THE INFLUENCE OF PATRIARCHY ON WOMEN'S SEXUAL AND REPRODUCTIVE HEALTH RIGHTS IN KAWANGWARE DIVISION, NAIROBI COUNTY

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DECLARATION

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

Signed:  **Date:**

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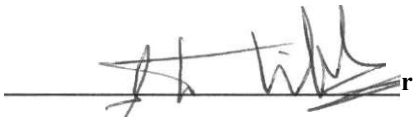
This project has been submitted for examination with my approval as the University Supervisor.

Signed:  **r»a(e:** **^ 11 \ 1 **

Prof. Simiyu Wandibba

DEDICATION

This project is dedicated to all women in Kenya whose sexual and reproductive health rights have been violated.

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This project would not have been possible without the guidance and support of several individuals who in one way or another contributed and extended their valuable assistance in preparation and completion of this study.

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Finally, "To God be the Glory for Great Things He has done."

Abstract

This study aimed to explore the influence of patriarchy on the realization of women's sexual and reproductive health rights and its contribution to HIV prevalence among married women in Kawangware Division of Nairobi Country. The study sought to examine patriarchal hindrances, to determine the effect of patriarchal systems and practices to HIV/AIDS prevalence, and to establish the relationship between patriarchy, realization of women SRHRs and the prevalence of HIV/AIDS among married women.

The study was confined to married men and women living in Kawangware location of Nairobi County. The research targeted 60 respondents who lived in this location at the time of study. The study employed a cross-sectional descriptive design. Purposive quota sampling was used to select the study subjects. Primary and secondary methods of data collection were used to gather both quantitative and qualitative data. The survey was the main method of data collection. Additional information was collected using key informant interviews. Documentary materials provided secondary data.

The study found that whereas decision-making within the household is done jointly, decision on contraceptive method of choice is made by the woman whereas whether to or not to use condom remains the preserve of men. Women are in a position to decide whether to have sex with the husband, however reasons given for this are mainly due to medical or biological reasons linked to pregnancy, childbirth and menstruation. This in itself indicates the overbearing attitude of men and societal expectation of the women on matters of sexuality. The study findings confirm that even in this day and age, sex within marriage is still being used as a weapon to punish or reward faithfulness. To ensure continued financial support, women continue to give in to sex despite the husbands' unfaithfulness. The results also demonstrate the existing belief system that once married, a man has the right to have sex with his wife regardless of the circumstances.

This study concludes that there exist hindrances to women's SRHRs due to the current structure of our society that deprives men and women a level playing field in decision making on sexuality matters. As a result, marriage relationships expose women to HIV/AIDS.

Acronyms and Abbreviations

ABC - Abstinence, Being Faithful, and Condom Use

AIDS - Acquired Immunodeficiency Syndrome

DHS - Demographic and Health Survey

FEMNET - African Women Development and Communication Network

FGD - Focus Group Discussion

HIV - Human Immunodeficiency Virus

ICPD - International Conference on Population and Development

JAIDS - Journal of Acquired Immune Deficiency Syndromes

KAIS - Kenya AIDS Indicator Survey

KDHS - Kenya Demographic and Health Survey

KNBS - Kenya National Bureau of Statistics

MDG - Millennium Development Goals

PAI - Population Action International

PoA - Programme of Action

SRH - Sexual and Reproductive Health

SRHRs - Sexual and Reproductive Health Rights

STDs - Sexually Transmitted Diseases

STIs - Sexually Transmitted Infections

TASO - The AIDS Support Organization

UN - United Nations

UNAIDS - Joint United Nations Programme on HIV/AIDS

UNFPA - United Nations Population Fund

UNIFEM - United Nations Development Fund for Women

CHAPTER ONE

BACKGROUND TO THE STUDY

1.1 Introduction

Patriarchy has been viewed over time as a society's organization of its social, economic, political and religious affairs to cater for and sustain men's supremacy over women (Masheti, 1994:1). It legitimizes men's control over women's reproduction, labour and conscience and concentrates powers in the hands of men, thereby locking women out of influential sectors of society. Patriarchy has been sustained through an ideology reflected in language and different social institutions such as education, legal systems and marriage that define from a male perspective norms, practices, and behaviour that are acceptable (Masheti, 1994:12). A number of writers have noted that patriarchal systems in families, culture, traditions and communities are often at the root of violations of the rights of women.

According to Okin (1999), many of the world's traditions and cultures are quite distinctly patriarchal, and have elaborate patterns of socialization, rituals, matrimonial customs, and other cultural practices aimed at bringing women's sexuality and reproductive capabilities under men's control. Many such practices make it virtually impossible for women to choose to live independently of men, to be celibate or lesbian, or to decide not to have children (Okin, 1999). Similarly, Mackinnon (1989:41) holds the view that sexuality and sexual relations remain central to women's oppression. In her view, women experience oppression and denial of their rights at the hands of patriarchal power. Patriarchy as such has been viewed to have a negative effect on the exercise of sexual and reproductive health rights (SRHRs).

Viewed from the optic of rights, SRHRs are essential for protecting human dignity and development. In fact, it is a fundamental human right indispensable for the exercise of other human rights. The International Conference on Population and Development (ICPD) Programme of Action, adopted by 179 governments in 1994, redefined reproductive health putting individual rights at the centre while also stressing larger social, cultural and economic contexts in which people operate. It defined reproductive health as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system, and to its functions and processes." It also

states that achieving such a state "implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so" (UNFPA, 2004: 45). It is a prerequisite for economic development, just as much as it is an outcome.

Reproductive rights have thus been defined to involve "the *right of couples and individuals to decide freely and responsibly the number, spacing and timing of their children; have the information, education and means to make the decisions; attain the highest standard of sexual and reproductive health and make decisions about reproduction free of discrimination, coercion and violence "* (UNFPA, 2004: 46). Sexual rights, on the other hand, has been defined as the "*right to have control over and decide freely and responsibly all aspects of their sexuality, including protecting and promoting their sexual and reproductive health, free of coercion, discrimination and violence; of equal relationships between men and women in matters of sexual relations and reproduction including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences "* (United Nations, 1996: 36).

Yet, this notwithstanding, lack of access to sexual and reproductive health (SRH) services and facilities, as well as the denial of this right remain commonplace. The impact of poor SRH is worse for vulnerable groups, especially women and children, and disproportionately affects people of low-income countries. This includes sexually transmitted infections (STIs), lack of sexual autonomy, consensual sexual relations and lack of access to family planning (UNFPA, 2002). Over the last two decades, policy makers and donors have congregated in major capitals of the world to find ways to address gender inequities. Core to the debate has been the institution of legal and policy frameworks and, more importantly, social change in enhancing sexual and reproductive rights for all, particularly for women and the girl child. Accountability for what has been promised falls short against the grandiose plans and strategies envisioned by these efforts (UNFPA, 2002). Closer home, different interventions and approaches have been initiated. These have included campaigns for setting up of the necessary medical facilities, campaigns against violence against women and HIV/AIDS campaigns.

Closer to the subject of study, women's well-being is particularly contingent upon the exercise of their sexual and reproductive rights and its relation to the HIV/AIDS prevalence

among women. In 2007, it was estimated that globally, 33 million people were living with HIV; sub-Saharan Africa accounted for 67 per cent of these and 72 per cent of AIDS-related deaths. Young people aged 15 to 24 years accounted for an estimated 45 per cent of new infections, whereas women accounted for half of all the people living with HIV in the world and nearly 60 per cent of HIV infections in Sub-Saharan Africa (UNAIDS, 2008:33). Despite this alarming trend, women know less than men about how HIV/AIDS is spread and the little they know is rendered useless by the discrimination and violence they face (UNAIDS/UNFPA/UNIFEM, 2004:iv).

In Kenya, HIV prevalence has not changed significantly in the past five years, compared with previous statistics. The 2008-2009 Kenya Demographic Health Survey (KDHS) included HIV testing of an estimated 7,000 women and men aged 15 to 49 years. The report indicates that HIV prevalence in the country is at 6.3 per cent for women and men aged 15 to 49 years, compared with 6.7 per cent reported in the 2003 KDHS and 7.4 per cent in the 2007 Kenya AIDS Indicator Survey (KAIS). The prevalence rate now stands at 8 per cent for women and 4.3 per cent for men. In 2003, the prevalence rate was at 8.7 per cent for women and 4.6 per cent for men and 8.8 per cent for women and 5.5 per cent of men aged 15-49 according to 2007 KAIS. According to the 2008 -2009 KDHS report, HIV estimates vary by age with women aged 40 to 44 and men aged 35 to 39 most likely to be HIV-positive, and people living in urban areas at slightly higher risk of infection (7.2%) than those living in rural areas (6.0%) (KNBS and ICF Macro, 2010: 15).

A UNAIDS' study in Kisumu found that 33 per cent of married female adolescents were HIV-positive, compared to 22 per cent of sexually-active unmarried girls of the same age, and that half of the married women whose husbands were 10 or more years older were infected with HIV, compared to none of the women whose husbands were up to three years older. Researchers posited that the increased risk was linked to older men's increased sexual experience and exposure to HIV outside marriage, younger wives' inability to make demands on older husbands, increased sexual relations and less use of means of protection. According to the same research, older married women also appeared to be at high risk for HIV/AIDS. In sub-Saharan Africa, 60 to 80 per cent of HIV positive women reported having had sexual relations only with their husbands (Glynn et al., 2003).

A critique of the ABC prevention strategies that propagates abstinence, being faithful and condom use indicates that the approach simply misses the point for the majority of women and girls in many cultures and situations (Kaleeba, 2004). According to Kaleeba, the approach cannot work for married women who cannot practise abstinence, where faithfulness offers little protection to wives whose husbands have several partners, where condom use requires the cooperation of men, and where requests for condom use would indicate a lack of trust. With less ability to control sexual encounters and increased physiological susceptibility to HIV, many women are finding that commonly accepted methods of prevention are insufficient. There is, thus, mounting evidence that the approach needs to be expanded to meet the needs of women and girls (UNAIDS/UNFPA/UNIFEM, 2004:15).

Additionally, in 2008 Population Action International (PAI, 2008) premiered a documentary on HIV in Marriage that demonstrates grave consequences of women's inequality on their health and the lives of their families. The film provides answers to arguments by the majority that if a woman makes it to marriage without contracting HIV, she is safe for the rest of her life. However, current research shows that increasingly marriage is not as protective as previously thought, leading to calls for the need to examine the risk of HIV within marriage and the particular challenges facing married women. The documentary seems to reinforce the critique by Kaleeba (2004) that the conventional HIV prevention strategies do not meet the needs of married women who cannot practise abstinence, cannot control the faithfulness of their husbands and find it difficult to negotiate condom use. Increasingly married women are at risk. Condom use within marriage is infrequent, and rates of extramarital partners are higher among men than women in Africa. The film thus urges a broader integrated approach to preventing HIV, which includes confronting damaging social norms that put all people, men and women alike, at risk (PAI, 2008).

Despite the causes of poor sexual and reproductive health being multiple, an important question that remains is the influence of the socio-cultural formation, in particular gender inequity and patriarchy, in the realization of the right to sexual reproductive health. The concern remains that few are the women who have free choice and control over their sexual and reproductive lives. Most women tend to fear violence, rejection and abandonment, or they may simply believe that they are required by marriage to be sexually available. Thus, it is only through an integrated approach to preventing HIV, including challenging social norms, that rates of transmission will be reduced in the long term. Therefore, there is need for

discussion and studies of the harmful gender and societal norms that put couples, and especially women, at risk for HIV particularly where they find themselves powerless to negotiate over their sexuality and sexual autonomy.

This study sought to explore the influence of patriarchal structures and systems, viewed as normal and natural in our societies, towards the realization of women's sexual and reproductive health rights. Specifically, the study sought to interrogate the contribution of patriarchal structures and systems to HIV/AIDS prevalence amongst married women.

1.2 Statement of the Problem

There has been marked increase in efforts by government, development partners and individuals of goodwill through policies, legislations and targeted interventions to enhance enjoyment of sexual and reproductive health in Kenya. Most of these efforts target improvement in infrastructure and resource capital allocation, increased women's ability to negotiate safer sexual relations and increase in access to female controlled prevention methods such as the female condom. This has been with the aim of enhanced access to and availability of reproductive health information and services as well as freedom of choice among women of reproductive age.

Despite these efforts, however, limited studies have been done to analyze the influence of male dominance over female sexuality and how this hinders enjoyment of SRHRs and its contribution to women's vulnerability to HIV/AIDS, even in closed setups like marriage. Existing studies have focused more on hindrances to access the SRHRs from economic reasons and infrastructural inadequacies in the health sector, in health seeking behaviour on reproductive health matters. Failure of critical analysis of the role of patriarchal systems, practices and norms in HIV/AIDS transmission amongst married women have resulted in approaches aimed at curbing HIV transmissions (such as ABC and campaigns on the female condom) that cannot adequately cater for the married women, in a marriage setup.

1.3 Research Questions

i. Do patriarchal systems and practices hinder the exercise of SRHRs among married women?
ii. Do patriarchal systems and practices contribute to HIV/AIDS prevalence among married women?

iii. Is there a link between patriarchy, the realization of women's SRHRs, and the prevalence of HIV/AIDS among married women?

1.4 Research Objectives

1.4.1 Broad Objective

To explore the influence of patriarchy on the realization of women's sexual and reproductive health rights and its contribution to HIV prevalence among married women in Kawangware Division of Nairobi County.

1.4.2 Specific Objectives

1. To examine patriarchal hindrances to realization of women's sexual and reproductive health rights, in Kawangware division.
2. To determine the effect of patriarchal systems and practices to HIV/AIDS prevalence among married women in the study area.
3. To establish the relationship between patriarchy, the realization of women SRHRs, and the prevalence of HIV/AIDS among married women.

1.5 Justification of the Study

Despite the growing interest, there is still scarcity of research on the realization of sexual and reproductive rights. Until now, the bulk of studies have considered the issues from a medical or health perspective, and very few, if any, have considered the phenomenon from the optic of human rights. Even so, there is a gap in the factors that undermine the realization of these rights. Also, the existing research has largely considered this from the infrastructural and economic standpoint, citing lack of facilities, capacity and human resources in the provision of sexual and reproductive health (UNFPA, 2002). Thus, research on the linkage between culture and women's sexual and reproductive health rights, in particular patriarchy, in Kenya is limited. It is this gap that justified this research. Within this context, the overall question is the interplay between patriarchy and the realization of women's sexual and reproductive rights in Kenya.

Patriarchy has been viewed as an important factor that increases women's vulnerability to HIV/AIDS, along with poverty, illiteracy and unemployment (Commonwealth Secretariat, 2001). Social norms and cultural values encourage men to wield power and impose their will

upon others, especially women and children. The power often leads to violence and sexual coercion. As a result in most countries women cannot refuse unwanted or unprotected sex. If they depend economically upon men, they feel and in reality experience powerlessness. Women living with HIV/AIDS also face special sexual and reproductive health risks but they do not always have access to care for STDs, cervical cancer and unwanted pregnancies. Thus, if the issue remains unaddressed, it will continue to increase the burden on already strained government allocations to health and HIV/AIDS programmes due to cases of children born infected and the increasing rates of orphans in the country.

There is thus a compelling case for research in this area. It is envisaged that this study will bring to the fore the debate on sexual and reproductive rights in Kenya, and provide guidance to the development of policies and programmes which promote SRHRs of women through a better understanding of the role of patriarchy and the social construction of femininity. It is also envisaged that the study will clearly display the influence of patriarchy towards the high prevalence of HIV/AIDS among married women beyond economic reasons and infrastructural inadequacies in the health sector, etc.

1.6 Scope and Limitations of the Study

This study focussed on the influence of patriarchy on the realization of women's sexual and reproductive health rights and its contribution to HIV prevalence among married women in Kawangware Division of Nairobi County. The study examined the role of patriarchal systems, practices and norms in HIV/AIDS transmissions among married women with the aim of achieving the specified objectives.

The culture of silence in most Kenyan societies on issues of sex and sexuality and attitudes to HIV/AIDS prevalence posed a great limitation to this study. This hindered free sharing of information by the respondents. This was mainly experienced among men, whereas women were more open to respond to the study questions, especially on questions of sexuality. The researcher took more time explaining the purpose of the study to build trust in order to get accurate and reliable data. The scope of the study and sample size of 60 respondents posed a methodological limitation on generalization of the findings beyond the selected research site, that is, Kawangware Division in Nairobi County.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter reviews relevant literature on patriarchal structures, women's sexual and reproductive health rights and HIV/AIDS prevalence among married women in Kenya. It also discusses the theoretical framework that was utilized to guide the study.

2.2 Patriarchal Structures, Systems and Practices in our Society

Patriarchy is an ideology and a hierarchy, based on the assertion of superiority of elite men to other men and of all men to women, which has historically dominated the world, its resources and ideas and continues to do so as it gives control and advantages to men that it withholds from women and vulnerable groups (PDHRE, 2005:4). As an ideology, patriarchy affects men and women as different groups in society often irrespective of class, caste or religion, but the degree of domination differs within the different categories. It gives men legitimate (from a cultural/historical point of view) control over women's reproduction, labour and even conscience, and hence the male ideology is defined as the "ideology". As a result, the patriarchal tradition ensures perpetuation of male institutions even when society changes from traditional forms of organization to modern forms (Masheti, 1994:1).

Historically, it has taken many different forms, while in modern times it dominates social organization and exerts control over all human institutions, including the political, economic, and knowledge systems, which in turn perpetuate and reinforce it. In a literal sense, patriarchy means the rule of the fathers. Throughout history in most human societies some form of patriarchy prevailed, reinforced by cultural values derived from systems of male dominance, and has been commonly and continually practised as to appear natural rather than a humanly constructed social order that is both changing and changeable. In its present forms, patriarchy has become more of an ideology and belief system than the explicit social and political systems of earlier times, that even in countries where legal equality of women and men has been established, the deep psychological and cultural roots of patriarchy survive as a belief system in the minds of many women and men (PDHRE, 2005:4).

For instance, modern African marriages and homes have largely retained the traditional structure through movement of the bride from her parents' home to the groom's and the payment of bride wealth which has implications for the bride. These practices not only implied loss of a bride's place in her parents' home but payment of bride wealth gave men a higher status. The new bride has to 'do all' within her ability to keep the marriage, or else the bride wealth would be re-payed. Most African marriages were polygynous; in itself an expression of power over women, as the reverse could not be contemplated. These features remain in most modern African marriages, with bride wealth being paid for similar reasons, in addition to being more commercialized, leaving girls as commodities for exchange (Masheti, 1994:5).

Patriarchy, thus, serves as a system that facilitates ground for other forms of supremacy, hierarchy and exploitation, sets the power regime between men and women and helps accepting and fueling other power regimes (PDHRE, 2005:4). These practices legitimize and enforce male control through a normative systems backed by ideas, beliefs and practices, while material culture legitimizes and enforces this male control (Masheti, 1994:10).

Within this context, the hallmark of patriarchal societies oppressive to women is the denial of property rights and reproductive health rights. A number of writers such as Okin (1999), and Correa and Petchesky (1994), have noted that patriarchal systems in families, culture, traditions and communities are often at the root of violations of the rights of women. Thus, patriarchy has been viewed as having effect on the exercise of reproductive health rights. Okin (1999), for instance, points out that [m]any of the world's traditions and cultures are quite distinctly patriarchal. They also have elaborate patterns of socialization, rituals, matrimonial customs, and other cultural practices (including systems of property ownership and control of resources) aimed at bringing women's sexuality and reproductive capabilities under men's control. Similarly, Correa and Petchesky (1994:110) suggest that for many girls and women, the most severe violations of their human rights are rooted deeply within the [patriarchal] family system, bolstered by community norms of male privilege and frequently justified by religious doctrines or appeals to custom or tradition.

Other writers of the dominance feminism school have focused on sexuality as the central source of women's oppression. Mackinnon (1989:41), for example, holds the view that

sexuality and sexual relations remain central to women's oppression. In her view, women experience oppression and denial of their rights at the hands of patriarchal power.

Patriarchy operates in various spheres of life including health matters on the premise that men are biologically superior to women. This premise of male superiority, female weakness and dependence has several implications where men take it as their legitimate duty to protect women even from themselves by controlling them (Masheti, 1994:10). It is assumed that women can only acquire happiness by submitting themselves to male authority and, in this context, the safest place for the woman is in the house where her husband ensures maximum protection. Marriage has in fact been looked at as a way of controlling women by domesticating them (Masheti, 1994:11)

2.3 Women's Sexual and Reproductive Rights

Sexual and reproductive rights are increasingly acquiring greater visibility in literature. At the core of the discourse are issues of non-discrimination, bodily integrity and personal autonomy that are fundamental to human dignity. Sexual rights have come to be viewed over time in recent debates as basic rights, essential to the realization of other rights.

But what is the content of the sexual and reproductive health rights? The ICPD Programme of Action defines sexual and reproductive health as encompassing issues related to physical, mental and social well-being in matters related to the reproductive system. At its core is the promotion of healthy, voluntary and safe sexual and reproductive choices for individuals and couples, including such decisions as those on family size and timing of marriage; such promotion is fundamental to human well-being (UN, 1996: 35).

Specific rights relevant to sexual and reproductive health as provided for in various treaties include the right to highest attainable standard of health, life and survival ensuring safeguards to women who die of pregnancy-related causes. The treaties also guarantee the liberty of person to engage in family planning, to decide on the number and spacing of their children, to marry with free and full consent and to have control over and decide freely and responsibly on matters related to sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Others rights include, right to the benefits of scientific progress and its application and consent to experimentation; privacy; participation; freedom from discrimination (on the basis of sex, gender, marital status, age, race and ethnicity, health

status, disability); access to information; education; and freedom from violence against women (UN, 2006: 28).

Correa and Petchesky (1994: 107) sought to address several fundamental problems that critics had raised about the rights discourse: its indeterminate language, its individualistic bias, its presumption of universality and its dichotomization of "public" and "private" sphere. They, therefore, sought to reconstruct it so that it specifies gender, class, cultural and other differences, and recognizes social needs. They hold the view that sexual and reproductive rights understood as private "liberties" or "choices" are meaningless, especially for the poorest and most disenfranchised, without enabling conditions through which this can be realized. They, thus, defined the terrain of reproductive and sexual rights in terms of power and resources: power to make informed decisions about one's own fertility, child bearing, child rearing, gynaecologic health and sexual activity; and resources to carry out such decisions safely and effectively. This involves some core notion of "bodily integrity" or "control over one's body". However, it also involves one's relationship to one's children, sexual partners, family members, community, caregivers, and society at large; in other words, the body exists in a socially mediated universe.

Correa and Petchesky (1994:113-117), thus, delineated four principles of a feminist ethical perspective on reproductive and sexual rights. The principles include *bodily integrity,* or the right to dignity and respect in one's physical body and to be free from abuses and assaults and *personhood,* which is closely associated with bodily integrity and implies the right to self-determination and respect in one's decisions about reproduction and sexuality. The other principles include *equality* in access to health services and all social resources and *diversity,* or the right to be respected in one's group affinities and cultural differences, insofar as these are freely chosen and women are empowered to speak on their own behalf, and not subordinated to group claims in the name of tradition.

The catalogue and concept of sexual and reproductive rights have been viewed as suspect by most patriarchal societies oppressive to women. They are viewed as insidious creep of Westernization, and as promoting corrupt sexual mores. The culture of these patriarchal systems is viewed as a safeguard that will maintain decency and order. And yet such culture is many times constantly and selectively reinvented to suit the agendas of the powerful in these systems (Hobsbawn and Ranger, 1992).

Overall, a cursory review of the literature reveals that there is a growing concern among writers to clarify the content, scope and application of sexual and reproductive rights. Within the literature, there is considerable consensus that sexual rights are crucial to sexual wellbeing and health generally, and are also a prerequisite for development.

Therefore, it is evident that world-wide, patriarchy gives men legitimate cultural, social, political and economic control over women's reproduction, labour and conscience where male ideology becomes the ideology. The foundation of patriarchy lies in different social institutions, which define from a male's perspective the norms, practices and behaviours acceptable. It has its roots in long established traditions of male dominance, which have made the male perspective the social perspective. Patriarchy has created institutional structures to maintain and reinforce itself and the culture that rises from these structures.

2.4 HIV/AIDS Prevalence among Married Women

HIV/AIDS is no longer striking primarily men. A decade ago, women were on the periphery of the pandemic. In the mid-1990s, about 4 out of every 10 people living with HIV/AIDS were women. Today they are at the epicenter. According to the 2008 UNAIDS report, women account for half of all the people living with HIV worldwide and nearly 60 per cent of HIV infections in sub-Saharan Africa. Young people aged 15 to 24 years account for an estimated 45 per cent of new infections. Despite the global percentage of people living with HIV having stabilized since 2000, the overall number of people living with HIV has increased as a result of ongoing new infections each year and the beneficial effects of more widely available antiretroviral therapy (UNAIDS, 2008:33).

In communities scattered around the globe, women and men are taking action to increase knowledge about the disease, expand access to sexual and reproductive health and educational services, increase women's ability to negotiate safer sexual relations, combat gender discrimination and violence and increase access to female-controlled prevention methods such as the female condom (UNAIDS/UNFPA/UNIFEM, 2004:iv). In sub-Saharan Africa, heterosexual intercourse remains the HIV epidemic's driving force, with the high rate of sexual transmission giving rise to the world's largest population of children living with HIV (UNAIDS, 2008:43). In 2007, an estimated 1.9 million people were newly infected with HIV, bringing to 22 million the number of people living with HIV in sub-Saharan Africa. This means, 67 per cent of the estimated 33 million people living with HIV in the world and

75 per cent of all AIDS-related deaths in 2007, respectively, live and occur in sub-Sub Saharan Africa (UNAIDS, 2008:39).

The vulnerability to HIV infection is determined not only by physiological differences between men and women, but also by interrelated economic and cultural factors. In sub-Saharan Africa, these factors tend to lead to a power imbalance between the sexes that have negative consequences for both men and women. In many instances, women's limited access to and control over resources leads to an economic dependence on men that translates into a loss of control over their bodies, significantly increasing their vulnerability to HIV infection. For their part, men (especially young men) tend to engage in risky behaviour that conforms to societal notions of masculinity which promote multiple sexual partners and sex at an early-age (Waafas et al., 2009:227).

Today, Kenya faces two pervasive and often fatal social crises: the AIDS pandemic and violence against women and girls. Until recently, the two were handled as separate social issues. But in light of alarming HIV prevalence rates for women, current anti-AIDS efforts had to be re-examined. According to the 2008 - 2009 KDHS statistics, 39 per cent of women aged 15 to 49 years in Kenya reported to have suffered from physical violence at some point since age 15, with 21 per cent having experienced sexual violence and 12 per cent having had their first sexual intercourse experience forced against their will. The statistics of women who have suffered violence were higher at 40 per cent among the married/divorced/separated/ widowed women than single women at 11 per cent (KNBS and ICF Macro, 2010: 13). Two-thirds of women who had ever experienced physical violence reported that the perpetrator of the violence was a current or former husband/partner. The experience of spousal violence was observed in this survey to decreases with increasing education and household wealth. Women whose husbands are often drunk are more likely to suffer from physical or sexual violence than women whose husbands do not drink (75 per cent and 34 per cent, respectively). In Kenya, the HIV prevalence among women aged 15 to 49 years was recorded as almost twice that of men (8 per cent of women versus 4.3 per cent of men). This is true despite the fact that women's sexual behaviour, traditionally, tends to be more conservative than that of men (KNBS and ICF Macro, 2010: 13 & 15).

The KDHS 2008-2009 statistics indicate a higher tendency among men to have multiple sex partners with 2 per cent of women and 13 per cent of men reporting to have had sex with 2 or

more partners in the 12 months prior to the survey. Among these men, 37 per cent used a condom during their last sexual intercourse. Women in Kenya have an average of 2 sexual partners in their lifetime, compared with men who have an average of 6 partners (KNBS and ICF Macro, 2010: 14). The results show that among respondents who had sexual intercourse in the previous 12 months with a person who was neither their husband, wife nor a cohabiting partner, 35 per cent of women and 62 per cent of men reported using a condom at the last sexual intercourse with that person (KNBS and ICF Macro, 2009: 31). This suggests that the high HIV prevalence among women can be linked to women's lack of bargaining power towards use of condom during sexual activities, as it happens despite men having three times the number of sexual partners in their lifetime compared to women. According to the 2008-2009 KDHS, almost all Kenyan adults have heard of HIV and AIDS, but knowledge of HIV prevention measures is lower. Among men and women aged 15 to 49, 71 per cent women and 78 per cent men know that the risk of getting HIV can be reduced by using condoms and limiting sex to one faithful, uninfected partner. Prevention knowledge was higher among those with higher levels of education (KNBS and ICF Macro, 2010: 14).

According to Noerina Kaleeba, founder of The AIDS Support Organization (TASO) in Uganda and now with UNAIDS, information on HIV transmission is not enough and women's lack of ability to control sexual encounters of their men is critical. A former promoter of ABC strategy, she asserts that the approach falls short of the needs of women and girls in many cultures and situations. For instance, girls are married off in their teens or they exchange sex for survival, often before they are biologically mature, not just taking risks but simply because they are vulnerable. In addition, many married men continue to have multiple sexual relationships, even if the majority of married women remain monogamously faithful and hence the message of faithfulness becomes a mockery in this situation. Furthermore, male condoms are more available, but many men refuse to use them whereas female condoms are more expensive and so women cannot afford them (Kaleeba, 2004:3). There is, thus, need for the ABC approach to be re-examined to meet the needs of women and girls, to who abstinence is meaningless as they are coerced or forced into sexual activity. Besides, faithfulness offers little protection to wives whose husbands have several partners or were infected before they were married and where condoms require the cooperation of men, who may refuse to use them. Furthermore, married couples frequently do not use condoms either because they want to have children or because condoms would indicate a lack of trust (UNAIDS/UNFPA/UNIFEM, 2004:16).

Additionally, Clark et al. (2006:86) argue that early marriage by females presents an important risk factor for HIV infection that is generally not being addressed and that could be contributing to the increase in HIV among this relatively large segment of the population (almost a third of girls aged 10 to 19 in developing countries marry before their 18th birthday). According to Bruce and Clark (2004:4) girls married before the age of 18 will face significant risks of HIV due to two primary reasons. First, crossing the threshold into marriage greatly intensifies sexual exposure via unprotected sex, driven by not only the implication of infidelity or distrust associated with certain forms of contraception, such as condoms, but often also by a strong desire to become pregnant. Second, marriage changes girls' support systems both inside and outside their households, often leaving them more isolated from external social and public support and in a lower position within their new household(Bruce and Clark, 2004:4).

Bruce and Clark (2004) examined demographic and health surveys data from 31 countries to determine adolescent girls' potential exposure to HIV risks via early marriage and found that, on average, 80 per cent of unprotected sexual encounters among adolescent girls occurred within marriage. This represents data from 26 countries as Bangladesh, Egypt, India, Indonesia, and Turkey did not have data on sexual behaviours of unmarried girls, and hence the overall estimate of sex within marriage in all 31 countries is probably higher than 80 per cent. Even as sexual relations outside of marriage are becoming more common in all parts of the world, marriage remains the most common route to regular, sexual relations and their attendant health risks for girls in developing countries. Of equal or greater relevance to HIV/AIDS prevention policies is the fact that sex within marriage, whether formal or common law, is overwhelmingly unprotected with respect to HIV and STIs (Bruce and Clark, 2004:4).

Marriage appears across the board to increase the frequency of sex with the proportion of married young women who had sex in the week before the study higher than that of unmarried, sexually active girls. Part of this increase in frequency may be attributed to access to privacy and availability of a partner, but part may also result from greater coerced or forced sex, as sex is plausibly less voluntary within marriage since it may be more difficult to say "no" to a husband than to a boyfriend. More disconcerting, in terms of HIV risk, is that

not only do married women have sex more frequently, but these encounters are much less likely to be protected with condoms (Bruce and Clark, 2004: 5).

Using data from 29 demographic and health surveys (DHS) conducted in Africa and Latin America and the Caribbean, Clark et al. (2006:83-84) concluded that several behavioural and social factors increase the vulnerability of married female adolescents to HIV infection. First, marriage dramatically increases the frequency of unprotected sex for most young brides. In almost all of the countries studied, the proportion of females aged 10 to 19 years who reported having had unprotected sex in the week before the study was higher among those who were married than those who were not. Second, many young brides marry older men, who are more likely to be HIV positive because of their increased window of sexual activity than boyfriends of unmarried female adolescents. Young brides are also more likely to be second or third wives in polygynous marriages. They have little power to ensure their husbands have only one partner, inside or outside marriage. Third, young brides often have less formal education and exposure to media than their unmarried peers, greatly reducing their opportunities to receive information about HIV/AIDS and potentially undermining their ability to negotiate safer sexual practices. Fourth, because of the age and education gaps between young brides and their husbands, young married girls and women have little possibility of using the most commonly promoted HIV prevention techniques of abstaining from sex or using condoms. Clark et al. (2006:86) concluded that young married females are at significant risk of HIV infection. Few prevention efforts are targeted at these girls and women. They, thus, suggest that efforts to delay early marriage and to make sex within marriage safer by increasing HIV testing, promoting condom use, and reducing spousal age differences may help address the problem of HIV infection among this group of young women.

However, Bongaarts (2007) draws an opposite conclusion. His analysis, based on demographic health surveys in Ghana and Kenya and on cross-country comparisons, suggests that late marriage and a long interval between first sex and first marriage are risk factors for HIV infection. Bongaarts (2007:73) used ecological data from 33 sub-Saharan African countries and individual-level data from DHSs in Kenya and Ghana in 2003 to assess the potential roles of late age at marriage and a long period of premarital sexual activity as population risk factors. The individual level analysis of the DHS data in Kenya and Ghana found that being married is less risky per year of exposure than being sexually active and

never married. The elevated risk of infection among never married sexually active women is probably caused by a higher rate of partner change and higher level of infectivity of partners of never married than married women (Bongaarts, 2007: 81). One set of factors puts unmarried women at elevated risk through frequent partner change and higher infectiousness of partners, whereas another set raises the risk for married women through higher frequency of sexual intercourse, lack of condom use, and the higher infection level of partner (Bongaarts, 2007:81). The common denominator is that marriage early or delayed greatly contributes to high HIV prevalence rates among married couples. It is, therefore, important that this group of women not be ignored in prevention efforts and policies.

Whereas diverging results across different countries may reflect cultural differences or different levels of the epidemic in the countries, the changing landscape of the HIV prevalence cannot be ignored. The spread of HIV/AIDS is fueled by inequalities between genders, particularly in sub-Saharan Africa. Gender-biased economic, socio-cultural, and legal norms shape the status and roles of women and men and determine attitudes towards sex, sexuality, and sexual behaviour and the availability of information about them. These norms play a critical role in the exposure to risk and the consequences of the infection, substantially determining the course of the epidemic (Waafas et al., 2009:227). HIV/AIDS has, thus, taken toll on everyone, but women are impacted more.

There is, therefore, dire need to deal with the variety of complex issues that must be taken into account to understand the susceptibility to HIV/AIDS that is determined by gender. Some of these reasons include biological susceptibility, multiple concurrent sexual relations, transactional and intergenerational sex, and lack of negotiating power to use protection among women and girls. Similarly, unprotected sex, especially at an early age, coupled with low and inconsistent condom use, as well as unplanned pregnancies which result in unsafe abortions, seriously increase the odds of contracting and transmitting the virus for both women and men. Structural factors such as poverty, displacement, and violence as a result of war and conflict increase HIV/AIDS risks for women and girls. Finally, lack of information about HIV/AIDS and misconceptions regarding susceptibility to the virus, perceptions of sexuality, and social expectations for women and men hinder the effectiveness of HIV prevention (Waafas et al., 2009:228). The need for an integrated approach to preventing HIV, including challenging social norms, cannot be underestimated, in the fight against transmission in the long-term.

2.5 Theoretical Framework

This study was guided by radical feminist theory, which asserts that all women endure sexist oppression. Radical feminism focuses on the theory of patriarchy as a system of power that organizes society into complex relationships based on an assumption that male supremacy oppresses women and so aims to challenge and overthrow patriarchy by opposing standard gender roles and oppression of women. It calls for a radical reordering of society. Mackinnon (1989:41) views radical feminism as a movement of mind which addresses the most basic questions of politics: the constitution of the person in society; social as against natural determinations of relative status; the relationship between morality, justice, and power; the meaning and possibility of willed action; the role of thought and the theorist in politics; the nature of power and its distribution; the nature of community; and the definition of politics itself.

Radical feminists are concerned with sexuality, and tend to view sex as a systematic division of social power, a social principle inseparable from the gender of individuals, enforced to women's detriment because it serves the interests of the powerful, men. That factors women have in common are greater than factors that divide them and that women share a common experience of oppression built around male control over women's bodies. They, thus, see all women in each one; and view that sexism is not just a disparity to be leveled but a system of subordination to be overthrown (Mackinnon, 1989:40). According to Mackinnon, gender hierarchy defines sexual politics and only a transformation in the equation of gender (gender difference) power relationship, a delegitimation of sexual dynamic of power and powerlessness as such can alter it (Mackinnon, 1989:41).

Therefore, for radical feminists women's subordination does not depend on other forms of domination, such as class, and is rooted in male control over women's fertility and sexuality, that is, over women's bodies.

Radical feminism seeks to unpack patriarchy, and emphasizes the patriarchal roots of inequality between men and women or, more specifically, social dominance of women by men. This is through viewing patriarchy as dividing rights, privileges and power primarily by gender, as a result oppressing women and privileging men, radical feminists provide a base to observe this. In summary, the theory recognizes the basic nature of relationship between men and women in a patriarchal society which appreciates male dominance, while keeping women

in a subordinate position or status which devalues them through being discriminated and which infringes on their full participation in society. Thus, the theory was appropriate for this study.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter highlights the methodology utilized in the study. It has several section covering the research site, study design, study population, sample size and sampling techniques, data collection methods, data analysis techniques and ethical considerations.

3.2 Research Site

The study was carried out in Kawangware location of Kawangware Division in Nairobi County (Map 3.1). Nairobi is a cosmopolitan and multicultural city and as such has people from different regions and different socio cultural beliefs and practices. Kawangware division was sampled from the 3 divisions in Dagoretti District of Nairobi County which has 4 locations (Kawangware, Gatina, Riruta and Ngando), out of which Kawangware location was purposively selected as the research site. The main economic activities in the area include industrial labour, construction, household chores, small-scale trading in groceries and careers in carpentry, masonry and tailoring.

Map 3.1: Map of Nairobi County showing Dagoretti District (Source: Mashada.com)

3.3 Research Design

This was a descriptive cross-sectional study. The major aim of the study was to elicit qualitative and quantitative data which were collected through semi-structured interviews, key informant interviews and case studies. The data collected was analyzed statistically for quantitative while content analysis was performed for qualitative data, and the findings presented in texts, charts, tabulations and graphics.

3.4 Study Population

The study population was drawn from married couples living in Kawangware division, one of the administrative divisions in Nairobi County. The individual married man and woman was the unit of analysis.

3.5 Sample Population

The sample population consisted of 60 individual respondents, that is, 30 married men and 30 married women of different ages.

3.6 Sampling Procedure

The first stage in sampling was to select a division and Kawangware division was purposively selected from the 3 divisions in Dagoretti District of Nairobi County. After selecting the division, Kawangware location was purposively selected out of the 4 locations in the Division.

Quota sampling was utilized in the selection of the 60 individuals for the study. The selection considered the respondent's gender (30 male and 30 female) in equal proportions as key independent variable. The researcher also took keen interest to ensure a good mix of respondents' of different ages (young, middle aged or old), educational levels and employment status.

3.7 Data Collection Methods

3.7.1 Secondary Sources

Documentary materials through library research were the major source of data for this study on theories and practices of patriarchy. Relevant literature was reviewed on issues of sexual and reproductive health rights and patriarchal ideologies as experienced in different African countries before embarking on the fieldwork. Written materials including books, journals, articles, magazines and the internet were utilized throughout the entire period of study.

3.7.2 Semi-structured Interviews

A semi-structured questionnaire (Appendix I) was the main instrument of data collection, ensuring all respondents were asked exactly the same set of questions in the same sequence. The instrument included both open-ended and closed-ended questions, and was used to collect cultural data on patriarchy, sexual and reproductive health and HIV/AIDS prevalence within the study site.

3.7.3 Key Informant Interviews

A key informant interview guide (Appendix II) was utilized to collect data to complement and reinforce the survey on the hindrances to realization of SRHRs as well as the relationship (or lack of it) between patriarchy, SRH realization and HIV/AIDS prevalence. The interview guide was administered to 4 key informants purposively selected for in-depth interviews. These included the Kawangware Location Area Chief, a Reproductive Health Nurse and 2 local elders (man and woman).

3.7.4 Case Studies

The research also involved collection of case studies to highlight the current situation of women's reproductive rights in Kenya and its possible link with HIV/AIDS prevalence among married women. Two life histories were documented through non structured interviews.

3.8 Data Processing and Analysis

Data were organized according to the research questions. Qualitative data were manually analyzed on content to show emerging trends of responses and the findings presented using text. Quantitative data were checked for consistency and completeness, cleaned then analyzed using the excel statistical systems. The findings are presented using tabulations and graphics. Case studies are presented as testimonials in parenthesis of not more than 500 words.

3.9 Ethical Considerations

The researcher was responsible for all the procedures and ethical issues related to the research such as full compliance with and awareness of local customs, standards, laws and regulations.

The research avoided undue intrusion into the lives of the individuals studied. The welfare of the respondents was of highest priority to the researcher in order to protect the dignity, privacy and interest of respondents. Freely given consent was obtained from all. They were informed in a manner and language that they understood the context, purpose, nature, methods and procedures of the research. Data analysis and presentation were not attributed to any specific respondents, and in case studies names were changed.

CHAPTER FOUR

PATRIARCHY AND WOMEN'S SEXUAL AND REPRODUCTIVE HEALTH RIGHTS

4.1 Introduction

This chapter presents the research findings. The chapter starts by describing the respondents' demographics and then moves on to discuss the research findings organized on the basis of the research objectives.

4.2 Demographic Information

In terms of age, 52% of the respondents were aged 30-49 years, 43% were aged 15-29years while 5% were aged 50 and above years (Figure 4.1). In terms of marital status, 80% of the respondents were married and 20% were either divorced, separated, widowed or living with a partner (Figure 4.1).

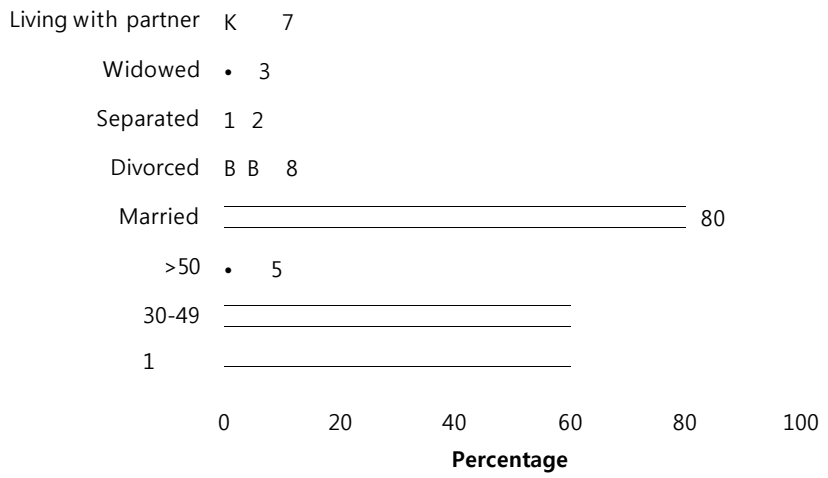

Figure 4.1: Age and marital status of respondents

In terms of educational attainment, 58% of the respondents had attained tertiary level of education, 27% had secondary level education and 15% only had up to primary level education (Figure 4.2).

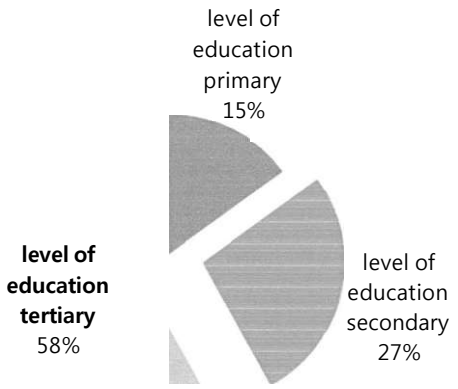

Figure 4.2: Education level of respondents

Of the 60 respondents, 80% were in employment, 42% of whom were in self- employment, 33% were in professional white collar jobs, 17% were in skilled manual and 8% were engaged in unskilled manual work (Figure 4.3).

Figure 4.3: Employment status of respondents

4.3 **Patriarchal Hindrances to Women's SRHRs**

The study sought respondents' views on the patriarchal hindrances to realization of women's sexual and reproductive health rights. The study findings are presented below:

4.3.1 **Decision-making in the Household**

The study findings indicate that decisions considered major in the household range from deciding on the place of residence, business/investment plans for the family, purchase of house assets and other property, finances and savings, healthcare planning for the family, family planning and deciding on education of children as well as social matters that affect future life and which include payment of bride wealth, relations with friends and extended family. Such decisions also include decisions on family basic needs - food, clothing and daily upkeep.

According to half of the respondents, it is the husband who makes the above decisions, 45% said this was taken by both husband and wife, while 5% viewed such decisions to be made by the wife. On the other hand, 87% of the respondents felt that decisions on sexual and reproductive health within a household are jointly done by both the husband and wife, 5% indicated that such decisions are made by the wife and 8% said that this was done by the husband (Figure 4.4).

Despite this, specific questions on specific SRHRs display a slightly different scenario. For example, although 87% of the respondents stated that both the man and the woman were involved in deciding on SRHRs, 55% of them indicated that it is the woman in the relationship who decides on the use of contraceptives while 40% indicated that this was done by both husband and wife. In terms of decisions on condom use, 38% said the decision is jointly made by husband and wife while 37% said the decision was made by the man (Figure 4.4).

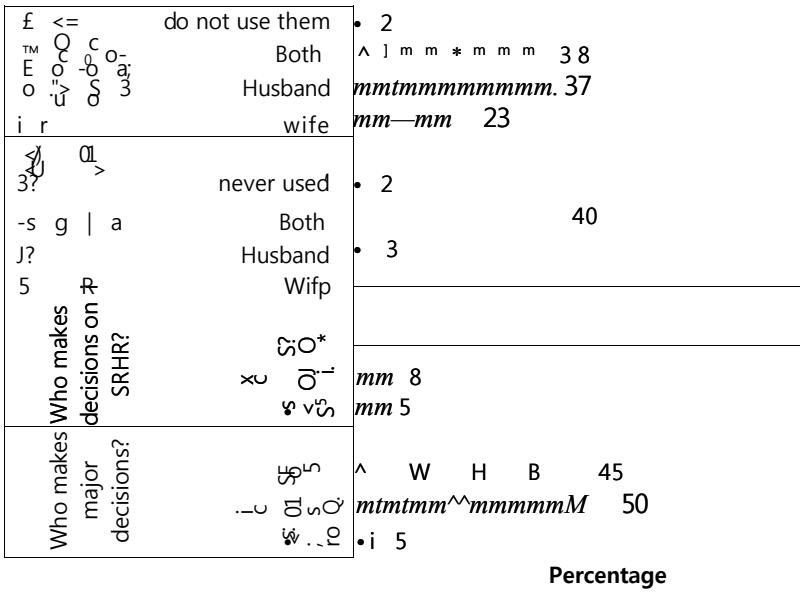

Figure 4.4: Decision-making in the household

Findings in Figure 4.4 suggest that the role of women in decision-making in the household is low, and where women are involved it is in the context where such decisions are made in consultation with the husband. The women, however, take an upper hand in deciding on contraceptive use.

4.3.2 Awareness of SRHRs

The research process and interactions with respondents revealed that there is awareness of reproductive health issues. Despite the general knowledge concerning family planning, this has not been internalized as rights for men and women by both respondents and key informants. In addition, the research subjects did not seem to appreciate issues of SRHRs.

Some of the common SRHRs reported by respondents include the right to decide when to have sex, right to spacing and number of children without coercion, right to choose a preferred family planning method, right to choose a sexual partner and to decline sex if husband has been unfaithful, and the right to know the health status of the other partner before sex and to seek right treatment whenever sick (Figure 4.5).

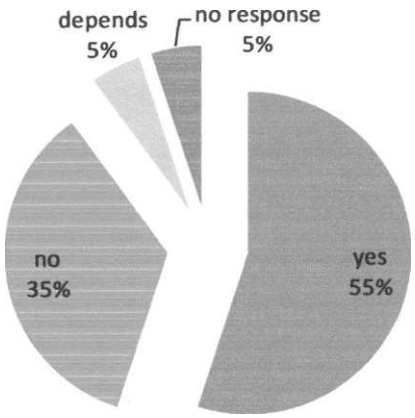

Figure 4.5: Enjoyment of rights by men and women

Figure 4.5 indicates that 55% of the respondents stated that men and women have been able to enjoy SRHRs, 35% were of the opinion these rights have not been enjoyed, while 5% said it depends on circumstances, time, household relations and hence hard to generalize. For those in support of the view that these rights have been realized in the community, there was general appreciation that family planning is accessible at the government health facility for as low as KES 20, and that there exists open communication between husband and wife on different issues, including sex. Other respondents argued that since social health workers are within easy reach in areas of residence, sexual and reproductive health information is easily accessible and households are facilitated to plan their families appropriately.

However, slightly over one third (35%) of the respondents' felt that SRHRs have not been realized. The reasons advanced for this argument indicate that lack of love and communication within a marriage inhibits the nature and level of agreement between a couple, and this leads to only one person deciding the direction the relationship takes. Similarly, some respondents indicated that men loath discussing with their wife's matters of sex and this hinders women rights in making SRHRs decisions.

According to the area chief, most of the conflict he had intervened in between husband and wife related to issues of drunkenness since this affects sexual relations in a marriage. These cases are reported by women who complain of having inadequate sex from their husbands. Other issues include: women undertaking family planning secretly, where the husband thinks

the wife is barren only to realize that is not the case; multiple sexual relations, especially where the man decides to keep more than one wife in different parts of the same locality; and people getting more children than they are able to provide for. The higher number of children affects the quality of life and this, according to the area chief, has been a major challenge in the lower parts of Kawangware. To address this, he and his team of administrators had resorted to counseling them. As part of government initiative, they also supply condoms to their clients either during barazas or when the individuals visited their offices.

The easy accessibility to family planning services, through government-sponsored family planning services and over-the-counter purchases, was viewed as a promoting factor for SRHRs by respondents. However, important to note is the type of family planning methods accessible to women in these 2 facilities - birth control pills and injections, as this is the much they can afford. This, according to the respondents, is devoid of appropriate information on how best the methods are suitable to them or what possible side effects might be depending on their differing health status.

4.3.3 Hindrances to Realization of women's SRHRs

This study sought to analyze hindrances to women's access to contraceptive use/family planning in a marriage set-up. Over half (55%) of the respondents felt that women decide on the use of contraceptives within a marriage, 87% stated that they have easy access to these contraceptives, while a paltry 8% indicated that women lack access to contraceptives (Table 4.1).

Table 4.1: Are contraceptives accessible?

	Responses	**Frequency**	**Percentage**
Do women have easy access to contraceptives?	Yes	52	86.7
	No	5	8.3
	Don't know	3	5

There was no major difference in the reasons advanced by men and women as stumbling blocks to the use of contraceptives. The reasons advanced as stumbling blocks to

contraceptive use include side effects by the users, perception that with some methods "women become cold", weight gain and lack of the urge for sex. Injections were viewed as contributing to delayed pregnancies and, in some cases, society gives the man the sole power to decide on the family size. As a result, men do not want their women to use such family planning methods.

Religious reasons were also cited as a hindrance to contraceptive use since some religions perceive use of contraceptives as ungodly. The religions opposed to the use of contraceptives include Seventh Day Adventists, Legio Maria and the Catholic Church. In addition, some cultures were viewed as being opposed to family planning as they are 'unnatural'. Some respondents viewed the cost of contraceptives as being a hindrance to family planning. As a result "*most women use what they can afford to use and what they have access to as opposed to what they would want to use and what is recommended by a medical practitioner*".

The views shared by the area chief, nurse and the local elders suggest that decision-making on contraceptive use is mainly done by the wife. The informants related to a number of family conflicts they have separately intervened in relation to women secretly taking a family planning option without the knowledge of their husbands, which later results in family feuds. The resistance by husbands for their wives to go on family planning was viewed by the nurse as a result of misinformation, with women normally reporting that their husbands believe *"family planning inafukuza mzee*". To prevent their men from knowing of the ongoing family planning, some of the women refused to take their clinic cards home, and requested the nurse they be allowed to memorize the clinic number. This is mainly facilitated by the easy accessibility of the birth control methods.

The study also found that inability of women to discuss sex with their partners still persists. While over half (56.7%) of the respondents indicated that women are able to discuss sex with their partners, 40% felt that women still face hindrances while discussing sex with their partners (Table 4.2).

Table 4.2: Are women able to discuss sex with their partners?

	Responses	Combined (percentage)	Men (percentage)	Women (percentage)
Are women able to discuss sex with their partners	**Yes**	**56.7**	**53.3**	**60**
	No	**40**	**40**	**40**
	Depends	**3.3**	**6.7**	-

The reasons cited by the respondents as facilitating open discussion on sex relate to the fact that women have been enlightened on sexual issues, and hence seem to have overcome cultural barriers and hence are able to discuss openly with their partners. However, this was viewed as depending on whether a couple considers itself modern, the age difference between partners and if one is given a hearing. Those who viewed inability of women to discuss sex with their partners indicated that some women shy off and hence fear mentioning anything on sex to their partners, and view it as a matter not to be discussed.

One respondent indicated that "60% of women are unable to discuss sex with partners because society and religion dictates that once married sex for the couple is unlimited except during menses and pregnancy, hence most men dominate sexual activity".

According to 83% of the respondents, a woman can refuse to have sex with the husband. Over half of the responses (44 out of 87) advanced the reason for this as being biological or medical, which included circumstances related to pregnancy and after child birth, menstruation period, reliance on natural family planning methods to avoid conception as well as when the woman is sick. These reasons were advanced by both men (26) and women (18). Other reasons advanced as to why a woman would refuse to have sex with the husband were cited to include conflict between partners, which include husbands' unfaithfulness (31 responses) and religious reasons especially relating to the Catholics, Seventh Day Adventists and Legio Maria followers (2 responses). Only 10 responses supported the view that a woman can refuse sex with the husband while not in the mood or when not willing to, 7 of which were by women and 3 by men (Table 4.3).

Table 4.3: Can a married woman refuse to have sex with the Husband?

	Responses	Combined (%)	Men (n=30)	Women (n=30)
a) Can a married woman refuse to have sex with her husband?	**Yes**	**83**	**27**	**23**
	No	**17**	**3**	**7**
b) If Yes, under what circumstances?	**Medical/Biological reasons (Pregnancy, Menses, Childbirth, sickness)**	**44**	**26**	**18**
	Conflict between partners (including husbands unfaithfulness)	**6**	**14**	**17**
	Religion	***2***	**1**	**1**
	Woman doesn't want (not in the mood, not willing)	**10**	**3**	**7**
	Other	**0**	**0**	**0**

This speaks to the existing belief systems that once married the man has the right to have sex with the wife regardless of the circumstances, and which hinders the right of men and women to consensual sexual relations. Despite some of the decisions within the household being made jointly by the husband and the wife, the belief in the superiority of men has resulted in accepted stumbling blocks to realization of women's SRHRs, by both men and women.

4.4 Patriarchy and HIV/AIDS Prevalence among Married Women

4.4.1 Effectiveness of ABC Prevention Strategy

The respondents displayed great awareness of the nature and mode of HIV/AIDS transmission as well as its prevention. In fact, 81.7% of them were aware of the fact that appropriate use of the condom was a means of preventing HIV transmission. The awareness on the modes of how HIV is transmitted are summarized in Table 4.4.

Table 4.4: Awareness of HIV transmission modes

	Percentage	
	Agree	disagree
A HIV/AIDS positive man can give the HIV virus to a woman when having unprotected sex with her.	100	
A HIV/AIDS positive woman can give the HIV virus to a man when having unprotected sex with him.	96.7	3.3
A child can be HIV positive.	78.4	22.7
A doctor/nurse/traditional healer can make you healthy again after you have contracted HIV.	21.7	78.3
HIV infection can be prevented by using a condom when having sex.	81.7	18.3

The ABC prevention strategy has been advanced by anti AIDS campaigners as a sure way of dealing with the challenge of HIV/AIDS facing our society today. However, 56.7% of the respondents in this study stated that the ABC is not effective as a prevention strategy among married couples. Only 26.7% held the opinion that the ABC is an effective strategy (Table 4.5).

Table 4.5: Effectiveness of the ABC prevention strategies

	Response to questions 1HHHHHIHI	Combined (%)	Men N=30	Women N=30
How effective are the ABC prevention strategies among married couples?	**effective**	26.7	5	11
	ineffective	56.7	18	16
	No response	16.6	7	3

There was similarity in the responses by men and women on the effectiveness of the strategy with 18 men and 16 women indicating the ABC strategy as ineffective, and 5 men and 11 women stating it to be effective.

Most of the respondents who viewed the strategy as ineffective indicated that abstinence within marriage is impractical as sex is basic in marriage and that men loath condom use due to the 'myth' that they reduce pleasure. According to some of the respondents, condom use within marriage would mean one partner is suspecting the other one of being unfaithful. Faithfulness as a HIV prevention method was viewed with suspicion amongst married couples as "nobody can be trusted". However, even within this category, there was general appreciation that faithfulness amongst partners is the only sure way, although it would only be effective if there is trust.

Of the 26.7% respondents who viewed the approach as effective, there was a common trend of viewing abstinence and being faithful as synonymous within a marriage context. For this group of respondents, in periods of separation due to work or sickness the couple should commit themselves to abstain from sex and remain faithful to each other. Those who viewed the approach as effective indicated that many couples in the city are informed of ABC and this can be a sure way of controlling the spread of HIV virus if appropriately followed. Emphasis among this group of respondents was placed on being faithful.

According to those for and against ABC as an effective prevention strategy, it emerged clearly that faithfulness of the partners is of critical importance and condom use would serve as back up if the partner has to engage in sex with others outside the matrimonial union.

4.4.2 Patriarchal Practices that facilitate HIV/AIDS Prevalence

The study sought to assess the respondents' sexual behaviour vis a vis HIV/AIDS prevalence. Most (72%) of the respondents (of whom 80% were married, 8% divorced, 7% living with a partner, 3% widowed and 2% separated) had not had more than one partner over the past one year while 28% indicated that they had had more than one partner over the same period. Fifty per cent of the 28% who had more than one partner had had 2 other partners, 19% had had 3 other partners and 25% had had more than 4 other partners with the highest being 10 (Figure 4.6).

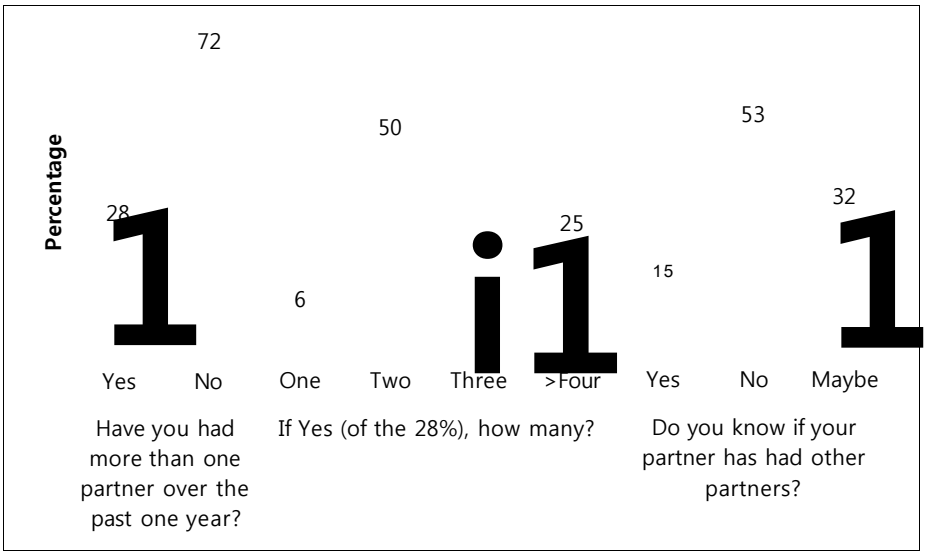

Figure 4.6: Distribution of responses on sexual behaviour

In terms of responses separate for men and women, out of 30 female respondents, only 3 indicated to have had other partners (2) outside marriage in the past 1 year. Of the 30 male respondents, 13 had had other partners outside marriage, with 5 indicating to have had 2 other partners, 3 had had 3 other partners, 2 had had 4 other partners. Only 17 respondents indicated that they had been totally faithful to their partners in the past one year (Table 4.6).

Table 4.6: Multiple partners vis a vis respondents' sex

How many other sexual partners have you had in the last 1 year?									
		Four	**N/A**	**One**	**Six**	**Ten**	**Three**	**Two**	**Total**
Sex	F	0	27	0	0	0	0	3	30
	M	2	17	1	1	1	3	5	30
Total		**2**	**44**	**1**	**1**	**1**	**3**	**8**	**60**

The study also sought to assess if respondents knew whether their sexual partner has had or are having other sexual partners besides them, Over half (53%) of the respondents indicated that they did not know or suspect, 15% reported being aware of their partners' extra marital affairs and 32% indicated this to be a possibility, but they had never caught them red-handed (Figure 4.6). According to the responses, a majority of men (17) and women (15) indicated lack of knowledge that their partners were cheating on them, 10 men and 9 women indicated

this as a possibility and 6 women and 3 men stated they knew they were being cheated on by their spouses (Table 4.7).

Table 4.7: Responses on faithfulness in marriage distributed by sex

Do you know if your partner has had or is having other partners besides you?					
		Maybe	**No**	**Yes**	**Total**
Sex	F	9	15	6	30
	M	10	17	3	30
Total		**19**	**32**	**9**	**60**

Despite this, women continue to have sex with their partners well aware they have other sexual partners. In fact, 92% of the respondents stated that women continue to engage in sex with their partners despite knowing or being suspicious they have other sexual partners, while a paltry 8% indicated that upon realizing their husbands' unfaithful tendencies women either leave or stay but refuse to have sex with them (Table 4.8). This is further supported by 47% of the respondents who either know or suspect their partners are having other sexual partners besides them (Figure 4.6).

Table 4.8: Do women continue to have sex with their partners despite knowledge of their partner's unfaithfulness?

	Response to Question	Percentage
a) ***Do women continue to have sex with their partners despite knowing they are unfaithfulness?***	Yes	92
	No	
b) ***If Yes, why?***	**Frequency**	
	Financial support	16
	Culture and religious norms	20
	Fear (of divorce, being battered, of child upbringing burden)	34
	Ignorance	6
	Alcoholism	3
	For sexual satisfaction	7

Fear was advanced as the main reason why women continue to have sex with their husbands despite knowledge of their unfaithfulness, as indicated by 34 of 86 responses. Women live in fear of divorce, fear of separation from their children, fear of being battered when they refuse to give in to sex, while others fear that denying their husband sex will result in conflict and consequently leak the unfaithfulness of their husbands to the locals and so shame the family. The other reason advanced for this behaviour by women is to avoid being left alone to shoulder the financial burden and responsibility of children's upbringing...."As mothers their children block them from walking away from the marriage....".

Culture and religion were also viewed as a key reason (20 of 86 responses). The respondents posited that in an African setting polygyny was normal and this has shaped attitudes that one man can relate to two or more women at a time and the woman has no choice but to accept it. This justifies why some women remain because the society expects them to understand. Other reasons given were for continued financial support whereby they continue giving in as a means of earning their livelihoods (from their husbands), ignorance as well as sexual satisfaction. Some of the respondents viewed this as the only natural thing as long as they are

sharing a bed. The ingrained attitude is best expressed through one of the respondent's response, "*He is the husband, there is nothing one can do. If you decided to get married then you have to sleep with your husband".*

Continued sexual relations within such a union predispose the women to HIV infections, if the man gets the infection outside the union. The study respondents (Figure 4.4) indicated that decision on condom use is made by the man (37%) and/or by both partners (38%). A majority (63.3%) of the respondents stated however that woman are able to negotiate condom use in marriage while 35% stated that women are not in a position to negotiate condom use. Despite the high percentage of women who can, 73% of the respondents argued that men do not appreciate when women suggest use of the condom, while only 20% of the respondents said that men appreciate such requests (Figure 4.7).

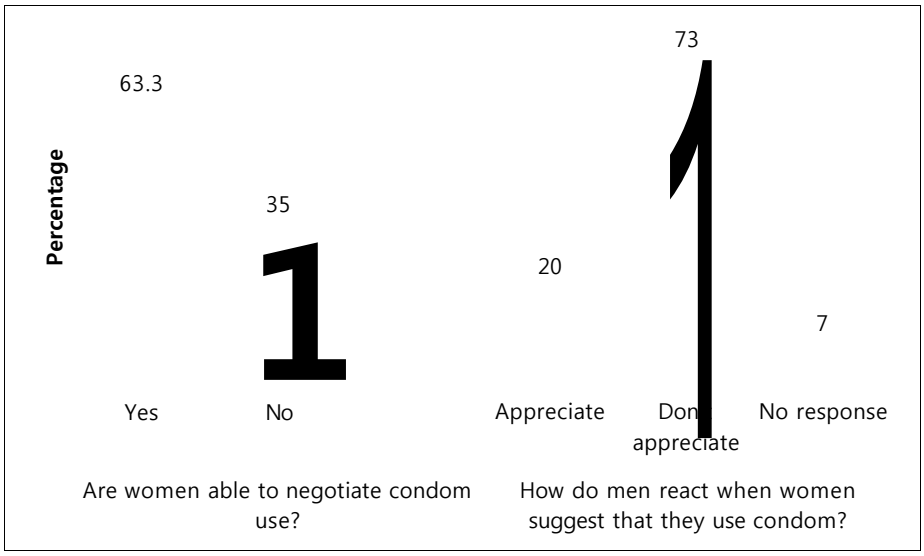

Figure 4.7: Women's ability to negotiate condom use

Most (73%) of the respondents who stated that men do not appreciate requests for condom use by their women indicated that such requests are interpreted as either lack of trust by the wife of the husband's faithfulness and/or the man starts to suspect the wife is having extramarital affairs. As a result, even when it is a justified request for conception prevention, it is met with a negative response most of the time. The respondents felt that, whereas it sounds like a caring idea for condom use during casual sex, it is viewed as an odd request within a marriage context. Condom use was viewed as not being necessary within marriage as the woman is deemed to be safe. Those who viewed men to appreciate such requests said

that this is mainly where the couple uses condoms as a birth control method during the woman's unsafe days.

The study findings thus suggest that there exists a lot of manipulation within marriage as regards condom use. On the one hand, the wife puts it as the only condition for any sexual intercourse to take place, while on the other, the man coerces the woman with either denial of privileges or guilt that she does not trust him enough.

This situation is further aggravated by the existing culture of silence on sex and sexuality despite the education advancement and awareness of rights. This in itself hinders free sharing and discussion on sex amongst the couple. Basing on 56.7% of respondents (Table 4.2) women are in a position to discuss sex with their partners. However, 40% of the respondents were of the view that women lack ability for such discussions with their partners. Both male and female respondents were of this view. Some of the sentiments shared by some of the respondents suggests that *"..women are objects of sexual pleasure for men and most often only men can initiate sex, women are therefore not able to discuss sex".*

4.4.3 Personal Perception of HIV Infection Risk

The study sought the perception of individual respondents relative to that of the community they live in, with 88% of the respondents indicating that HIV/AIDs is a major health risk in Kawangware location. Despite HIV being widespread in Kenya where it can affect anyone and has no cure, most of the respondents stated that there is a high rate of alcoholism through illicit brew in the area coupled with poverty which has resulted in a lot of casualization of sex. As a result, people are having multiple sexual encounters that are unprotected and prostitution is rampant in the area both as full time or part time (Figure 4.8). In terms of the respondents' personal perceptions of risk of contracting HIV/AIDS, 67% of them viewed their risk of contracting HIV as low, 30% viewed their risk as medium and a paltry 3% indicated their risk as being high (Figure 4.8).

Some of the reasons advanced for the low risk of contracting HIV were that the respondents are married and are faithful to their one sex partner, while others indicated their use of protection whenever they have sex with other persons other than their partner. Those who defined their risk as medium (30%) stated lack of trust in the partner, unfaithfulness of the

partners, especially men, as well as the existence of multiple sexual partners as some of the factors that expose them to HIV. Some of the sentiments expressed by this category of respondents include "only if my partner infects me but I always tell him to use condoms whenever he sleeps elsewhere but he just keeps quiet and never answers me". "My partner may infect me, he even refuses to go for testing with me and when am in the rural area, 1 hear romours that he sleeps around..". A lot of reckless sex was reported as possible reasons by the 3% of respondents who indicated their risk of contracting HIV as being high.

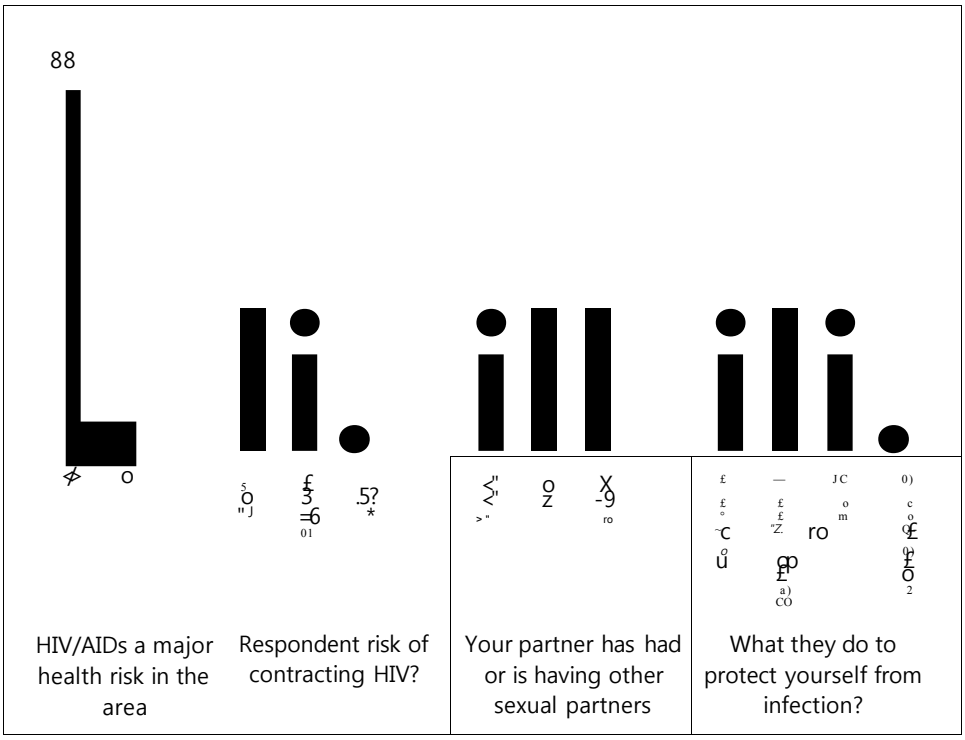

Figure 4.8: Personal Perception of HIV/AIDS Infection Risk

The study also sought to understand what the respondents do to protect themselves, and varied responses were given. Over one third (35%) of the respondents indicated they were faithful to their partners, 34% used condoms, 23% used condoms and were faithful to their partners and 8% perceived the question as very personal hence did not respond (Figure 4.8).

Despite the majority (67%) of the respondents rating their own risk of contracting HIVAIDs as low, only 53% could authoritatively say that they knew their sexual partners had had or were having any other sexual partners besides them. About a third (32%) of the respondents felt a maybe (50/50) chance of their partners having other partners and 15% were aware their

partners were cheating on them (Figure 4.8). This can be contrasted with the 35% (Figure 4.8) who rely on faithfulness as means of protecting themselves.

Due to existing power plays between men and women, women suffer the risk of HIV exposure. They are presented with limited options in negotiating consensual sexual relations, in negotiating condom use and the majority tended to feel tied down to their marriage despite their partner's unfaithfulness.

4.5 Patriarchy, SRHRs Realization and HIV/AIDS Prevalence among Married Women

4.5.1 Patriarchy and the realization of women's SRHRs

The study findings indicate that decisions within the household are made by men (50%) and 45% of the respondents felt these decisions are made jointly by both (Figure 4.4). Similarly, SRHRs decisions are considered major and 87% of the respondents stated are made by both husband and wife. However, decision-making on some specific SRHRs such as condoms and contraceptives present a different scenario. Women are majority (55%) in decision-making on contraceptive use, and men lead (37%) in decision-making on condom use and - or these decisions are made jointly (38%) by the man and women (Figure 4.4). In addition, only 56.7% of the respondents held the view that women have ability to discuss sex with their partners (Table 4.2). The findings suggest that the culture of silence on matters of sexuality still persists and lack of open, honest and candid discussions between the spouses pose as hindrances to SRHRs.

Whereas the majority (83%) of the respondents displayed an appreciation that a woman has the right to, just like a man engage in consensual sex relations and indeed can refuse to have sex with her husband, most of the reasons advanced for this were mainly natural relating to biological functions or ill health of the woman (Table 4.3). Only a small number of 10 responses (compared to 44 responses advanced for biological/medical reasons) were advanced that a woman can refuse sex because she is not in the mood. This in essence shows that it is not a right per see for a woman to engage in consensual sexual relations or it has not been understood as so in the community, but only when there are other over-bearing factors.

A majority (63%) of the respondents support the view that the way our society is structured exposes women to HIV transmission. Some of the reasons advanced in support of this include women's limited rights over their bodies since the woman culturally is supposed to obey the husband and submit. This, in case of the husbands' unfaithfulness, increases the wife's vulnerability to HIV transmission. According to some respondents, our societal socialization permits men to have more than one sexual partner.

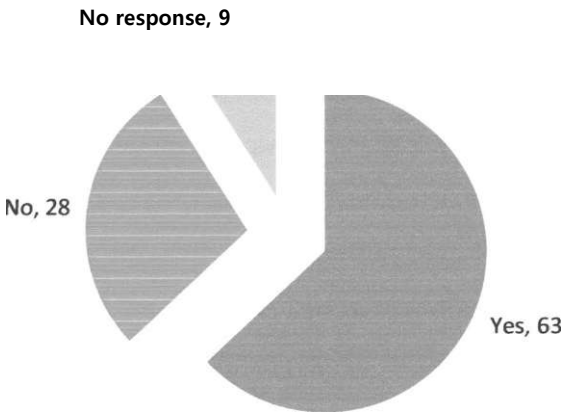

Figure 4.9: Structure of our society exposes women to HIV /AIDS

On the other hand, 28% of the respondents felt that the way our society is structured does not expose women to HIV/AIDS as transmission is beyond a man and woman issue but rather an issue of conscience. As a result, both the man and the woman are vulnerable to HIV and therefore it is an individual's decision to be safe. Some respondents held the opinion that nowadays women can do all that men can do if they wish, which include having multiple partners and all have been enlightened about ABC through different sensitization forums.

The study findings indicates that, the structure of our society and the societal expectation on women poses a challenge to HIV prevalence even within marriage set-up, as men's faithfulness is not guaranteed. The case study below reveals that HIV transmission is possible within marriage even when the spouses have been tested negative at the commencement of the marriage.

James married Tess in the year 2006 and together they have a 5-year old daughter. Recently, Tess on a regular VCT visit realized she is HIV positive. The VCT attendant asked her to go along with the husband for a re-test. James vehemently refused to accompany Tess to take the test together and claimed he has 'taken' the test and he is negative. As it is, James continues to have sex with Tess without any protection (condom), who has already tested positive to the virus. Tess believes that James is already aware of his positive status otherwise he would not be risking infection. Despite this, James insists that Tess should get a second child, a matter Tess has refused to accept and despite bringing his in-laws to help intervene, he has refused to bulge. Their 5 year old child is negative. Tess insists she has been faithful within her marriage and to her James is the one who brought the virus into their marital bed. Previously, Tess was in formal employment but James influenced her termination from work. Currently, she is engaged in selling second-hand clothes in Kawangware area to keep her busy and avoid going into depression.

Tess experience may not be an isolated case, but indicates the level of exposure a married woman can be subjected to within her marriage. Of great concern is that the husband does not perceive the risk of exposure for the child born out of such a relationship, and expects the wife to agree to his irrational demands for a child whereas she knows the risk of infecting an unborn child.

4.5.2 Best Prevention Method among Married Couples

The practice where women continue to engage in sex with their partners well aware of their unfaithfulness (92%) raises doubts about the effectiveness of ABC prevention strategies within a marriage relationship (Table 4.7). Additionally, the perception of condom use within a marriage, the ability of the woman to negotiate and the reception of such requests by the man raises an alarm on applicability of the ABC prevention method as a protective measure for HIV transmission within marriage.

Over half (57%) of the respondents stated that being faithful is the best HIV prevention method, 15% suggested condom use, and 23% indicated a combination of being faithful and condom use (Figure 4.10). Of the 57% respondents who cited being faithful as the best preventive measure, only half of these felt it would adequately cater for the married woman bearing in mind the structure of our society. The reasons advanced for this suggest that this would only work in an environment of open communication amongst partners, trust within marriage and as a result being faithful eliminates all possibilities of contracting HIV/AIDS if the couple is tested prior to marriage. However, this study found that women continue to engage in sex with their partners even when they know or suspect they have other partners. As such, a woman remaining faithful may not protect her from getting HIV.

Out of the 15% of the respondents who cited condom use as the best prevention method, 67% felt this would adequately cater for the needs of a married woman and 33% felt it would still fall short considering the power dynamics in matters of sexuality. Those in support of condom use as an adequate preventive measure stated that where faithfulness cannot work 100%, condom use would address the challenge as long as the woman is in a position to negotiate its use. Proper condom use reduces risks of contracting HIV. The shortfall of the measure is that not all women (as held by 35% of respondents) are able and/or in a position to negotiate condom use with the partners (Figure 4.7). Despite the 67% of the respondents indications that condom use can cater for the needs of married women, a concern is the attitude with which condom use is treated within marriage.

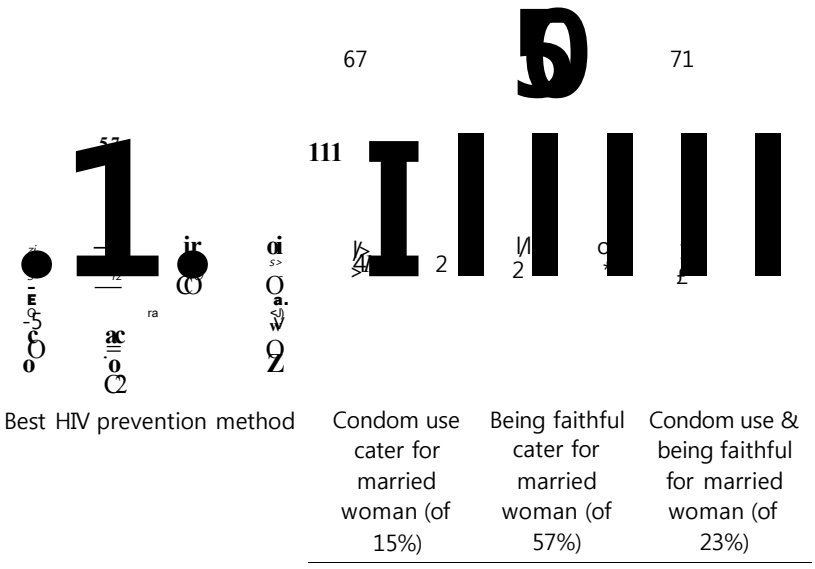

Figure 4.10: Best HIV prevention method

Of the 23% of the respondents who stated that the best **HIV** prevention method was a combination of condom use and being faithful, 71% felt that this would adequately cater for the needs of the married woman. A combination of these 2 methods was viewed to reduce risks of diseases and unplanned pregnancy and hence the best method within a marriage set-

Over half (56.7%) of the respondents were in agreement that a husband has the right to have sex with the wife without using the condom when he felt like it. On the other hand, 75% of the respondents indicated that a wife has a right to insist that her husband uses a condom if she feels like it. About half (48.3%) of the respondents agreed with the statement that women who carry condoms sleep around. This was a shared feeling by both men and women with 13 women and 16 men agreeing with this assertion (Table 4.9).

Table 4.9: Sexual and Reproductive Health Rights Awareness

	Percentage	
	Agree	Disagree
A husband has the right to have sex with the wife without using condoms when he feels like it.	**56.7**	**43.3**
A wife has the right to insist that her husband uses a condom when having sex with her when she feels like it.	**75**	**23.3**
A woman can refuse to have sex with her husband/partner if he does not want to use a condom.	**70**	**28.3**
Women who carry condoms sleep around.	**48.3**	**51.7**

The study findings suggest that lack of level playing ground for women to negotiate condom use in marriage with men challenges the ABC prevention strategy. This practice increases the woman's vulnerability to **HIV** transmission, and according to the study respondents, whereas condom use outside the marriage is considered a caring idea, its use within marriage faces major challenges, as presented in the case study below.

Maryanne a 27year old married lady shared through her experience that the ABC prevention strategy is not effective because despite taking care of herself, the partner might not reciprocate. Together with the husband they took a HIV test before marriage and had a re-test after 3months, when they were trying for a child. She currently suspect the husband is having an extramarital affair, as a result she frequently requests and reminds the husband to use a condom while having sex, but he does not answer her back. Despite lack of condom use in their sexual relations, she suspects that he uses condoms with other women he has sex with. She once travelled from their rural home without informing the husband and found a used condom in the house. Since the husband has refused to use a condom in their relations, she had resorted to reminding him to always remember the condom, whenever he sleeps with others. She feels this is the only way she can protect herself. However, not being assured of so and generally not being able to discuss with the husband, she feels her risk of contracting HlV/AlDS is medium (as she suspects he at times uses the condom). Maryanne is a primary school dropout and is currently engaged in gainful self-employment.

Maryanne is one in many women who remain in their marriages, when they know or suspect their partners of being unfaithful. Her experiences confirm that there exist hindrances to realization of women's sexual and reproductive health rights despite awareness of how HIV transmission happens and what one can do to protect themselves, especially when they feel trapped between keeping to their marriage and protecting themselves. The continued existence of such practices is justified according to this research by the existing unequal relationships between men and women.

CHAPTER FIVE

SUMMARY AND CONCLUSIONS

5.1 Introduction

This chapter summarizes the research findings, draws conclusion from the findings and makes recommendations.

5.2 Summary

The study analyzed the patriarchal practices relating to SRHRs. The study findings suggest that women play a lesser role in decision making at the household level, but they hold a comparatively greater responsibility on decisions on contraceptive use. There exists access to low cost family planning within the government facilities and over-the-counter drugs in local chemists in case of birth control pills as well as at the chiefs office or chiefs' barazaas in case of condoms.

The study findings also indicate that in marriage, a woman can refuse to have sex with the husband. However, the reasons advanced for this are obvious, being biological and medical reasons associated with sickness, childbirth and menstruation. Only 10 responses out of a possible 87 linked such refusal to a woman's free will, either not willing or not in the mood. This can be compared to 44 responses advanced for cases of biological or medical reasons and 31 responses advanced for conflict amongst the couple (Table 4.3). To this extent, the study findings agree with the theoretical framework of a belief system that upon marriage a woman loses the right over her body and her sexuality.

Due to the patriarchal nature of our society, there not only exist lopsided discussions on sex amongst partners, but also male unfaithfulness is justified. On the one hand, compared to women, men make decisions on condom use in a relationship or such decisions are jointly made, with a substantial percentage (35%) of respondents stating that women are not in a position to negotiate condom use. Even among women who are able to negotiate condom use (63.3%). most (73%) of the respondents felt that such discussions are not appreciated by men (Figure 4.7). Despite the findings that women have ability to have an open discussion with their partners on sex, such an environment for free discussion was viewed to only thrive basing on whether a couple considers itself modern or traditional and the age difference

between partners. However, a substantial percentage (40%) of the respondents, felt that women are yet to achieve a level playing field with men when it comes to discussion on matters of sex.

On the other hand, the study findings confirmed that multiple sexual relationships amongst men are justified within our society. Out of the 30 men interviewed, 25 of them were married or living with a partner. However. 13 of them stated that they have had had other sexual partners in the last one year, who ranged from two to ten. Only 17 male respondents stated that they had been faithful to their wives, compared to 27 female respondents in the past 1 year (Table 4.6).

The practice where women continue to have sex with their partners well aware of their unfaithfulness (as stated by 92% of the respondents), in itself raises a doubt about the effectiveness of the ABC prevention strategies within a marriage relationship. The continued sexual relations in this context increase the chances of HIV transmission, within the closed set-up of marriage. This is further worsened by the inability of women to negotiate condom use, and where condoms are only deemed relevant with partners outside marriage or where it is the only viable birth control method. This aggravates the situation and provides chances for HIV/AIDS transmission, even within marriage. The findings to this extent agree with the reviewed literature that marriage in itself is not a sure way of preventing HIV/AIDs prevalence. The continued existence of such practices is justified according to this research by the existing unequal relationships between men and women.

Additionally, the findings indicate that the current ABC approach suffers glaring shortcomings as far as the needs of the married woman are concerned. The structure of our society not only denies women an equal playing ground on matters of sexuality like men but also exposes them to HIV transmission. The study holds the view that abstinence within marriage is impractical and could only be used as a medium during long periods of separation of sexual partners. On the other hand, though being faithful was vouched for by over half of the respondents as the best prevention method, the respondents indicated reservations as it is dependent on the conscience of the partners concerned. It was viewed to only hold a 50-50 chance of adequately catering for the married woman considering the patriarchal nature of our society.

Condom use was seen as having insurmountable challenges. Not only was it considered lowly as the best prevention method, 35% of the respondents stated that women lack the ability to negotiate condom use, and 73% said that men do not appreciate when women request condom use in the relationship. Despite a majority suggesting that condom use would serve the needs of married women in terms of prevention of HIV transmission, the attitude to condom use within marriage presents a major challenge. To this extent, the study findings agree with the reviewed literature that the ABC prevention strategy cannot serve the HIV preventive needs of the married woman.

The study finds that the different expressions of patriarchal and male dominance over women within the study area, just like in other parts of our society presents hindrances to full realization and enjoyment of women's sexual and reproductive health rights as granted in different national and international human rights instruments. Such expressions of male dominance, destroys the social fabric of our society and in itself exposes married women to the risk of contracting HIV/AIDS.

5.3 Conclusion

The study findings reveal glaring politics of sex basing on the structure of our society, its systems and practices, and which opens loopholes where marriage partners are exposed to HIV transmission. With the best prevention method to adequately cater for the married woman being faithfulness amongst the partners and condom use where faithfulness is not assured, this presents major concerns. Even with a combination of these, the prevention of HIV is not guaranteed due to societal attitude on condom use and acceptable behaviour amongst men.

This study concludes that there exist hindrances to women's SRHRs due to the current structure of our society that deprives women a level playing field with men in decision-making on sexuality matters. This, in turn, exposes women to HIV transmission.

5.4 Recommendation

There is need to interrogate the nature of reproductive health services offered in government facilities to ensure they are not only within the means of the target women, but that they are

guided through sufficient information provision and an assessment done on their suitability to different women to mitigate any side effects.

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APPENDICES

Appendix I: Semi Structured Questionnaire

My name is Virginia Munyua, a student at the University of Nairobi's Institute of Anthropology, Gender and African Studies.

I am undertaking a research project titled *'the Influence of Patriarchy on Women Sexual and Reproductive Health Rights, in Kawangware Division of Nairobi County* 'for a Masters of Arts Degree in Gender and Development Studies. The study will specifically focus on the contribution of patriarchal social systems to HIV prevalence among married women in Kawangware Division of Nairobi County. I kindly request that you spare some time to respond to this questionnaire and I believe your responses will grant me better insight into this study area, with the aim of producing a research project paper. Your responses will be used in strict confidence and will not be attributed to you without your express permission. Thank you in anticipation of your cooperation. Your honest and reliable response will be highly appreciated. Please sign here below to indicate your acceptance to start with this questionnaire.

Signature_____Date

Questionnaire Number: Date:

Demographic Information

1. Gender: a) Male b) Female
2. Age Bracket: a) (15-29 years) b) (30- 49years) c) (50 years and above)
3. Marital Status a) Married c) Divorced d) Widowed e) Separated d) Living with partner
4. Level of education:
    a. No formal education
    b. Primary
    c. Secondary
    d. Tertiary (Includes University and college)
5. a) Are you employed? a) Yes b) No

b) If yes, what type of employment are you in: a) Skilled manual b) Unskilled manual c) House wife d) Self-employment, e) Professional white collar job f) Other (Specify)

Patriarchy Systems/ Practices, Sexual and Reproductive Health & HIV/AIDs Prevalence

** Researcher: From now on the questions that I will be asking may be very persona! because they deal with sexuality and HIV/AIDS. I hope that you will be fine with this and will try and answer all questions as honestly and openly as possible. All responses will be confidential.*

6. Who makes decision in the household? a) Husband b) Wife e) Other(Specify)
7. What are some of the decisions you consider major within a marriage household setup? *Name at least 5 levels of decisions.*
8. Who makes these decisions: a) Man b) Woman.
9. How does this affect other members of the family? (*Probe the influence of the way the community is organized in the lives of men and women)Give three ways*
10. What are some of the sexual and reproductive health rights for both men and women you familiar with? (*Probe to see if respondents (men and women alike) understand the women sexual and reproductive health rights)* Name at least 5 rights.
11. Who makes decisions regarding sexual and reproductive health rights in your family? a) Husband b) Wife c) Both d) Other (Specify)
12. Have men and women been able to enjoy these rights as expected in your community or in your family? Why? (*Probe how these rights have been enhanced or hindered - Family planning and birth control methods to be adopted: determining number and spacing of children; Choice of partner; initiating sexual intercourse within the households)*
13. Who decides on the use of contraceptives within a relationship? *(Probe to find out whether women make this decision or if their partners do);*
14. Do women have easy access to contraceptives? (Contraceptives *include condoms, pill, injection, IUDs)*
15. What are the stumbling blocks to the use of contraceptives? (*Probe for any cultural, social or economic factors that may prevent or inhibit the use of contraceptives)*
16. In your opinion, how effective are the ABC prevention strategies among married couples?

17. Are women able to discuss sex with their partners? (Probe *for the culture of silence that surrounds sexual issues and the taboos)*
18. a) Do you think a married woman can refuse to have sex with the husband? a) Yes b) No b) If yes or no, explain under what circumstances this can happen.*(List up to three reasons)*
19. Have you had more than one sexual partner over the last 1 year? a) Yes b) No If, yes, how many?
20. Do you know if your sexual partner has had (or is having) any other sexual partners besides you? a) Yes b) No c) Maybe
21. In your opinion do you think some women continue to engage in sex with their partners when they know/ suspect that they have other sexual partners as well? What reasons have been advanced for this?
22. Why do men and women still engage in unprotected sex despite lots of information being available? *(Probe for the reasons that people do not use condoms, for example.)*
23. Who makes decisions about condom use in a relationship? (Probe *to see the power relationships and where the decision making power lies within the relationships)*
24. Do you usually use a condom when having sex with: a) Husband/ Wife b) Casual sex (one night stand) Explain your answer.
25. Are women able to negotiate condom use? *(Probe to ascertain the amount of control women may have over condom use).* How do men react when women suggest they use a condom when having sex?
26. Do you think IIIV/A1DS is a major health risk in this area?

    a) Yes (Explain)

    b) No (Explain)
27. How would you rate your risk of contracting HIV/AIDS? a) Low (why) b) Medium (why) c) High (why)
28. What do you do to protect yourself against infection? *(Probe for prevention strategies that individuals actually use)*
29. Why do women still fall pregnant when they know the risks of infecting their babies if they are HIV positive? (Probe *to find why they still want to bear children despite the risks of unprotected sex to themselves and the risk of infecting the baby)*

30. Statement (please tick if agree or disagree)

No	Statement	Agree	Disagree
a)	A H1V/A1DS positive man can give the HIV virus to a woman when having unprotected sex with her		
b)	A HIV/AIDS positive woman can give the HIV virus to a man when having unprotected sex with him		
c)	A child can become I IIV positive		
d)	A doctor / nurse / traditional healer can make you healthy again after you have contracted HIV		
e)	HIV infection can be prevented by using a condom when having sex		
f)	A husband has a right to have sex with his wife without a condom when he feels like it		
g)	A wife has a right to insist that her husband uses a condom when having sex when she feels like it		
h)	A woman can refuse to have sex with her husband/partner if the husband / partner does not want to use a condom		
i)	Women who carry condoms sleep around		

31. Do you think the way our society is structured exposes women to HIV transmission?
32. According to you, what do you think is the best HIV prevention method among married couples?
33. Will the best method adequately cater for the married women, bearing in mind the way our society is structured? Explain your answer?

**Researcher*

Thank you for your lime.

Appendix II: Key Informant Interview Guide

1. What are some of the sexual and reproductive health rights you are familiar with for both men and women? Are these rights being realized?
2. What are the hindrances to realization of Sexual and Reproductive Health (*Probe for any cultural, social or economic factors that may prevent or inhibit the use of contraceptives / family planning and birth control methods adopted;* determining number and spacing of children; choice of partner; initiating sexual intercourse within the households)
3. Have any violations relating to SRHRs been reported to you and what action did you take? How often do these cases come up and which category of women is mainly affected? What is the general take of the community within the area on the same?
4. In your opinion, have these violations fueled the spread of HIV/AIDS in this location *(Probe for issues of intentional (or not) infections with IIIV/AIDS amongst men and women; initiating sexual intercourse within the households; marital rape*)? Please explain further.
5. In your opinion, is there a relationship between how society is structured (relationship between men and women), realization of women SRHRs and HIV/AIDS prevalence in this community?
6. What is being done in this community to address the above situation?

Thank you for your time.