EFFECTS OF INTIMATE PARTNER VIOLENCE ON WOMEN'S REPRODUCTIVE HEALTH: A CASE OF EAST KANYAMKAGO, MIGORI COUNTY, KENYA

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DECLARATION

This project is my original work and has not been presented for examination in any other university.

Signature----------Date---23rd November 2018

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

Signature----------Date---23rd Nov. 2018

Prof. Owuor Olungah

DEDICATION

To the most valuable people in my life; my husband Mr. James Fredrick Ochieng, my children; Herana Grace and Hiram Kinda.To the most inspiring and supportive mentor; my father Mr. Daniel Okech. With gratitude that they are the most important in my life after God.

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
CEDAW	Convention of the Elimination of All forms of Discrimination Against Women
COVAW	Coalition on Violence Against Women
CSO	Civil Society Organizations
FIDA	International Federation of Women Lawyers
FVPF	Family Violence Prevention Fund
GBV	Gender Based Violence
HIV	Human Immunodeficiency Virus
HRCP	Human Rights Commission of Pakistan
IAGAS	Institute of Anthropology, Gender and African Studies
IPV	Intimate Partner Violence
IPVAW	Intimate Partner Violence Against Women
IUDs	Intrauterine Device
KDHS	Kenya Demographic and Health Survey
KII	Key Informant Interview
KNBS	Kenya National Bureau of Statistics
LBW	Low Birth Weight
NACOSTI	National Commission for Science, Technology and Innovation
NGEC	National Gender and Equality Commission
PADV	Protection Against Domestic Violence Act
PTB	Preterm Birth
SPSS	Statistical Package for Social Science
SSA	Sub-Saharan Africa
STIs	Sexually Transmitted Infections
UN	United Nations
UNICEF	United Nations International Children's Emergency Funds
UNIFEM	United Nations Development Funds for Women
US	United States
USAID	United States Agency for International Development
WHO	World Health Organization

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ABSTRACT

Intimate partner violence is one of the most widespread and socially tolerated forms of human rights violations, cutting across nationality, race, class, ethnicity, and religion. It has a profound social and economic impact on families, communities, and the entire nation. The overall objective of the study was to determine the effects of intimate partner violence on women's reproductive health amongst the women living in East Kanyamkago, Migori County, Kenya. The study adopted a cross-sectional descriptive study that aimed at collecting both qualitative and quantitative data through semi structured interviews, case narrative and key informant interviews with 5 key selected informants. The study sampled 50 respondents (women between the age of 15-49 years, who were in an intimate relationship and survivors of IPV). 5 key informants were also sampled, this included the area chief, women group leader, religious leader, counselling psychologist and the civil society organization representative. The data was collected using both questionnaires and interview guides. Quantitative data was analyzed using the Statistical Package for Social Sciences (SPSS) tool and descriptive statistics such as percentages and frequency distribution used to present the data. Qualitative data was analyzed using thematic analysis along the lines of the specific objectives.

The study established that cultural beliefs and practices accompanied by the socialization that women and men receive from childhood provide a fertile ground for intimate partner violence, men are deemed to be more powerful than women and as such, are given superior position in society and allowed authority over women in terms of decision making and control over women, including use of violence to exercise such control. Women are regarded as subordinate to men or as having stereotyped roles that perpetuate widespread practices involving violence or coercion. The other observation was that men had given themselves to excessive drinking thereby neglecting their responsibilities in the families and this was a major cause of increased intimate partner violence in East Kanyamkago. Finally, women's overall health and social wellbeing is severely influenced by forms of physical, psychological or sexual violence perpetrated against them by their intimate partners.

The study recommends that the county government of Migori should introduce laws that will pass deterrent punishments to the perpetrators. They should also to organize for seminars which discourage men from irresponsible drinking, hence engage in productive activities. Need for the government to focus on empowering both the men and the women so that no one sees himself/herself as better that the other. The government through local leaders such as the Chiefs and the religious leaders should sensitize the community on the need for peaceful co-existence and where possible, a re-socialization process that inculcates new values regarding the relationships between men and women.

CHAPTER ONE: BACKGROUND TO THE STUDY

1.1 Introduction

All over the world, women are vulnerable to violence from many different sources. According to Sharps (2007), intimate partner violence is one of the most common forms of violence against women and includes physical, sexual, emotional abuse and controlling behaviours by an intimate partner. Intimate Partner Violence (IPV) occurs in all settings and among all socio-economic, religious and cultural groups (Awang & Hariharan, 2011; WHO, 2013). Overwhelming global burden of Intimate Partner Violence is borne by women who are of reproductive age. In as much as women can also have violent tendencies in relationships with the opposite gender, more often this happens in self-defense, and violence sometimes occurs in same-sex partnerships, the most common perpetrators of violence against women are male intimate partners or ex-partners (Garcia-Moreno et al., 2006). The WHO study on women's health and domestic violence against women of 2005 concluded that majority of cases on violence against women are perpetrated by an intimate partner.

Intimate Partner Violence stands out as the most common form of violence against women globally. It is most likely to occur during pregnancy. As a result, it is predominantly singled out as one of the principal risk factors for negative health outcomes for both the newborn and the mother. Violence during the pregnancy cycle is prevalent than several recognized reproductive health conditions for which it is common practice to screen during antenatal care (Laisser et al., 2007). This includes among others, pre-eclampsia, which has been identified as a source of complication in pregnancies globally, and gestational diabetes, which has an estimated 15% prevalence in the United Kingdom and the United States of America. Intimate Partner Violence can result directly to serious injury, disability or in extreme cases death. It can also indirectly lead to mental disorders, drug and alcohol abuse, infertility and personal autonomy, (Makayoto, 2013). IPV during pregnancy is especially a hazard, as it is associated with detrimental outcomes to the mother and the unborn baby (Laisser et al., 2007). Women experiencing IPV during pregnancy are at a higher risk of miscarriage. They are also predisposed to complications during and after pregnancy and are at a higher risk of contracting sexually transmitted infections (including HIV). These women also have higher prevalence of mental disorders (such as depression, anxiety, sleeping disorders and eating disorders) compared to their non-abused peers. The United States

Department of Justice (National Intimate Partner and Sexual Violence Survey, 2010) estimates that over a lifetime, about 52% of women experience IPV. Additionally, 45% of those abused also reported being forced to have sex with their partners. Between 1.5 to 4 million US women are victims of intimate partner violence each year.IPV is the leading cause of injuries and death among US women of childbearing age, the United States Department of Justice (National Intimate Partner and Sexual Violence Survey, 2010).

In Sub-Saharan Africa, the prevalence of Intimate Partner Violence among pregnant women is one of the highest reported globally. It is deeply rooted and culturally accepted in most of the African communities and religions. In fact, in some communities, the socialization process is such that girls and women are made to believe that IPV is a normal way of enforcing discipline and is the prerogative of men (Uthman et al., 2009). Hence if a woman is deemed to have violated or challenged the culturally approved patriarchal authority or dominance, then the male spouse or boyfriend is permitted or encouraged to use force or violence to discipline that woman. In some settings, women are socialized to believe that IPV is an expression of love. Women in Sub-Saharan Africa (SSA) are more likely to justify Intimate Partner Violence Against Women (IPVAW) as a response to women's transgressing gender norms than even the men (Olalekan et al., 2009). IPVAW therefore, is a product of social context with complex and multidimensional risk factors (WHO, 2010; Jewkes, 2002).

The prevalence of IPV in Kenya is sufficiently high. According to Hatcher (2013), more than half of rural Kenyan women experience IPV in their lifetime. COVAW (2002) postulates that high incidence of IPV happen because Kenyans do not consider IPV as a crime. A review by USAID (2008) on IPV among couples in 10 developing countries rank Kenya among the countries with the highest prevalence rate of reported sexual violence in current relationships at 15%. This finding supports a domestic violence survey in Kenya carried out by Federation of women Lawyers in 2002 indicating that most common human rights violation in Kenya is domestic violence.
The 2008/2009 Kenya demographic and health survey indicated that 45% of 15-49-year-old women reported having experienced either physical or sexual violence in their life time. In the same survey, Nyanza region recorded highest, 50.4% of women having experienced either physical or sexual violence where the perpetrator is an intimate partner or ex-partner. According to Sen

(1998), two essential factors underlying violence against women and girls are their subordinate status and the general acceptance of interpersonal violence in society. The use and the meaning of violence is connected with power. It is broadly the case that in most societies, social, economic, political and interpersonal power remains with men. In this context, violence is an expression of power, a means through which people seek control. As a result, expectant women are faced with very harsh consequences including miscarriage, unsafe abortion, infant mortality, maternal deaths and many other challenges. Due to these reasons, the study has highlighted the impact of intimate partner violence on women's reproductive health in East Kanyamkago location, Migori County, of Western Kenya.

1.2 Statement of the Problem

Intimate Partner Violence is recognized as a serious public health problem worldwide. It is associated with serious mental and physical injuries, disability or death. Global studies carried out by WHO (2002) have estimated that between 10% and 70% of women suffer from IPV at any one moment in their lifetime. It is also crucial to note that the greatest risk of violence happens during the reproductive years. Intimate Partner Violence against expectant women has significant negative effects not only on the individual women but also on the unborn child and the entire society. The violence experienced by women is still viewed as detached and isolated events taking place in the private confines of relational conflict between partners beyond the realm of other family members, security agencies, legal authorities, policy makers and healthcare providers (WHO, 2013).

In several developing countries, IPV is surrounded by secrecy and culture of silence. It is invisible due to shame and stigma, fear of husband's retaliation, protection of family prestige and privacy, love and affection to the husband as well as levels of cultural acceptance (Awang & Hariharan, 2011; Ahmad & Jaleel, 2015). In some cases, women are blamed for having invited the IPV through their anti-cultural behaviors or lack of discipline/respect to their spouses (Garcia-Moreno et al., 2006).

In acknowledging the prevalence and burden of violence against women and children, the Government of Kenya has ratified several international and regional conventions, treaties and human rights standards and programs of action. This ratification seeks to prevent or eradicate

gender inequality and discrimination which are the major causes of gender based violence in Kenya including the Convention of the Elimination of All forms of Discrimination against women (CEDAW), Maputo Protocol among others. Furthermore, the government has enacted several legislations and regulations to prevent and control various forms of violence against women. These include the Sexual Offences Act, 2006, the Penal Code of 2009, Articles 10, 28, 29, 43 and 45 of the Constitution of Kenya (2010) (Republic of Kenya, 2006), and the National Gender and Equality Commission Act (2011) and the Protection Against Domestic Violence Act (PADV) 2015.

The topic of intimate partner violence has been studied in varied dimensions. The cultural perspective of violence against women was a study undertaken by Obonyo (2012), a case study of Suba community on Rusinga Island. Makayoto, (2012) did a similar study basing his analogy on prevalence and evidences associated with intimate partner violence (IPV) affecting pregnant women in need of antenatal care at Kisumu District hospital. However, very few researchers have considered the effects IPV has on women's reproductive health. To that end, this study sought to provide an in-depth analysis of IPV in line with its forms, determinants, and effects, with a special focus on women's reproductive health in East Kanyamkago location, Migori County. To do this, the study was guided by the following research questions;

i. What are the forms of intimate partner violence affecting women of reproductive age in East Kanyamkago location, Migori County?
ii. What are the social determinants of intimate partner violence in East Kanyamkago location, Migori County?
iii. What are the effects of intimate partner violence on women's reproductive health in East Kanyamkago location, Migori County?

1.3 Objectives of the study

1.3.1 Overall objective

The overall objective of this study was to investigate the effects of Intimate Partner Violence on women's reproductive health in East Kanyamkago location, Migori County.

1.3.2 Specific Objectives

i. To establish the forms of Intimate Partner Violence affecting women of reproductive age in East Kanyamkago location, Migori County.
ii. To examine the social determinants of Intimate Partner Violence on Women of reproductive age in East Kanyamkago location, Migori County.
iii. To determine the effects of intimate partner violence on women's reproductive health in East Kanyamkago location, Migori County.

1.4 Assumptions of the study

i. Intimate partner violence exists in the study area.
ii. There are specific causes of intimate partner violence.
iii. Intimate partner violence has serious consequences on women's reproductive health.

1.5 Justification of the study

The findings of this study are expected to contribute to the academic knowledge, to empower implementers on the impacts of Intimate Partner Violence on women victims and the society as a whole. This is not only expected to increase the probability of disclosure and reporting of intimate partner violence incidences by the women victims but also to improve community members' and other researchers' understanding of the impact of IPV.

1.6 Scope and Limitations of the Study

This study was carried out in East Kanyamkago location in Migori County. The study focused on the effects of IPV on women's reproductive health in this area. The researcher acknowledged that Intimate Partner Violence affects both men and Women, however, the study was focused specifically on women due to the unique reproductive health challenges they experience.

The study employed both quantitative and qualitative techniques. Semi structured interviews were conducted on 50 appropriately sampled respondents to ascertain the nature of how IPV affected women of reproductive age in East Kanyamkago. Key Informant Interviews (KIIs) were used to obtain qualitative information. Local administration, religious leaders, women leaders, medical personnel and civil society representatives formed part of the study as key informants. The selection was on a voluntary basis using appropriate sampling methodology as is detailed in

chapter three. This study was guided by the Marxist feminism theory which was developed by (Karl Marx and Friedrich Engels, 1848).

The study ensured strict adherence the cultural norms and beliefs around issues of IPV. The researcher ensured that confidentiality and anonymity were emphasized as informed consent was sought from participants in the study and the rights of withdrawal maintained throughout the process. The study instruments were administered in a private setting so as to ensure the participants feel confident enough to share information openly.

1.7 Definition of key terms

Domestic Violence: Aggressive and violent behavior within the home setup, typically perpetrated by one partner involving the violent abuse of a spouse or the other partner.

Economic determinants: Factors associated with income, wealth or commodities such as socio-economic status, unemployment, poverty, etc.

Gender Based Violence: Any form of harm that is meted out against an individual's will based on their gender and that is based on socially ascribed beliefs and norms i.e. physiological differences between male and female sexes. It includes actions that inflict mental and physical injury, suffering, and coercion, threats and other restrictions of liberty. These acts can occur either in public or in private.

Intimate Partner Violence (IPV): Any form of behavior within an intimate relationship between a current partner, former partner or spouse) that causes physical or psychological harm.

Maternal Health: This is used in reference to the reproductive health of women during pregnancy, childbearing and the postpartum period.

Sexual Violence: Any conduct or sexual act, attempt to perform a sexual act, unwanted sexual advances, comments or using coercion, by any individual regardless of their relationship to the victim, in any setting, including but not limited to home and workplace.

Social determinants: Factors related to society such as culture, age, race, peer pressure, religion, dating behavior, family characteristics, parental support and control among others.

Violence Against Women (VAW): Any action of gender-based violence that is likely to result in physical or psychological injury or suffering to women, including but not limited to threats of such actions, arbitrary limitation of liberty and coercion whether occurring in private or public life.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

The section presents a review of the literature on the effects of intimate partner violence on women's reproductive health. The literature is included books, journals articles, online sources as well as past projects and theses on the study topic. The section covers review of theories on intimate partner violence and its impact on women's reproductive health globally, regionally and locally among the different communities in Kenya. Finally, the section discusses the theory that guided the study.

2.1.1 Intimate Partner Violence globally

Intimate Partner Violence is a phenomenon that persists in all countries, it is a global epidemic that tortures, maims and kills. From the year 1993, the World Conference held to discuss Human Rights and the Declaration on the Elimination of Violence against Women, international community has acknowledged that violence against women is an important public health, social policy, and human rights concern. IPV is a serious problem around the world, it is both a serious public health issue and a severe impediment to economic development. Women are victims of violence in approximately 95% of the cases of domestic violence (WHO, 1996). A study undertaken by the Family Violence Prevention Fund (FVPF, 2006) found that, 1 in 3 women had experienced sexual, physical, emotional or other abuse in her lifetime.

The World Health Organization statistics (2017), gives the following facts on domestic violence:

- Violence against women – particularly intimate partner violence and sexual violence – is a major public health problem and a violation of women's human rights.
- Global figures published by WHO show that approximately one in three (35%) women worldwide have experienced either sexual and/or physical an intimate partner violence or sexual violence from a third party in their lifetime.
- Most of this violence originates from intimate partners. Globally, about 30% of women who have at any given time been in a relationship report that they have been victims or have experienced one form or another of sexual and/or physical violence from their partner in their lifetime.

- Worldwide, up to 38% of women murdered have died in the hands of a male intimate partner.
- Violence has the potential of negatively affecting women's physical, sexual, mental and reproductive health, and can increase the risk of exposure to HIV in some settings.
- Men with lower levels of education are more likely to perpetrate violence against women
- Women are more at risk of experiencing intimate partner violence if they have limited education, exposure to fellow women being abused by a partner, childhood abuse, and society acceptance of violence, male privilege status in society, and women's subordinate status.

The World Health Organization (2006) found that domestic violence was widespread and had serious impact on women's health. At the 24th November 2005 Geneva meeting, it was revealed that intimate partner violence is the most common form of violence in women's lives. The study presented findings on the negative impacts that physical and sexual violence by spouses and partners has on the overall health and well-being of women around the globe and the extent to which intimate partner violence was and is still largely hidden. The study was based on 24,000 women from rural and urban areas in ten countries, namely, Bangladesh, Japan, Namibia, Peru, Samoa, Brazil, Ethiopia, Serbia and Montenegro, Thailand and Tanzania.

Women are more at risk of violence at home than in the streets and this has serious repercussions for women's health (Lee, 2006). It is therefore, important to highlight the issue of domestic violence globally and consider it as a major social public health issue. Intimate partner violence appears to have a similar impact on women's health and well-being regardless of where they live, the prevalence of violence in their setting or their cultural or economic background (Watts, 2003).

A report by UNICEF (2000), gives the following statistics on IPV for five countries:

- Estonia: 29% of women aged 18-24 fear domestic violence, while 52-62% of women had experienced Intimate partner violence according to the 1994 survey of 2,315 women.

- Poland: 60% of divorced women surveyed in 1993 had been hit at least once by their ex-husbands. 25% had reported repeated violence.

- Tajikistan: 23% of 550 women aged 18-40 reported physical abuses by their Intimate partners.
- United States: 22.1% of all women in the United States had experienced some form of assault by an intimate partner. Each year 4.5 million physical assaults were committed against women by intimate partners.
- Hong Kong: between 1998 and 2005, cases of abuse within families had tripled. Of the 719 cases reported, 500 involved serious assaults on women.

According to Human Rights Watch (2006), in Pakistan, seventy to ninety per cent of women suffer some form of domestic violence. In 2002, there were at least 3,296 cases of violence against women. The Human Rights Commission of Pakistan (HRCP) documented 895 cases of abuse against women in 2003, consisting of 260 murders and 124 cases of gang rape. Up to 50% of women who reported that they had been raped were jailed under the Hudood Ordinances. The ordinance criminalizes sexual relations outside of marriage including rape. These Ordinances, implemented in 1979, abolished recognition and punishment for marital rape. Pakistan has no specific legislation against intimate partner violence and police are reluctant to get involved in family matters. In 2012 there were 450 women murders. In the same year, Pakistan had 280 women killed and 750 injured from acid attacks. Up to three women die in a day from stove bums in Pakistan, from accusations of disobedience, failure to give birth to a son, and allegations of adultery. Many women do not survive by the time their cases go to trial and their cases are dropped. Police are often reluctant to investigate the cases since they view them as "family matters". Officials at all levels of the criminal justice system believe domestic violence is not a matter of criminal courts.

According to the US Department of Justice Statistics (2014), the following are noted:

- One in three women and one in four men in the United States have experienced some form of physical violence by an intimate partner.
- On a normal and routine day, home violence hotlines receive close to 21,000 distress calls. This averages close to 15 calls every minute.
- Intimate partner violence accounts for 15% of all violent crimes.
- 72% of all murder-suicides involved an intimate partner; 94% of the victims of these crimes are female.

Half of all women will be hit at least once while in marriage or in long-term relationships, women are victims of abuse 95% of the time (Sian and Trevillion, 2015). The fact is that domestic violence can happen in any type of relationship, married, heterosexual, gay, lesbian, separated or even dating. One in four women in heterosexual marital relationships will be a victim of abuse. According to Summers (2002: 10), in six Australian Jurisdictions, there were 3,000 cases of domestic violence over one month". On the other hand, Watchtower (2001: 1) reports that in one year, 14,500 Russian women were killed by their husbands and a further 56,400 were disabled or badly injured in domestic attacks. Moreover, the number of women who say they had been beaten by their partners had soared by more than 40% in 2000.

2.1.2 Intimate Partner Violence in Africa

Intimate partner violence is a daily reality in Africa as elsewhere in the world. It is a complex issue that has its root from structural inequalities between men and women that result in the persistence of power differentials between the sexes. Women's subordinate status to men in many societies, coupled with a general acceptance of interpersonal violence as a means of resolving conflict, renders women disproportionately vulnerable to violence from all levels of society: individual men, within the family and community, and by the state. The traditional view is that, although most African countries have signed and ratified CEDAW, there has been no political will to domesticate legislation and to outlaw intimate partner violence against women, (Okech-Owiti et al., 1999).

Intimate partner violence is prevalent in all societies, but the level and the degree to which it is considered acceptable both vary greatly (Cools, 2017). The countries of Sub-Saharan Africa (SSA) stand out with the highest levels of violence against women in the world (Garc a-Moreno et al., 2005; Devries et al., 2013). Also, 14 out of the 15 countries with the highest share of women who deem wife-beating justifiable are found in Sub-Saharan Africa (World Bank, 2011).

According to the United Nations Development Fund for Women (UNIFEM, 2005), acts of violence against women happen with impunity. Governments, communities and families are not doing enough to prevent violence against women. IPV in Africa can be termed as a pervasive

gender inequality. The patriarchal nature of traditional African society makes the position of a woman subordinate to that of a man. Institutionalization of this inequality remains common in African customary law. Unless the systematic inequality between women and men is addressed, the problem of violence will persist. Vernellia (1999), stated that the power of tradition and norms within African culture also contribute to the widespread incidences of domestic violence. Wife battering is regarded as normal within traditional African culture. For example, in Nigeria, at the social welfare office, police officers remind wives that Yoruba culture allows men to beat women (Bowman, 2003). Other cultural explanations for intimate partner violence include the uneven distribution of power within traditional African marriages, the impact of polygyny, and the acceptance of male promiscuity, the power of the extended family over the married couple and the issue of bride wealth, all of which underlay the widespread abuse of women.

According to Thomas (1995), "South African women are not safe in their homes, their places of work or in the streets". Women who seek redress for abuse often face police officers who are indifferent or hostile medical examiners who are ill-equipped and inaccessible, prosecutors who are inexperienced and at times biased, and judges who doubt women's credibility as survivors or witnesses to violence and therefore, hand down lenient sentences to those convicted of abuse. Thus, the ineffective legal and social systems exacerbate the effects of domestic violence against South African women. It is estimated that half of the reported sex offences and assaults on women occur in private homes.

In 1998, a survey carried out by Hutch (1998), found that 66.7% of women in Sierra Leone had experienced physical abuse at the hands of their partners. According to Morash (1998: 337), by the mid-1990s, attention had begun to be paid in most African countries to the wide spread problem of domestic violence. The subordinate status of women is well known in all African societies. The history of women in most African societies has been one in which women have been victims of physical assault (Dobash and Dobash, 1979).

2.1.3 Intimate Partner Violence in Kenya

In Kenya, Intimate partner violence occurs across all socio-economic and cultural backgrounds and women are socialised to accept, tolerate and even rationalise domestic violence (Wanyeki,

1996). According to the United Nations (2005), in Kenya many women are falling victims to intimate partner violence, and at least half of all Kenyan women have experienced violence since the age of fourteen. Kenya has no law that specifically prohibits spousal rape and wife beating is common and often condoned in many cultures. In 2003, the highest number of intimate partner violence incidences occurred in Eastern Province (31.6%). This was followed by Central Province (26.3%), while Nairobi was third (15.8%) and Rift valley was fourth (10.5%). The lowest incidences occurred in Coast (5.3%), North-Eastern (5.3%), and Western (5.3%) Provinces (Muchai, 2003: 67). In all the above cases, physical violence was the most used against women; this violence took place both in the urban as well as in the rural areas.

Alcohol and drug abuse and irresponsibility were the major causes of the intimate partner violence. According to a report by Muthengi (2005), the year 2005 alone saw fifty women reportedly killed by their intimate partners. The report further stated that wife beating is rampant in Kenya, but only a few cases are reported in the local media or to authorities. Women are expected to suffer in silence. Generally, marital violence is an age-old practice, which has defied the process of social change and the nation's response to domestic violence has been uneven.

The Kenya Demographic and Health Survey (2014), reveals that more than one-third of ever-married women had experienced physical violence by their husband or partner. An additional 32% reported emotional violence and 13% reported sexual violence. There are regional variations in reports of intimate partner violence. About half of women in Nyanza region of Western Kenya reported partner violence, whether sexual or physical, compared to only 10% of their counterparts in North Eastern Kenya. Moreover, familial violence was the next biggest contributor to physical violence in Kenya as more than two thirds of women who reported abuse, stated that their abusers were their intimate partners or other relatives.

The position of women in Kenya is particularly vulnerable. Traditionally, as well as legally, their rights are restricted whilst they can be subjected to various forms of harassment and brutality at all levels of the society without any guarantee of being protected by traditional institutions or by the law. Moreover, women cannot rely on the law or law enforcement agents to protect them from

IPV. The cultural indifference towards marital rape, barriers to recognizing IPV as illegal, and police involvement in marital cases have subjected women to continued suffering.

2.2 Forms of Intimate Partner Violence

2.2.1 Sexual violence

This is a broad term used to describe any acts of unwanted sexual contact (Ballard and Aless, 2002). Any form of unwanted sexual advances constitutes sexual violence, whether attempted or otherwise performed. More than this, all of these acts occur without the victim's consent, including cases in which the victim is not in a consenting position due to intoxication (e.g., incapacitation, lack of awareness, or lack of consciousness) through knowingly or involuntary using alcohol or drugs (Ballard and Aless, 2002). Un-consented sexual contact, which, among others, may include intentional and indecent contact with the victim or making them touch the perpetrator against their free will, either directly or through the clothing, on the anus, groin, genitalia, breast, buttocks or thighs without the victim's consent (Kelly, 2005).

Sexual violence can occur in a range of contexts, but universally, it is recognized as being predominantly a crime in which the victim is female and the perpetrator is male (Gavey, 2005; Lievore, 2004). Most of the sexual violence is committed by men who are known to survivors (Heenan and Murray, 2006; Lievore, 2003; Jewkes et al., 2002) as date rapes, acquaintances rapes or marital rapes. In the aftermath of a sexual assault, survivors can face extremely difficult and painful emotions and experiences. The effects of the trauma can be short-term or last long after the sexual violence.

A study by Black et al., (2013), found that 44.6% of women and 22.2% of men had experienced sexual violence other than rape in their lifetime, including being made to penetrate someone, sexual coercion, unwanted sexual contact, and unwanted non-contact sexual experiences.

2.2.2 Physical Violence

This is the deliberate application of physical force with the potential and intention of causing actual and visible injury, disability or death. This kind of violence includes, but is not limited to, punching, scratching, pulling, pushing, knocking, shoving, throwing, hitting, grabbing, biting,

choking, aggression, slapping, stabbing, use of a weapon and use of restraints or body size or physical strength against another person. Physical violence is also applied in the form of coercing other people to commit any of the above acts in any form (Garcia-Moreno et al., 2005).

Coker et al., (2009), carried out a survey to establish if the women had ever been exposed to domestic violence, the duration they were exposed and the nature of violence experienced. The study found that up to 35.9% of the women who took part in the survey had experienced at least one form of domestic violence. Of the women who reported being victims of domestic violence, 3.5% also indicated having cervical cancer at some point, while 1.3% of the women who had never experienced violence also reported cervical cancer. The study concluded that women who had experienced domestic violence were more likely to have contracted human papilloma virus, to use illegal drugs, and to smoke cigarettes, all of which are contributing factors to cervical cancer.

2.2.3 Stalking

This is an obsessional following (Meloy, 1996), unwanted pursuit behaviour pattern of repeated, attention and contact that causes fear or concern for one's own safety or the safety of someone else, for example, family member or friend (Langhinrichsen-Rohling et al., 2000). Some typical examples include harassment through repeated unwanted phone calls, text messaging or emails, letters, flowers, or other items when the victim is not interested in them. Others include watching or following from a distance (Rosenfeld, 2003), spying, approaching or appearing in places when the victim does not want to see them, sneaking into the victim's place of work, family home or car, damaging the victim's property, threatening or harming the victim's pet, family members and close friends (Spitzberg, 2002).

Stalking can encompass behaviours that at first appear un-harmful to the innocent bystander; however, behaviours can be menacing, threatening and persistent. This debilitating social problem has caused serious health consequences for stalking victims whether intimate or otherwise (Hall, 1998). According to the study carried out by Tjaden and Thoennes (2000), most victims of stalking are women (4 out of every 5) and that the majority of female stalking victims (59%) report being stalked by a current or former intimate partner, the study also identified a crucial link between stalking and intimate partner violence, finding that 81% of women who were stalked by a current or former (marital/cohabiting) partner also experienced physical assaults by those partners.

2.2.4 Psychological Aggression

This is the manipulation of someone's emotions through gestures, words or some form of behaviour with the intention to cause mental harm on another person or to destroy them emotionally, and/or to exert control over another person (Tjaden and Thoennes, 2000).This form of aggression can include public embarrassment, humiliation and coercive control such as limiting access to transportation, money, friends, and family and excessive monitoring of the victim. Others include threats of sexual or physical violence and control of sexual or reproductive health. Examples include refusal to use birth control or protection gears and forced pregnancy termination (Heise & Garcia-Moreno, 2002).

Other forms of psychological aggression include acts of exploitation of vulnerability (e.g., immigration status, disability), and presentation of false information to the victim with the intent of making them doubt their own memory or perception (Cerulli et al., 2012). According to the National Gender and Equality Commission (NGEC, 2016), a physically handicapped woman in Migori County had a relationship with a man which resulted in pregnancy. However, after she delivered, the man forcibly took away the infant, claiming that her disability prevented her from being accepted as his wife by his family and also from taking care of the child properly. He placed the child under the care of his mother, exposing the newborn to possible disease and emotional distress. The woman was traumatized by this act, as she was extremely worried about the welfare of her child.

2.3 Social Determinants of Intimate Partner Violence

According to USAID (2006), causes of gender-based violence include:

- Traditional gender norms that support male superiority.
- Social norms that tolerate or even justify violence against women.
- Weak community sanctions against perpetrators.
- Poverty.
- High levels of crime and conflict in society.
- Low income or academic achievement.
- Attitudes that justify violence against women.

Women encounter violence due to a combination of biological, psychological and individual characteristics as well as socio-economic and political factors. Several studies (Abramsky et al. (2011); Djkanovik et al. (2010) and Walton-Moss et al., 2005), have examined the factors associated with IPV in different parts of the globe. Some of these studies highlight the role of personal factors while others demonstrate the role played by environmental circumstances, attitudes and cultural factors. In Kenya and other African countries, various social determinants play a key role in intimate partner violence among young couples. Some of the social determinants areas discussed and explained below:

Culture: Culture varies across regions and across societies. It usually plays a significant role in IPV. Dominating culture and the right to privacy has resulted in IPV being largely under reported. Many abused women believe in cultural inhibitions against public discussion of domestic issues and prefer to keep to themselves, thereby promoting a culture of silence (Kalra and Bhugra, 2013). These cultural norms and practices and the perceived social stigma attached to IPV more often discourage reporting and, as a result, prosecution is very rare in many countries. Shaming of sexuality and lack of sex education among young men and women enhances the belief that sexual violence needs to be a secret; this shows how culturally shared notions of shame, secrecy and privacy, amplify the stigma of IPV (Jackson and Sullivan, 1999).

Cultural factors play a big role in Kenya where issues of intimate partner violence are concerned, especially in rural settings. The submissive expectations on women have also led to them being vulnerable to sexual violence especially during conflicts (Mukabi, 2015). Different societal and cultural practices support different types of hypotheses, for instance, traditional beliefs that men have a right and responsibility to control, direct and discipline women through physical actions of beatings and battery exposes women to violence by intimate partners. This places girls at a risk of sexual abuse. Additionally, cultural tolerance to violence including sexual violence, as a private husband and wife affair hinders outside intervention (Heise, 2011).

In many societies, victims of sexual violence feel stigmatized which inhibits reporting and hence the authorities are unable to take any action. The biased and uninformed social belief that a woman's place is in her in-laws home is also entrenched in a woman's mentality. This makes it difficult for a woman to find recourse outside the circle of her husband's relatives. The social value places women in a complex situation to redeem themselves and protest against domestic violence (Farouk, 2005). In cases of family and marital conflict, society in most cases exclusively puts the blame on the woman, holds her accountable, blames the woman for her failure of not being able to maintain strong foundation in the family and heaps pressure on her. She will take the blame for not being able to maintain tranquility and inability to fit in within the family environment (Farouk, 2005). Therefore, women are reluctant to complain and rise against IPV or file complaints against their spouses because they fear stigmatization. Women also have limited alternatives to move elsewhere when living with their husband becomes untenable (Farouk, 2005).

Substance Abuse: Various studies have shown that there is a correlation between Intimate Partner Violence and alcohol and substance abuse. A survey of violence against women conducted in Russia 2010 revealed that half the cases of physical violence were associated with the male's excessive use of alcohol. Alcohol may impair judgment, reduce inhibition and increase aggression. Alcohol has however, been used by the perpetrators of domestic violence as an excuse for their behavior. The men will rid themselves off the responsibility of their behavior by blaming it on the effects alcohol (FIDA Kenya, 2009).

However, the prevalence of substance abuse is a manifestation in both husband and wife who are engaged in abusive relationship, even though the pattern is different. Alcohol consumption has also been associated with IPV due to conflicts resulting from influence of alcohol (Jewkes et al., 2005). Alcohol is also associated with increased risk of most forms of interpersonal violence. Heavy substance use is a significant risk factor for domestic violence. Drug and alcohol abuse may enhance an abuser's pre-existing violent tendencies. However, there is no conclusive evidence suggesting that using alcohol or drugs causes domestic violence (Jewkes, 2002).

2.3.1 Socio-economic status

Financial insecurity: Financial pressure, social and material deprivation can have strong negative effects on intimate relationships (Stock et al., 2014; Ghate & Hazell, 2004), as well as

compounding and exacerbating existing patterns of vulnerability of IPV, for example, employment or lack thereof, availability of social support, etc. At the same time, financial insecurity and the patterns of interpersonal dependency created by this can also trap people in abusive relationships and generate a significant financial penalty on those escaping abuse and violence. Lack of court – mandated child support, limited options on child care and interference by abusive partner and their friends or relations which limits women's ability to work are just but a few of the barriers to labour market participation faced by women and which prevent them from escaping poverty (Bell, 2003; Swanberg & Logan, 2005).

Education: The KDHS 2008/09 clearly indicates that young women with at least a secondary school level of education are least likely to have suffered most type of violence at the hands of their husbands. Education can improve the chances of a good marriage since educated young women enjoy a better health and are likely to meet an equally educated and enlightened partner. An educated woman has the potential to give birth to a healthy child and can build a strong social network (Amin and Robert, 2008). High literacy levels have the potential to offer a young girl a variety of choices of selecting a life partner due to wider levels of interactions and awareness of her legal rights. The woman also has choices in cases of marriage based on mutual understanding of men and women (Suran and Chowdhury, 2004).

A husband's level of education is protective against IPV in rural sites (Naved and Perssons, 2005). A husband with higher levels of educational attainment tends to protect women from violence because education helps to fight the conventional gender norms, which are still held very strong in some rural settings. Moreover, if husbands are well educated, they tend to be tolerant, understanding and cooperative with their wives in many cases. Therefore, it is evident that besides women's education, male education is an important indicator in reducing domestic violence (Naved and Perssons, 2005).

2.4 Effects of Intimate Partner Violence on women's reproductive health

2.4.1 Physical injury and death

Women's overall health and social wellbeing is severely influenced by forms of physical, psychological or sexual violence perpetrated by a current or former partner (O'Neill et al., 2014). Physical violence involves all acts determined to cause actual bodily harm on the victim. This includes hitting, kicking, slapping punching and use of objects to hit or cut the survivor with the intention of causing injury to the body. This can also include use of one's body, size, or strength against another person, (Garcia-Moreno et al., 2005).

Another study carried out by Cerulli et al, (2012) concluded that physical symptoms of battered women were primarily chronic body pain and aches. Women were diagnosed with constant fatigue, weight and immune system problems, various bodily injuries and breathing difficulties. Facial injuries like swelling and bruises were more common among abused women as well. Physically abused women have higher levels of prevalence in most categories of physical problems than women who have not been exposed to abuse. Abused women suffer more from virginal infections and digestive problems than non-abused woman (Cerulli et al., 2012). These can be fatal such as homicide, suicide, and AIDS-related deaths or non-fatal such as chronic pain syndromes, traumatic injury, or traumatic gynecological fistula. Gender-based violence is a pervasive public health and human rights problem throughout the world, but the patterns and prevalence vary from place to place.

According to a study by Dunkle et al. (2004), in South Africa, 1366 women who attended health centres in Soweto and tested for HIV showed that 48% of them had been beaten by their partners or boyfriends. Those who were emotionally or financially dominated by their partners were 52% more likely to be infected with HIV.

2.4.2 Unintended pregnancy

Unintended pregnancy occurs more commonly for women in abusive relationships (Cripe et al., 2008). In most cases, victimized women are faced with compromised decision making regarding the use of contraceptives and family planning, including forced sex, condom use, and fear of

violence in the event she refuses to have sex and difficulties negotiating use of condom and contraception in the context of an abusive relationship all these contribute to increased risk for unintended pregnancy and STIs (Miller et al., 2010). IPV and reproductive health are interlinked and one cannot be properly addressed without addressing the other. IPV leads to high rates of unplanned pregnancies, second-trimester abortions, repeat abortions, STIs, and inconsistent condom use, IPV itself is a reproductive health problem.

Violence and reproductive health are strongly linked. Unplanned pregnancies increase women's risk for violence and violence increases women's risk for unplanned pregnancies. Women who are IPV victims are more likely to be in relationships with a partner who controls their contraceptive methods (Miller et al., 2010). Research by Demographic and Health Survey 2000 in Colombia were used to explore the relationship between intimate partner violence and unintended pregnancy, which was included as a measure of fertility control. Regional differences in the relationship were also explored, and population-attributable risk estimates were calculated. The sample consisted of 3,431 ever-married women aged 15-49 who had given birth in the last five years or were currently pregnant. 55% of respondents had had at least one unintended pregnancy, and 38% had been physically or sexually abused by their current or most recent partner. Women's adjusted odds of having had an unintended pregnancy were significantly elevated if they had been physically or sexually abused (Pallitto et al., 2013).

2.4.3 Birth outcome

Intimate Partner Violence always escalates during pregnancy (Wiist and McFarlane, 1999). Violence at this time is associated with poorer general health, obstetric, and reproductive outcomes for pregnant women. Adverse gynecological and obstetric results include low weight gain during the pregnancy cycle (Moraes et al., 2006), anaemia, infections and first and second trimester bleeding (McFarlane et al., 1996). Women who experience physical violence during pregnancy also have a greater chance of miscarriage (Taft et al., 2008), higher level of depression during pregnancy (Martin et al., 2006), and injury (Ei Kady et al., 2005).

Violence during pregnancy is more prevalent than other routinely screened complications of pregnancy such as pre-eclapsia or gestational diabetes with resultant adverse health consequences affecting women and their newborns (Murphy et al., 2001). Women of child bearing age experiencing sexual and physical abuse have a higher tendency of hospital admissions during pregnancy and after delivery and are more likely to abuse alcohol and drugs (Murphy et al., 2001; Silverman et al., 2006).

The National Study on Violence against Women in Vietnam in 2010 demonstrated an association between violence during pregnancy and low birth weight (LBW) or preterm birth (PTB) (Black et al., 2008). More than one-third of the women had been exposed to IPV during pregnancy; 32.5% reported exposure to emotional, 3.5% to physical and 10% to sexual violence. In comparison, a recent meta-analysis focusing on IPV during pregnancy, reported the prevalence of emotional violence to be 28.4%, physical violence to be 13.8%, and sexual violence to be 8.0%, all these resulted into delay in seeking prenatal care, poor nutrition, substance use, low birth weight, preterm delivery and miscarriages (James et al., 2013).

2.4.4 Sex selection (male child preference)

In Africa and other parts of the world, there has always been tension over the preference of the male child over his female counterpart. Such preference sometimes hinges on the biased perception of women through ages and other misconceptions which have continued to survive in many societies (Purewal, 2010). Son preference is one of the principal forms of discrimination and one which has far-reaching implications for women. Son preference is deeply rooted in patriarchal cultural and religious beliefs that uphold the essential value of having a son in a family. The kinship and inheritance systems in a family also powerfully drive son preference. The belief that sons are essential for social survival for a family by carrying on its patrilineage sustains the ideology of son preference. Sons are also seen to ensure a family's economic security over time as providers of income and resources to parents in their old age.

Women experience intense societal and familial pressure to produce a son and failure to do so, often carries the threat and consequences of violence or abandonment in their marriage (Das Gupta, 2006). Women may have many pregnancies until a boy is born, putting their own health at risk.

The desire for a male child has resulted in a situation where husbands keep pressuring their wives to have more children, which in turn predispose the health of the wives to danger. When this fails to produce the desired results, men might resort to polygyny in the hope that the other women would give them the son they need (Elele, 2002). To avoid being divorced, most women give birth to many children, jeopardizing their lives in the search for that elusive boy. This practice is one of those observed issues that have contributed to high rate of maternal deaths in Africa (Milazzo, 2012). Many marriages become shaky simply because the woman was unable to have a male child.

Male child preference has been a major issue that has led to female infanticide, sex-specific abortions, and pre-marital sex selection. Preference for sons among couples has also contributed immensely to a large family size, high population, gender discrimination and low girl-child empowerment (Milazzo, 2012). A study on the prevalence of male child preference by Rossi and Rouanet (2014) in Africa shows that male child preference is more prevalence in North Africa than other regions of Africa as well.

2.4.5 Birth control sabotage

Practicing contraception is more difficult for women who have experienced IPV because of partner unwillingness to use contraception (Gee et al., 2009). Additionally, women who are exposed to IPV by the man who got them pregnant are more likely than non-abused women to have a second-trimester abortion (Jones & Finer, 2011). Examples of reproductive coercion include; hiding, withholding, or destroying a partner's birth control pills, intentionally breaking condoms or removing a condom during sex not withdrawing during intercourse when that was the agreed upon method of contraception, removing contraceptive patches, rings, or IUDs, attempting to force or coerce a partner to have an abortion against their will, controlling abortion-related decisions (Chamberlain & Levenson, 2012; Silverman et al., 2010).

The fact that men are attempting to control women's reproduction is not new. The fact that couples disagree on desired fertility goals is also not new there are high rates of couple disagreement about their desired number of children worldwide (Voas, 2003). What makes reproductive control something that deserves public health attention is the threats and coercion men enacted on these women to try to get them pregnant and resolve pregnancies in the manner the men wanted, often leaving the women unable to act autonomously. High rates of birth control sabotage and pregnancy

pressure and coercion in abusive relationships are correlated with unintended pregnancies (Miller et al., 2010).

2.4.6 Mental health

According to Heise and Garcia (2002), women who are abused by their partners suffer higher levels of anxiety, depression and phobias than their non-abused counterparts do. A research conducted by Finck et al. (2005) revealed that women victims of IPV have psychological symptoms such as anxiety, panic attacks and paranoia. The women are emotionally exhausted due to constant fears and nightmares, feelings of anger and self-destructive behavior were found among this category of women victims. These women had increased risk of addiction and they purposefully isolated themselves from society. The women's memories and thoughts concerning the violence are affected in a way that they would remember the past situations unrealistically (Finck et al., 2005). They are extremely traumatized to a point even where a single reminder can trigger the memory of the trauma they once experienced. This contributes to the constant emotional and psychological pain that makes the women powerless and their everyday life exhausting and frustrating (Cerulli et al., 2012).

Women who are abused are likely to suffer from conditions such as post-traumatic stress syndrome, panic attacks, depression, sleeping and eating disturbances, elevated blood pressure, alcoholism, drug abuse, and low self-esteem. For some category of women, demeaned and fatally depressed by their intimate partner who has chosen to abuse them, there is little recourse from the violent relationship other than committing suicide (WHO, 2011). Domestic violence is a specific example of an event that places women at risk of suffering from post-traumatic stress disorder (Smeltzer, 2004: 104-105).

2.4.7 Homicide and other related mortality

Homicides accompanied by suicide correlate strongly with intimate partner contexts (Barraclough & Harris 2002; Bossarte et al., 2006; Campbell et al., 2007). A systematic review of IPV in 66 countries found that the number of female victims of intimate partner homicide exceeded the number of male victims in all but two countries and in all countries, women's main risk of homicide is from an intimate partner (Stockl et al., 2013). IPV may also heighten a woman's risk of committing suicide (Golding, 1999), contracting HIV and AIDS related deaths (Campbell,

2002). The consequences of gender-based violence include physical and mental pain, suffering, disfigurement, temporary and permanent disabilities, maiming and even death (Capelon, 1994). These can be fatal such as homicide, suicide, and AIDS-related deaths or non-fatal such as chronic pain syndromes, traumatic injury, or traumatic gynecological fistula. Gender-based violence is a pervasive public health and human rights problem throughout the world, but the patterns and prevalence vary from place to place. Around the world, at least one woman in every three has been beaten, coerced into sex, or otherwise abused in her lifetime (USAID, 2005).

2.5 Theoretical Frameworks

2.5.1 Feminism theory of violence against women

This study was guided by the Marxist feminism theory, it states that IPV exists as part of patriarchal social structures and is an intentional pattern of behavior utilized to establish and maintain power and control over a female partner or ex-partner (Bograd, 1988). The family is understood and analyzed as a historically constructed and situated social institution.

No one pattern of kinship or social arrangement for partnership and childrearing is natural or morally superior. Male power is located not only primarily in physical power and aggression but also in the major institutions, structures and ideologies of capitalism (Bograd, 1988). The feminist/domestic violence movement explains domestic violence as resulting from historically created gender hierarchy and sexual division of labour in the home in which men dominate and control women.

The combination of blue-collar status, drinking or substance abuse and cultural approval of violence is significantly associated with the highest rate of wife abuse. Of the three factors, cultural approval of violence by men against women has the strongest association with wife abuse (Ogle & Baer, 2003). Violence in some societies is socially approved and often culturally legitimized. It is not a natural expression of biological drives of innate male characteristics. It is constructed and learned behavior. The theory also states that men's violence is triggered by factors such as women disobeying or arguing, questioning him about money or girlfriends. Other factors include not having food ready on time or in the right way, failure as a mother or housekeeper, women refusing to have sex or man being accused of infidelity.

2.5.2 Relevance of theory to the study

Marxist feminism theory of violence against women relates to the study as it demonstrates patriarchal nature of society that places men above women and gives men authority over women thus allowing for treatment of women in whatever form desired by their male counterpart. This exposes women to a variety of negative treatment including violence that is considered justified by the society (Bograd, 1988). The women have also culturally come to accept this situation and receive the punishment without any resistance in show of respect, submission and sometimes 'love' for their partners.

In most societies, women are socialized to submit to their partners regardless of the circumstances. Until recently, the patriarchal society has prioritized education of boys to the detriment of the girl child. However, in societies where education has not been wholly embraced, lack of education stands out as a recipe for domestic violence due to high levels of ignorance. Women with higher levels of education and higher income (generally elevated socio-economic status) levels are also less vulnerable to domestic violence (Bates et al., 2004). The activists against domestic violence have gone further to demonstrate that domestic violence is experienced by women as a result of historically and culturally created gender hierarchy favouring men against women and which has formalized and sanctioned domination and control of women by men (Bograd, 1988).This theory also exposes the role played by drunkenness and substance abuse on intimate partner violence. Half of the men in batterer intervention programs appear to abuse alcohol or drugs (Ogle & Baer, 2003).

2.6 Conceptual Framework

The conceptual framework explains the constructs studied and illustrates the relationship of the determinants to the dependent variable identified for the study. In this study, Intimate Partner Violence was the independent variable while the dependent variables were identified as demographic factors, social factors and economic factors (See Fig 1).

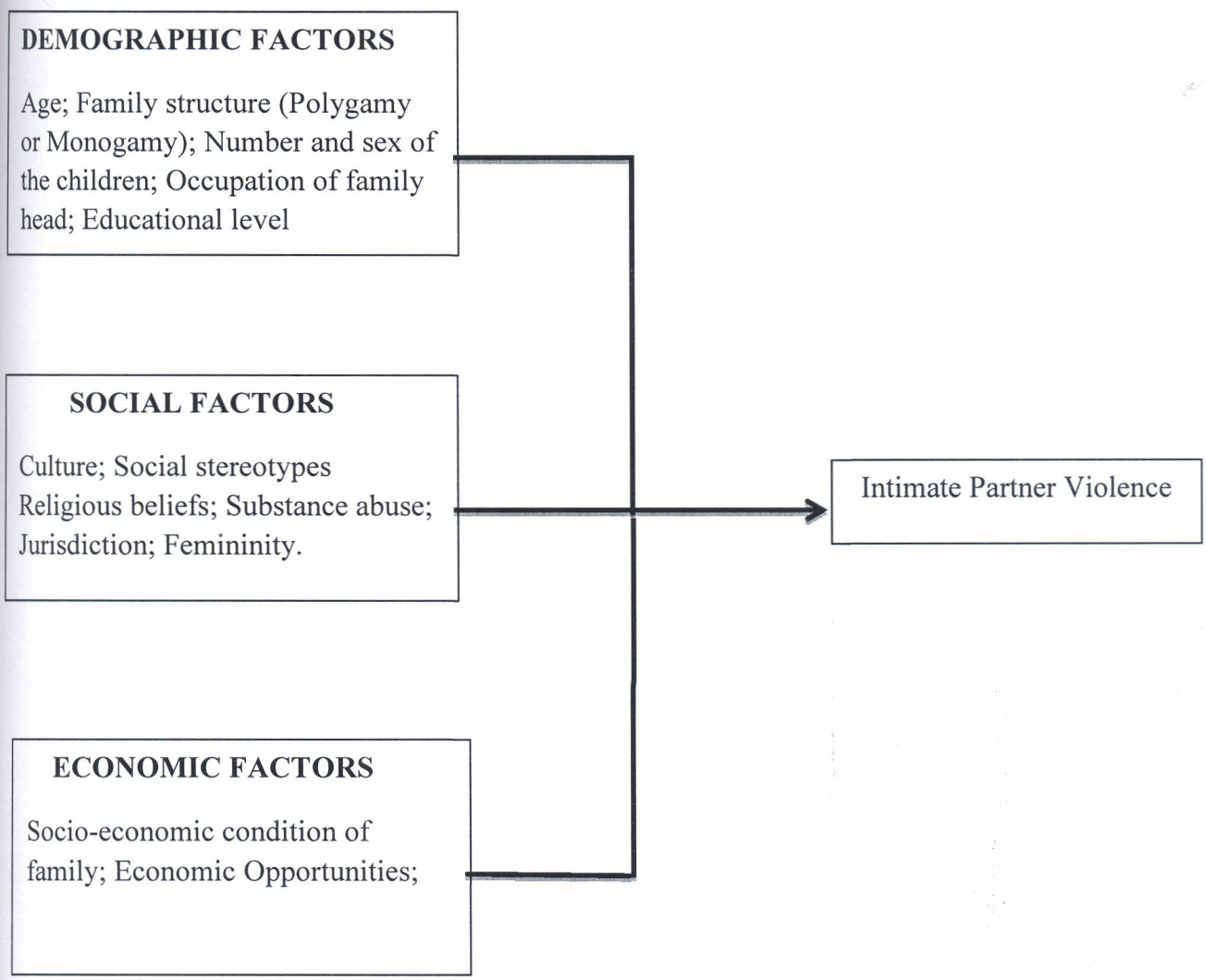


Figure 2.1: Conceptual Framework (Source: Author)

CHAPTER THREE: METHODOLOGY

3.1 Introduction

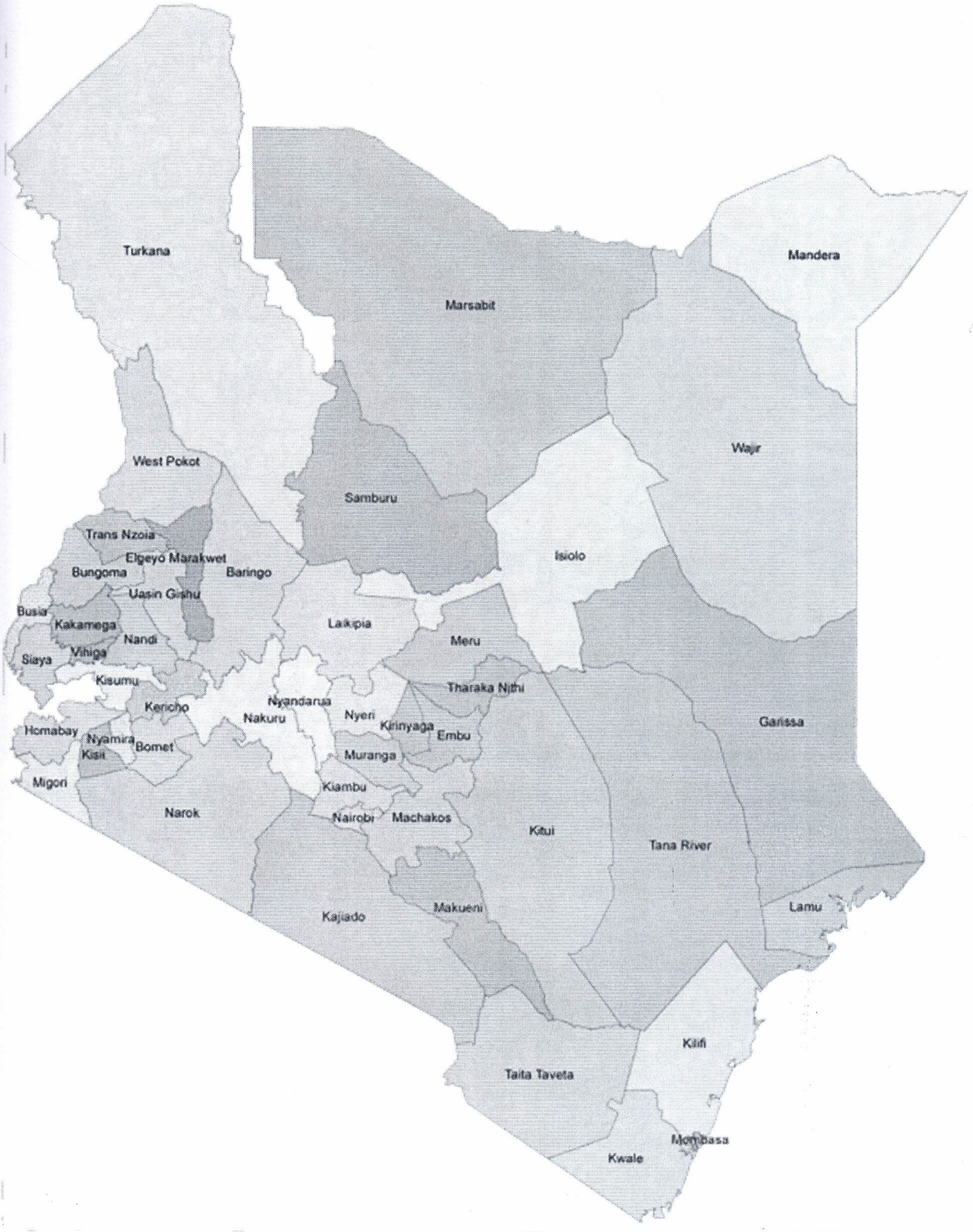
This section describes the methodology used in the study. The chapter includes the data collection strategies, the procedures and techniques used in data processing and analysis. The section also describes the research site, the research design, study population, sample population as well as ethical considerations.

3.2 Research site

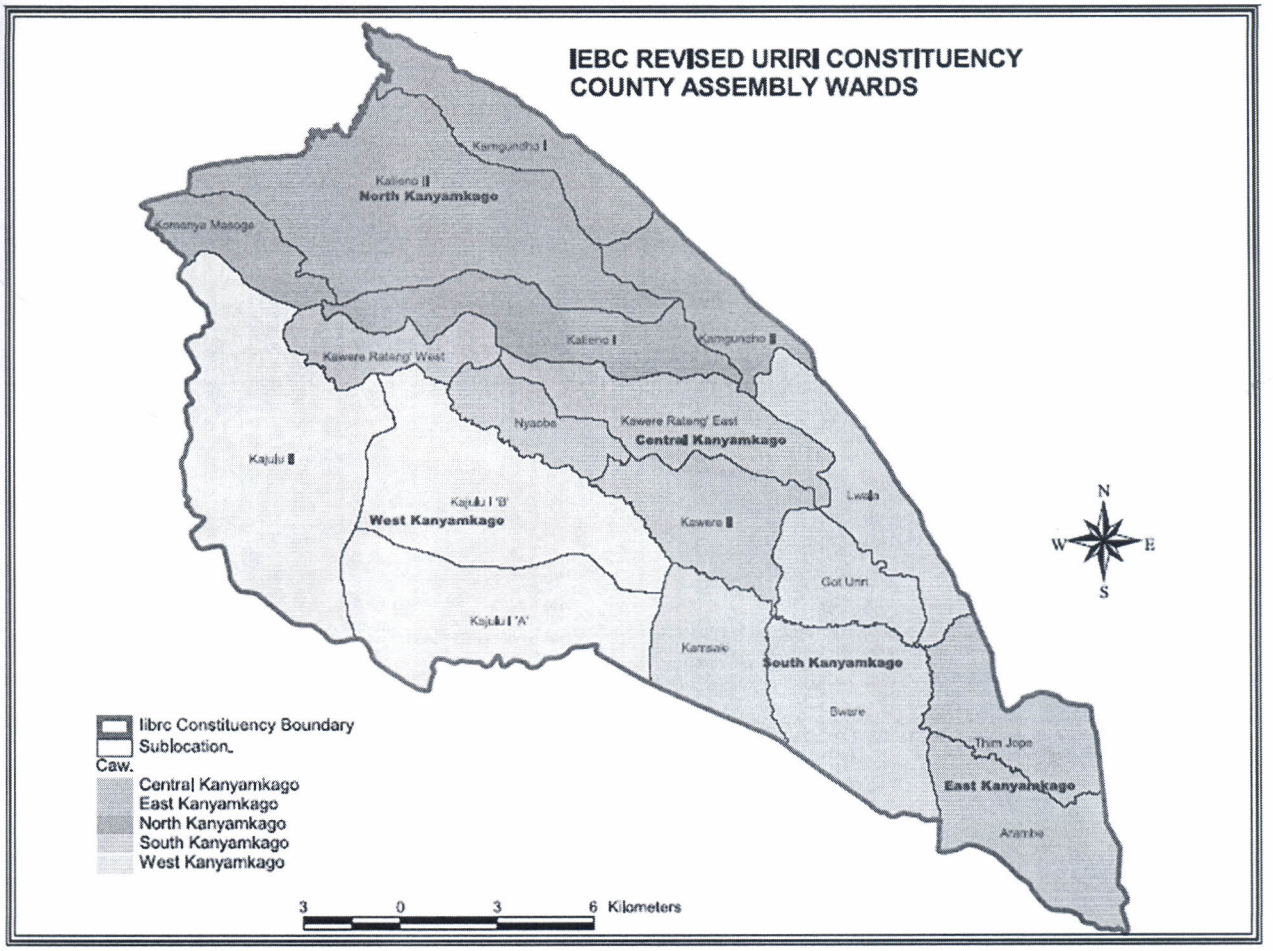
This study was carried out in East Kanyamkago location of Uriri sub-county in Migori County. The research location is shown in Fig. 2 below. East Kanyamkago location consists of Arambe and Thimjope sub-locations. The location covers an area of approximately 35.7 km^2 with a total population of approximately 16,620 people of whom 9,012 are women of reproductive age. East Kanyamkago location is a cosmopolitan ward inhabited by the Luo, Luyia, Maasai and Kisii (Soft Kenya, 2017).

This location was considered appropriate for this study because it is a typical rural African setting where cultural practices are still prevalent, i.e. polygyny, wife inheritance, a relative introducing a future wife/ husband to the future partner, boy child preference, and payment of bride wealth. The major occupation of the communities in the location is farming, mainly planting of beans, maize, millet, sorghum, cassava and potatoes. For cash crop, the community mainly grows sugarcane due to the proximity to Sony Sugar Company.

A good number of inhabitants live in semi-permanent houses, and there is one police post and one dispensary offering essential services for battered women. The community is accessible throughout the year by road. There are low levels of education in this location, about 11% having accessed formal education to a secondary level or above. Poverty levels are generally high in this area and there still exist challenges of alcohol and other substance abuse. The location is also part of the larger former Nyanza Province administrative area where IPV is prevalent according to the Kenya Demographic Health Survey of 2008/2009.



Map 3.1: Map of Kenya showing Migori County on the Western part of the Country



Map 3.2: Map of Migori county Showing East Kanyamkago location on the South Eastern part of the County; Source: www.softkenya.com

3.3 Research Design

This was a cross-sectional descriptive study and to a large extent aimed at collecting both qualitative and quantitative data through semi structured interviews, case narratives and key informant interviews with key selected informants. The overall goal was to assess the women's attitudes and knowledge on the impact of intimate partner violence. Qualitative data was transcribed, coded and then analyzed thematically in line with the study objectives.

3.4 Study Population and unit of analysis

The study targeted women of child bearing age (15-49), who were in an intimate partner relationship and residing within the rural area of East Kanyamkago location. The unit of analysis

was the individual survivor of intimate partner violence, that is, the individual woman who had faced violence from her husband or male partner.

3.5 Sample size and Sampling Procedures

The researcher collected data from a sample of 50 women of child bearing age, using a semi-structured questionnaire. A purposive sampling technique was used to select study participants. The selection was on the basis of snowball sampling, the local administration selected few women, who in turn led the research to other survivors of intimate partner violence within the community. Key informants were purposively drawn from the existing local organizations offering GBV response services at the community level. Specific individuals were selected for case narratives based on their level of understanding and willingness to share their experiences regarding intimate partner violence.

Table3.3 Distribution of Key informants by gender and age

Respondent	Sex	Category	Number	Age
1	Male	Local administration	1	47
1	Female	Women Leader	1	38
1	Male	Religious leader	1	52
1	Female	Counseling Psychologist	1	39
1	Female	Civil Society Organizations	1	49

3.6 Data Collection Methods

3.6.1 Semi structured interviews

A semi-structured questionnaire was used to collect data, which was administered to a sample of 50 respondents. Data was collected on their level of education, source of income, opinions, attitudes, views and experiences of domestic violence. It was a combination of closed and open-ended questions. The semi-structured questionnaire helped the researcher to explore the forms of intimate partner violence, social determinants and the impact it has on women's reproductive health.

3.6.2 Case narratives

A case narrative guide was used to capture the effects of Intimate Partner Violence, social determinants among the women of East Kanyamkago location. Case narrative was derived from 15 informants who were in an intimate relationship and were survivors of intimate partner violence. The informants told the stories of their lives in their own words. Questions pertaining to their experiences with intimate violence, the cultural aspect and institutions available in the study area and any efforts they make to address the problem of domestic violence were narrated by them.

3.6.3 Key Informant Interviews

Key informant interview guide (Appendix III and IV) were used to conduct intensive individual interviews with a small number of informants to explore their individual thoughts on the social determinants and effect of IPV on women's reproductive health, their experiences and expectations related to community level prevention and response mechanisms. A total of 5 Key Informant Interviews were held with those informants who were custodians of specific knowledge by virtue of their positions and knowledge such as the chief, women leader, medical personnel, religious leader and Civil Society Organization representative.

3.7 Data processing, analysis and presentation

The quantitative data from the questionnaire was analyzed using the Statistical Package for Social Sciences (SPSS). Data presentation has been done in the form of frequencies, percentages, tables and bar graphs.

Qualitative data was transcribed, coded and analysed. Audio recordings collected during case narratives and KIIs was transcribed and where they were not in English, they were translated. This

data was then analysed thematically. Themes and content that reveal findings to the question of the study was categorized together.

3.8 Ethical Considerations

Participating in studies dealing with sensitive matters can affect more than the future course of people's lives. Authority and research permit to conduct research was obtained from the National Commission for Science, Technology Innovation (NACOSTI). Clearance was sought from the Institute of Anthropology, Gender and African Studies (IAGAS).

The participants were made aware of the research and its purpose; therefore, an informed consent was sought and a consent form signed before any tool was administered. The participants were advised of their rights before taking part in the survey including their right to refuse to answer a particular question, right of withdrawal from the survey, anonymity and confidentiality were as well observed.

Permission was obtained from the informants before any recording of interviews. The researcher guaranteed the participants to observe the principles of confidentiality and anonymity throughout the study by using codes and pseudonyms to protect their identity. Further, it is envisaged that the outcome of the research will be shared by members of the local administration for feedback purposes and the copies of the project will be available in the University of Nairobi library. Attempts will be made to publish this work in refereed journals for wider scientific community consumption.

CHAPTER FOUR: INTIMATE PARTNER VIOLENCE AND LINKS TO REPRODUCTIVE HEALTH

4.1 Introduction

This chapter presents information on background of the respondents including Demographic factors (age, family structure, number and sex of children, occupation of family head and education level), Social factors (culture, social stereotypes, religious beliefs, substance abuse, jurisdiction and femininity) and Economic factors (socio-economic conditions, economic opportunities) in relation to Intimate Partner Violence.

The researcher gave out 50 questionnaires to the respondents who were all married women survivors of Intimate Partner Violence. All the questionnaires were duly filled and analysed. 5 key informants were also interviewed to reinforce and bring out different perspectives on the survivors. In addition, Case narrative was derived from 15 informants who were in an intimate relationship and were survivors of intimate partner violence. They were randomly selected from the 50 respondents who participated in filing up the questionnaire.

4.2 Demographic and socio economic information of respondents

4.2.1 Distribution of respondents by age

The ages of the respondents ranged from 15-49. The respondents were required to indicate their respective ages. The age ranges are illustrated in table 4.1.

Table 4.1: Distribution of respondents by Age

Age of respondents	**15-25**	**26-35**	**36-45**	**46-49**
Number of respondents	12	20	11	7
Percentage	24%	40%	22%	14%

24% of the respondents were between the ages of 15-25 years, 40% of the women were between the ages of 26 – 35 years, 22% between 36-45 years, while 14% of the women were between the ages of 46 – 49 years. Results from the survey showed that most of respondents were between the age 26-35 years.

> *"For us who are young, the police look down on us whenever we report incidences of intimate violence and we feel intimidated. They claim that it is childish to report marital issues since marriage is sacred."* (**Interview narrative #1 with a 20 years old IPV survivor**).

On the same, one of the key informants, religious leader, repeated similar comments as those given by one of the respondents in the narrative guide.

> *"Women's young age could also catalyze violence perpetrated against them by their older husbands, since they are considered children and should not argue with the husband."* (**Key informant#1 with women's leader**).

4.2.2 Distribution of respondents by ethnicity

The respondents were requested to indicate their ethnicity, the results showed that they came from different ethnic backgrounds as illustrated in Table 4.2 below

Table: 4.2 Respondents' ethnic groups

Ethnic Group	Frequency	Percentage
Luo	18	36.0
Luyia	12	24.0
Masaai	8	16.0
Kisii	6	12.0
Kuria	6	12.0
Total	**50**	**100%**

The result represented diverse ethnicity. This is attributed to the fact that the study area is a settlement scheme which attracted people from different ethnic backgrounds within and outside the general luo population. Most of the settlers have bought land as opposed to ancestral land inherited from the clan. As reported above in the table, 36% of the respondents were from the luo community with the lowest population of respondents coming from the Kisii and Kuria communities at 12% respectively.

4.2.3 Number and sex of Children

This research established the number and sex of children that the respondents had. 58% of the respondents reported that they have had tension over the preference of the male child over his female counterpart. The respondents further reported that they experience intense societal and familial pressure to produce a son and failure to do so, they often face the threat and consequences of violence or abandonment in their marriage. Table 4.3 illustrates the relationship between the age of the respondents and the number of children while table 4.4 illustrates the relationship between age and sex of children.

Table 4.3: Distribution by Respondents' Number of children

Number of children	Age of respondents					
	15-25	26-35	36-45	46-49	N	%
1-5	11	9	2	1	**23**	**46**
5-8	1	10	4	2	**17**	**34**
More than 8	0	1	5	4	**10**	**20**
Total	**12**	**20**	**11**	**7**	**50**	**100**

The outcome in table 4.3 above indicates that 46% of the respondents had between 1-5 children, 34% between 5-8 children and 20% had more than 8 children.

> *"My husband forced me to have a large family, as his name would be great with many children. When I declined his proposed agenda, he started attacking me with words and threatened to marry a second wife. Since then I have never had joy in my heart"* **(Interview narrative #2 with a 38 years old IPV survivor).**

Table 4.4: Distribution by Respondents' Sex of children

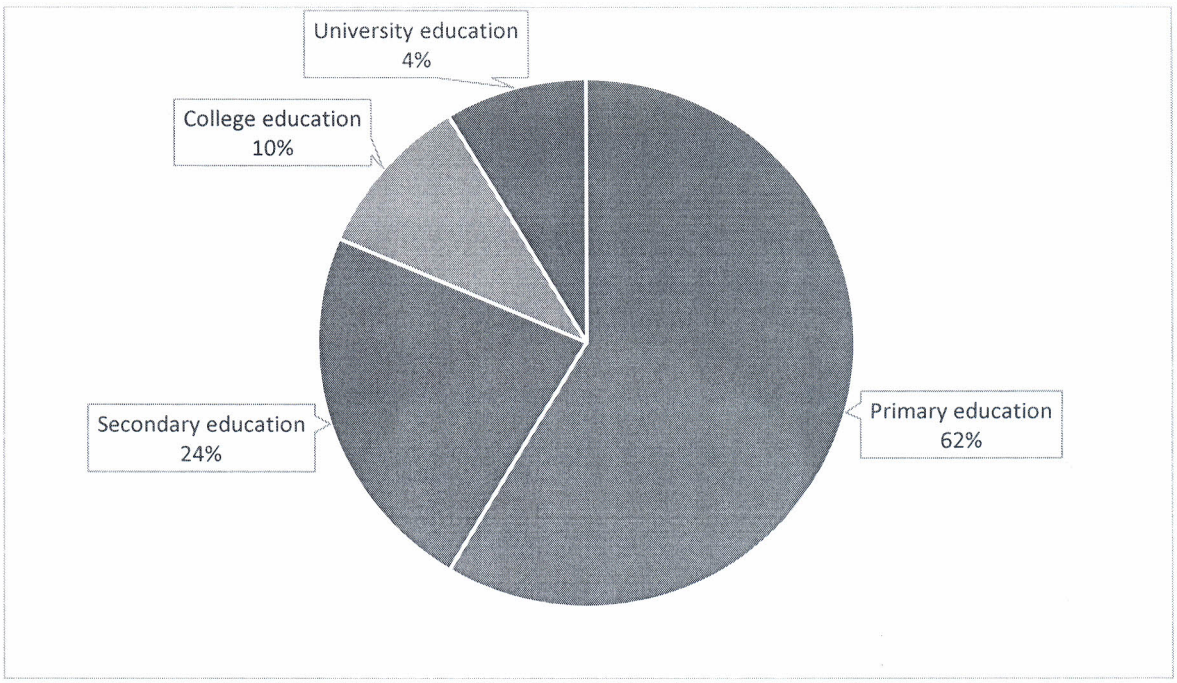
Sex of children	Age of respondents				Total	
	15-25	26-35	36-45	46-49	**N**	**%**
M ale	2	3	1	0	**6**	**12**
Female	6	5	4	1	**16**	**32**
Both	**4**	**12**	**6**	**6**	**28**	**56**
Total	**12**	**20**	**11**	**7**	**50**	**100**

Table 4.4 indicates that 56% of the respondents had children of both sexes, 32% had only females and 12% had only male children. This may be attributed to the fact that questionnaires were distributed to respondents who are survivors of IPV who face the abuse among others because of the sex of the children they have.

4.2.3 Educational status of the respondents

The study set out to establish the level of education of the respondents. This was to determine how many of them had studied up to university level, college level and secondary or primary school levels.

Fig 4.1 Literacy level of the respondents

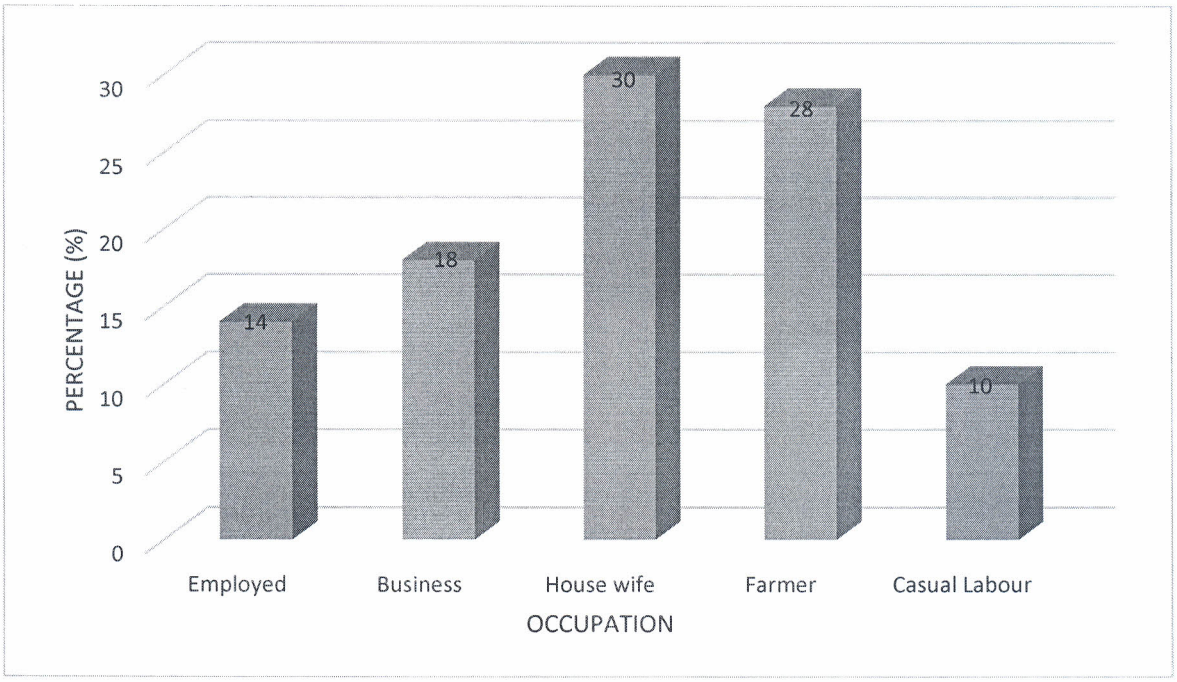


The figure 4.1 above depicts the literacy levels of the women. About 62% of the respondents had primary education, 24% had secondary education, 10% had college education while only 8% attained university level of education. This has implications on the ability to resist or come out of relationships that are violent prone.

4.2.4 Occupation of the respondents

Results from the survey indicate that most of the women had no reliable sources of livelihood. 30% were housewives who relied on their husbands for survival thus raising their vulnerability to abusive relationships. Table Figure below illustrates occupation of the respondents;

Fig 4.2: Occupation of the respondents

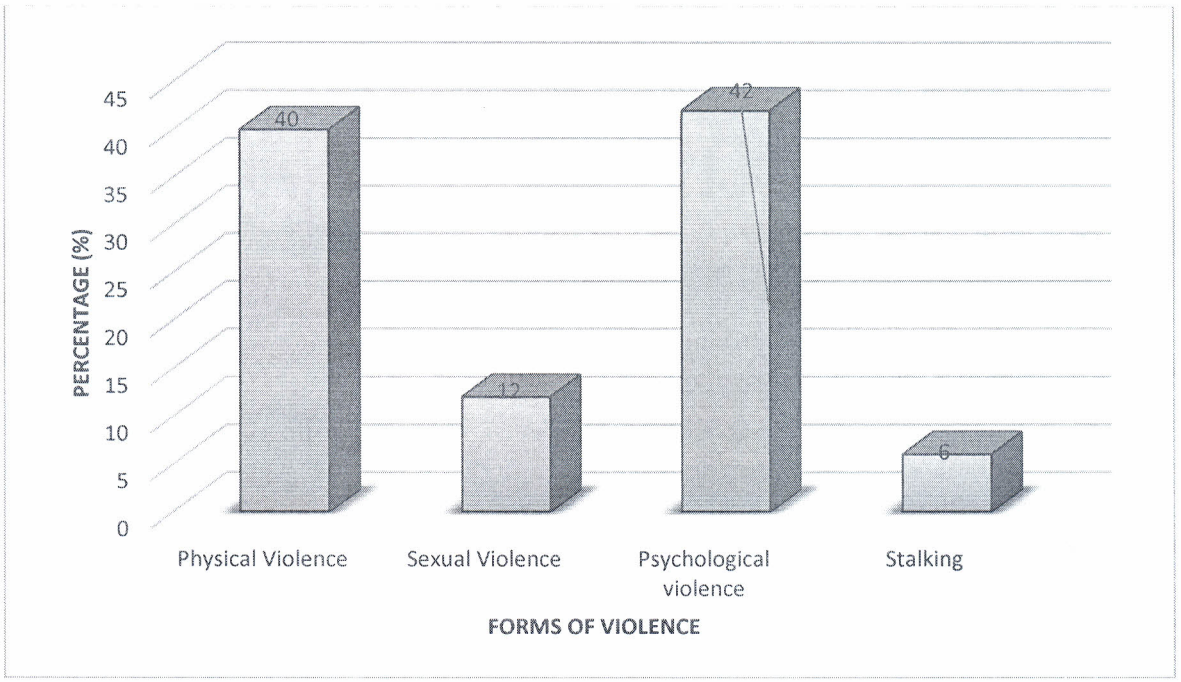


The findings of the study showed that 30 percent of the respondents were housewives and were not engaged in any sustainable means of livelihood activity, 28 percent of the women fully depended on farming as their major source of income. 18% of the respondents managed different small scale businesses, i.e. hair dressing, groceries, selling second hand clothes, cooking food and selling merchandize. 14 percent of the women were found to be employed as teachers in primary schools and as early child educators. while 10 percent of the respondents indicated that they were engaged in casual jobs in order to meet their basic needs.

4.3 Forms of Intimate Partner Violence

Fig 4.3 below analyses the different forms of intimate partner violence women experience within east Kanyamkago location.

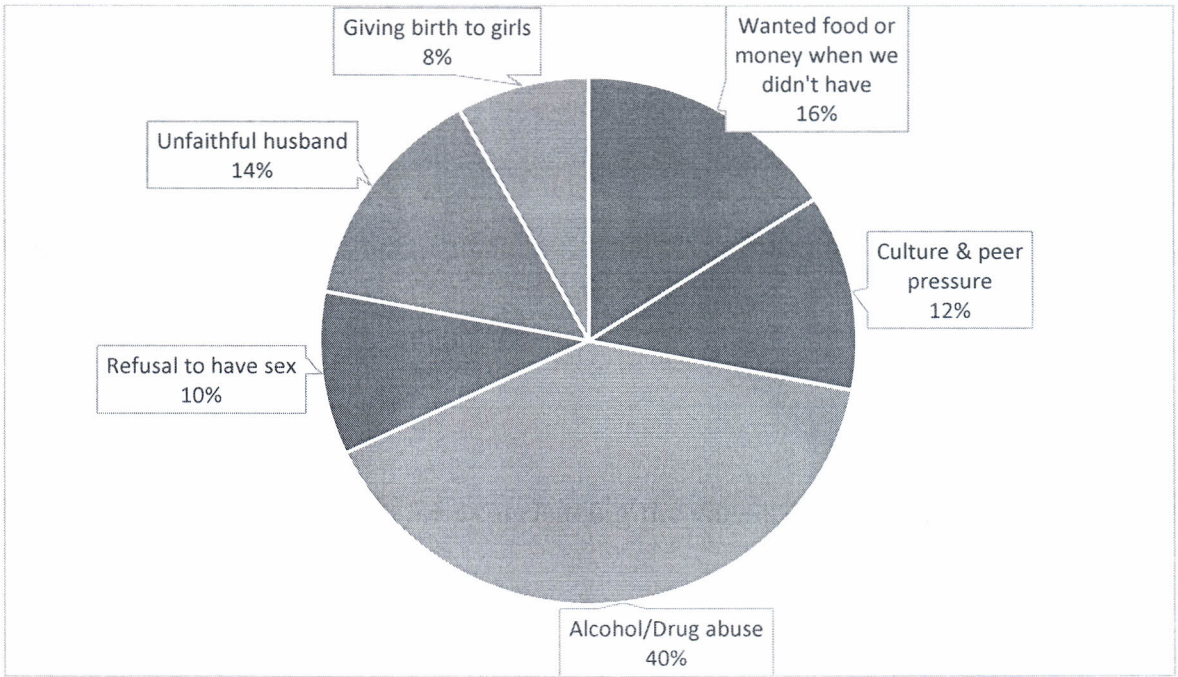
Fig 4.3 Forms of intimate partner violence experienced by respondents



Out of the total number of women interviewed, 40% had been physically battered by their husbands. 12% have experienced sexual violence, 42 % have experienced psychological violence while 6% have experienced stalking as a form of violence. Each and every respondent gave their own reasons which led to the violence. Psychological/emotional violence was the most common form of violence in east Kanyamkago location, followed by physical violence. 42% of the respondents suffer silently in the hands of their intimate partners. They reported that they have been socialized not to share their private affairs with anyone hence the low level of reporting on the same.

Fig 4.4 below illustrates the reasons for exposure to intimate partner violence by the respondents. Various reasons are put forth by the respondents on why they experience the various forms of violence.

Fig 4.4 Respondents reasons for experiencing the various forms of violence



Study findings also showed that male child preference has been a major issue that has led to intimate partner violence within east Kanyamkago. 12% on cultural reasons, and 10% on refusal to have sex. 8% of the respondents reported that their husbands keep pressuring them to have male children who will carry on the family patrilineage, when this fails to produce the desired results, men resort to polygyny which brings tension with the first wife hence domestic violence, women end up suffering both physically and emotionally.

Culture is one of the factors that contribute to intimate partner violence, one of the respondents had this to narrate.

> *"I have been married for 12 years now. We have four children together with my husband, all the four are girls. It has never been easy for me since my husband constantly humiliate me, he claims that I am a good for nothing woman because I can't give birth to boys. Currently, I am four months pregnant with our fifth child, my husband has given me warnings to go forever if the child will not be a boy. He has also threatened to marry a second wife who would give him boys. I feel drained and unable to carry the baby to full term".* **(Interview narrative #3 with a 34-year-old IPV survivor).**

Alcohol and other substance abuse have contributed to IPV as indicated by 40% of the respondents within East Kanyamkago location. When one is drunk, his judgement is impaired and cannot make an informed decision. 16% of the violence was as a result of demand for food while the money that was available for the family was consumed on alcohol.

> *Alcohol has been my greatest enemy, not even my husband who batters me all the time. When he is not drunk we will relate so well, wait until he meets his friends and drink together, he will start shouting right from the gate, demanding beef and fish, if I fail to serve him these, he will start hitting me, blaming me for not feeding the family. He comes home with all the mud on his clothes and shoes, he throws himself on the bed next to me, most of the time I am unable to bear the stench, as a result I choose to sleep on the floor leaving him on the bed. Sometimes this man vomits and urinates on the bed, I am meant to clean his mess, I am so stressed about the whole thing. Additionally, when he comes home drunk, we are not able to get intimate, which I find very frustrating.* **(Interview narrative #4 with a 27-year-old IPV survivor).**

14% was attributed unfaithfulness on the part of the husband. Most men become wild whenever they are found cheating on their wives. One of the respondents narrated her story as being the major contributor of violence in her marriage.

> *"I am a secondary school teacher, I had been very suspicious concerning my husband's private affairs, whenever I asked him about infidelity, he would rebuke me and even hit me very hard. We fought severally over received and sent text messages on his phone. One day I came home early from work and walked in on them, he was right on top of my former student, since then we have been constantly fighting."* ***(Interview narrative #5 with a 32-year-old IPV survivor)***

4.4 Consequences of IPV on women's reproductive health

Women's overall health and social wellbeing is influenced by different forms of IPV including physical, sexual and psychological violence. The respondents reported on the consequences of daily and long term IPV such as emotional and physical injuries as experienced by the survivors, unstable homes as well as other health related consequences as overwhelming. Abused women

suffer a lot of both mental and emotional distress coupled with some of their coping mechanisms that predispose them to further harm.

Table 4.5. Distribution of consequences of IPV on women's reproductive health

Consequences	Frequency	Percentage
Physical injury	20	40
Unintended pregnancy	7	14
Complications during pregnancy	3	6
Sex selection	10	20
Birth control sabotage	8	16
Mental health	2	4
Total	**50**	**100%**

Consequences of IPV vary from physical to emotional and sometimes sexual and economical. The respondents reported on the consequences of daily and long term IPV such as emotional and physical injuries as experienced by the survivors, unstable homes as well as other health related consequences as overwhelming. Abused women suffer a lot of both mental and emotional distress coupled with some of their coping mechanisms that predispose them to further harm.

> *My sister in-law lost her life while she was seven months expectant due to constant fights with her husband. She was admitted at Migori District hospital for two weeks only to find out that she had an internal bleeding in her lower abdomen after her husband kicked her. A Cesarean section was carried out but the unborn child did not survive, it had an injury on the scalp. One day later, the mother also passed on.* **(Interview narrative #6 with 28-year-old IPV survivor).**

Study findings also indicate that male child preference was one of the principal forms of discrimination and one which has far reaching implications amongst the women of East Kanyamkago. Son preference is deeply rooted in patriarchal and religious beliefs that uphold the essential value of having a son in the family. About 20% of the respondents suffer emotionally for having been blamed of not giving birth to male children.

Twenty percent of the respondents also reported that practicing contraception was very difficult for them since their husbands are unwilling to support them. Men are attempting to control their wives' reproduction, and most of the time they disagree on the desired number of children. This birth control sabotage has led to unintended pregnancies which is a threat to the health of the women.

> *"Using any form of contraceptive has never been easy for me, we are ever fighting about it, most of the time my husband hides my birth control pills, he intentionally breaks the condom during sex or he fails to withdraw during intercourse when that was the initial agreement. We have nine children together, the last four I delivered through cesarean section, my medical condition has since deteriorated and I don't think I want another child. I am emotionally drained about this issue"* **(Interview narrative #7 with a 41-year-old IPV survivor).**

4.3.4. Reactions of the respondents to domestic violence

The respondents action after attack was demonstrated by frequent escapes from their partners, with 50% of the women reporting to have run away from their partners after the assault while 20% just kept quiet. 16% of the respondents reported the attack to their parents/relatives and local authorities. A majority of those who reported the attack to the police said that the police were rude and did not consider their cases serious. Of the reported cases, few were not recorded and out of the recorded ones, only few arrests were made. Those arrested were later released without any charges being preferred against them. Some survivors who reported to have sought help from relatives, friends and their families were advised to protect their marriages since it is a taboo to expose marriages. The few who sought help from their pastors reported that they had received comfort or support as a result. Women who sought counselling services reported to have been taught how to handle the stress arising from domestic violence.

"They ask too many questions before offering any form of assistance, however the information we give them is not kept confidential the whole village might end up knowing your story." **(Interview narrative #8 with a 26 year old IPV survivor).**

Table 4.6: Respondents' action after attack

Action	Number of respondents	Percentage
Ran away/escaped	25	50%
Fought back	7	14%
Kept quiet	10	20%
Reported to parents/relatives/ authorities	8	16%
Total	50	100%

When Key informants were asked about some of the constraints they faced in trying to stop the violence, women leader reported that the respondents were economically dependent on their husbands for all their basic needs hence they had no money of their own to depend on. Another key informant, who is a counselling psychologist, reported of stigmatization. She noted that women had developed low self-esteem and they feel that when they talk about their marital issues, people will be judgmental.

Local administration talked of men feeling that they are above women, traditionally, they have been socialized that men have the primary power over women and they are allowed to control everything in the family.

> *"Even here in the village, I have since presided over many cases of physically injured and psychologically disturbed women, due to violence in the family" the men are never apologetic on their actions, they feel they are more superior" (**KII #2with the local Assistant Chief).***

Religious leader blamed alcohol since the respondents often run to them to seek spiritual guidance and prayers for their husbands who are ever lost in alcohol.

> *"It is possible to solve family disagreements without violence. Families that always fight also remain unstable and cannot progress" the major problem in this village is the rate at which men take alcohol, it is very hard to make sober decision when one is not in the right state of mind. I pray with these families day after day, I offer counseling sessions too but they never change. Alcohol consumption has separated many families in this village, men are always fighting their wives and their children end up in a miserable condition".* **(KII #3with a male church elder).**

Civil society organization representative blamed cultural practices and beliefs. She noted thus:

> *"We receive patients who have suffered physical injuries and have been battered. There is need for the urgent setting up of more comprehensive GBV recovery centres, which are important for counselling. Patients who have physically recovered remain bitter and traumatized since there is no follow-up after release. Hospital staffs in most cases have no idea what happens when patients leave the hospital. Some may die from repeated battering, while others become perpetrators by killing or injuring the original perpetrators. Thus IPV undermines the safety, dignity, health, and human rights of the people who experience it, and the public health, economic well-being, and security of the nation"***(KII #4 with Civil society organization representative).**

4.3.5 Respondents views on causes and consequences of Intimate Partner Violence

Table 4.7: Respondents view on intimate partner violence

	Statement	Strongly agree	Agree	Disagree	Strongly disagree	Don't know	Total
1	I am aware that women suffer from Intimate partner violence perpetrated by men.	46	4	0	0	0	50
2	I know some women who have been battered in the past by men.	41	8	0	0	0	50
3	Married women are likely to be battered by their partners	38	5	3	3	1	50
4	Substance use predisposes women to violence by men	44	4	2	0	0	50
5	Suspicion of infidelity influences men to batter their wives	32	10	5	2	1	50
6	Patriarchal structures in the society make women shy away from reporting incidences of violence.	38	8	2	1	1	50
7	Intimate partner violence have serious consequences against expectant women	46	4	0	0	0	50

The study findings show that 92% of the respondents were aware that women suffer from intimate partner violence perpetrated by men, 82% agreed that they know some women who have been battered. Seventy six percent (76%) of women were in agreement that married women are likely to be battered by their partners, 88% reported that substance use predisposes women to violence by men, while 64% of the respondents strongly agreed that suspicion of infidelity influences men to batter their wives. Further, 76% of the respondents were in agreement that patriarchal structures in the society make women shy away from reporting incidences of violence while 92% of the respondents strongly agreed that intimate partner violence have serious consequences against expectant women.

> *"I once went to a public hospital that I prefer not to disclose in this study. The nurse serving me had separated with her husband due to unfaithfulness. On finding out that I was battered because I questioned my husband's unfaithfulness, she advised me to pack my belonging, including my children and separate with that man. I don't have any source of income, how will I meet the basic needs of my children?* **(Interview narrative #9 with a 31-year-old IPV survivor).**

Table 4.8: Respondents' evaluation of Stakeholder's efforts to stop domestic violence

Evaluation	Number of respondents	Percentage
Good	10	20%
Bad	26	52 %
Fair	12	24%
Don't know	2	4 %
Total	50	100%

All the respondents interviewed would advocate for a society that is free of domestic violence. More than half (52%) of the women said that the Government's response/effort in stopping domestic violence against women was bad, 24% felt that it was fair and 20% felt that the government response was good, while 4% did not know whether it was good or bad. Onduso, a survivor of IPV, illustrated how she suffered judgment from a health care provider,

> *"One day I went to the government health centre, I was in so much pain because I was suffering from fresh bruises that by husband had caused, hence the need for urgent medical attention. On getting to the health facility, the doctor asked what had happened, I told him I was physically assaulted by my husband. Instead of commencing treatment, he kept probing and asking why I was beaten. In his opinion, it was my fault that I had been beaten, I insisted he should just treat me and disregard the reason I was beaten. He took to advising me on how I should be submissive to my husband, he further mentioned traditions that a woman must do everything her husband requests because according to culture, the man is the king of the house and should not be disrespected. The blame kept on from time to time until I finally got annoyed and left without treatment to seek help elsewhere"* **(Interview narrative #10 with a 19-year-old IPV survivor).**

The above Narration from a survivor of IPV is a clear illustration on the intensity of judgment that the survivors go through at public health facilities. She had been physically assaulted by her beloved husband, on reaching the health facility the doctor already judged her and made conclusions that she was to be blamed to have caused the incident. Anyone can be a survivor of IPV regardless of their occupation and class. It was also unfortunate that the health care provider took to judging and probing the survivor instead of offering treatment. She finally left without getting treatment. In this particular case judgment from the healthcare provider got in the way of treatment.

CHAPTER FIVE: SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter presents a summary of the study findings, discussions, conclusions and recommendations. The findings are summarized in line with the objectives of the study which was to investigate the effects of intimate partner violence on women's reproductive health in East Kanyamkago location, Migori County. It also makes suggestions for further research.

5.2 Summary of findings

5.2.1 Demographics

The study revealed that majority of the respondents were illiterate, they do not know their rights and they were also unable to make individual decisions concerning the steps to take whenever they experienced violence from their partners. This finding is in agreement with (Amin and Robert, 2008) who found out that high literacy levels have the potential to offer a young girl a variety of choices of selecting a life partner due to wider levels of interactions and awareness of her legal rights. The woman also has choices in cases of marriage based on mutual understanding of men and women (Suran and Chowdhury, 2004).

On the other hand, the study showed that the level of education attained by the respondents had direct relationship with the knowledge of their rights. A small number of respondents who participated in the study had tertiary and university level of education. The study showed that these respondents were unlikely to be exploited in regards to their rights when it comes to human rights, (Naved and Perssons, 2005) agrees that empowered women, who are also educated, are less likely to be taken advantage of with their husbands and are likely to fight for such rights.

5.2.2 Forms of intimate partner violence

The study established that intimate partner violence is manifested in various forms amongst the women in East Kanyamkago, **Sexual violence;** the study established that women in East Kanyamkago experience sexual violence, respondents reported that once the bridal wealth is paid, it implies that they are bought off by men and can be treated as any property or object. This is done in the premise that being under the charge of a man a woman should give in to sexual advance at any moment the man is interested. This finding was supported by the literature which indicates that different societal and cultural practices support different types of hypotheses, for instance,

cultural tolerance to violence including sexual violence, as a private husband and wife affair hinders outside intervention (Heise, 2011).

Physical violence; The study revealed that most men use physical violence with the intention of causing actual bodily harm in resolving conflict. This is one form of violence that is prevalent in East Kanyamkago with 40% of the respondents reported as victims of physical violence. Their partners use violence with the intention of causing actual bodily harm in resolving conflict. This finding is in agreement with Mukabi (2015) who found out that traditionally, men have a right and responsibility to control, direct and discipline women through physical actions of beatings and battery which exposes women to violence by intimate partners.

Stalking; Interestingly, the study revealed that stalking is a very common type of intimate partner violence amongst couples living in East Kanyamkago. Some respondents reported harassment through repeated unwanted phone calls, text messaging, following from a distance spying. Some reported being stalked to discourage them getting into relationships with other partners The findings revealed that women who are stalked by their partners also experience partner violence. This finding is in agreement with Rosenfeld, (2003), who identified that there is a crucial link between stalking and intimate partner violence, a good percentage of women who were stalked by a current or former (marital/cohabiting) partner also experienced physical assaults by those partners.

Psychological aggression; the study established that women victims of IPV have psychological symptoms such as anxiety, panic attacks and paranoia. The women are emotionally exhausted due to constant fears and nightmares, feelings of anger and self-destructive behavior were found among the survivors of intimate partner violence. The finding was supported by the literature which indicates that women's memories and thoughts concerning the violence are affected in a way that they would remember the past situations unrealistically (Finck et al., 2005). They are extremely traumatized to a point even where a single reminder can trigger the memory of the trauma they once experienced. This contributes to the constant emotional and psychological pain that makes the women powerless and their everyday life exhausting and frustrating (Cerulli et al., 2012).

Social determinants of intimate partner violence

The study found out that traditional gender norms have dictated male dominance over women and created a fertile ground for IPV as an expression of male prestige. The respondents reported that

men are deemed to be more powerful than women and as such, are given superior position in society and allowed authority over women in terms of decision making and control over the woman, including use of violence to exercise such control. Some respondents also reported that poverty and lack of education is also a cause of IPV amongst them. This is supported by USAID (2006), who identified causes of intimate partner violence to include; traditional gender norms that support male superiority, social norms that tolerate or even justify violence against women, weak community sanctions against perpetrators, poverty, high levels of crime and conflict in society, low income or academic achievement and attitudes that justify violence against women.

5.3 Consequences of Intimate partner violence on women's reproductive health

The study established that Intimate partner violence can lead to numerous health problems, limiting the productivity of women, and directly impacting the well-being of families and communities. The study further showed that there are significant links between intimate partner violence and a range of other reproductive and sexual health problems, including sexually transmitted diseases, unwanted pregnancies, contraception issues and abortion, maternal morbidity and mortality, and adverse pregnancy outcomes. This finding is supported by (O'Neill et al., 2014) who found out that long-term consequences of intimate partner violence including; depression, post-traumatic stress disorder and low self-esteem. These conditions often go undiagnosed and untreated; the victims' ability to undertake social and economic activities tends to reduce, which in turn limits their income. Study findings have shown that intimate partner violence has major physical and psychological effects on survivors. The most visible effects include loss of income for those in gainful employment, physical bodily harm, violation of privacy, and destruction of ego.

This finding is also in agreement with Heise and Garcia (2002) who found out that intimate partner violence causes untold physical suffering and psychological torture and trauma. This in turn denies survivors self-esteem and the 'feel-good' factor about themselves, their families, and their country. It also weakens societal links and greatly hampers efforts towards eliminating it.

5.4 Conclusion

IPV destroys victims and family units, and has severe consequences on both survivors and perpetrators. It is a complex issue that sometimes goes unnoticed or is deliberately hidden.

Effectively bringing out the key issues in different environments and settings requires time and resources. Standardization of a common understanding of GBV is important for effective multi-sectoral GBV programming. Enhanced awareness of the costs of GBV to society should strengthen arguments for urgent interventions by government, civil society, and businesses. It provides a reference point for understanding the magnitude of the problem and for informing such interventions. Since the costs affect everyone (even though in some cases the abuse may be private), it brings GBV into the open as a pressing societal issue. At the community level, concerted efforts are necessary to change the socialization process that insubordinates women and place men at a higher pedestal and with the rights to inflict pain on women without being apprehended. The increasing realization of the effects of IPV and the subsequent awareness around it is a good indication that in future, women will have the courage to talk out freely and be able to get societal attention against the perpetrators of this heinous act.

5.5 Recommendations

5.5.1 Forms of intimate partner violence

Having identified the various forms of intimate partner violence, i.e., Physical violence, Sexual violence, psychological violence and stalking as a form of violence. It is recommended to the government and other stakeholders that there are multiple forms of IPV hence various policies and intervention measures should be put in place to address these different forms of IPV. This is to ensure that all possible forms of violence are highlighted and addressed independently and collectively.

5.5.2 Social determinants of intimate partner violence.

It was noted that some identified social factors; culture, financial security, education and substance abuse, determine the nature of exposure to IPV. It is therefore recommended that these social economic issues are addressed for instance, empowering women academically by setting programs for adult education, economic empowerment of women through mechanisms like merry go round, table banking, saccos and financial literacy. In culture, the relevant stakeholders should create awareness and discouraging harmful cultural practices like wife battering. Creating awareness on the harmfulness of substance abuse, putting in place mechanisms for rehabilitation of the affected and regulating sell of alcohol e.g. drinking hours.

5.5.3 Effects of intimate partner violence on women's reproductive health.

The study noted that IPV affects women's physical health, emotional health and general social well-being. It is recommended that stringent penalties be applied to the perpetrators of violence against women. Rescue centers should be established to support survivors of IPV, counseling centres should be established at reachable distance for survivors who needs such services. Gender desk should be established in various centers like, chief's office, police stations, health centres and in places of worship.

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APPENDICES

Appendix I: Informed Consent Form

Student Name: Rebecca Akoth Okech

Name of Institution: University of Nairobi

Introduction

I am a graduate student at the University of Nairobi at the Institute of Anthropology, Gender and African Studies. I am doing research on the subject of Impact of Intimate Partner Violence on Women's reproductive health. This is a form of gender based violence that very little is said about.

Purpose of Research

IPV is a form of violence that exists in our communities and I would want us to find ways to prevent it from happening. I believe that you can help by telling what you know about it, its causes and why one gender suffers more than the other, as well as learn the different ways that people in this community use to prevent and respond to IPV.

Participation

You are invited to participate in this study because I feel that your experience can contribute much to my understanding and knowledge. There is no risk of participating in this study, the session will last about one hour and your participation is voluntary.

The researcher may ask you to share some very personal information that you may feel uncomfortable talking about. You do not have to answer all questions if you do not wish to do so. You will not be provided with any incentives to participate. Since the study will be conducted in the community, it is bound to draw attention and we would like to assure you that we will not share your information with anyone outside the study team.

Certificate of Consent

I hereby agree on my own volition to participate in the study having understood what it is all about.

Name of Participant: _____

Signature: _____

Date: _____

Appendix II: Semi-Structured questionnaire

Introduction

The researcher is a student from the University of Nairobi – Institute of Anthropology, Gender and African Studies. She seeks to establish the Impact of intimate partner violence on women's reproductive health.

The respondent is requested to give correct and independent response. The information gathered will strictly be used only for the purposes of this study. Should you have questions or anything you do not understand, kindly ask the researcher and she will be glad to assist you.

This questionnaire is divided into three sections.

Note: (Tick the appropriate box or fill the space provided as the case may be.)

SECTION I

General information

1. Which Age bracket do you belong (Years)

   15 – 25 ( )

   26 – 35 ( )

   36 – 45 ( )

   46 – 49 ( )

2. Ethnic group

   Luo

   Luyia

   Maasai

   Kisii

   Others (specify)

3. How many children do you have? ----------

☐How many boys

☐How many girl

4. What is your highest academic qualification?

   Primary School level ( )

Secondary School level ( )

College ( )

University ( )

6. For how long have you been living in East Kanyamkago?

0-1 yrs ( )

1-2 yrs ( )

2-5yrs ( )

5-10yrs ( )

Over 10 yrs ( )

7. Which Sub-location of East Kanyamkago do you come from?

Arambe ( )

Thimjope ( )

SECTION II

1. In your opinion, what do you think is likely to cause Intimate Partner Violence in the community?.....

.....

.....

2. Does your husband drink alcohol to excess or use drugs? If yes, does he become violent when drunk?

.....

.....

.....

3. How much money do you spend in a day in your family?

.....

.....

.....

4. Did you ever witness violence in your family while growing up? .....(if yes, what was the reason (s))

.....

.....

.....

5. Have you ever experienced violence in your marriage? If yes, is the behavior increasing in frequency and intensity?

.....

.....

.....

6.Whattriggers his violent reaction?

.....

.....

.....

7. Have you ever experienced violence while expectant? If yes, how often?

.....

.....

.....

8. What do you think might have caused the violence?

.....

.....

.....

9. What was the nature of violence you experienced?

.....

.....

.....

11. What were the consequences of the violence?

.....

.....

.....

13. What do you do to protect yourself from intimate partner violence?.....

.....

.....

14. Do you think your extended family should protect you from domestic violence?

.....

.....

.....

15.Has the chief or the village elders been involved in protecting women from domestic violence?

.....

.....

.....

16. Do you know of any organizations that offer women protection from intimate partner violence?

a) Yes b) No

17. If yes, which ones do you know?

18. Are there such organizations within East Kanyamkago location?

a) Yes b) No

SECTION III

(Respondents views on causes and consequences of Intimate Partner Violence)

To what extent do you agree or disagree with the following statements.

	Statement	Strongly agree	Agree	Disagree	Strongly disagree	Don't know
	I am aware that women suffer from Intimate partner violence perpetrated by men.					
	I know some women who have been battered in the past by men.					
	Married women are likely to be battered by their partners					
	Substance use predisposes women to violence by men					
	Suspicion of infidelity influences men to batter their wives					
	Patriarchal structures in the society make women shy away from reporting incidences of violence.					
	Intimate partner violence have serious consequences against expectant women					

Appendix III: Narrative Guide

Please give as much detail as you can

i. Describe a typical week in your life; is this reasonably typical of people of your status; if not, how does it vary.
ii. Tell me about your partner, How did you first meet
iii. When did your problems with your partner start
iv. How long has this continued? Are there times when this has improved or worsen
v. What is the most common form of abuse that you encounter in your relationship?
vi. Has it had a great effect on your physical well-being? In what ways? How has it affected your feelings about yourself?
vii. What have you done to stop the abuse
viii. Have your actions yielded any results? Explain your answer.
ix. What are some of the constraints you face in trying to stop the violence meted on you?
x. How do you rate women's knowledge of domestic violence as a crime?
xi. Do you think women provoke their own battering?
xii. What action should battered women should take?
xiii. In your opinion, what should be done to a batterer?
xiv. Looking back at your situation, what advice would you give another woman who has just started to have the same problems with her partner?
xv. How do you evaluate the government's efforts in stopping domestic violence against women?

Appendix IV: Key Informant Interview Guide – Opinion Leaders, Women Leaders, local administration, religious leaders and CSO Representative.

Please circle/indicate/fill in the appropriate answer.

A. Personal information.

1. Name.....
2. Age.....
3. Name of your Church/Women group/Village/Organization.....
4. Do you think IPV is a problem in this community?
5. What do you consider as the contributory / risk factors of IPV in this community?
6. Do you think women are to blame for the violence they get in their homes?
7. Do you think domestic violence should be outlawed in Kenya?

   If yes, what punishment would you recommend to be meted on offenders?

   If No, what recommendations would you give to battered women?

8. Why do you think, from your experience, women do not seek redress or use the mechanisms available against domestic violence?
9. What advice would you give to the state/couples/communities as far as the issue of domestic violence is concerned?
10. How does the community respond to the needs of women who experience violence?
11. What do you view as your role in IPV prevention and response?
12. What are the challenges in preventing and responding to IPV?
13. What would you recommend as a community intervention strategy to address IPV?

Appendix IV: Key Informant Interview Guide – Counseling psychologist

1. Do you think IPV is a problem in this community?
2. What percentage of the clients you see are women?
3. What are the most frequent reasons women give for coming to the counseling room?
4. Do you (or your colleagues) routinely ask questions to determine whether the clients might be a victim of intimate partner violence?
5. How many people with this type of problem does your institution serve per month? Do you have a way of keeping records on cases? Is there a form and procedure for recording them?
7. How often do you offer services to expectant women who report at your facility as a result of intimate partner violence?
8. What are the common health consequences experienced by expectant women as a result of intimate partner violence?
9. What are the challenges in preventing and responding to IPV?
10. What intervention strategy would you recommend as a counseling psychologist to address IPV?