of AIDS partners if from similar contexts.

Dependability (consistency) ensured that the findings were steady if the study would be repeated (Prochaska, 2013). This criterion was ensured through auditing the research process, documenting all the data generated and assessing the method of data analysis. Finally, Confirmability ability (neutrality) is the objectivity of data, the degree of neutrality of data, and the extent to which the study findings were shaped by the respondents’ motivations and perspective, with another researcher agreeing about the meanings emerging from the data (Prochaska, 2013). The researcher ensured neutrality in the study by scrutinizing the data from the three study respondents.

3.7 Data Collection Procedures

After meeting the requirements for the research proposal at the Faculty of Education, Department of Postgraduate Studies at the Catholic University of Eastern Africa, a letter from the same institution was issued. Thereafter, the researcher applied for a research permit from the Ministry of Higher Education, Science and Technology through the National Council for Science and Technology. Then made visits to Nyeri County commissioner, the District Education Officer (DEO) Kieni West District, MUFOA Manager and submitted copies of the research permit seeking clearance before making arrangements on how to conduct the study.

Further, clearance was sought from MUFOA manager who assisted the researcher in contacting the widows for in-depth interviews and booked for different meetings with the professionals and the priest. Thereafter, the researcher personally met with the widows and other respondents on the programmed days for on one on one interview with participants to elicit
descriptions of their experiences about psychosocial challenges and adjustment of widows bereaved by AIDS partners.

The researcher conducted unstructured open-ended interviews and audio taped them with the consent of participants. The participant’s responses were complemented with the researcher’s field notes which included observations of both verbal and non verbal behaviors as they occurred and immediate personal reflections about the interview (Friesen, 2010).

3.8 Data Analysis Procedures

Qualitative data analysis often follows a general inductive approach since explicit theories are not imposed on the data in a test or specific hypotheses; rather data are allowed to speak for themselves by the emergence of conceptual categories and descriptive themes (Merriam, 2009). Thematic analysis was employed in analyzing data in this study derived from interviews conducted on widows, professionals and the priest. The raw data was examined and analyzed to establish accuracy, usefulness and completeness (Greg, 2012).

Systematically data was organized, broken into manageable units, synthesis and patterns looked for among the variables. The researcher categorized data into themes and used thematic analysis through the process of coding data in six phases in order to create established meaningful patterns of, familiarization with data by listing codes with their meanings and sources generating initial codes, documenting the occurrence of patterns and transcribing data into written forms (Greg, 2012). Themes were searched among codes describing their meanings (Foss &Waters, 2011). Thereafter, reviewed them looking at how they supported the data and ensured accuracy. Themes that contributed to the understanding of the data were defined and named. Finally the final reports were produced in line with the themes that made meaningful contributions to the study in forms of narratives, direct quotes and excerpts (Greg, 2012).
3.9 Ethical Considerations

According to Miles, Huberman (1994) and Lincoln (2009), the qualitative data analysis is never far from ethical issues and dilemmas. The researcher ensured that, the purpose of this study was fully explained in advance to the participants. Informed and voluntary consent was obtained from all the respondents before the in-depth interviews by requesting each of them to sign a consent form together with the researcher.

The researcher built rapport and credibility with respondents by respecting their rights to voluntarily participate or withdraw. Widows were treated with respect, dignity and were encouraged to share only what they felt comfortable with. The researcher was sensitive to the participants by first identifying her biases, values, personal interests about the topic and process.

Respondents’ privacy was protected and confidentiality maintained. Anonymity of the identity of the participants during the interviews was safeguarded by use of letters and numbers (Lincoln, 2009). The recorded tapes after transcribing were safely kept together with the consent forms for a reasonable period, then would be discarded upon the completion of this study. A research Permit was sought from the Ministry of Education so as to conduct the study. Information obtained from other sources has been acknowledged.
CHAPTER FOUR

PRESENTATION, INTERPRETATION AND DISCUSSION OF THE FINDINGS

4.1 Introduction

This chapter presents the findings of this study, which investigated psychosocial challenges and adjustment of widows of AIDS partners in Mugunda Location, Nyeri County Kenya. Summary of the demographic data is presented in tables of frequencies and percentages. The study findings were presented in themes that are in form of narratives and direct interview transcripts, as per the research questions. Qualitative data was analyzed using thematic analysis where data was derived from the 9 widow and 6 professional respondents.

4.2 Collaboration Rate of Respondents

In chapter three, the researcher had proposed a sample of 15 participants. Respondents were both widows bereaved by AIDS partners, professionals and the priest who interacted with the widows belonging to MUFOA therapy group. Widow participants were 9, (15%) of the total number of widows belonging to MUFOA therapy group. Professionals who participated were 5 and one priest that was 10% of all MUFOA staff. All the widows and professional respondents collaborated during the individual interviews. Only one professional declined from responding to one of the sections. The total number of the actual study participants was 15 which gave 100% of response rate.

4.3 Demographic Characteristics of widow Respondents

Table 4.1 presents demographic information of widow participants in terms of age, education level, employment, widowhood duration and number of dependants.
Table 4.1

Demographic Information of Widow Participants

<table>
<thead>
<tr>
<th>Demographic Data</th>
<th>Frequency</th>
<th>Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Females</strong></td>
<td>9</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-29 years</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>30-39 years</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>40-49 years</td>
<td>1</td>
<td>11.1</td>
</tr>
<tr>
<td>50-59 years</td>
<td>6</td>
<td>66.6</td>
</tr>
<tr>
<td>60 and above years</td>
<td>2</td>
<td>22.2</td>
</tr>
<tr>
<td><strong>Educational level</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Below Standard 7/8</td>
<td>6</td>
<td>66.6</td>
</tr>
<tr>
<td>Standard 7/8</td>
<td>2</td>
<td>22.2</td>
</tr>
<tr>
<td>Form 1-4</td>
<td>1</td>
<td>11.1</td>
</tr>
<tr>
<td>Form 6/university</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Employment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>House wife</td>
<td>1</td>
<td>11.1</td>
</tr>
<tr>
<td>Civil Servant</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Business Women</td>
<td>1</td>
<td>11.1</td>
</tr>
<tr>
<td>Farmer</td>
<td>6</td>
<td>66.6</td>
</tr>
<tr>
<td>Casual labour</td>
<td>1</td>
<td>11.1</td>
</tr>
<tr>
<td><strong>Widowhood Duration</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-5 years</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>6-10 years</td>
<td>2</td>
<td>22.2</td>
</tr>
<tr>
<td>11 years and above</td>
<td>7</td>
<td>66.7</td>
</tr>
<tr>
<td><strong>Average number of dependants per widow</strong></td>
<td>5</td>
<td>56</td>
</tr>
</tbody>
</table>

Based on the information in Table 4.1, all of the respondents were widows bereaved by HIV/AIDS partners. Majority of the Respondents, 67% were aged between 50-59 years showing that most of them were already considered as mature adults, (22.2%) were in the 60 and above status and 11.2% were 40-49 years. Lastly, none of respondents were in the ages between 20-39 years. There were more widows of 50-59 years old who were charged with the responsibility of about five dependants each despite their age and health condition. These findings revealed that
the lives of widows who lost partners due to AIDS could be burdensome on top of the grief emotions they have to bear.

The findings show that, 78% of the widows’ had 11 years and above of widowhood and only 22.2% had experienced the same status for 6-10 years. This shows that, the sampled target group of widows was appropriate to respond to the study of the psychosocial challenges facing them and how they adjusted to widowhood status due to their lived experiences for a number of years. Most of the widow’s level of education was below standard 7/8, (66.6%) which could explain why such widows were unable to claim their rights to own property especially when evicted from their marital homes. For their livelihood, many widows depended on small scale farming 66.6%, as shown by the study and the others 11.1% were housewives, women with small businesses 11.1%, and casual laborers 11.1% and Zero percent (0%) of the respondents were civil servants. The results indicated that the widow’s low levels of education kept them in the kind of jobs mentioned above thus rendering them to be of low social economic status. Such widows were deprived of support from the families and other service providers such as care, provision of basic needs and the sense of belonging which subjected them to a lot of suffering.

**4.4 Demographic Characteristics of Professional and Priest Respondents**

Table 4.2 presents demographic information of the professionals and the priest in terms of gender, age, number of years worked with widows, educational level, training to handle widows and frequency of interacting with the widows.
Table 4.2

Demographic Information of Professionals and Priest Participants

<table>
<thead>
<tr>
<th>Demographic data</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>2</td>
<td>33.3</td>
</tr>
<tr>
<td>Female</td>
<td>4</td>
<td>66.6</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-29 years</td>
<td>2</td>
<td>33.3</td>
</tr>
<tr>
<td>30-39 years</td>
<td>1</td>
<td>16.6</td>
</tr>
<tr>
<td>40-49 years</td>
<td>1</td>
<td>16.6</td>
</tr>
<tr>
<td>50-59 years</td>
<td>1</td>
<td>16.6</td>
</tr>
<tr>
<td>60 years and above</td>
<td>1</td>
<td>16.6</td>
</tr>
<tr>
<td>Years worked with widows</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-5 years</td>
<td>4</td>
<td>66.6</td>
</tr>
<tr>
<td>6-10 years</td>
<td>1</td>
<td>16.6</td>
</tr>
<tr>
<td>10 years and above</td>
<td>1</td>
<td>16.6</td>
</tr>
<tr>
<td>Educational Level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Certificate</td>
<td>2</td>
<td>33.3</td>
</tr>
<tr>
<td>Diploma</td>
<td>3</td>
<td>50</td>
</tr>
<tr>
<td>Masters</td>
<td>1</td>
<td>16.6</td>
</tr>
<tr>
<td>Any other)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Years of interaction with widows</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Once per week</td>
<td>2</td>
<td>33.3</td>
</tr>
<tr>
<td>Five days in a week</td>
<td>1</td>
<td>16.6</td>
</tr>
<tr>
<td>Once in a month</td>
<td>2</td>
<td>33.3</td>
</tr>
<tr>
<td>Other specifications</td>
<td>1</td>
<td>16.6</td>
</tr>
</tbody>
</table>

The results depicted in Table 4.2 indicated that, there were more females 66% than males 33.3% so not an equal distribution among gender, an indication that more females are more involved in the helping professions. Thirty three percent (33.3%) of the respondents were 20-29 years old, showing that most of them were already considered as young adults. Seventeen percent (17%) of the respondents were between 30-39, 40-49, 50-59 years old respectively, and sixteen percent (16.6%) of the respondents were in the 60 years and above status. More than half of the respondents 66.6% had worked with the widows for about five years and the rest had contacts
with widows for 6-10 years, (16.6%) and 10 years and above (16.6%). All the respondents due to the number of years of experience and contact with the widows gave valid information about the psychosocial challenges and adjustment of widows. Half of the respondents 50% had diploma educational levels of different social science specializations, then 33.3% had certificate and 16.6% had a masters levels of education. The research findings revealed that, the professional’s expertise had potential contributions to the current study. Since all the respondents had contact time with the widows ranging from once a week, once a month (33.3%) followed by five days in a week, (16.6%) and three times in a week, (16.6%) an average time of two days in a week per respondent. All the respondents had worked with widows for 5 years or more, showing they were conversant with the plight of widows who lost partners due to AIDS.

**4.5 Sociological Challenges Faced by Widows Bereaved by AIDS Partners**

The aim of this research question was to find out sociological challenges that faced widows bereaved by AIDS partners in Mugunda Location, Nyeri County. Fifteen participants, widows, professionals and a priest were involved in the interviews. The results were analyzed by the thematic framework. Anonymity of the participants was safeguarded by the use of letters; (W) stood for the widow and (P) professional respondents for in depth interviews. The findings indicated that, several themes on social challenges experienced by widows of AIDS partners revolved around six aspects such as: Stigma/Discrimination, conflicts with in-laws, cruel accusations, economic constraints, engagement in risky behaviors, and inability to handle teenage behavior problems.

**4.5.1 Stigma and Discrimination**

Stigma and discrimination suffered by widows who lost partners of AIDS were prejudice, negative attitudes, abuse and maltreatment directed to them simply because their husbands died
of HIV virus. This was directed to widows since they were perceived to have AIDS as well as their children. Discrimination led to widows being denied opportunities such as work or participation to the community activities on the basis of their HIV status. The stigma associated with AIDS stemmed from lack of knowledge about the disease, how it was transmitted and the extent of denial about its existence. Again, the fear of contagion was coupled with value based assumptions about people who are infected as being immoral engaging in behaviors such as prostitution and promiscuity that are already stigmatized in many societies. The infected with the HIV virus were also suspected to be irresponsible and so alone had to bear the consequences of a life threatening disease. Therefore, people reacted towards the infected in very strong ways. However, AIDS stigma is not static. It changed over time as infection levels, knowledge about the disease advanced and people understood that it could be both prevented and treated. This facilitated change in people’s attitudes and reduced stigma and discrimination against people living with AIDS.

Stigma and discrimination as reported by all the study participants was majorly due to the fear that came from the family, educational settings, society and Self stigmatization. Almost all widows’ respondents shared how family members and friends rejected and avoided them even from engaging in any discussions or contacts.

After the death of my husband due to AIDS everybody rejected me, my children included. I could not bear all that pain. So I left my home and took refuge at the house of my sister whom I felt could understand my sufferings. When I got infected with TB I was given a plastic cup, plate and was to sleep in a room next to the animals. Her entire family rejected me. My suffering became unbearable and I began to contemplate suicide. (W 1a)

Most of the widows reported to have held negative beliefs about AIDS and stigmatized themselves.
After the death of my husband I felt like I was to die the following week, so for a whole week I remained in bed and did not want to see or be seen by anybody. After all everybody knew that I was also HIV positive. (W 1e)

Most of the participants had the experience of being gossiped about by family members and the community thus intimidated them in different ways. Majority of the widow participants unanimously reported that with the loss of their partners they felt rejected especially during community celebrations since no duties were allocated to them like other women.

My neighbors stopped buying milk from me in fear of transmission of the HIV virus. Neither did they allocate any duty to me during the community functions nor did they give the casual work to me as they had done before the death of my husband. (W 1h)

A few widows participants reported that the family and the community gave them support and love.

My own mother and brothers together with the community cared about me and my children after the loss of my husband. They organized a fund raising so that I could clear the hospital bills for my deceased husband. (W 1i)

Most of the children of the widows were discriminated in the school by both the teachers and other learners if they knew of the parents HIV status as reported by majority of the widow respondents.

My three children complained that the teachers and the learners segregated them by not greeting them with the hands. They were left to sit alone in class and other children refused to play with them, which made them to feel like dropping out of school. (W 1k)

All the professionals confirmed that, widows who lost partners due to AIDS experienced stigma and discrimination both on the personal, family and the societal levels. In addition, they said that
stigma in the family setting deprived the widows the unconditional love and support which families were expected to provide.

She got fired from a job where she worked together with her husband before he died. When the employer discovered that she was HIV positive, her job was terminated suddenly. The lady felt that her right to work was violated because of her HIV status. Today she lives in poverty and untold suffering since she is unable to care for her five children. She has no money to take the case to the court. (P 1b)

According to the professionals many widows belonging to MUFOA group were able to fight stigma and discrimination since most of them had accepted their AIDS status and were not afraid of the public opinion. Four out of the six professionals agreed that AIDS stigma can negatively affect the health and the total wellbeing of HIV positive persons.

Most of the professionals reported that, internalized stigma prevented widows to seek support due to the fear that family or friends will abandon them or suffer the same stigma they experienced. Majority of the experts felt that widow’s experiences of social rejection, disapproval and discrimination related to AIDS decreases their motivation to live a normal life. (P 1d)

The participants’ responses from the interview transcripts revealed that, most of the widows who lost partners due to HIV virus suffered stigma and discrimination. Basically, they experienced stigma from the family, society, denial and self stigmatization which had more negative consequences than the external stigma.

These study findings concur with UNAIDS (2011) that the stigma and discrimination associated with AIDS often are as a result of peoples lack of knowledge about it and mode of transmission. Further, the same study showed that, the stigma caused the perception of people living with HIV as weak, therefore a burden on the community. However, stigma decreased the more infected and affected gained knowledge about AIDS and this has been the case with
widows of MUFOA therapy group. Again, the tendency of people living with AIDS to internally stigmatize themselves decreased not only because of their contacts with professionals but also due to interactions with others living positively with the disease. According to Bank Ki Moon (2013) on the personal level stigma discrimination made many widows reluctant to take care of their health or assuming a normal life thus making it difficult to deal with the loss of their partners. For him stigma and discrimination made AIDS a silent killer because people feared social disgrace of speaking about or taking easily available precautions. Moreover, self Stigmatization kills many of those living with AIDS more than the deaths caused by the HIV infection itself (Bank Ki Moon, 2013).

Oye’s (2006) findings were similar to the current findings in that, the consequences of stigma and discrimination to widows who lost partners due to AIDS are wide ranging such as being shunned by family, peers, wider community and poor treatment in educational settings, an erosion of rights and psychological damage and a negative effect of the success of treatment and coping with widowhood. UNAIDS (2012) concurs with the study findings in that many widows, who loose partners due to AIDS in Kenya reported having felt suicidal, regularly excluded from attending the family, social activities and being gossiped about by members of their community. Again, today many families do not care for the widow like in the past where the widows were respected and assisted (Rachuonyo, 2012). This was confirmed by a small number of widow respondents who said that they had received support from their families of origin. UNAIDS (2011) contends that, in majority of the developing countries families play an important role in providing support and for care PLWHA. However, not all family responses were supportive, since many widows who lost husbands of HIV virus found themselves stigmatized and discriminated within their homes.
The implications of these findings were that, combating stigma and discrimination against widows who were affected by AIDS were necessary to prevent and control its spread. There was need to educate widows and the entire community for proper understanding of the AIDS disease. Further, enact laws and policies that protect the dignity of widows who lost partners due to HIV virus. In addition, a more enabling environment needs to be created in the family, schools and the society so as to increase the visibility of PLWHA as normal part of society.

4.5.2 Conflicts from In Laws

The death of a husband due to AIDS sometimes, resulted in deterioration of the relationship between the widow and her in laws. Conflicts came up if there were attempts or the widows were evicted from their marital homes by the brothers or parents in law, or when the family claimed their son’s property and there was absence of “wills”. Again, if the widow objected to the promise of marriage or sexual advancement by brothers in law conflicts and tension could arise.

More than half of the widow participants that is, reported that, they had an experience of an attempted eviction or had been evicted from their marital homes after the death of their partner due to AIDS by their in laws who had interest with their son’s property. All the professionals unanimously agreed that most of the widows had conflicts with their in laws related to possession of properties. Both groups of respondents said that very few in laws seemed to care about the welfare of the widows and their children.

On the burial day of my husband, the worst happened. I was not allowed to bury my husband. My brothers in law chased me away from home that morning with my five young children. They accused me to have killed my husband with the HIV virus. I left the only place that I called home that morning sobbing loudly. Nobody defended or helped me. I wished I were dead. (W 1c)
Only a few of the widow participants said that they had received support from their own families of origin but not from the in-laws after the loss of a partner. A small number of widows said to have heeded to wrong advices that raged from selling of the properties they had secretly to being submissive to the sexual needs of their brothers in law in obtaining favors from them. This eventually brought about a lot of conflicts in the family. A high number of professionals concurred with the widows sentiments that, many brothers in law had an interest to exploit widows sexually other than taking them for marriage.

I overheard my parents in law with their three sons one evening discuss about me after the burial of my spouse. They were wondering what to do with me as a woman who had brought death to their son, and what to do with the deceased properties. I felt the death of my partner had opened to me a life of sufferings and was scared about my future in the in-laws home. Then somebody advised me that if I submitted to my brother in laws sexual needs my security would be assured. (W 1d)

A good number of professionals confirmed that, many widows had little information about succession and property rights. As the widows narrated their experiences related to property ownership, many expressed different feelings of anger, bitterness, revenge, helplessness desperation, and injustices as they shed tears. A sign that the widows were not only having the pain of the loss of their husbands but also the pain they were still undergoing in regard with the rights to own property.

When I had gone for casual labour, my brothers in law came with a lorry and carried all the variables furniture and electronics from my house. They moved them to an unknown place. The only thing they left in the house was a box of clothes. I cried uncontrollably when I entered the house just to find it empty. My heart was greatly wounded. I felt to hate the entire family of my in laws. I became very bitter due to the injustice. I wished I was dead. With time I decided to let go my anger and give God room to be my sole provider. (W 1e)
The participants’ responses from the interview transcripts revealed that many widows after the death of their husbands due to AIDS, experienced conflicts from their in laws that caused them a lot of suffering. Again, a majority of the widows were unaware of their rights to own property.

These findings are in line with Human rights watch (2011) who contends that for many widows who are illiterate, untrained, without land, often are evicted from their marital homes. According to Barrett and Mulegeta (2010) conflicts from in laws when a woman loses a husband due to HIV virus occur because when the partners die rarely they leave “wills.” A factor that made many in laws to take advantage of the widows by taking every property from them. Similarly the study results concurs with Otieno (2006) who portends that widows who lost husbands to AIDS are often dispossessed their properties by in laws or even their grown up children. The study findings are contrary to a report by UN women (2011) who argue that, today widows are more educated, economically independent and aware of their rights, factors contributing to a growing trend of widows’ refusal to continue in abusive and unsatisfying family relationships. Very few of the widow respondents under study were economically stable or knew about the rights of property ownership. Majority of them had educational levels that were below standard 7 and 8.

Implications of this finding were that, the widows and community need awareness about rights to property ownership and a community based justice interventions. There is need for more support from governments, churches in fighting unfair treatment of widows. Advocacy is needed to raise awareness through public forums, informational materials, social media; lawyers who work probono assist widows in obtaining justice and training them on how to prepare memory books and wills. Communities could establish rescue centers for widows.
4.5.3 Cruel Accusations

Many widows who lost spouses due to AIDS received serious accusations from their in-laws, family members and the society. Accusations could be due to misunderstanding of the causes and mode of transmission of HIV virus. Sometimes it was just a case of finding someone to blame and generally the most vulnerable and marginalized like widows were targeted. Accusations brought about a lot of tension in the family. The allegations generally were that the widows were responsible of bringing death to the family having infected their husbands with the HIV virus, or being involved in witchcraft.

Many widow respondents reported that, they were accused to have brought death in the family by infecting their partners with AIDS. A smaller number of widows reported to have been accused of being involved in witchcraft that led to the death of their partners. Half of the professionals shared that, they were aware of widows who were accused of being responsible of the death of the husbands. Relatively a smaller number of widow reported that they were forced to leave the marital homes due to the accusations that associated them with witchcraft.

My in laws accused me to have brought death to their son so that I could posses his properties. For them, that was the reason why I denied him food to die as a skeleton. I felt they treated me like a criminal who deserved to leave my marital home. These accusations left my heart with deep wounds and a feeling of helplessness. (W1f)

Two out of the six professionals had encountered cases of widows who had been both accused of witchcraft and abused physically by the brothers in law, after the death of their brother.

She was accused by in laws of killing her spouse with HIV virus. The husband worked in a big firm, was fairly wealthy by local standards. When he died his brothers took away everything of value including the pickup he owned. The process of grabbing was carefully planned. The deceased had the log book of the car, land title deeds, bankcards and other important documents kept by his mother and not the wife. They took away
those documents and anything else they could lay their hands on. She was left with only
the option of going back to her aging mother where life turned to be also hostile. (P 1a)

The participants’ responses from the interview transcripts revealed that many widows who lost
partners due to HIV virus, suffer cruel accusations that subjected them to maltreatment by in
laws. Condemning the widow is seen as a fair result of their sexual misbehavior by the accusers
(Mbabane, 2012). The mistreatment rendered many widows to be particularly vulnerable, lowered their status in the community and made caring for themselves more difficult (Otieno,
2006). The results of this study are in agreement with UN (2011) that, many African widows
remain victims of harsh accusations associated with the passing on of their beloved partners due
to AIDS. Muchunguzi (2008) adds that even where death occurs under circumstances that are
well known like in cases of AIDS or is a natural death, many Africans tend to attribute it to
witchcraft or sorcery brought about by widows who are accused and blamed for the deaths of
their partners. Again in some African communities widows were looked upon with hatred,
suspicion and were considered to be evil since they brought death to the family of their in-laws.
The study findings contradict a report by UN Women (2013) from Tanzania that in the year 2000
hundreds of older widows were killed because of being accused of witchcraft, having brought
about the death of their partners. The same report adds that, the widows accused of witchcraft
were tortured and attacked by community members to the point of being murdered or forced to
commit degrading acts. Apart from a few professional respondents who reported to be aware of
widows who were physically abused none of the respondents talked about being tortured to an
extent of being killed or forced to carry out degrading acts.

Implications of these study findings are that, in order to eliminate the cruel accusations
against widows bereaved by HIV partners, communities need to be educated about the women’s
rights and raising awareness of the harmful consequences of witchcraft allegations, misconceptions about AIDS.

### 4.5.4 Financial Constrains

With the loss of husbands due to AIDS, many widows suffered a lot of financial constraints. Majority were left with families to provide for, without any source of income. Others had overwhelming responsibilities as they assumed also the ones of the deceased. All the widow participants unanimously agreed that, many widows after the loss of a partner suffer financial constraints. All the widows in this study had an average of 5 dependants and were of low social economic status.

> Alone I carry all the burdens of my family. I have children both in primary and secondary schools. Their school fees have been paid by well wishers. It is difficult to accept this situation of always living like a beggar. I feel that I am a burden to the community. I only go on with life because I feel that the Lord is providing for my family. (W 1g)

More than half of the widows said that they depended on small scale farming for their livelihood, with a similar percentage having levels of education below standard 7 and 8. Among the widow respondents, a majority agreed that, they found themselves financially insecure and totally dependent on others for their livelihood. More than half of the widows reported that, they were unaware of the rights they had to own property.

> My husband was the sole bread winner in the family. After his death, I had to move from house to house in the neighborhood washing people’s clothes. In some homes due to the stigma, I was never given the work. Up to date that is how I earn my life to support my children. The little I earn hardly meets the upkeep of my family. (W 1h)

Only a few were aware of insurance coverage schemes. A group of less than half of the widows showed that, they had to settle debts incurred by their deceased spouses for hospital bills. Majority of the professional respondents reported that, most of the widows totally depended on
their husbands’ income. This situation had rendered many widows to end up living in abject poverty. All the professionals agreed that, the low levels of education and lack of training made widows incapable of getting jobs to support themselves or their families. The expert respondents also agreed that, widows in some places were denied their right to work due to their HIV status.

She and her husband worked for the same company which had no medical cover for its workers. After the death of her husband due to AIDS, the company enforced a medical exam on the widow where she tested HIV positive. Later she was fired from the job and denied her right to work because of her HIV positive status. Today she languishes in poverty and untold sufferings because she has no finances to file a court case. (P 1b)

The participants’ responses revealed that, many widows when they lost husbands due to AIDS experienced a lot of economic hardships, especially if they entirely depended on their husband’s income. Again, many were charged with family responsibilities that overwhelmed them since many were not economically stable. Due to the low levels of education and training of the widows a good number engaged in low paying jobs, that left them unable to provide for themselves and their families.

These findings concurs with Human Right Watch (2011) who confirms that many widows in Kenya suffer a lot of economic hardships particularly, if the husband was the sole breadwinner, which lead the nucleus family to be deprived of their husband’s income. In addition, for the widows who were illiterate and untrained or without land, their financial challenges were greater. According to Aliber and Walker (2006) in some incidences the widows land rights were further threatened as a result of AIDS in situations where the husband may have used land rights as loans in order to pay for AIDS related health problems and thus upon the husband’s death the family could be left with a debt that is beyond the widow’s financial capabilities. As reported on 23rd June 2013 by Puri on the international widow’s day, many
widows lack rights to the property of their deceased partners. For this reason many widows find themselves financially insecure and totally dependent on charitable institutions. Many widows were unaware of the insurance schemes and so unable to access credit in becoming solely responsible of providing for their families and the liabilities they have for clearing debts incurred by the deceased in funeral and medical expenses (Bankole, 2006). Similarly, most women in Africa rarely prepare for eventualities, but tend to think that their husbands will always be there for them. Such widows often are hard hit by the death of their husbands since they never built their capacities towards being economically independent (Bankole, 2006).

Therefore, the implications of these findings are that, the widow’s economic self-reliance needs to be strengthened through income generating activities and education. More support is needed in fighting the injustices against widows who lose partners due to AIDS. There is also need for widows, of being diligent and hardworking despite their HIV positive status. Educational bursary funds should be accorded to widows unable to settle school fees for their children.

4.5.5 Indulgence into Risky Behaviours

With no male to depend on and limited livelihood means, many widows who lost partners of HIV virus may be forced to resort to income generating activities that are considered immoral by the society, such as commercial sex, brewing of illicit liquor, begging which places women and others at further risk of HIV infection as asserted by (Kessy et al, 2010). Majority of the 15 respondents affirmed that, many widows who lost husbands due to HIV virus tended to engage in risky sexual behaviors with a high rate of partner change irrespective of their AIDS status. Many widows reported that, they engaged in casual labour to support themselves and their families. Seven out of the nine widows shared their experiences of proposals from different men who were
promising them to provide for their basic needs in return for sexual favors, but not for a marriage commitment. One out of the nine widows, only one talked of being cleansed after the death of the partner. All the widows felt that their sexual needs were not fulfilled.

Unanimously, all the professionals expressed that they had encountered widows after the death of their partners who had remarried with either men who were HIV positive or negative but many of those marriages did not last. Four out of the six professionals said that many of the widow’s sexual needs were unmet. A high number of the experts agreed that a good number of widows engaged in different risky sexual behaviors once they lost partners due to economic insecurity.

After the death of my partner, I was also diagnosed to be HIV positive. For a number of months, I lived in denial and refused to take the ARVs. I became physically weak unable to carry out even the ordinary daily activities. I was left with the option of having different sexual partners who could provide for my basic needs. (W 1i)

The participants’ responses from the interview transcripts revealed that the vulnerability of some widows and their economic insecurity forced them into risky behaviors for survival. However, other widows engaged in positive activities to earning their living. These study findings concurs with Benefo (2010) who asserts that, in developing countries widowhood often affects younger women due to AIDS epidemic, such widows faced with homelessness and poverty would be more likely to engage in unsafe sexual activities or become involved in commercial sex works.

According to the report by UN Women on 23rd June 2013 on the International Widows day, the economic insecurity stemming from widowhood could drive some of them and their children to engage into sex works, servile domestic services, living in the streets, begging and prostitution. UN Women Secretary Puri adds that the sexual reproductive health needs of widows may go unaddressed, including the fact that widows are often victims of rape.
Similarly, Ncube, Akunna and Jolly (2012) argued that many widows in the Sub-Saharan, live in poverty where they not only lack money but also assets and skills. Therefore, such women strive to get basic needs and mostly indulge in risky behaviors such as commercial sex in order to acquire basic survival resources. However, a good number of widows were diligent and hard working, became entreprenuering, ran small business, farm in support of their children and contributed to Nation building (Mwali, 2013).

The implication of this finding is that, many widows who lost partners due to AIDS need education on how they can become self supporting economically and on the consequences of engagement in risky behaviors so as to change their attitudes.

4.5.6 Inability to Handle Adolescents Behaviour Problems

According to Naswa and Smarfatia (2010) adolescence is a stage of individuals in the 10-19 years old and a phase of accelerated physical growth and development accompanied by sexual maturation. They also added that adolescence is often marked by psychological and behavioral changes in social expectations and perceptions as the individual transits from childhood to adulthood. Many teenagers had sad memories of their bereaved fathers and sick mothers that often left them with a lot of fear of becoming orphans. Majority of widow interviewees agreed that they experienced challenges bringing up their teenage children. Only few of the widows felt that, they had not encountered difficulties in disciplining their children.

The death of my husband came as a shock to me and my children. As an introvert I found it tough to discipline my teenage children. Before, my husband was in charge of the discipline and the family ran smoothly. Today my children have become irrespective, disobedient and two abuse hard drugs. I feel helpless. (W 1b)

Almost all widow participants felt that, it was not easy to support their children both physically and psychologically so as to adjust and go on with life without their father. A very small number
had disclosed their HIV status to their adult teenage children and had enhanced their discipline where children became more compassionate and caring to their sick mothers.

When I disclosed to my teenage children about my AIDS status they cried a lot. But I felt a lot of relieve and peace. Immediately they changed the attitude they had towards me of fear and suspicion. They became more compassionate and caring towards me. They also became more responsible and very supportive to the entire family. (W 1c)

Most professional interviewees concurred with the widow participants that, many widows encountered a lot of challenges in handling their teenage children. Half of the professionals reported that, the loss of a husband due to AIDS had serious consequences to children who sometimes became depressed, rebellious, angry and bitter by venting their anger on their sick mothers. Other children seeing the way their mothers were mistreated by their in laws become more aggressive to the mother thus making it tough for them in handling their behavior. Unanimously all of the professions said that, many widows lacked the courage to discipline their adolescent children due to the fear they had of being rejected by them. The results also indicated that, the children of the deceased due to AIDS were vulnerable, sometimes abandoned, rejected and denied help by their relatives who only exploit them. In relation, some of those children become difficult to discipline.

In our office we have a case of one of the widows who found one morning that his teenage son had committed suicide. The son had a lot of conflicts with the mother due to discipline issues. The lady had not even recovered from the loss of her husband. (P 1c)

The participants’ responses in the above interview transcripts revealed that many widows experienced challenges in handling the problem behaviors of their teenage children. Though a small number of widows were managing the discipline of their children the greater majority were experiencing challenges. As asserted by Naswa and Smarfata (2010) study findings are in line
with their arguments that children whose mothers have lost spouses due to HIV experienced negative changes in their lives and suffered physical, social and emotional neglect as they imagined of the possibility of becoming orphans.

These findings imply that, there is need to create different opportunities for widows in helping them to discipline and protect their children. Again the provision of practical pastoral care to both the widows and their children is necessary.

4.6 Psychological Challenges faced by Widows of AIDS Partners

The study sought to find out the psychological challenges affecting widows of HIV and AIDS partners in Mugunda Location, Nyeri County. The study findings indicated that, several themes on the psychological challenges affecting widows of AIDS partners revolved around six aspects such as: shock and denial, sadness, loneliness, depression, low self-esteem and resilience.

4.6.1 Shock and Denial

The grieving process begins with a deep sense of shock followed by denial. Widow’s who lose partners due to AIDS suffer shock and denial as the initial reactions to loss. Denial is experienced as an individual’s emotional protection from being too suddenly overwhelmed by the loss and grief. Denial is experienced by the bereaved as the inability to believe what their mind knows to be true, the fact of the partner being gone forever. Majority of widow respondents, eight out of nine confirmed that, the first emotional reaction to the loss of a partner was shock that was followed by denial which manifested itself in different forms. The same phenomenon was attested by all the professionals who said that they had encountered widows who had prolonged denial even after many years of the loss of a partner. Half of the widow respondents felt that living in denial distorted their thinking and behavior making it difficult for them to face the reality of the loss of the partner.
I was not prepared for the death of my husband, but the virus took his life. We still had many things we needed to do together. Our four children were still very young. For a whole year I cooked food daily for my husband as I had done previously. I imagined he would come to eat it in the evening. I even convinced my children that their father would come back, so as to continue preaching in the church as he did before as a pastor. (W 2a)

More than half of the professionals reported that they had encountered widows who had failed to work through denial emotions, thus promoting their own helplessness.

For years, this widow lived in denial that her husband had died of AIDS and the fact that she was HIV positive. Later she realized that, she needed to take control of her life. In her denial she became addicted to alcohol and exchanged sexual partners. Her family and society condemned her behavior patterns, which influenced her to change and became very spiritual, believing strongly that God would heal her deep wounds of denial. (P 2a)

The participant’s responses in the above interview transcripts showed that, the death of a spouse due to AIDS is followed by emotional reactions of shock and denial. As time goes, feelings of shock and denial can change to a profound sadness, anger and guilt (Christy, 2013). The shock of the widows sometimes, is as a result of imagined HIV diagnosis and the fear of facing the pain of a possible death. The study results are in line with Haskings (2012) who argues that when widows lost spouses, they experienced some grief reactions such as shock and denial that occur simultaneously, stressing the widows to an extent of not being able to carry out normal daily activities. She also added that if the widows were not in touch with their shock, deny their feelings and emotions of loss, they risk suffering depressive symptoms to an extent of needing medical attention, or engage in drug addiction, withdraw from society or commit suicide by not adhering to the ARVs drugs. According to Network Africa (2013) the study findings are similar with the argument that, widows’ denial of the loss of their husbands makes them experience
mental confusion, leaves them with feelings, thoughts and behaviors reactions they themselves do not understand thus, rendering them disorganized and detached from the realities of life.

The implication of these findings is that, for widows who lost partners due to AIDS, it is important to recognize and accept the reality of the loss by working through their pain. Professional counseling and group therapy would assist widows in adjusting to the world without the deceased.

4.6.2 Sadness

Every widow who loses a husband due to AIDS experiences a profound sadness which is a universal response to loss of a lifelong partner. All the study participants both the widows and the professionals confirmed that widows who lose husbands because of HIV virus experience great pain and sadness as they attempt to come into terms with a life without their friend and partner. Majority widow respondents expressed that the great sadness they experienced resulted not only because of the loss of a husband but mostly because most of them were HIV positive and were afraid of an impending death.

The death of my husband made me feel I had lost the most important person in my life. We loved each other. When I discovered that I was also HIV positive, I suffered a lot of pain and sadness. I felt my life would soon come to an end. I cried everyday for a whole year with no one to console me. (W 2b)

More than half of the widow participants felt that no human being could understand the kind of pain and sadness they were undergoing, but only God who was the source of consolation to many.

My husband died three years ago. Up to now I feel that I have not recovered from that loss. Each day sadness and pain hits me harder. No one understands the depth of the crushing pain in my soul, unless they go through it themselves. My family members
condemn me of exaggerating the sadness. They think I should have gotten better and stronger by now. I am unable to forget my husband since I still love him. (W 2c)

All the professional participants confirmed that, many widows after the loss of a partner had decided to turn to God for solace. A small number of widow respondents shared of having been overcome by their emotions of pain and sadness which lead them to depression and withdrawal from society to an extent of contemplating suicide.

I have an experience with widows who had shared that in their pain and sadness of the loss of a partner, for them each day they had experienced the power of prayer, finding God and getting lost in his love as a healthy way of handling their grief. (P 2b)

The participants’ responses from the interview transcripts revealed that all the widows who lost husbands due to AIDS are likely to experience certain amounts of pain and sadness as part of normal expression of grief. Bereavement is a state of loss, grief is the reaction to loss, a healthy and natural response, the emotional suffering and sadness one feels having lost a marriage partner (Sanders, 2013).

Again, for some widows, pain and grief might be severe and lasting longer than for others. The study findings concur with Haskings (2012) who argues that pain and sadness are some of the grief reactions that occur to the bereaved simultaneously and if not addressed would incapacitate the grieving from carrying out their normal daily activities. The study findings are contrary to the studies done by Network Africa (2013) reported that, many widows bereaved by HIV partners could have the tendency to rejected depressive symptoms as something socially and culturally unacceptable. This was not the case of widows in Mugunda Location. However, many widows hid their feelings of pain and sadness as a way of avoiding to scandalize their children who suffer similar feelings due to the loss of their father. Wordens Grief Task Model Theory (2008) proposes that, widows need to work through a range of emotions like pain and
sadness in adjusting to the world without the deceased. If the widows fail to work through such emotions, it becomes hard for them to face the reality of the loss of their partners (Fasoranti, et al, 2007). Many people both in the family and society might not understand what widows go through after the loss of their spouse. Majority of the widows in Mugunda Location said that they had decided to entrust their lives to God and live as if they never got married.

Implications for these findings were that, widows who lost partners due to AIDS need to work through their grief emotions of pain and sadness in a healthy way in order to achieve psychosocial well being. Going through the process of grieving is not the same for everyone, but the aim is to accept the loss, pain and sadness not necessarily eliminating all the pain or memories of the loss, but be able to move on with the normal life.

4.6.3 Loneliness

Loneliness in widows is very devastating and more than a feeling of desiring company or doing something with another person. Often widows are overwhelmed by feelings of insecurity, emptiness, being isolated, and disconnected from themselves and other people. Further, it hinders them from having any form of meaningful human contacts. In addition, feelings of loneliness, helplessness and loss were normal reactions to loss and grief and lessened with time. All the widow interviewees attested that, after the loss of a partner they experienced the difficult feelings of loneliness and the loss many other things. Three out of nine widows said to have sought help from friends, family members and God in order to be helped to cope with their loneliness.

The death of my spouse left me in depression. I didn’t know with whom to share my feelings of loneliness, I felt no one could understand me. I withdraw from myself and the entire world. After only three months of bereavement I was a very depressed person, very much afraid of dying. (W 2d)
Five out of six professionals reported that, many widows with the death of their AIDS partners suffered loneliness that had lead some to anxiety, stress and depression. Most of the professionals had encountered widows who were struggling in dealing with the loneliness without the partners. A good number of widow participants reported to have fallen victims of multiple sexual partners in order to meet their sexual and financial needs.

In our office we have handled several cases of widows with cases of multiple sexual partners irrespective of their HIV status. Many widows justified their behavior arguing that both their sexual and physical needs had not been met and so loneliness had crept into their lives. (P 2c)

Half of the widow respondents said that, they feared disclosing about their loneliness, thus withdrew from themselves and the entire world.

I felt like the death of my husband took everything from me. I felt helpless, useless and ashamed of myself even in front of my adult children. Again, I felt like everybody was laughing at me and knew about my HIV positive status. I would hide from people and became very envious of other women who had their partners. This situation made me depressed to a point of attempting suicide. (W 2e)

The above excerpts from interview transcripts showed that, loneliness was difficult to handle and challenging feelings experienced by widows who lost husbands due to AIDS. If such widows failed to work through their loneliness they were likely to experience intense emotional process that produced anxiety, depression and engagement in risky behaviors (Christy, 2013). The study results agreed with Haskings (2012) in her argument that, when widows lost spouses, loneliness is one of the grief reactions likely to be experienced. The same findings concur with Net Work Africa (2013) who reported that, widows in their efforts to work through their feeling of loneliness, shared the experienced emotions for psychosocial support and adjusted better to
the loss of their partners. The results also showed that, majority of the widows had decided to entrust their lives to God and lived as if they had never married. Worden (2008) affirms the study findings contending that, widows with the grief tasks need to work through their loneliness in adjusting to the world without the deceased. They have to be aware that, healing happens over an extended period of time because such widows had also lost love, sexual satisfaction, companionship, confidants, friends, shared activities and above all someone who made them feel important, needed and loved on daily basis (Byrne, 2014).

Implications of these findings were that, loneliness as a grief reaction needs to be identified and worked through, so that it does not lead widows to make decisions harmful to them and others. Further, handle loneliness by reinforcing their self-esteem and acquisition of social skills.

4.6.4 Depression

Virtually everyone, whose husband died, exhibits some signs and symptoms of depression which was assumed to be a normal and a natural expected reaction to loss according to the DSM-V. Following the death of a partner due to AIDS a widow begins to realize and feel the true extent of the death and the loss of their partner.

Depression as reported by both widow and professional respondents was experienced by most widows who lost partners due to AIDS. However, most cases were not severe enough to be considered major depression of prolonged periods of sadness, withdrawal, suicidal thoughts or exhibition of behaviors that were noticeably different from a person’s normal behavior as was attested by all the fifteen respondents.

After the burial of my husband, when every relative had left our home, I began to feel and realize the truth about the loss of my partner. We loved each other and nothing seemed to fill the gap he had left, so I became depressed and experienced insomnia, self
pity, loneliness, isolation and eventually contemplated suicide. After all, I felt due to my health status I was dying soon. (W 2g)

Only a small number of widows said they suffered unresolved grief which was arrested through the MUFOA therapy group. All the widows under study confirmed to have experienced one or more depressive symptoms especially during their early stages of bereavement. Six out of the nine widows had experienced fears and insecurity that had aggravated their levels of stress. Only one widow felt that the death of the husband was a relief to both her and the family.

The heart of a widow is full of pain and tears I felt a lot fears and insecurity when my husband died. It is hard to just forget about him. It was better if he was still around, though sick. Life is very stressful without him. (W 2h)

All the professionals’ respondents said that they had encountered cases of widows who died because they failed to deal with depression appropriately.

“I am aware of many widows who died because they failed to manage their depression after they lost husbands. Surprisingly, they were in the category of the learned and the highly educated.”(P 2d)

The excerpts from interview transcripts from the respondents revealed that, almost all the widows experienced symptoms of depression but at different extents. Again, there was a consensus that if grief emotions were suppressed would lead the griever to experience a lot of health problems.

The study findings were in agreement with Network Africa (2013) who argued that widows bereaved by AIDS partners reported common depressive characteristics which they experienced during their first three months of bereavement. The mentioned were difficulties in concentration, crying a lot, insomnia, lowered appetite. Similarly, Vachon (2013) asserts that a bereaved woman living with HIV virus, their stress could become overwhelming and can
damage their immune system and cause physical and emotional illness. She adds that long periods of high stress could lead to depression manifested in sleep problems, loss of appetite, guilt, helplessness, worthlessness, and difficulties in concentration as was also confirmed by the respondents under study. Elaine (2008) confirms the current study findings in that if widows tried to suppress the emotions and feelings of grief, the grieving process might prolong and lead to unresolved grief characterized by intense longing of the deceased, intrusive thoughts and images of the deceased. She also adds that complete denial of death of the partner, extreme anger, bitterness would make the survivors very anxious, suffer suicidal thoughts, feelings of helplessness and worthlessness and inability to function normally and a likelihood of engagement in substance abuse or experience a lot of health problems.

Implications of the findings were that, widows should be monitored closely by friends, relatives so that depression is handled before escalating into a major depression.

4.6.5 Low Self Esteem

The loss of a partner due to AIDS was sometimes a disruptive life event which affected the widow’s self-esteem. Many widows felt insignificant and no longer needed and sense of powerlessness and inability to move on with life. The widows HIV positive status facilitated the drastic change of life with the uncertainty of the future making widows to feel very vulnerable and victims.

More than half of the widow participants felt that, after the death of their partners, sooner or later they would also die because of their HIV positive diagnosis. Four widows out of the nine respondents had neglected their personal health by declining to adhere to the ARV drugs.

When I discovered that I was also HIV positive I was really shocked and couldn’t believe it. I neglected my personal hygiene, refused to go for the ARVs, became withdrawn I felt like dying every day. My being admitted to one of the hospitals saved my life. (W 2i)
Almost all the widows affirmed that they felt rejected, unloved and not needed by some of their family members and the society. Half of the widows said that, the death of their partners made them feel very insecure about their future and that of their children.

My husband left me when I was only 24 years old, with three small children. We lived in fear especially when evenings came. I felt we had no security, I didn’t like the way my brothers in law visited us in the evenings. (W 2j)

All the professional participants reported that, all the widows encountered through the MUFOA therapy group self esteem was affected by the loss of their partners. They also added that, a good number of widows belonging to MUFOA therapy group were no longer participating in the therapy meetings, and their health had deteriorated. The professionals felt that, the many challenges the widows were undergoing rendered them vulnerable. “Once the widows failed to adhere to the ARVs not only did their health deteriorate but also their self esteem and eventually they died.” (P 2f)

The participants’ responses in the highlighted interview transcripts revealed that, many widows self esteem was affected after the death of their husbands. As contended by Byrne (2014) the study findings were in line with her argument about common experiences shared by some people who lost loved which affected negatively their self-esteem. She also adds that the death of a loved one brings a sense of powerlessness and a sense of inability to move on with life. Also when widows feel that their grief over a reasonable amount of time does not move quickly enough their esteem lowers. Lampe (2014) concurs with the same findings asserting that, low self esteem experienced by widows could lead them to keep themselves and others at a distance emotionally, where they refuse to engage in any relationships with others since they are also detached from themselves. Again, low self esteem could manifest itself in many ways such as self destructive behaviors as seen with the widows of Mugunda who neglected their personal
health. Widows with low self esteem sometimes take unnecessary risks, nurture negative thoughts about the self, live in great fear of the new situations and their future. Rarely they interact with others and nurture feelings of being unwanted, vulnerable and victims. Like Worden (2008) confirms the need to work their grief feelings in order to regain their psychosocial well being.

Implications for this finding are that, widows who lost partners need to be aware of the feelings that could be detrimental to their self-esteem. There is need for widows to find nurturing support groups where one would feel acceptable able to share one’s life. Moreover, awareness of the negative thoughts would help widows in changing their attitudes.

4.6.6 Resilience

Many grievers are able to handle the pain of their loss on their own, without counseling or any professional help simply because human beings are naturally resilient. Bereavement by a partner though overwhelming or unending is a human experience that does not leave the griever indifferent. Resilient widows after the loss of their partners, to withstand the traumatic and the stressful experiences drew strength from themselves, others and God. With time they stabilized emotionally and experienced growth that enabled them to persevere in life despite the pain and loss.

Majority of widow interviewees were unaware of being resilient due to the experience they had of overwhelming emotions that left them disorganized and detached from the reality. For all the widow respondents and the professional, more than the self and others, God was perceived to be a source of strength for many widows in coping with death and loss of their partners.

I made a conscious decision that I have to live for the sake of my children. I tried to participate in all community activities. Accepted myself the way I am has been
reciprocated by the community. If I am absent during their meetings, often leaders ring to me. I feel the community is concerned about my welfare. (W 2d)

Three quarters of all the study respondents, felt that human beings are naturally resilient but the loss of a spouse was accompanied by many other loses that rendered the bereaved helpless and worthless. All the widows felt the departure of their partners had a negative impact on their lives in many senses, with some wishing if their husbands were still alive though sick. “How much I wished my husband was still alive even if sick, it is hard to live without him” (W 2k)

The professionals felt that they enhanced resilience in widows during the encounters they had with them during the MUFOA therapy group meetings. The results also indicated that how each widow handled their loss was unique depending on the kind of relationships they had with their loved ones as confirmed by all the study respondents.

I know of a number of widows after the loss of their spouses who lived terrible days of guilt feelings, broken hearts, low self esteem, sadness, depression, but with time nurtured the ability to adapt to their loss successfully. They were able to re-organize their lives. (P 2g)

The interviewee’s responses from the excerpts showed that, it is possible for griever to handle their losses on their own as long as they are aware of the sources from where to draw strength that would stabilize them to experience a new sense of life. The study findings are confirmed by Bonanno (2012) who argues that every bereaved person possess a natural resilience as the main component of grief and traumatic reactions. Additionally, he argues that there are different ways of coping with grief emotions with what he refers to as “coping ugly” thus differing from the traditional ways proposed by (Kubler-Ross (2012) of crying and talking about emotions through a therapeutic process. The findings also show that, majority of the widows had consciously entrusted their lives to God as one of their sources of strength in the process of overcoming grief. Again, the study results agree with Worden (2008) who recognizes
grieving as a challenging process, accompanied by feelings and emotions that are essential part of an individual’s life. According to Berger (2011) resilience assists the mourner to work through their emotions and feelings with the help of the mind and body helping the individual to normalize and regain personal strength.

For Owen (2011) apart from just losing a partner, the widow loses many other things that were related to the departed such as love, companionship among others. The study contradicts the assumptions of Laura (2014) that widows have the ability of immediately re organizing their lives from what has been the experience of the widows in Mugunda after bereavement, since they found it challenging, the aspect of having the ability of going on with lives despite the pain and overwhelming responsibilities.

Implications for the findings are that, widows should be reinforced in being resilient in order to rebuild their lives even after the loss of a partner. Assistance is needed for enlightening them on how to draw strength from selves, others and God in overcoming the loss and gaining stability to experience growth and beauty in life.

4.7 Ways how Widows Adjusted to their New Status

This study also sought to find out how widows adjusted to their new experiences. The sub topics revolved around six aspects such as: seeking divine intervention, assistance from family members and friends, seeking support from groups, remarriage and engagement in risky sexual behaviors and disclosure of HIV status to adult children.

4.7.1 Seeking Divine Intervention

Losing a loved one due to AIDS sometimes made many widows feel, believe and behave as if they would never live, never be happy again, smile or reconstruct their life for a good future as noted by (Berger, 2011). However, the loss of a partner affects entirely the lives of widows in
a way that they had to relearn organize their lives. Apart from other helps that assisted widows in coping with loss and grief, God was the irreplaceable source of inspiration where many widows drew strength in reorganizing their lives.

Majority of the widow and professional respondents, attested to the fact that, turning to God assisted widows in overcoming grief in a healthy way. They felt that God understood the plight of widows in a way that no-one else could.

With all the pains I undergo as a widow, I decided to try God. He is the only one who understands the struggles I go through. I feel God very close to me, he wipes my tears, gives me hope, courage and peace that the world cannot give. (W 3a)

Half of the widow respondents belonged to a group in the church, with few of them being leaders. Pastors and church members had visited some families of the widows either for prayers or in offering other helps to them. Only a small number of the widows felt very angry with God and blamed him for the death of their partners.

I became angry with God, blamed him for the injustice of allowing my husband to die. I blamed myself, wondered why I had not done something to prevent him from acquiring the HIV virus. For two years I deserted my church but later I joined another one. (W 3b)

Others, according to the professionals had moved to different churches hoping for miracles that would have cured the HIV virus and made them fail to adhere to the ARV drugs and eventually died. “A number of widows had left even the mainland churches in search of miracles that could heal them from the HIVvirus where a good number had died.”(P 3i)

From the respondent’s excerpts it is revealed that, God is able to intervene in the lives of the widows in terms of giving them hope and courage of living positively despite their HIV status. However, widows who failed to put their trust and hope in God failed to cope appropriately with their grief and loss. The study results indicated that God had always in mind
the welfare of widows and orphans as affirmed by scriptures such as Exodus 22:22, “certainly I hear the cry of the widows when they cry to me.” 2 Timothy 5:5, “she who is truly a widow, left all alone, has set her hope on God and continues in supplications and prayers day and night.” Psalms 68:5, “Father of the fatherless and protector of widows is God in his holy habitation.”

Implications of these study findings were that widow’s search for God gave meaning to their grieving process. Therefore, joining a Christian community, prayer groups could enhance their ability to handle the loss of their beloved partners in healthy ways.

### 4.7.2 Assistance from Family Members and Friends

Though the bereaved had similar feelings and emotions, the grieving process was different for everybody and lasted longer for some. Some widows adjusted to the loss of an enduring emotional relationship, through the help of family members and friends as they managed the daily decisions and responsibilities that were once shared with the partners.

Majority of widow interviewees reported that, some family members and friends who were HIV positive assisted them to cope with their loss.

My sister who was also HIV positive and a widow stayed with me for some time after the burial of my husband. We shared a lot about our experiences. I needed to share with someone who could understand me. My sister was a great gift to me. (W 3e)

The same idea was confirmed by almost all the professionals with a distinction that, some of the in laws were not very supportive to the widows. However, a few widows felt that, their parents in law had been very supportive even when their sons wanted their sister in law evicted from their marital home.

My parents in law after the burial of my husband allocated to me a piece of land where I was supposed to settle with my children. It was in that place that I managed to re organize my life. (W 3f)
More than half of the widows had received emotional and social support from and friends during the therapy meetings. “It was from the MUFOA therapy group meetings that most widows felt supported to live in hope and positively with HIVvirus.”(P 3g) A small percentage of widows said that, due to the denied support by their families forced them to engage in risky sexual behaviors so as to provide for their families. “I had no choice apart from engaging with multiple sexual partners in order to provide for my family.” (W 3 f)

The participants’ excerpts responses revealed that, family and friends were paramount in assisting widows who lost partners to cope with their grief. These findings agree with Laura (2014) who argues that in order for the widows to rebuild their lives, even after loss of a partner is much facilitated by having supportive relationships with family, friends, peers and the personal beliefs that help the individual widow to cope with their losses. She also added that, the family generally provided widows with more empathy, more appreciation that enables them to have a new sense of purpose, stability and experience growth. Denial of emotional and financial support to widows by family members forced some of them to resort to income generating activities that are considered immoral by the society as was already confirmed by a small number of the widow respondents.

Implications for these findings were that, family and friends should be sensitized on their role of supporting widows to adjust to their conditions.

4.7.3 Seeking Support from Groups

Social contacts were an important resource because they provided support that was helpful in the widow’s adjustment. Social contacts of widows bereaved by HIV virus were with friends, HIV and AIDS therapy groups, work groups, participation in different community activities associated with the feelings of psychosocial well being among the widows. Moreover,
immediately after the death of the spouse, arose a particular need for emotional support from other widowed persons. All the widow interviewees belonged to MUFOA therapy group which had facilitated their process of coping with grief.

After joining MUFOA therapy group, I began to accept myself, my attitude towards people changed. Interacting with other widows helped me to stop fearing about the public opinion regarding my HIV positive status. During our monthly meetings, I shared my experiences as a widow living positively with AIDS with the group without feeling victimized. (W 3g)

Professionals, comparing the widows belonging to MUFOA therapy group with other widows who did not belong to any support group felt that, there was a big difference in the levels and extent of coping with widowhood. All the professionals reported that the highly educated widows rarely joined support groups comprised of widows of low educational and social economic levels.

A number of widows, especially the ones with high levels of education and high social status, had died in denial of their AIDS positive status and fear of disclosure and associating with widows of low social economic levels. (P 3a)

Unanimously all the widow participants agreed that joining even other support groups other than MUFOA made them realize they were not alone in the world of grieve and began to live. The expert respondents disclosed that, to the widows of MUFOA they had provided them awareness workshops, group and personal therapy which had greatly influenced widows positively in adjusting to their new experiences.

After joining MUFOA therapy group, I began to accept myself, my attitude towards people changed. Interacting with other widows helped me to stop fearing about the public opinion regarding my HIV positive status. During our monthly meetings, I shared my experiences as a widow living positively with AIDS with the group without feeling victimized. (W 3g)
Through the helps from the group and personal therapy, I made a conscious decision to continue living like any other normal woman. I adhered to the ARVs drug and today with my family we live better. (W 3h)

The participant responses from the interview excerpts revealed that, support groups were a helpful part of the widows’ bereavement process. They offer hope, emotional support and services for the bereaved. These study findings are in agreement with Mwali (2013) who cites a number of ways how widows after bereavement coped with loss by using their determination and courage in collaboration with other widow recovery groups as is the case of MUFOA therapy group. Owen (2012) contends that, widows adjusted better if they get support not only from family and friends but also from widow support groups.

Implications of these findings are that, awareness, advocacy, education to the grieving and the community should be provided. Therefore, the need to provide support resources such as support groups, written materials, counselors, legal advices, group counseling therapy, pastoral counseling among others.

4.7.4 Remarriage

Remarriage by few widows who lost partners took place as a way of adjusting to widowhood. Some widows chose to remain unmarried after bereavement. The reasons why some widows desired to re-partner stemmed from the interest of the individual widow had in fulfilling their unmet needs. In majority of the widow respondent’s re-marriage had not been highly practiced among widows who lost partners due to AIDS. Only a few widows reported to have attempted re-partnering but those relationships had not lasted long.

Many of the remarriages between AIDS partners had not lasted long, so I was afraid of engaging in a relationship that I felt wouldn’t have lasted. (W 3i)
The professional interviewees said that, they encouraged remarriage of HIV positive widows with male partners who were also HIV positive as a way of minimizing the spread of the HIV virus.

Through the MUFOA therapy group, I understood the risks involved in re-partnering with a man who was not HIV positive. Even if my sexual and other needs had not been met, I changed my mind and opted to remain as a single parent. (W 3j)

A number of younger widows expressed the desire that they would remarry if only they had identified partners who would love them genuinely together with their children despite their HIV status. Only a very small number of widows said to have been cleansed after the death of the husband. “To be accepted fully in the family of my in laws, I had to undergo a cleansing ritual.” (W 3a)

The interview excerpts from the study respondents revealed that fewer women after the loss of partners due to AIDS remarried. If they re-partnered, preferably was done with a male who was HIV positive. Again, a big number of widows said that they would remarry if they found partners who would love them and provide for their children. In addition, some cultural norms such as widow inheritance and cleansing in the past that made remarriage likely for widows have changed due to the fear of acquiring of the HIV/AIDS virus as confirmed by (Munguti et al, 2007).

These findings were similar to the studies done in Uganda by Ntozi (2006) that showed a high number of widows whose husbands had died of AIDS did not remarry as compared to likely remariages of widows bereaved by husbands who had other diseases other than AIDS. Similar findings are confirmed by Gregory et al (2007) from a more recent study done in Tanzania, indicating that remarriage was significantly less likely for HIV positive women due to the fear of reinfection or infecting their new partners. Many widows under study considered remarriage on condition that, they could identify partners who could love and provide for their dependants. This
aspect concurs with the studies done by Carr, (2004) arguing that, the desire of widows to re-partner may stem from different benefits women would want to receive inside or outside a marriage relationship. The study of Carr also differ from the current findings when she argues that, widows are more likely to report that they were reluctant to give up new found freedom and independence, since many of them perceive a sense of liberation for not taking care of another person, valuing freedom more than additional companionship. Many of the widow’s under study wished if their partners were still alive even if they would be sick as compared to the psychosocial challenges they were experiencing.

Implications of these findings were that, for remarriage to be considered by widows bereaved by AIDS partners, widows should be helped in building new relationships that would provide them with mental health and other benefits received inside or outside a marriage relationship.

4.7.5 Engagement in Different Activities

Many widows, who lost spouses because of the AIDS endemic, engaged in activities that were meant to restore normalcy to them. With a positive disposition through the engaged activities, the widows got opportunities of handling grief in a healthy way. A good number of widows worked through their loss which enabled them to grow rediscovering their personal identity. The activities widows engaged in included; income generating activities, self care activities, interpersonal activities, spiritual activities and physical activities. Widows who had a strong spiritual encounter with God through prayer were reported to have adjusted better to their pain and loss. Such widows found peace, hope and encouragement to endure in their new status.

All the widow respondents unanimously agreed that, it was crucial for them to adhere to the ARV drugs and taking great care for their personal health. The professionals attested to the
importance of the widows who lost partners due to AIDS in joining therapy groups like MUFOA.

Many widows had grieved for a long time with a lot of low-self esteem, when they joined MUFOA therapy group, they understood that few people were dying of HIV virus today. So changed their attitude towards life, began to work hard and stopped withdrawing from themselves and the community for the fear they had of rejection. (P 3b)

According to all the professionals there was a notable difference between widows belonging to a support group from those who handled grief alone in terms of the ability to cope with their loss. Only a few widows shared that they hoped for a miracle to happen in their expectations for healing and relieve from their pain. All the widows felt that once they understood and took a conscious decision to continue living they became hardworking.

Joining a group with other widows where I could share my experiences, I realized I was not the only one of my kind in the universe. I began to live positively adhering to the ARVs. (W 3c)

Some engaged in odd jobs like washing clothes for neighbors, farming, keeping animals actively participated to the community functions

When no duty was allocated to me during the community functions like in selecting rice, cutting cabbages. I took a plate and fetched rice from other women trays uttering the words such as HIV virus is not transmitted by selecting or touching the rice or in sharing the cups. Other women could keep silence but I had clearly communicated. In such occasions I enlightened other women about AIDS hoping they stop discriminating people who live positively with AIDS. (W 3d)

The participant’s responses from the interview transcripts revealed that, widows who engaged in various activities were assisted in moving through the grieving process. The study findings were confirmed by Mwali (2013) who cites a number of ways how widows after
bereavement coped with loss when they used determination and courage in collaboration with other widow recovery groups. She added that with time such widows became self-supporting, entreprenuering, farmed and reared animals in support of their children thus contributed actively to Nation building. As asserted by Punnose (2013) the results agreed with what many widows do to adjust to their status by getting involved in exploitative informal sectors such as putting children to work, begging and engagement with sex commercial works and brewing illicit liquors.

The findings also differed from the results of Gallagher (2011) who argued that when the period of grief and mourning had passed or lessened some widow’s found that they enjoyed their new independence, free time and reduced house work. Moreover, many widows in Mugunda felt that the responsibilities they had were insurmountable and overwhelming. The findings also differed with Colette (2013) who argued that dealing with widowhood had largely remained in the private domain and that the families of the widow were the only ones left to help them adjust to their new experiences. The findings of Colette again confirms some experiences of the respondents in that, the bereaved could experience the loss of the partner as a positive transition, in developing the capacity to plan and implement decisions made in life. Owen (2012) contends that widows adjusted better if they were involved in physical activities, got support from family members and friends and when they developed new interests. This was also confirmed as the experiences of how widows adjusted even in Mugunda Location. Grief counseling though few widows received it would be recommended as proposed by Janalee and Weaver (2010).

Implications for these findings were that, widows should be encouraged to join different groups of their choice in order to facilitate their grief process.
4.8 Alternative Support Systems that can be used in Support of Widows

The research question sought to find out the support systems that could be used to support the widows who were bereaved by AIDS partners. The study findings on this question revolve around four aspects such as: reinforcement of self-concept, workshops and seminars, creating awareness in community about AIDS and seeking loans.

4.8.1 Reinforcement of the Self Concept

The self concept of widows was considered to be the personal resource that they used to cope with the psychosocial challenges. The way widows lived, grieved and adjusted to widowhood were highly influenced by their self-concept and the identity they were given by others in social interactions.

More than half of the widow respondents reported they felt that they did not deserve to continue living after the death of their husbands. Four out of the nine widow respondents felt that other people were laughing at them because of their HIV positive status and withdrew from themselves and the public. Only few widows had accessed professional help in dealing with the grief emotions, but the majority of the widows had nurtured their identity through the inputs given during the MUFOA group meetings.

I am aware of widows who became faithful in taking the ARVs with the right diet, stopped the business of exchanging sexual partners and have regained their dignity. The way they perceived themselves totally changed and they became very positive about life. (P 4a)

All the professionals reported that, many widows who didn’t belong to MUFOA therapy group had a poor self concept as compared to the ones who regularly attended the meetings. Half of the widow interviewees had regained their peace after disclosing to their adult children about their HIV positive status who eventually became very compassionate towards their mothers.
After a number of counseling sessions I was able to disclose to my adult children about my HIV status. Hearing it from me they cried a lot. After this disclosure I felt relieved from a heavy burden. I began perceiving myself worthy in front of my children who became very compassionate and ensured I was okay. (W 4a)

The self concept of widows depended on the relationships they hand with God, themselves, their children and the society as argued by most professional participants.

I am aware of widows who became faithful in taking the ARVs with the right diet, stopped the business of exchanging sexual partners and have regained their dignity. The way they perceived themselves totally changed and they became very positive about life. (P 4a)

The participant’s responses in the interview transcripts showed that, the widow’s resources as well as the identity given by the others influenced the ability of widows to adjust to bereavement. The study findings agreed with Carr (2006) who argued that, lived life experiences by widows were dependent on their self-concept, after the loss of their partners. She added that, the self concept assisted widows to maintain a sense of personal identity throughout the widowhood process. Again, the way widows lived, grieved and adjusted to widowhood were highly influenced by their self-concept and the identity they were given by others in social interactions (Crippen, 2014).

Implications for these findings were that, widows who lost partners because of the HIV virus need to be reinforced in their self concept mostly dependent on the relationship they had with themselves, others and God.

4.8.2 Workshops and Seminars

Workshops and Seminars would be helps offered by community and church leaders, governments, different professionals and NGOs to address different issues affecting the lives of widows in assisting them to adjust to their widowhood experiences. Majority of the 15 study
participants felt that the government and other service providers would consider widows bereaved of AIDS partners as special population, deserving assistance like others who benefit from available resources.

The government has not done much to assist widows who lose partners due to AIDS. My children did not go to secondary school because I lacked the money for their school fees. The money I got from cleaning cloths in the neighborhood could hardly meet the family’s basic needs. (P 4b)

Unanimously a hundred percent of all the respondents agreed that workshops and awareness seminars addressing issues affecting widows would facilitate their process of adjustment. The widows who had joined MUFOA therapy group confirmed the importance of widows joining with other peers sharing the same HIV positive status. Further, many widows hoped the local authorities would intervene especially when widows were evicted from their marital homes and their properties grabbed.

For the internally displaced persons from one of the camps in the country, the local authority of the camp was suggesting that widows bereaved by AIDS partners should be built for only mud houses. The houses for people without the HIV virus were to be constructed with iron sheets. Since the future of such widows was uncertain. (P 4c)

From the above respondent’s excerpts, the government and other service providers generally had done little to ensure that, widows were protected or assisted in obtaining their human rights. The study findings agreed with Scholz (2014) who argues that, according to the widows, African governments generally do not provide enough protection to ensure that widows are able to realize their rights to housing and land. Scholz added that, governments and other service providers were accountable for protecting widows from gross mental, physical and other types of abuse that lead to slowing down the process of how they adjusted to life.
Implications for these findings were that, due to the struggles experienced by widows, governments, churches, NGOs and other service providers should give them priority as special populations.

4.8.3 Seeking Loans

Most widows bereaved by AIDS husbands in rural areas possessed little education, had few properties, did not hold jobs neither did they have the skills to easily find work. Many survived by doing odd jobs as casual laborers that paid them poorly and rendered them incapable of providing for their basic needs.

More than half of the widow respondents were engaged in casual labour where they got less than 300 Ksh per day with the family income oriented to the first needs. Majority of the widows had low levels of education below standard seven and eight which only qualified them to engage on low paying jobs. Only a few widows had accessed loans from a cooperative or credit saving groups, since the majority lived from hand to month. A number of widows expressed the fears they had of not being able to get loans due to a poor income.

From MUFOA therapy group, we gave milking goats to some members, which after breeding they were supposed to give the ewe to another widow bereaved by a husband due to AIDS. (P 4e)

Professionals agreed that there was need to educate the widows about loan schemes and other income generating activities.

From the MUFOA therapy group seminars we have tried to educate the widows about credit saving groups, small businesses, farming skills, self-income-generating activities that are gradually empowering widows economically. (P 4f)

The participants’ responses from the interview transcripts revealed that there was need for widows to be empowered economically through various economic activities as a way of
facilitating their process of adjusting to loss. The study findings concur with Puri (2013) who called upon the world leaders to facilitate the economic empowerment of widows through self-income generating activities, so that they can live in dignity and fully participates in building society. According to Crippen (2014) grieving people on average tend to isolate themselves, so it was important for such people to engage with income generating activities with others and maintain social ties in order to be assisted in their grieving process. She also added that, what basically influences a widowed woman’s world throughout her life included the presence or absence of opportunities and resources.

Implications for these study findings were that, seeking loans for widows bereaved by AIDS partners would empower them economically. So there was need for provision of opportunities and economic resources to the widows.

4.8.4 Creating Awareness in community

There was need of creating awareness and sensitizing the community about the psychosocial challenges faced by widows who lost partners due to AIDS. This would increase the knowledge of communities about the reality of widows. Awareness would be created through seminars, public education, campaigns, outreach programmes, community based trainings and dissemination of information through the social media to the general. All the widow respondents felt that, if the communities had the proper knowledge about AIDS epidemic stigma and discrimination against PLWHA would reduce. They also added that lack of awareness about the land and property ownership rights left the widows denied of their rights. Three out of the nine widow respondents had contributed in educating the public through public declarations about their HIV positive status and the precautions to be taken in curbing its spread.

In MUFOA, on AIDS world day we celebrate it with the local community. Included were widow’s public testimonies about their HIV status. We feel our celebrations help
educate the community appropriately regarding AIDS, aimed at reducing the stigma and discrimination related to it. (P 4j)

All the professional respondents were part of the stake holders who had attempted to educate the widows, general public by raising awareness of the PLWHA. Again, the same professionals reported to be networking with other organizations, playing leadership roles in providing local people with access to information and provision of different services and supports to widows.

We have the MUFOA Newsletter printed once a month, with a lot of information about PLWHA and other issues affecting our organization. We also get feedback from the general public about what we write. (P 4i)

The participants’ responses from the interview excerpts revealed that, creating awareness and sensitizing the general public about the plight of widows facilitated the change of attitude towards people living with HIV/AIDS.

The study findings were in agreement with Sandler et al (2008) whose studies revealed that, for the bereaved persons to change or adjust it took time and their lives could be shaped by the environmental and the individual protective factors like education to the public and interactions with other people.

Implications for these findings were that, creation of community sensitization about the psychosocial challenges faced by widows bereaved by husbands due to AIDS would enable people in the society to provide them with appropriate support systems and services.
CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter presents a summary of the research findings, conclusions, recommendations and finally gives suggestions for further studies.

5.2 Summary

This study sought to find out psychosocial challenges and adjustment of widows bereaved by AIDS partners in Mugunda Location, Nyeri County, Kenya. The following four research questions guided the study;

1. What are the sociological challenges faced by widows bereaved by HIV and AIDS partners in Mugunda Location, Nyeri County?
2. What are the psychological challenges experienced by widows bereaved by HIV and AIDS partners, in Mugunda Location, Nyeri County?
3. In what ways do widows in Mugunda Location, Nyeri County adjust to widowhood?
4. Which alternative support systems could be used to assist widows in Mugunda Location, Nyeri County in their experiences?

The study employed qualitative research paradigm and a case study research design to collect the information needed. Purposive sampling was used to select the samples; 9 widows bereaved by AIDS partners, 5 professionals and a priest who had direct contacts with the widows. Tools used to collect data were in depth interview guides for both widows and the professionals. Qualitatively, data was analyzed using the thematic framework and finally categorized into themes, presented in form of narratives and direct quotes.
The analysis of the study findings indicated that Loss of partners due to HIV virus can be a devastating event, since beginning a life as a widow is not an easy task. Such widows are faced with many psychosocial challenges that impacted negatively on their adjustment process. The findings further revealed that, many widows struggled to survive with HIV diagnosis. Others lived in poverty due to lack of resources, skills and education. Many had no access to justice systems because their rights were denied in private sphere of the family. Again, most widows were left with few support systems in coping with grief and loss. However, the lives of many widows were gradually improving depending on their resilience, availability of support systems, presence or absence of resources, ability to handle grief emotions and engagement in various activities that facilitated their adjustment to widowhood.

5.3 Main Findings

From the study it is evident that, widows who lost partners due to HIV virus were affected by a number of social challenges such as conflicts with in laws, cruel accusations, stigma and discrimination both on the personal, family and societal levels. Lack of knowledge about HIV and AIDS as a life threatening disease made people to react strongly towards PLWHA. Further, widows who were illiterate, untrained, and unaware of their land and property rights were evicted from their marital homes. Cruel accusations to widows and conflicts in the family, subjected them to maltreatment by in laws thus lowering their dignity. Lack of resources, skills and low levels of education, led many widows to experience a lot of financial constraints. Further, lack of resources forced many widows to engage in risky behaviors that placed them and others at further risks of HIV infection. Again, handling the adolescent behavior problems was a challenge to the widows. Generally, the life of the widows changed drastically with bereavement, since it made them feel very vulnerable as victims of HIV virus.
The results of the study in question two indicated that, similar grief emotions were experienced by widows who lost husbands due to AIDS. What differed was the grieving process which was unique for each individual. When widows discovered that, they were also HIV positive, the thoughts of dying soon were in evitable. Suppression of grief emotions escalated to major depressive symptoms or engagement into other risky behaviors which caused a lot of harm to widows and others. Resilience, grief counseling on the personal and group therapies emerged as important helps to widow’s adjustment processes.

Widows had different ways of coping with bereavement majorly dependent on their ability to seek divine intervention, ability to handle grief emotions, engagement in various activities and the availability of support systems such as the family, friends and professional helps that facilitated the adjustment process. A number of alternative support systems such as reinforcement of widows self concept, workshops and seminars, intervention of governments, churches, NGOs, community and other service providers should give priority to widows by providing them with services and resources.

A number of basic assumptions from the literature reviewed differed from the research findings such as stigma and discrimination stemming more from the family and society due to lack of knowledge about HIV and AIDS. The respondents felt that the self-stigmatization was more harmful since it had more negative consequences than the external stigma. The current study also revealed that, the bereaved widows adjusted better due to their resilience and the ability they had in seeking divine intervention. Among the many challenges the widows faced, emerged the inability many had of handling the adolescent behavior problems of children who struggled to adjust to life without fathers. However, the disclosure of widows to their adult children about their HIV status brought more compassion and understanding to the family.
Self concept of widows who were in touch with some support systems had reinforced their desire to live normal lives. Many hoped that the government and other service providers would empower them economically and accord them justice systems to safeguard their dignity and those of their families. Some cultural practices such as widow cleansing and inheritance that affected the life of the widows negatively had greatly changed as was reported by the current study respondents.

5.4 Conclusion

The study investigated on the psychosocial challenges and adjustment of widows bereaved by AIDS partners. The research questions were adequately answered with the study concluding that, the death of a husband due to HIV and Aids related diseases is a difficult reality for widows of all ages and their children. Apart from just losing a partner the widow loses many other things that were related to the departed. Again, many widows were charged with insurmountable responsibilities that overwhelmed them especially if they were not financially stable. Low levels of education and lack of training kept many widows in low paying jobs or engagement in risky behaviors that left them unable to provide for themselves and their families.

The grieving process of widows was accompanied by many emotions and feelings which needed to be handled properly. To combat the psychosocial challenges faced by widows who lost partners because of HIV virus, there is need to educate the widows and the entire community for proper understanding about the AIDS disease and the rights of widows. Laws and policies need to be enacted that would provide justice systems to them. Opportunities need to be created in order to assist widows and their families to cope with bereavement.
5.5 Recommendations of the Study

Unless the society becomes aware of the psychosocial challenges cited in this research, widows who lose partners due to AIDS will continue to bear the burden of the same challenges. Therefore, based on the findings of this study, the researcher made the following recommendations:

Widows bereaved by AIDS partners need to be reinforced in their self concept, self-esteem, resilience, ability to seek divine intervention, in their ability to handle adolescent behavior problems and the knowledge to retain social skills. Families and friends should be sensitized on their role in supporting widows to adjust to their conditions.

Community needs to be sensitized about the psychosocial challenges facing widows and be educated about the HIV and AIDS, the rights of widows in order to reduce the stigma/discrimination and injustices against widows. Again, create an enabling environment in increasing the visibility of widows and their children as normal part of society. They could also establish rescue centers for widows.

Professionals should provide the needed helps to the widows in order to facilitate their adjustment to the world without the diseased. Widows should be encouraged to join support groups such as therapy, self care, interpersonal, spiritual, income generating activities that, would facilitate their adjustment to widowhood.

Governments, churches, NGOs and other service providers should empower widows by enacting laws and policies that would assist them in accessing services and resources. Advocacy is needed to raise awareness about the plight of widows who lose partners due to AIDS endemic, through public forums, informational materials, social media, lawyers assisting widows in obtaining justice and training them on how to prepare memory books and “Wills”.

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5.6 Suggestions for Further Research

The following areas are suggested for further research.

1. Psychosocial challenges and adjustment by widowers bereaved by AIDS partners.
2. Impact of professional counseling on adjustment to widowhood.
3. Psychosocial challenges faced by adolescents of widows bereaved by AIDS partners.
4. Impact of Resilience on the bereaved widows/widowers of AIDS partners in adjustment to widowhood.
5. Impact of divine intervention on adjustment to widowhood.
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The Catholic University of Eastern Africa
P.O. Box 62157- 00200
Nairobi, Kenya
Dear Respondent,

I am a post graduate student at the Catholic University of Eastern Africa, pursuing Master of Education Degree in Counselling Psychology. I am carrying out a study on psychosocial challenges and adjustment of widows of HIV partners of Mugunda location, Nyeri County Kenya. You are kindly requested to participate in this research being conducted by Sr. Rose N. Mwangi.

The information you give will be highly appreciated in participating in the interviews. The shared information will be treated confidentially and anonymity ensured, since it is meant for research purposes only.

Participants Signature_____________________________________________________

Researcher’s Signature_____________________________________________________

Thank you for your availability to participate in this study. God Bless you.

Sr Rose Njoki Mwangi
Cell phone 0720793642
E-mail rosemwangi56@yahoo.it
APPENDIX II

INTERVIEW GUIDE FOR WIDOWS

Demographic information

Researcher ticked (√) where appropriate as guided by respondents.

1. Age: 20 – 29 ( ) 30 – 39 ( ) 40 – 49 ( ) 50 – 59 ( ) 60 and above ( )

2. Educational level: Standard7/8 and below ( ) Form1-4 ( ) Form6/university ( )

3. Employment: House wife ( ) Civil servant ( ) Business woman ( ) Any other ( )

4. Widowhood duration: 5 years and below ( ) 6 – 10 years ( ) 11 years and above( )

5. Financial dependence: Self ( ) In-laws ( ) Siblings ( ) Any Others ( )

6. Number of dependants: ( )

Section A: Sociological Challenges faced by Widows of HIV/AIDS Partners

1. In your experience, what challenges face widows in the society if they lose husbands of HIV/AIDS?

2. How do widows handle the challenges they experience in the society?

3. What other losses apart from the partner do widows experience after the loss of a husband due to HIV/AIDS?

Section B: Psychological Challenges Experienced by widows of HIV/AIDS Partners

1. What emotions are experienced by widows who lose partners due to HIV/AIDS?

2. To what extent do the psychological challenges faced by widows affect them?

3. How do the widows handle the emotions they experienced after the loss of a partner?

Section C: Ways of how Widows Adjust to their New Status

1. How do widows cope with loss of a spouse due to HIV/AIDS on the personal level?

2. On the family and societal levels how do widows cope with bereavement of a partner?
3. What kind of activities do widows engage in as a way of coping with loss of a partner?

Section D: Alternative Support Systems Used to Assist Widows

1. Are you aware of any attention given to widows who lose partners due to HIV/AIDS from the government or other service providers?

2. Do you think widows are able to identify positive alternatives that would help them to live widowhood meaningfully?

3. What support systems should be put in place to assist widows bereaved of HIV/AIDS partners?

4. Kindly share any other information that you feel would be helpful as far as psychosocial challenges, adjustment strategies and support systems are concerned.

Thank you for your responses and time. Be blessed.
APPENDIX III

INTERVIEW GUIDE FOR PROFESSIONALS AND PRIEST

Demographic Information

Please tick (√) the most appropriate response and use the spaces provided.

1. Indicate your gender: Male ( )   Female ( )

2. Age: 20 – 29 ( )   30 – 39 ( )   40 – 49 ( )   50 – 59 ( )   60 and above ( )

3. No of years worked with Widows: 0 – 5 years ( )   6 -10 years ( )   10 years and above ( )

4. Educational level: Certificate ( )   Diploma ( )   Masters ( )   Any other ( )

5. Have you been trained to handle widowed persons: If No indicate ( )
   If yes, specify to what level: Certificate ( )   Diploma ( )   Masters ( )   Any other ( )

6. How often do you interact with Widows who lost partners due to HIV/AIDS? Once a week ( )
   Five days in a week ( )   Once in a month ( )   other specifications ( )

Section A: Sociological Challenges Facing Widows of HIV/AIDS Partners

1. According to your experience what social challenges do you consider as affecting widows who lose husbands due HIV/AIDS.

2. In your opinion, what led to the sufferings of widows in the society?

3. How do widows bereaved by partners handle the social challenges they face?

4. Do you think the society is aware of the challenges experienced by widows?

Section B: Psychological Challenges Affecting Widows of HIV/AIDS

1. Which psychological challenges do you consider to affect widows who lose partners due to HIV/AIDS?
2. What emotions do you perceive to be experienced by widows who lose partners due to HIV/AIDS?

3. How do the widows handle the emotions they experience after the loss of a partner?

Section C: Ways of how Widows Adjust to their New Status

1. What do the widows do themselves in order to adjust to the loss of a spouse due to HIV/AIDS?

2. How do the family and the society help widows to adjust to their widowhood experiences?

3. How do widows overcome the psychosocial challenges affecting them after the loss of a husband?

Section D: Alternative Support Systems Used to Assist Widows

1. What services do the government and other service providers give to widows who have lost partners due to HIV/AIDS?

2. What social support systems do you think should be put in place to assist widows in adjusting to their new experiences?

3. How do you think the widows bereaved by HIV/AIDS partners would assist themselves in coping with the loss?

4. Kindly share anything you feel would be helpful to assist the plight of windows bereaved by HIV/AIDS partners.

Thank you for your availability and time. God Bless you.
APPENDIX IV

LETTER FROM THE CATHOLIC UNIVERSITY OF EASTERN AFRICA

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THE CATHOLIC UNIVERSITY OF EASTERN AFRICA

Faculty of Education
Department of Psychology

26th November, 2013

TO WHOM IT MAY CONCERN

Ref: Rose Njoki M MED 1018315: Master of Education Degree Thesis Research

I am writing to introduce to you Sr. Rose Njoki, who is a final year Master of Education Degree student at the Catholic University of Eastern Africa, Nairobi, Kenya, and to request you to assist her to accomplish her academic research requirements.

Sr. Rose’s Master of Education Degree specialization is Psychology (Counselling Psychology). She has completed all course work requirements for this programme. However, every student in the programme is required to conduct research and write a report/thesis submitted during the final years of studies.

Accordingly, Sr. Rose’s proposal for research has been approved. She will conduct research on the following topic:

“Psychosocial effects and adjustment of widows of HIV/AIDS partners: A case Study of Muganda Location, Nyeri County, Kenya”

Thanking you in advance for any assistance you will offer to Sr. Rose.

Sincerely,

Prof. Belainesh Araya
Head of Department
Psychology

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THE CATHOLIC UNIVERSITY OF EASTERN AFRICA
P. O. Box 62157 - 00200, Nairobi

28 Nov 2013

DEPARTMENT OF MASTERS IN PSYCHOLOGY
COUNSELLING PSYCHOLOGY AND
GUIDANCE COUNSELLING

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THE CATHOLIC UNIVERSITY OF EASTERN AFRICA (CUEA) P.O. BOX 62157 00200 Nairobi – KENYA
Tel: 020-2525811-5, 8999023-4, Fax: 8991684, Email: paaa@cuea.edu, Website: www.cuea.edu
Founded in 1964 by AMECEA (Association of the Member Episcopal Conference in Eastern Africa)
APPENDIX V

LETTER FROM THE NATIONAL COUNCIL FOR SCIENCE AND TECHNOLOGY

NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

9th Floor, Utalii House
Uhuru Highway
P.O. Box 30623-00100
NAIROBI-KENYA

Date:

19th December, 2013

NACOSTI/P/13/0994/465

Rose Njoki Mwangi
The Catholic University of Eastern Africa
P.O.Box 62157
NAIROBI

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on “Psychosocial effects and adjustment of widows of HIV/AIDS partners: A case study of Mangua Location, Nyeri County, Kenya,” I am pleased to inform you that you have been authorized to undertake research in Nyeri County for a period ending 31st March, 2014.

You are advised to report to the County Commissioner and the County Director of Education, Nyeri County 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.

Said Hussein
FOR: SECRETARY/CEO
NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY & INNOVATION

Copy to:

The County Commissioner
The County Director of Education
Nyeri County.
APPENDIX VI

RESEARCH PERMIT

THIS IS TO CERTIFY THAT:

MISS ROSE NJORI MWANGI

of CUEA, 63-40139 Nyeri, has been permitted to conduct research in Nyeri County. She is undertaking research on the topic: PSYCHOSOCIAL EFFECTS AND ADJUSTMENT OF WIDOWS OF HIV/AIDS PARTNERS: A CASE STUDY OF MUGUNDA LOCATION, NYERI COUNTY, KENYA.

Purpose:

For the period ending:

31st March, 2016

Applicant:

MRS. ROSE NJORI MWANGI

Date of Issue: 31st December, 2013

Fees: Kshs USD11.3

Conditions:

1. You must report to the County Commissioner and the County Education Officer of the area before embarking on your research. Failure to do that may lead to the termination of your permit.

2. Government Officers will not be interviewed without prior appointment.

3. Specimens will be used unless it has been approved.

4. Specimens, filming and collection of biological samples are subject to further permission from the relevant Government Ministries.

5. You are required to submit at least two (2) hard copies and one (1) soft copy of your final report.

6. The Government of Kenya reserves the right to modify the conditions of this permit including its cancellation without notice.

RESEARCH CLEARANCE PERMIT

Serial No: A 782

CONDITIONS: see back page
APPENDIX VII

LETTER FROM THE COUNTY COMMISSIONER

OFFICE OF THE PRESIDENT
MINISTRY OF INTERIOR AND CO-ORDINATION OF NATIONAL GOVERNMENT

Regional CO-ordinator
Central Region
P.O. Box 33-10109
Nyeri

Telephone: 063 2038223
Fax: 061 203289
E-mail: mbukamo@yahoo.com

When replying please quote

REF: ADM 1/57/(220) 20th December, 2013

TO WHOM IT MAY CONCERN

RE: RESEARCH AUTHORIZATION
ROSE NICKI MWANGI – THE CATHOLIC UNIVERSITY OF EASTERN AFRICA

The above named has been authorized to carry out a research on “Psychosocial and adjustment of Widows of HIV/AIDS partners. A case study of Magunda Location, Nyeri County, Kenya” for a period ending 31st March 2014.

Please accord her all the necessary assistance to facilitate her research.

L.M. RUKWARO
FOR: Ag. REGIONAL CO-ORDINATOR
CENTRAL REGION

/am
APPENDIX VIII

LETTER FROM COUNTY DIRECTOR OF EDUCATION

MINISTRY OF EDUCATION SCIENCE & TECHNOLOGY
STATE DEPARTMENT OF EDUCATION

CDE/NI/GEN/23/VOL.1/27

The District Education Officer
KIENI WEST

RE: RESEARCH AUTHORIZATION

Reference is made to Secretary National Commission for Science, Technology and innovation letter Ref.No NACOST1/P/13/0994/465 dated 19th December, 2013 on the above subject.

Please note that Rose Njoki of the Catholic University of Eastern Africa has been authorized to carry out research on "psychosocial effects and adjustment of windows of HIV/AIDS partners: A case study of Mugunda location, Nyeri County". She has been authorized to undertake the research for a period ending 31st March 2014.

Kindly accord her the necessary assistance.

KABORA I. M.
FOR: COUNTY DIRECTOR OF EDUCATION
NYERI COUNTY

c.c: Rose Njoki Mwangi
The Catholic University of Eastern Africa
P O Box 62157
NAIROBI