AIDS AND MARITAL STATUS: A STUDY OF WOMEN'S HIV/AIDS KNOWLEGDE AND PREVENTIVE BEHAVIOUR IN SABATIA DIVISION OF VIHIGA DISTRICT , KENYA

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DECLARATION

This thesis is my original work and has not been presented for an academic award in any other University.

Signed ..... Date 16/11/99

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This thesis has been submitted for examination with my approval as the University supervisor.

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CONTENTS

CHAPTER 5 HIV/AIDS AWARENESS KNOWLEDGE, AND BELIEFS ABOUT VULNERABILITY

CHAPTER 7 SUMMARY, CONSLUSION AND RECOMMENDATIONS

LIST OF TABLES

LIST OF ACRONYMS

ACRONYMS

ATRCW		African Training and Research Centre for Women
CBS	-	Central Bureau of Statistics
GDP	-	Gross Domestic Product
MTD	-	Medium Term Plan
NAC	-	National AIDS committee
NASCOP	-	National AIDS and STD's Control Programme
NCPD	-	National Council for Population and Development
UNICEF	-	United Nations Children's Fund
USAID	-	United States Agency for International Development
UNDP	-	United Nations Development Programme
WHO	-	World Health Organisation

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ABSTRACT

This study focused on married women in Sabatia division of Vihiga District. It had the main goal of investigating their levels of awareness and knowledge of AIDS as well as examining their HIV/AIDS preventive behaviour. This was in view of understanding their role and capability in influencing marital sexual behavior related to HIV/AIDS prevention.

The main objectives of the study included; investigating knowledge among married women concerning HIV transmission and prevention; examining their attitudes concerning personal vulnerability and the preventive strategies they have adopted; exploring their capacity to influence marital sexual behavior related to AIDS prevention as well as the male perspectives on women's role in sexual decision making and AIDS prevention; and identifying factors that promote or hinder married women's ability to influence marital sexual behavior in HIV/AIDS pevention.

This study employed a combination of both quantitative and qualitative techniques. Qualitative techniques used included Focus Group Discussion, informal interviews, key informants and observation. Quantitative techniques included use of questionnaires and interview schedules which included both written and unwritten questions. Data processing and analysis were quantitatively and qualitatively applied.

The study found that despite the inaccurate and distorted views about AIDS most married women in Sabatia were aware of the heterosexual transmission of AIDS. They were also acutely aware of the seriousness and consequences of AIDS infection although majority of them tended to deny their own vulnerability. Most of the strategies that women reported to have adopted to protect themselves from HIV infection were those which they felt would not challenge their husband's sexual superiority and freedom. Although men generally felt that there was need for women to protect themselves from HIV/AIDS infection there was skepticism among them on the role of women in sexual decision making in this regard. It was noted that a majority of the married women had either no or low ability to influence marital sexual behaviour related to AIDS prevention.

The major factors that promote married women's ability to influence adoption of HIV/AIDS preventive behaviour were found to be their awareness as well as knowledge of AIDS and their realisation of the need to change some long established beliefs about marital sexuality that give husbands superior status to their wives. The main barriers included the negative attitudes towards condom use in marriage; women's surbodinate economic status; and finally the long established beliefs about sexual rights and the culturally rooted expectations of marital sexual behaviour which promote male sexual superiority over women.

This study therefore recommends that HIV/AIDS surveillance, education and condom distribution programs must continue with even greater support and determination. However, a fourth component, namely, normative change, must simultaneously be addressed. This approach would infuse current AIDS prevention activities with empowerment – oriented strategies which place AIDS in the context of women's sexuality and social status. The blue print for action must therefore now include not only informing, educating and motivating, but also enabling.

CHAPTER ONE

INTRODUCTION TO THE STUDY

1.1 INTRODUCTION

AIDS stands for Acquired Immune Deficiency syndrome. It is a collection of pathological signs and symptoms said to be caused by the HIV Virus. The disease has become a serious health problem especially in developing countries where the number of cases has been increasing rapidly among women. (UNICEF 1992). As of mid 1993,about four fifth of all people infected with the AIDS Virus lived in developing countries with over 7 million of them to be found in sub-Saharan Africa (WHO 1994).

Since the first cases of the disease were officially recorded in Kenya in 1984, reported cases of HIV/AIDS in Kenya have continued to swell rising from 843 in 1985 to 5,949 by March 1989 (Ministry of Health 1989). Recent statistics indicate that so far over 200 thousand people have developed AIDS since it started in the country and well over 60 percent of these have already died. (Ministry of Health 1989). The sentinel surveillance system which operates in 13 sites in the country indicates that the disease has spread throughout the country with cases reported for every district (Ministry of Health 1997).

As the cases of AIDS continue to rise, the impact of the disease on Kenya's development must be understood in the context of the country's on-going critical social and economic challenges. While the human crisis is overwhelming, it only shows a partial picture of the impact AIDS will have on the country. The draining effect the disease has on individual household, community and national resources is very enormous. The disease has been found to affect mainly the economically active members of the society. The demands for people with AIDS is a liability to both families and the state as they exert pressure on already overstretched family and government budgets (Forsythe 1992).

With no recognised cure of AIDS at the moment, there is evidently urgent need for measures to be undertaken to control the epidemic especially in developing countries like Kenya which are struggling desperately to pull themselves out of economic crisis. According to WHO (1994) such measures should have the objective of reducing the spread and minimise the impact of HIV infection, increasing the awareness of the consequences of HIV/AIDS and addressing the socio-economic, gender and racial inequalities that increase vulnerability to the disease.

In response to the emergence of AIDS in Kenya, the government decided to establish a national infrastructure under which matters and activities pertaining to the disease could be coordinated. National AIDS Committee (NAC) in the Ministry of Health was formed in 1985. (Ministry of Health 1989). Soon after a diagnostic surveillance and reporting infrastructure was established which entailed screening all blood in the country. A five year Medium Term Plan (MTP) for AIDS control which incorporated World Health Organisation (WHO) effort and technical advice was formed. In 1987 the Kenya National AIDS Control Programme was launched whose main major components included health education, epidemiology,. Clinical services, laboratory and blood transfusion services. The AIDS programme secretariat was established to promote public health education campaigns and create awareness of the disease and its prevention. Since the laying down of the infrastructure both success and failure have been realised in all areas.

The behaviour modification strategy was taken into consideration in laying down the above infrastructure. Indeed the government recognized the role of behaviour change in the control and management of HIV/AIDS in the country. In the first five year AIDS control plan (1987-1991) the ministry of Health notes that:-

> " *through information and education, people will be helped to make informed decisions in adopting lifestyles that do not favour transmission of AIDS" (Ministry of Health 1989:16).*

The assumption here is that if people get information on AIDS, then they will take steps towards sexual behaviour change to avoid infection. The government therefore went ahead

to undertake rigorous AIDS awareness campaigns through the print and electronic media and other agencies.

Whereas the country in general has achieved modest success in creation of awareness about HIV/AIDS, evidence on the ground shows that this has not translated into sexual behaviour modification among a majority of the population in both urban and rural areas. (Ngugi 1987). Thus the number of new cases of AIDS has continued to rise although the level of awareness has been rising. The implication of this is that there is a gap between AIDS knowledge and sexual behaviour change which warrants investigation.

One of the major hindrances to sexual behaviour modification as recognised and advanced by HIV/AIDS intervention programmes in Kenya is that sexual negations are impaired by unequal gendered power relations. Thus the question of power relations becomes central in the behaviour modification strategy. (Nzioka, 1994;36). Most of the HIV/AIDS intervention programmes/strategies in Kenya are yet to adequately address among other issues the role of power relations and the economic, cultural and social factors that influence and shape sexual behaviour.

The socio-economic and cultural situations women find themselves in, both in and outside of marriage continue to put them at greater risk of HIV infection than men (Forsythe 1996). The dominant social constructions of sexuality among most Kenyan communities also seem to put women at the risk of HIV infection as they constrain women's ability to challenge male domination. (Nzioka 1994). Thus the impact of AIDS in Kenya differentiates not only in its medical manifestations but also in its disappropriate impact on women. This scenario is by no means unique to the Kenyan situation but can also be found in most of the developing world especially in sub-Saharan Africa where the behaviour modification strategy employed in programmes targeting women has faced a lot of problems (Cabrera et al 1996).

With the dramatic increase in infection levels among women in both developed and developing world, there has been an increasing shift in the global demographics of HIV

infection. This shift is forcing a reassessment of the sexual behaviour modification strategies with a view to examining the role of socio-economic and cultural factors in increasing women's HIV/AIDS vulnerability. Indeed UNDP (1993) calls for systematic studies of women's AIDS/HIV preventive behaviour in order to come up with effective programmes to reduce their vulnerability to the disease. In Kenya most such programmes rely either on foreign or inadequate literature due to lack of data from local studies.

For the sexual behaviour modification strategy to succeed in programmes targeting women in HIV/AIDS control, it is imperative that information regarding specific behaviour of target populations be obtained. This is a basic ingredient in the development of maximumly effective programmes aimed at controlling AIDS. We note that most of the communities in Kenya encompass a myriad of ethnic groups which represent distinct bodies of cultural social norms and practices. Together with the impact of the policies and infrastructure imposed by the development of the country, their distinct cultural systems channel and limit the range of behaviour including that of sexual practices to be found in any particular social setting. Indeed Nzioka (1994) notes that it is difficult to conceptualise Kenyan sexuality due to ethnic and cultural diversity. This means that various communities in Kenya portray varied aspects of women status and their socio-economic and cultural contexts in relation to their HIV/AIDS preventive behaviour. However most studies conducted in Kenya have failed to take specific ethnic group affiliation as units of analysis.

This study focuses on the Maragoli sub-ethnic group of the Luhya community. It targets married women with a view of examining their awareness, and knowledge of HIV/AIDS as well as their preventive behaviour. It is hoped that this will provide a contribution to the effort to control the spread of AIDS by giving vital information to programme planners and implementors for intervention on behaviour change.

1.2 PROBLEM STATEMENT

The impact which HIV/AIDS has had on both female and male populations worldwide has been very devastating. However the rate at which HIV has been increasing among women has become an issue of concern. The number of infected women rose sharply during the second half of the 1980's in developing countries especially in Africa with a four-fold increase over a period of between two and four years. It has been projected that during the next decade the prevalence of HIV infection among women in developing countries will equal and in some cases overtake that of men (UNDP 1993).

Though cases of AIDS among women are increasing, the long established beliefs that AIDS are restucted to particular; apparently well defined and often marginalised groups has reinforced stereotypical views and prejudices about sexual identity and immoral sex, rather than emphasizing what is common to all sexual behaviour. The epedomeological descriptions of HIV/AIDS in women especially those in marriage have sufferred from such stereotypes and prejudices making marital HIV/AIDS sexual preventive behaviour not to be critically examined.

The prevalence of HIV in both rural and urban areas in Kenya has been increasing (NASCOP 1996). A majority of the population in Kenya and most of the developing countries live in rural areas. Women in Kenya represent over half of the population and more than three quarters of the rural dwellers (CBS 1989). Women are an important category of economic and social actors who facilitate the role of the family in human survival in their various multiple roles. The increase in the number of cases of AIDS among women both in and out of marriage especially in rural areas is worrying and if not checked, leaves little scope for optimism.

A large number of women who visit ante-natal clinics both in rural and urban areas in Kenya have been reported to be HIV positive. Estimates have shown that 10 percent of women attending the ante-natal clinics at Kenyatta National Hospital are HIV positive. The 1996 National AIDS Sentinel Surveillance results indicated that some places in Kenya such as

Kisumu, Nakuru, Nairobi, Busia and Tiwi the proportion of women infected with HIV virus is greater than 20 per cent. Some other sites such as Mombasa, Kakamega, Thika, Maragwa, Mbale (in Maragoli area) and Mosoriot have reported 10 - 20 per cent of pregnant women attending their facilities to be HIV positive (NASCOP 1996). A worrying revelation is that some of the women are married meaning that the marriage institution is no longer safe.

Marriage has been seen to portray patterns of sexual fidelity and provides a norm of social organisation in most societies of the world including Kenya. Indeed, in Kenya, the government and other change agents, particularly those associated with religious groups are making fidelity messages a cornerstone of their AIDS preventive policies. This is especially so the case where condoms are in short supply, opposed on religious grounds or unable to be used for various other reasons. Since marriage has for along time been seen as more likely to exhibit elements of fidelity, there has been atendency to view this institution as being less vulnerable to the epidemic. This perception even seems to have permeated research in the area of AIDS and sexual behaviour change.

The rising cases of sexual transmission of AIDS among married, women is thus a clear indication that marriage is not a static structure. Nor does it involve only one form of sexual practice or access. Though an important issue in AIDS education and control, fidelity is problematic. For it to be meaningful in HIV/AIDS prevention it requires joint responsibility and commitment between the married partners. According to Cabriera et al (1996) in most marital unions all over the world there is always a limit to such commitment and responsibility due to the various situations marital partners find themselves in. This puts to question the role of fidelity in AIDS prevention and marriage as a safe haven.

Indifelity may not be exclusive to men, but in many societies, especially in developing countries such as Kenya, different pre-conceptions about male and female sexuality make women more likely than men to observe fidelity. Though marriage partners could infect each other with AIDS, the more pronounced infidelity of men puts women more at risk. The question therefore is, can married women protect themselves from sexual transmission of

AIDS from their husband? To what extent can they do this and what problems do they face?

The extent to which women can protect themselves from marital sexual transmission of AIDS will depend on among other factors their ability to influence their male counterparts to adopt HIV/AIDS preventive behaviour. In Kenya, though studies have shown that in most communities men dominate women in sexuality matters, the extent to which women can be able to influence sexual behaviour in AIDS prevention has yet to be explored. The extent to which men may also be apprehensive of women's concerns has yet to be investigated. This are some of the areas the WHO (1996) recommends that be addressed in terms of research in AIDS and sexual behaviour change. In trying to address some of the issues above this study primarily focuses itself on HIV/AIDS knowledge and preventive behaviour among married women in Maragoli. The following research questions form the basis of this study;

1] What level of awareness and knowledge do married women have on AIDS?

2] How do married women percieve the risk of HIV infection and what steps have they taken towards proection?

3] How do men perceive the right and responsibility of married women to protect themselves from marital sexual transmission of AIDS?

4] What opportunities and barriers are there to married women's ability to influence adoption of HIV/AIDS preventive sexual behaviour?

1.3 OBJECTIVES OF THE STUDY

General Objective

The study aims at examining level of awareness and knowledge of HIV/AIDS as well as HIV/AIDS preventive behaviour among married women in Maragoli, Vihiga District.

Specific Objectives

1] To investigate the knowledge among married women concerning HIV/AIDS transmission, modes of prevention.

2] To examine married women's attitudes concerning personal vulnerability and look into the action strategies they have adopted to protect themselves from infection.

3] To explore married women's capacity to influence marital sexual behaviour related to AIDS prevention and the male perspectives on women's role in sexual decision making and AIDS prevention.

4] To identify factors that promote or hinder married women's ability to influence marital sexual behaviour in HIV/AIDS prevention.

1.4 SCOPE AND RATIONALE OF STUDY

1.4.1 Scope of the study:

This study was undertaken in Vihiga District of the Western province of Kenya. It focused on currently married women in one of the administrative divisions of the district, namely; Sabatia. This is one of the two divisions within the district which are predominantly inhabited by the Maragoli sub-ethnic group of the Luhya.

1.4.2 Rationale of the study:

In view of the forestated objectives, the essence of this study lies in the following considerations that justify it as a subject of academic inquiry.

The discourse in which sexuality in Kenya as elsewhere in Africa is constituted has meant that women have always been viewed as recipients in matters pertaining to sexuality. Men have always been seen to posses a natural tendency to promiscuity and controlling the sexual encounter. (Nzioka 1994:36). Because of this, men have not only been seen as the major actors in sexual behaviour modification, but they have also received a lot of research attention. Women have thus received little

research attention and their role in sexual behaviour modification in this era of AIDS has yet to be explored. There is need to explore women's capacity to influence sexual behaviour change and their role in adoption of HIV preventive behaviour.

Cases of HIV/AIDS infection among married couples have continued to be reported in Kenya yet so far no studies have focused on marital AIDS/HIV preventive behaviour. This is because for a long time married couples have been seen to be less vulnerable to the disease. As the risk of HIV infection among couples becomes increasingly evident there is need to understand marital HIV/AIDS preventive behaviour.

Statistics not only show that there are many cases of AIDS among women in Maragoli but they also reveal that the increase in the number of cases has been very rapid. This is evidenced by the fact that the proportion of pregnant women infected with the HIV virus in the area rose sharply from less than 5 percent in 1989 to almost 10% in 1993 (NCPD 1994). This infection of HIV among women has been found to open way to peri-natal HIV transmission to women's new-borns on a large scale. Indeed the Vihiga District Development Plan (1994-1996) acknowledges the emergency of the phenomenon of "AIDS orphans" in the area. It also gives a worrying revelation that some of the HIV/AIDS victims have been reported to be married women.

Various agencies from both public and private sectors have set up massive AIDS awareness campaigns and control programmes in the study area (Vihiga) to facilitate adoption of desirable HIV/AIDS preventive behaviour. Some of the intervention initatives target women at both individual and communal level. However, the increase in the number of cases of HIV/AIDS among women shows that adoption of HIV Preventive behaviour has been difficult. To achieve sexual behaviour modification it would be important that such programmes targeting women pay attention to the broader socio-economic and cultural contexts in which high risk

behaviour occurs. To do that adequate data on women's knowledge of AIDS and their HIV preventive behaviour is needed.

In summary therefore, this study is an attempt at providing systematic and detailed information about married women and AIDS which has not been availed by studies done in Sabatia. It will therefore contribute useful data for intervention on sexual behaviour which has been identified as the best means of managing AIDS given that there exists no recognised cure for the disease.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 LITERATURE REVIEW

2.1.1 Introduction

In this section there may be a preponderance of literature from the west and other non-African developing countries such as those of Asia and Latin America. Indeed, given that in a country like Kenya the phenomenon of AIDS is relatively "new," literature on the subject is inadequate. Much of the available literature on AIDS in Kenya is mainly journalistic due to censorship which for along time has inhibited free and open discussions on the subject. (Nzioka 1994). Generally there has been a lot of reliance on the west for information and research as the government has so far not been able to conduct meaningful independent researches in the country. Most of the studies conducted have mainly focused on prevalence of the disease and its awareness.

This section draws from literature on sexual behaviour change and the status of women. The literature has been reviewed under the following sub-sections:-

a] The information supply model and HIV knowledge in Kenya.

b] Promotion of condom use and safer sex in Kenya

c] The status of women and sexual behaviour change

d] Sexuality in traditional Maragoli.

2.1.2 Information supply model and HIV Knowledge in Kenya

Most HIV/AIDS control programmes in the world contain two aspects, information

supply and promotion of "safer" sex practices. (Nzioka 1994:38). Information supply can be said to be the pillar of the anti-AIDS campaign in Kenya and is based on the framework of rational choice. Information supply thus involves making available facts about HIV/AIDS with the assumption that individuals will make informed decisions in adopting life-styles that do not favour transmission and spread of HIV/AIDS (Ministry of Health, 1989).

The assumption in this model is that people fail o adopt new behavioral traits that do not favour transmission and spread of HIV/AIDS because they lack information. or this reason, the Kenya Government and other change agents here continued to supply packets of information to the public on the dominant modes of HIV transmission, and on the ways of avoiding risk of transmission. (Forsythe 1992), Thus the information supply model is also based on the theory of reasoned action or planned behaviour (Ingham et al 1992, cited in Nzioka 1994). In this theory of planned behaviour, introduction of new ideas and encouragement of people to experiment on them is hoped that such ideas will become integral part of their lives.

Both the government and other change-agents especially Non-Governmental Organizations (NGO's) in Kenya have been involved in information supply as a means of controlling AIDS spread. The Ministry of Health in Kenya has for example used Kenya Broadcasting Corporation facilities to pass AIDS/HIV messages to the public. Both Television and radio have been used in this regard. Nzioka (1994) argues that such messages by the government lack details in comparison to HIV/AIDS programmes placed by private companies and NGO's on the same network. Such messages have been found to be more elaborate, detailed, information and analytical. Thus the private companies and NGO' s seem to be taking a more integrated approach than the government.

Due to information supply, the Ministry of Health has noted high levels of HIV/AIDS awareness in the country. (NASCOP 1996). Okoth and Walji (1996) argue that whereas this is the case, this awareness has not translated into sexual behaviour changes and

particularly adoption of safer sex practices. According to Forythe (1992) in most cases the message content of the AIDS education campaigns lacks in sensitivity to culture, key beliefs, traditional values and emotional needs of the target population. It has also been argued that sheer knowledge of risks involved in certain lifestyles, may not provide sufficient deterrent effects unless individuals are confronted with factual evidence of the dangers involved (Jackson, 1988 cited in Nzioka, 1994). According to the Panos Dossier (1990) there has also been a lot of sensational reporting which places emphasis on death and fearful statistics meant to sell newspapers than increase public knowledge and understanding of HIV.

In criticizing the information supply model, Nzioka (1994) argues that information about risks involved in a certain activity, though necessary for behaviour change, it may not be sufficient to bring about clear-cut and lasting sexual behaviour change. He thus notes:

> *"For safer sex messages to be effective, they must include not only lay beliefs about the origins, aetiology and effects of the syndrome, but also socially, culturally, ethnically, religiously and politically specific significations of sexual desire and practice (Nzioka 1994:96)*

2.1.3 **Promotion of Condom use and safer sex in Kenya.**

According to Nzioka (1994) the concept of safer sex remains obscure and the term is still used in a generic sense without explication. In official programmes in Kenya, safer sex simply means condom use. Hart (1993) cited in Nzioka (1994) however argues that 'safer sex' is any activity which reduces the risk of transmission of HIV infection and some other sexualy transmissible diseases, which can include penetrative intercourse, but only when a condom is used correctly and with no breakage. Since in Kenya the government definition of safer sex is condom use, success in its promotion is evaluated in terms of the number of condoms distributed or sold.

The government has sought ways of making condoms easily available to the general

population. Free condoms are available in most family planning clinics and are easily bought at subsidized prices. According to Onyango and Walji (1998) not all people can go to family planning clinics to obtain condoms. This is partly because not all clinics are physically located within easy reach especially in the rural areas where the bulk of Kenyan population lives. In heterosexual relations use of condoms has been hindered by many factors. This has especially been the case in gendered sexual relationships.

The Kenya government has not espoused condom use as a formal government policy due to the fear of moral sensitivities surrounding condom use and the fact that it could generate hostility from some religious bodies such as the Catholic Church and parents (Forsythe). According to the Ministry of Health (1992 b) one of the requirements given by donors of condoms is that among other purposes they should be used for population control. Therefore condom use has been disguised within Family Planning Programmes to avoid a lot of criticism.

Whereas government figures show that demand for condoms rose from 1985 to 1992, Nzioka (1994) argues that it may be difficult to tell whether this increase can be attributed to the fear of contracting AIDS. This is because condoms may be used for multiple purposes such as birth control devices as well as against sexually transmitted diseases. Thus the degree to which promotion of condom use has been effective as a means of controlling HIV transmission in Kenya is still obscure. The reliance on quantity of condoms distributed to asses the success of condom use in AIDS control can be very misleading.

It has been indicated worldwide that use of condoms in heterosexual relations is very problematic (WHO 1994,UNDP 1995). Condoms carry with them symbolic meanings which may hinder their use even when the risks of infection are apparent. For example in most African communities, in marriages, introduction of condoms could be very problematic because condoms carry with them a host of symbolic meanings such as lack of trust, denial of paternity to men and control of sexuality by women- all which

contravene culturally cherished beliefs. Marriages are build ideally on trust and penetrative sex is an integral part of the normative expectations of marriage (Nzioka 1994:86))

Promotion of condom use has also been impared by the fact that in most societies sexual relations are characterised by unequal power relations. These unequal power relations could stem from material deprivation, physical strength or looks, intelligence or culturally prescribed gender behaviour. Caldwell (1990) cited in Nzioka (1994) concludes that condom use, especially in marriage will not prove to be a major force against AIDS because African women lack influence over their husbands sexual behaviour.

There has been a lot of resistance to condom use in Kenya. Such resistance has been spearheaded by church Organisations which see condom use as synonymous with immorality. Such church organizations include the Roman Catholic church which advocates for moral restraint in the control of AIDS. Nzioka noted that in Kenya traditionalists opposed to condom use advocate for polygamy which goes against the Christian teaching of monogamy as a way of tackling AIDS. The church and the traditionalists both see celibacy and marriage as the solution to the AIDS problem. But evidence shows that marriages are not safe from AIDS(Tuju 1996, Ngugi 1987).

Despite attempts to distribute condoms freely and extensively in the country some remote parts of the country experience shortages. Condoms are still affordable by a small proportion of the wider population. Forsythe (1992) has also noted a high rate of condom failure in Kenya.

From the foregoing we note that for successful control of the spread of AIDS there is need for programmes which are socially and sexually meaningful to the people. Promotion of condom use alone without clearly addressing factors which militate against their use will not help much. There is need for systematic data/literature on how safe sex is negotiated between spouses. Such literature is lacking. Although Tuju (1996) and

Ngugi (1987) argue that women have problems in sexual negotiation and condom use in HIV prevention there is no detailed information on how safe sex is negotiated within heterosexual relations among various Kenyan communities. Such information, can be very useful in developing programmes for AIDS education and promotion of condom use.

2.1.4 The status of women and sexual behaviour change

As the heterosexual spread of HIV increases, the relationship between socio-economic and cultural subordination of women and risk behaviour is becoming increasingly evident. In many societies, there is a significant power differential between men and women, supported by social and cultural systems that posit the control by males. (Berer, 1993).

In some African cultures, women do not even have the "permission" to talk about sexual matters. In a study in Uganda it was found that to do so may have serious repercussions ranging from stigma to fear (Topouzis, 1994). Such findings have been confirmed by studies done in other parts of Africa including Kenya (Tuju 1996, Mead 1992, Ngugi 1987). Despite this, many HIV/AIDS prevention programmes have expected women to assume responsibility for prevention of HIV infection in a context in which they have limited control over when, with whom and how they engage in sexual activity (Kisseha 1988).

The gender power differential is also compounded by age differences. In countries with high HIV infection rates, men justify the selection of young adolescent girls, even female children, on the grounds that they are less likely to be infected with HIV/AIDS. In Kenya it has been found that women typically marry or have sex with older men, who have been sexually active longer enough hence are more likely to become infected with HIV themselves. (NCPD, 1994). Mead (1992) observes that this practice is common in most of the countries of sub-Saharan Africa where it has been linked to the transmission of HIV among women.

In most African communities, culturally it is the role of men to initiate sex. Such role expectations are flustered by the belief that endorses the biological notion that men have a problem in controlling their sexual encounter (Gupta 1992). Such role expectations have been found to constrain sexual negotiation. In Natal, South Africa, it was found that most women believed that men could not control their own sexual encounter (GPA, 1993). Such women could live with the risk of being infected with AIDS from their husbands without trying to influence the men's behaviour (Mead, 1992).

Many societies promote monogamy and mutual fidelity and discourage multiple casual partners as a social norm. However in some African cultures men are expected and even encouraged to have more than one sexual partner while women are expected to have one life-long sexual partner (UNICEF 1992). In Kenya some communities expect women to adhere strictly to the norm of fidelity while condoning male deviations from it (Forsythe 1992). In communities where multiple partnership for men is allowed women may even have the belief that multiple partnership is essential for "men as men" but is not acceptable for them. With such kind of belief women may find it difficult to negotiate for AIDS protective sexual practices, or insist on faithfullness from husbands..

Societies which promote monogamy and mutual fidelity and discourage multiple casual partners as a social norm have also encouraged these values as a primary AIDS prevention strategy. Such reliance on "monogamy and mutual fidelity" as explained above as a principle solution to the spread of HIV/AIDS can be very misleading for women. This is because fidelity protects against HIV only when it is mutual and life-long. According to UNICEF (1992) for most women in sub-Saharan Africa fidelity and monogamy only create an illusion of safety for those who are monogamous but cannot be sure of their partners. Indeed Nzioka (1994) notes that AIDS campaigns that stress on monogamy and fidelity only may not be successful as they are misleading to women.

Making independent decisions in matters of sexuality is very difficult for women in many cultures. In most developing countries female ignorance of sexual matters is considered a sign of purity. Consequently, knowledge of sexual matters is considered a sign of easy virtue. "A good woman" in some African cultures is defined as one who is ignorant of sex and is bound to have a negative effect on women's sexual negotiation power and HIV/AIDS preventive behaviour (Panos Dossier 1990).

Various cultures project different images of sexuality. Reid (1995) argues that in societies that view sex and reproductive life as being sacred, the probability that partners will talk to each other about sexual matters is very small. In India for example, partners, including married couples were found to rarely talk to each other about sexuality or AIDS (USAID 1992). In Kenya whereas level of awareness of AIDS has increased, HIV/AIDS related issues are still regarded as unpopular among family members including married couples (, Onyango and Walji 1990). Gupta (1994) concludes that in most sub-Saharan countries lack of communication among sexual partners has consequences for HIV infection to women because it makes it impossible for them to learn about their spouse's sexual lives.

Male resistance to condom use and women's inability to negotiate safer sex, puts women as well as men at greater risk of HIV infection. (Schoepf et al 1991). For many women the reason for not using condoms as a protection against HIV is the need for their partners' consent (agreement). For men, the rationale for resisting condom use ranges from concern over reduced sensitivity, ignorance about how to use them properly and fear that using them will permanently interfere with fertility (Tuju 1996). In addition, within marriage or other long term relationships the very suggestion of condom use comes with it an indication of "infidelity" or other behaviour that could threaten the security of the relation. The GPA (1993) notes that women are more disadvantaged in this regard as far as use of condoms in AIDS//HIV protection is concerned.

A study in Uganda showed that one major obstacle for women who wish to protect themselves against HIV infection is the desire to have a child. This is because safe sex (no penetration or condom use) pre-supposes sex without conception yet most communities value motherhood very much. Indeed status and respectability was seen to be accorded to women as child bearers. Childless women may face stigma and sometimes the penalty may be desertion or divorce. This makes women's choices about prevention against HIV or negotiation for safe sex very minimal. (Topouzis , 1994).

In most sub-Saharan communities, marriages were and are still contracted through payment of bridewealth, the size of which varies from one community to another. In patrilineal societies, bridewealth signaled transfer of women's reproductive capacity from her father and her relatives to her husband and his relatives. (Gupta 1994). The more the bridewealth the more a woman got bound to her husband. Some studies have found a link between this practice and the lack of freedom of expression and decision making in household matters including those governing sexuality. (WHO 1994, UNDP 1995). Thus vulnerability of HIV infection among women especially from their husbands is likely to be increased by the practice of payment of bridewealth/dowry.

In some matrilineal societies, where bridewealth is low, the husband does not retain his children and the wife retains close contacts with the maternal home/family. Divorce is signaled through the return of bridewealth. It is easier for divorce to take place because women can acquire the necessary bridewealth to return to their husband's family. But in patrilineal societies where bridewealth is very high, the frequency of divorce in many cases is very low (Elayne, 1997). Thus where bridewealth is high freedom of women is curtailed. They are always required to submit fully to their husbands even in matters of sexuality whatever their feelings. In some instances they are even considered as property. This shows the extent to which women may be bound by culture to refuse to acknowledge their husbands behaviour due to their powerlessness in matters of sexuality. Such denial means that they are unable to take first steps towards responding to the risk of HIV/AIDS infection.

In virtually every society, women face discrimination in employment and social status resulting in economic vulnerability to HIV AIDS (Corrorano, 1992). Such has been the case mostly in Latin America and Africa. (WHO 1994). The discrimination against women manifests itself in different ways. In African communities, it has become common for some girls to be withdrawn from school to assume domestic responsibilities. There is also occupational segregation of women into low paying clerical and service jobs, unequal pay and fewer promotions (vis-avis men), fewer work place benefits and concentration of women in the informal sector. The WHO (1994) has noted that such practices translate into lack of access and control over resources by women which eventually reduces their bargaining power in household matters including those related to sexuality.

According to Nzioka (1994) women's economic dependence on men brings with it not only an increased risk of HIV infection through inability to influence sexual negotiation, it also influences women's access to health information and health services such as sexually transmitted diseases treatment (STD's) and condom supplies.

It has been found that women who have the desire to use condoms may not be able to when they rely on their husbands economically. Nzioka notes:-

> *Negotiating condom use is further problematised by threats of cutting financial and material assistance to women. Where a wife or female lover has children, and relies on the male partner for assistance, rights to decisions relating to her sexuality might be limited"(Nzioka 1994:188).*

The WHO (1994) notes that some cultural practices and national policies reinforce women's economic dependence on men. Customary laws and contemporary legal systems sometimes restrict property ownership and inheritance to men, and some cases limit women's ability to enter into independent contracts or obtain credit under their own

names. This impedes women's ability to control income and property and reinforce their economic dependence on male relatives which reduces their sexual decision making power.

Domestic violence has also been linked to women's powerlessness in sexual negotiation. It has been found that sometimes women do nothing even when they know that their husbands are promiscuous and could infect them with AIDS. This is because some of them can not tolerate the violence that will follow. (Onyango and Walji 1990, Tuju 1996). Women fear requesting for condom use sometimes for fear of violence Nzioka notes:-

> " *Women cannot choose to use condoms even when the prospects of HIV infection are high. Censoring men against promiscuity may lead to violence against women" (Nzioka 1994:188)*

Education levels have always been cited in association with health behaviour variations. In reference to HIV/AIDS various studies have shown inconsistent findings as to the relationship between education and women's sexual negotiation power. While orboloye (1990) found that in Nigeria certain cultural barriers to the adoption of HIV preventive behaviour among the population could be eroded by high education levels for both men and women he also noted in another study in another community that there was no link between levels of education and sexual decision making power.

Cabrera et al (1996) observe that women with higher education levels are more likely to be accessible to HIV information and have feelings of personal vulnerability to the disease. However the efforts of such women to negotiate for safer sex are always hampered by cultural and economic factors. Thus although levels of education have been found to be related to women's health behaviour, studies have not been conclusive as to the extent to which education per-se influences women's HIV/AIDS preventive behaviour.

From the foregoing we note that the link between powerlessness and the risk of exposure to HIV, provides the key to understanding the source of women's vulnerability to HIV infection. The literature has clearly shown that socio-economic situations and socio-cultural factors related to marital sexuality, marriage, childbearing and gender roles have an influence on risk factors as well as the ability of women to adopt HIV protective behaviour. This can be attributed to remnants of the traditional patterns of family structure, social and economic arrangements which have evolved over time due to historical experience, cultural and economic development within a given context. This, according to Thomas & Zananiecki (1994) meets the convenience of given societies depending on how they see and define their situations.

2.1.5 Sexuality in traditional Maragoli

In the previous section we have tried to analyse how socio-economic and cultural factors relate to women's HIV/AIDS vulnerability. It was noted that traditional values influence sexuality in most communities. In this section we look at some Maragoli traditional values and the bearing they had on marital sexuality.

Various studies have been done among the Maragoli people dating back to the time before during and after the colonial period (Wagner 1949, Were 1987). Some studies have investigated the social aspects of the Maragoli people (Munroe and Munroe 1977, 1989, 1984, Munroe et al 1983, Munroe and shammin 1979, Whiting and Edwards 1988). Demographic characteristics among the Maragoli have also been examined (Ssenyonga 1978,1977, Omurundo 1988, Bradley 1989).

Whereas all the above studies have not addressed themselves specifically to sexuality among the Maragoli, some aspects of their findings can give insights into some traditional Maragoli values related to marriage and marital sexuality. We examine some of this works in light of their relevance to the current study.

It is documented that among the Maragoli marriage was considered a very sacred institution. However, from a sexual point of view, matrimony involved no decisive change in the life of a man. This is because young men who decided to marry did not necessarily give up their privilege of carrying on courtships and paying visits to unmarried women. Wagner (1949) notes that initially during early years of matrimonial life, the wives would not condone this. However, this changed with time. As a married woman got older and her domestic duties increased she generally welcomed her husband's courtships. Sometimes such courtships were seen as steps leading to another marriage, a practice that was culturally in order. From this we note that traditionally Maragoli women to an extent condoned multiple partnership for their husbands.

The respective sexual rights and duties of husband and wife among the Maragoli as most Bantu communities were ill-balanced. The husband held exclusive sexual rights over his wife (provided that he was not impotent). Any extra-marital indulgence on her side was considered adulterous and the husband could demand a cow as compensation both from the wife and her family. The wife on the other hand had no exclusive sexual rights over her husband. This sometimes made women not to question extra-marital sexual practices of their husbands (Wagner 1949, Were 1967).

Traditionally among the Maragoli, women married early and bride price was paid in cattle (Wagner 1949). Although this is still the case, money has become an important part of bride price because of lack of grazing place for cattle (Ssenyonga 1977, Bradley, 1989). Bradley (1989) also contends that although bride price payment served as guarantee for the wife's proper treatment, it almost had an opposite effect in most cases. This is because it induced the wife's father to persist in sending her back to her husband irrespective of the ill-treatment to which she may be exposed to at his place. This strengthened the man's sexual rights over his wife.

Under ordinary circumstances, it seldom happened that a wife's unjustified and selfish

desire to leave her husband met with any approval on the part of her own kinsmen. The brothers of a wife who had run away would as a rule make every effort to fetch her back and to hand her over to him. They would do so particularly if they hear that their sister's husband is not willing to give back bridewealth. The deposit of brideweath therefore did in fact strengthen the husband's hold over his wife as the unpleasant prospect of having to hand it back to the husband in case of divorce induced the wife's kinsmen to use their influence in maintaining the marriage. They compelled the wife to return to her husband if she ran away with a lover.

The social valuation of parenthood did not merely affect the status of husband and wife in the eyes of their tribesmen, but it also strongly influenced the husband-wife relationship itself. A prolific wife was seen to command more respect from her husband and his kinsmen than a wife who was barren or bore daughters only, a fate for which the wife alone was held responsible. .

Among the Maragoli there was always a desire to have numerous offspring. This was expressed in various matrimonial customs. Wagner (1949) identifies such customs. He notes that there was always desire for polygamous marriages especially if there was no child from the first marriage. There was also the existence of elaborate magical rites and sacrifices which were performed as remedies against bareness of the wife or impotency of the husband. Incase the wife was barren or did not bear sons, there was open approval of the extra-marital sex relations of the husband. In case the wife died without bearing children the husband had a right to reclaim all or part of the bridewealth. Also, there was remarriage of a widow to the deceased husband's brother, provided that she was not past the child bearing age.

Ndege (1990) identified desire for numerous offspring and preference for sons as one of the factors influencing husband-wife communication on the utilisation of contraceptives including condoms among the Maragoli.

Wagner (1949) further noted that formal "Social" relationship between husband and wife was ill-balanced as well. The husband all along enjoyed a superior status and expected formal obedience and certain outward signs of submission from his wife in most matters including sexual issues.

The legal - as distinct from the social status of the wife was also inferior to that of her husband. Her position was characterised by the fact that she had no ownership status whatsoever. In her quality as a wife, she had a claim to be supplied by her husband with certain objects for her own and her children's use. She however had no right of ownership to any of the objects which she handled. All material objects whether they accrued to the family from without or as a result of the family's combined economic effort were owned by the husband. The wife had no right to dispose of any of these objects unless she acted upon her husband's orders. Even what she realised through the sale of goods she produced came under the husband' control. If marriage became dissolved the wife had no claim of anything in the house. On the other hand the husband rights of ownership were limited only by number of kinship obligations within his lineage.

At this point in time it is expected that the conditions under which the traditional Maragoli marriage operated have undergone far reaching changes. Whereas some of these changes may have affected the entire community (Bradley 1989), their range of influence may be limited to some sections, which may have been more exposed or shown greater initiative in responding to the changes. As regards the status of women and marital sexuality, various forces may have constantly worked to undermine some of the traditional values described above. However the extent to which this values have changed is still obscure. There may be in existence remnants of the described traditional values which influence women's HIV/AIDS preventive behaviour which need to be investigated.

2.1.6 **HYPOTHESES**

From the selected literature reviewed above three main hypotheses were formulated to guide this study. The central argument behind this hypotheses is that the extent which married women can be able to influence sexual behaviour related to AIDS prevention depends mainly on the economic, social, cultural situations that shape their sexual experiences. The three hypotheses for this study are:

1. High knowledge of HIV/AIDS among married women may not necessarily translate into adoption of effective HIV/AIDS preventive behaviour.
2. Women's low economic status which leads to their dependence on husbands for subsistence has a bearing on their ability to influence adoption of effective HIV/AIDS preventive behaviour.
3. Socio-cultural values related to marriage, marital sexuality and parenthood have a bearing on married women's ability to influence adoption of HIV/AIDS preventive sexual behaviour.

2.1.7 **DEFINITION OF CONCEPTS AND KEY VARIABLES**

2.1.7.1 **Sex**

The concept "Sex" has many meanings with biological, psychological, socio-cultural, economic, moral and political contexts (Caplan 1987). For purposes of this study the concept sex is defined as sexual intercourse or coitus.

2.1.7.2 **Sexuality**

There is a lot of broadness and elusiveness inherent in definition of sexuality. For purposes of this study sexuality is used to mean sexual expression, preference and behaviour.

2.1.7.3 **Awareness of AIDS**

This refers to whether respondent has any information on the existence of a disease called AIDS.

2.1.7.4 **Knowledge of AIDS**

For the purpose of this study, knowledge of AIDS refers to the possession of information on the modes of transmission, methods of protection against HIV, symptoms of HIV/AIDS as well as the kind of risk behaviour that can lead to HIV infection.

2.1.7.5 **Effective HIV/AIDS preventive behaviour**

For purposes of this study effective HIV/AIDS preventive behaviour refers to modes of conduct or acting that will minimise or prevent the chances of a woman contracting the HIV Virus from among other sources the husband.

2.1.7.6 **Ability to influence HIV/AIDS protective sexual behaviour.**

This refers to the process whereby a wife is in a position to communicate freely and express her opinions about HIV/AIDS to husband, ability to make husband appreciate and accept her right to protect herself from infection, and ability to insist on either faithfulness from husband or protective sex (condom use) when one deems necessary.

2.1.7.7 **Women's economic dependence on husbands**.

This refers to a woman's economic reliance on her husband for meeting basic household needs. Such needs may include medical expenses, food, fees payment, clothing, farm inputs or hired labour.

2.1.7.8 **Levels of education**

This refers to the number of years completed by the respondent s in formal schooling. For cross-checking purposes respondents were also asked the highest level of formal schooling attained.

2.1.7.9 **Socio-cultural values**

Bilton et al (1987) define vales as rules which are not attached to particular roles but are more general standards concerning worthy behaviour. Values influence action and give general direction to behaviour, acting as significant forces in ones socio-cultural environment. Above all values add an element of predictability to social life (Kluckhohn, et al 1956: 66).

For this study we limit our definition of the concept social-cultural values so that conflicts in meaning and interpretation are minimised. This study uses the term socio-cultural values to refer to specific norms, values and beliefs related to marriage, role of women in marital sexuality and parenthood which influence their entire sexual behaviour. This values, norms and beliefs are held by the community in general and they influence action and give direction to women's sexual behaviour.

2.2 THEORETICAL FRAMEWORK

2.2.1 INTRODUCTION

In this section I outline the main theoretical approaches from which this study was conducted. Kerlinger (1994:11) defines a theory as;

" A set of interrelated constructs (concepts), definition and proposition that presents

systematic view of phenomena by specifying relations among variables with the purpose of explaining phenomena"

Sociological analysis involves theorizing because the act of research necessarily involves making certain questionable assumptions about the nature of reality and how it becomes itelligible to us. The theoretical assumptions tht are made structure the scope and nature of research including what are considered appropriate data.

There is a distinction between physical aspects of AIDS from the social aspect. Nzioka (1994:23) explains this by noting that the reality of AIDS, the "disease", has to be located in the bio-medical world while the reality of AIDS the illness has to be located in the socio-cultural world. This impies that diseases belong to the objective sciences of the body and occur independently of human evaluation, but the various ways different social groups respond to it and experience it are social hence concerns of sociological analysis. Therefore my study adopts asocial phenomenon perspective rather than a bio-physical approach. In doing so, this study is guided by the following three main theoretical approaches:-

a] socialization theory
b] symbolic interractionism
c] the situational approach

2.2.2 THE SOCIALIZATION THEORY

The main argument behind this theory is that human behaviour is learned behaviour. According to Zectman (1973)and Marlowe (1971) socialization is that processes through which individuals acquire knowledge, motives, norms, beliefs, skills and other characteristics expected in groups of which they are or seek to become members. Thus socialization may be said to perform two major important functions;

i] It gives skills of acting which are distinct to a given society (where the socializee is a member)

ii] Socialization reinforces established patterns, helps in the adoption of new ideas and ensures minimal deviations.

According to this theory therefore, every individual person and his/her behaviour pattern, including sexual behaviour can be understood in the context of a particular socialization process. Thus intersocietal variations in sexual behaviour may be considered to be a consequence of variations in socialization on sexual behaviour. I.e. can be attribute to conditions of learning rather than genetic differences. In essence, various societies through the process of socialization use different parties to block or channel individual sexual characteristic which may be seen to pose a threat to the social-order. Thus individuals come to develop specific operations which is continuous and begins during childhood. For instance they come to learn what the society considers to be desirable marital sexual behaviour. A proper understanding of HIV/AIDS preventive marital sexual behaviour according to this consideration the various norms beliefs and attitudes tat individuals develop during the process of socialization and impact on their sexual behviour.

In this study this theory can be seen to have potential explanations with regard to some of this questions;

i] To whom by socialization does society ascribe more authority in marriage in making decisions over sexuality?

ii] Does the socialisation of Maragoli women influence their sexual behaviour even with the risk of contraction of HIV/AIDS?

iii] What is the norm of the Maragoli society as regards marital sexual behaviour and decision making and how does this have an effect on women's sexual decision making as regards AIDS prevention. ?

2.2.3 SYMBOLIC INTERRACTIONISM

This theory was brought to prominence by the ideas of George Herbert Mead (1934). It is based on the Chicago School of Sociology and was propounded by among others, Gooffman (1959); Garfinkel (1967), Blummer (1969), Berger and Lickman (1967).

This theory sees human behaviour as a form of interaction in which individuals define, interpret and give meaning to each others actions instead of merely reacting to them. Blummer (1969) notes that human behaviour is meaningful and people individually or collectively rationalise behaviour on the basis of the meanings and impressions of objects that characterise their world.

According to the theory, this interpretive process does not occur in a vacuum but it is defined by particular group contexts and is influenced by charactive moral order (Blummer 1969). People therefore make sense out of everyday life and actions through " interprevetive rationality" in reference to this moral order. This moral order is the basis of society which is sunctioned by taboos which are coeraine powers, that define and constrain human behaviour.

The theory also argues that society is dynamic and evolving. As this happens the strengths and effects of the norms are seen as being determined by the nature of society which the individuals interact (Merton, 1957).

It is also recognised in this theory that behaviour in general and sexual behaviour in particular is a product of cultural impositions on biological forces and vary from culture to culture (Caplan 1981). The main argument here is that it is the socialization process rather than biological factors that influence sexual expressions (Money, 1981) hence related to socialization theory.

This theory has the potential of guiding this study for a number of reasons. Fr one this

study is about husbands and wives as they interact in a sexual way. Sexual behaviour and relationships are interactive and are full of symbols and meanings that people give to themselves, to each other, as well as objects exchanged in the relationships. AIDS preventive behaviour will thus be seen to be interactive and interpretive.

We also note that this theory recognises the fact that human behaviour including sexual behaviour cannot be separated from historical, economic, political and cultural matrix in which it is embedded. Thus we cannot discuss women's HIV preventive behaviour in a vacuum since sexuality cannot escape its cultural dimensions.

2.2.4 SITUATIONAL APPROACH THEORY

The situational approach theory was profounded by Thomas and Zaanuecki (1974). The core arguments in the theory focus on

i] The ideas of crisis
ii] The definition of the situation
iii] The concept of socio-disorganisation

According to this theory therefore "crisis" is seen as the most significant of human experiences affecting the definitions of individuals and groups and also influencing the context of culture and personality as well as the direction of socio-cultural change. Behaviour therefore is seen as situationally determined. For example a new situation/experience or problem calls for a redefinition of the situation.

Explaining the process of redefinition of a situation, Steward (1973) introduces the concept of "reinterpretation". This is a process of cultural change which can be change in attitude and behaviour of individual members of society. It can be in adapting or rejecting values different from the individuals. He further argues that when a new behavioural trait is introduced for example, its acceptance depends on whether it is good

enough to make acceptance worth the trouble. Adoption or rejection of the new behavioural trait will depend on how member so the society define their situation.

According to the proponents of this theory, redefinition of a situation depends on;

i] Cultural factors which either independently or collectively influence subsequent behaviour
ii] Socio-economic factors
iii] Biological factors
iv] Psychological factors

In addition to the above, physical environment, the social norms, values, attitudes and the people one interacts with contribute to redefinition of a situation. Further, the individuals perception of the situation, its definition and meaning have a bearing on the next approach to the situation.

Within this framework, sexual behaviour can be seen as situationally determined. This perspective will therefore inform this study in various ways. It has the potential to answering this questions:-

i) With the emergence of AIDS, do married women in Maragoli feel that they are faced with a crisis which necessitates sexual behaviour modification?

ii) After analysing their situation on knowledge of risk of HIV/AIDS transmission, what approaches/steps do Maragoli women decide to take (if any) and why do they do so?

iii) Are the approaches they take compatible with their expected marital sexual roles?

iv) How do factors such as social norms, values and attitudes related to marriage and parenthood influence the way married women view the AIDS epidemic and the necessary steps taken for protection.

CHAPTER THREE

3.0 SITE DESCRIPTION AND METHODOLOGY

Having defined and linked the conceptual apparatus to the research objectives in the previous chapter, this chapter deals with the presentation of the theoretical, analytical and statistical methods for the study.

3.1 SITE DESCRIPTION

3.1.1 SELECTION

Sabatia is one of the two divisions in Vihiga District predominantly inhabited by the Maragoli sub-ethnic group of the Luhya, the other being Vihiga division. (See map at appendix).

Sabatia was preferred to Vihiga by the researcher due to the good connection evidenced by all-weather Kisumu-Kakamega and Chavakali-Eldoret roads which traverse the division. The division has also got a net work of good murram roads making most parts of the division easily accessible.

Moreover the researcher comes form the area. He is well versed with the administrative organisation of the area, knows the area quite well and could easily make contacts in the area. These factors were very important because they helped to economise on time, money and personnel.

3.1.2 LOCATION

Vihiga is one of the administrative districts of Western Province of Kenya. It boarders Kakamega District to the north, Nandi District to the East, Kisumu District to the South and Siaya District to the Southwest. It is one of the newly created districts in the country

having been curved out of the extensive Kakamega district in 1991.

The research site, Sabatia division lies to the north of Vihiga district.

3.1.3 POPULATION

Sabatia division covers about 115 square kilometers making it the largest division in Vihiga district. Although population in the district is evenly distributed, Sabatia has the highest population which is about 23.8 per cent of the total population of the district. It has a population density of 1220 persons per square kilometer. (Vihiga District Development plan 1997-2001). Due to population pressure available land has been divided into sub-economic units. The sub-economic land units are posing problems to attainment of food self sufficiency as they are too small to work on.

The high population has also induced out-migration in search of land elsewhere. With very many people within the age group 15 -59, (labour force) moving out of the area in search of employment in other districts and major towns and with the male to female ratio being about 91:100 the percentage of female headed households is very high in the area.

3.1.4 ADMINISTRATION

Administratively, the division is among the six divisions under the jurisdiction of a district commissioner sitting at Vihiga town. The immediate authority rests with the district officer (DO) who is assisted by the chiefs for eight locations. The divisional headquarters is at Sabatia market located on the all-weather Chavakali-Eldoret road. There are a total of 31 sub-locations in Sabatia division headed by sub-chiefs.

3.1.5 TOPOGRAPHY AND CLIMATE

This area falls within the Lake Vectorial basin. Its altitude ranges from 1300M above sea level in the West to 1,500M in the East. There are hills which rise above the general level. The division has a system of rivers running from North East to South-West. The

main rivers are Edzava and Yala which flow through the upper zones of the division. The area's annual rainfall ranges from 1800 mm to 2000mm. It is reliable, adequate and well distributed throughout the year. There are two main seasons namely; the short rains and the long rains. The long rains are received between April and May and are the highest. The short rains are received between September and October. The months of December and February are characterised by low rain.

3.1.6 HEALTH STATUS

Vihiga District as a whole has about 30 health facilities distributed unevenly across the divisions. There are two main mission hospitals in the District namely,Kaimosi Friends Mission Hospital and Kima Mission Hospital. Kaimosi hospital has the largest bed capacity of 150. The Government is currently building a district hospital at Mbale. In the absence of a District Hospital, Mbale Rural Health Training Centre has been doubling up as a District Hospital offering referral and in-patient services to the residents of the District. Serious cases are referred to the Kakamega District Hospital. There is one Nursing Home and six dispensaries in the District which are ran by NGO's. The government runs fifteen health centres and four dispensaries which are scattered in the District.

Sabatia Division has got two government dispensaries and 3 Private dispensaries. The number of private clinics operating in the urban centres of the division has been rising.

The most prevalent diseases in Sabatia division are Malaria, Respiratory Tract Infections, Skin disease phenomena and ear/eye infections.

During the years 1993 to 1995, the HIV seropositivity rate from ante natal clinics and referred suspect patients was between 15 - 21 per cent in the area. The most hit areas are the small urban centres along Kisumu-Kakamega road and Chavakali-Eldoret Road.

3.1.7 STATUS OF WOMEN

Women in Sabatia division participate in economic activities. They produce most of the food crops and cashcrops grown in the area although incomes arising from the sell of this crops are controlled by men. Men are usually the traditional household needs. However some households in the division are headed by women after their husbands migration to urban areas, divorce, separations and single motherhood. The culture of the Maragoli people demands that a woman has to be married.

Women do all the domestic chores and are sometimes forced to take over male duties such as clearing, digging and tilting land as men go to towns for wage labour or get engaged in beer drinking. Some of the women have organized themselves into income generating groups where they are involved in activities like handicrafts, brick making and planting of trees. Traditionally women in the Maragoli society do not own assets and have no control over disposal of family assets.

3.1.8 ECONOMY

Sabatia division is predominantly an agricultural area. It has one of the most fertile lands in Kenya (Bradley 1989). Household income is majorly derived from agricultural and livestock activities which account for 94 percent of total household earnings. Wage employment which covers both public and private factors accounts for only 6 percent of total household earnings. Some of the subsistence crops grown here are maize, beans, millet, bananas, cassava, sorghum and sweet potatoes. Vegetables are also grown. Tea has become a popular cash crop with the setting up of the Mudete Tea Factory in the division. Both indigenous and exotic breeds of cattle are kept for milk production which is in abundance.

3.1.9 RELIGION

Religious institutions are common in Sabatia represented mainly by the Friends African

Mission (Quakers), Pentecostal Assemblies of God (PAG), The Salvation Army, and the African Divine Church.

3.2 METHODOLOGY

3.2.1 RESEARCH DESIGN

As a new and frightening phenomenon, AIDS is a topic charged with emotion ranging from suspicion and doubts to fear and anger (Ulin et al 1993). On the other hand sex is private, individual, sensitive and taboo subject that is not easily discussed (Kinsey et al 1948). This means that matters on sexuality and AIDS involve subjective meanings which cannot be easily understood without indepth exploration.

For an indepth exploration, this study integrates both qualitative and quantitative approaches to improve on the interpretation of meaning as well as the validity of information gathered. However, in this study extensive use has been made of qualitative methodology than the quantitative ones.

Qualitative approach has been given more prominence in this study for various reasons. Qualitative methodology are descriptive, exploratory and holistic (Bogdan & Toylor 1975). They are concerned with the understanding of the natural contexts within which behaviour is taking place and they look into the process rather than simply the outcomes and products of behaviour (Bailey 1987). The concern of qualitative methodology is also with the "meaning" of behaviour from the actor's perspectives. Thus they were seen to be very useful in such a study which demands the researchers familiazation and understanding of the problem in greater depth.

Though AIDS preventive behaviour is individual in nature, it is essentially social as far as the community defines which sexual practices are acceptable. The extensive use of qualitative techniques along side the quantitative ones enabled the researcher to capture

the perspectives of individual married women, men and the community as they interpreted and responded to community values.

The quantitative techniques in this study have majorly been used in the selection of some respondents, the presentation of basic socio-demographic data of respondents, and for illustrative purposes in presentation and analysis of data.

Blalock's (1972) argument about qualitative techniques is that they lack generalisability and representativeness. This study uses both quantitative techniques and qualitative techniques to reduce bias and improve on representativeness and generalisability. However, the objectives of this study, the sensitive nature of the topic, the cultural specificity of the setting and depth of data required made such concerns secondary.

We note that this study is not so much aimed at matters of fact or with some objective representation of reality, but with more elusive topics of perception, cognition and expression of reality.

3.2.2 SELECTION OF RESPONDENTS

Both probabilistic and non-probabilistic procedures were used in the selection of respondents for this study. Those to be selected as respondents for this study included:-

a] A sample of married women who lived in Sabatia division of at the time of study. Married women were the units of analysis in this study.

b] Focus group discussants. Such respondents were composed of married women and men of various ages ranging from 15 - 45 years.

c] Key informants. Key informants were supposed to be people knowledgeable in community matters, history and value systems, HIV/AIDS and women affairs.

3.2.2.1 **Selection of focus group discussants**

This was not an easy task given the sensitive nature of the subject. There was also need to get respondents who would capture such characteristics as various ages, educational backgrounds and economic status. There was also the need to ensure that those selected were resourceful persons.

Convenience and purposeful sampling were used. The services of contacts in the research site such as women leaders, administrative leaders and health personnel were enlisted.

As many respondents as possible who were available and showed willingness to participate in the discussions were identified in each of the four locations randomly selected.

Those who actually participated in the discussions were selected from those identified in the initial stage. Various considerations were used in including respondents into group discussions. First and foremost, due to logistical problems there was need to have small manageable numbers. Secondly those selected were those deemed resourceful by the contacts. Thirdly, it was ensured that at least various ages, educational backgrounds and economic status were captured. The basic qualification for inclusion was that one had to be married.

3.3.2.2] **Selection of a sample of married women**

Multistage sampling was in the selection of a sample of married women who live in Sabatia division. Vihiga division is made up of eight administrative locations. The sampling of married women was done in stages. In the initial stage of sampling four locations were selected using the lottery method. Those selected

were Munoywa, Etsava, North Maragoli and Chavakali.

In the second stage, using the lottery method, 3 sub-locations were selected from each of the 4 locations selected in the first stage. This made a total of 12 sub-locations.

In the third stage there was randomization of households in the 12 sub-locations. Through the help of the respective Assistant chiefs in each of the 12 selected sub-locations, a list of village headmen (*magutu*) for each of the sub-locations were obtained.

From all the lists of headmen, two village headmen were randomly selected from each sub-location. Each village headman selected above provided a list of households under their jurisdiction. From this lists of households a sample of fifteen households was selected from each sub-location. Therefore from the entire division represented by 12 sub-locations, a total of 180 households were obtained. A household in this study is equated to the usual tenant homestead in which people eat and work together.

From each of the selected households a married woman would be interviewed at her convenient time. Due to the sensitive nature of the topic under study and other problems only 156 women were interviewed. This represents a coverage of 86.7 percent. Some researchers such as Money (1980) have identified problems of non-representativeness in studies related to sexuality. Such problems are therefore not unique to this study.

3.2.2.3 **Selection of key informants**

For selection of key informants, purposive sampling was used. Local administrative leaders and other contacts the researcher made in the community

were very instrumental in the identification and selection of such respondents. Such respondents were those considered to have knowledge in community, traditional, religious, historical, cultural, medical and other important matters of importance in the community that may have a bearing on women's HIV/AIDS preventive behaviour. A majority of such respondents were identified among administrative leaders, HIV/AIDS educators, health personnel, village elders (opinion leaders), women and church leaders.

3.2.3 DATA COLLECTION METHODS

A combination of data collection techniques which were complimentary were used in this study. They include:-

3.2.3.1 Focus group discussions

Focus group discussions were used to elicit data from groups of married women and men which were deliberately constituted for purposes of the study.

In a pilot study it was revealed that it would be difficult for female discussants to express themselves freely if mixed with the males. For that reason, male and female discussions were held separately. The composition of this focus groups was as indicated in the table below;

Location	MALE No. of Sessions	MALE No. of Participants	FEMALE No. of Sessions	FEMALE No. of Participants
Chavakali	1	9	2	24
Wodanga	1	8	1	8
Etsava	1	11	2	21
North Maragoli	1	10	1	9
TOTAL	4	38	6	62

Women of various ages were put in groups of between 8 - 12 members. The same was done for men. The age composition of women ranged from 15 - 40 years while that of men ranged from 20-45 years. The educational levels of both men and women ranged from no-education to post secondary education. Four and six group sessions were held for men and women respectively with a total of 100 discussants. This was large enough a number given to sensitive nature of the discussions.

The discussions were led by a moderator using a discussion guide and eliciting details through probes. The guide was designed to explore perceptions concerning norms that govern sexual decision making, and behaviour associated with the risk of HIV transmission to women. Emphasis was primarily put on the role of women in sexual relationships, particularly with respect to the potential of initiating sexual change and secondarily on the perspectives of men on issues which influence women's HIV preventive behaviour.

In designing the discussion guide, the issues to be explored were embedded in a vignette in which a hypothetical character, a woman named Mideva is portrayed to be married to a man named Amadi whose sexual behaviour puts her at the risk of HIV infection. The purpose of this adaptation was to relieve the pressure of disclosure by asking participants to comment on the decisions and problems of another person. This is because of the sensitive nature of the subject. A tape recorder was used to record the proceedings.

Although the discussions were time consuming and yielded unstandardised information, which was difficult to quantify, they proved useful in directly revealing important cleavages of opinion. The richness of the discussant's expressions in spontaneous dialogue offered clues to understanding of women's HIV/AIDS preventive behaviour.

In the discussions, although every effort was made to encourage individuals to express their opinions and observations honestly, one important caveat remains. Discussions in this study were particularly susceptible to effects of group interaction. The knowledge and opinions of more outspoken members could as well have had an influence on the views expressed by others. The tendency of a group to move towards consensus is a normal outcome of interaction on controversial topics (such as this one) however, and in that sense reflects a natural process. (See copy of discussion guide at the appendix).

3.2.3.2 **Indepth Interviews**

Indepth interviews were used to solicit detailed data from a total of 156 married women from the sample of married women selected for the study. Indepth interviews were also used on key informants.

The interview schedule used on the sample of married women included questions related to the study problem and objectives. It was also meant to gather basic socio demographic data on married women in Maragoli. Although closed ended questions were used, the extensive use of many open ended questions was meant to give respondents a chance to articulate themselves and also give room for probing.

Although the interview schedule was used to obtain some kind of conformity, the responses were not limited to the questions asked. During the interviews, the respondents were encouraged to speak freely, elaborate on answers and bring out other relevant or important topics that were not included in the interview schedules. This is to say that the interviews were flexible and detailed. Answers to questions were written in guiding sheets and probes were recorded on separate sheets of papers where necessary.

After formulation the interview guide was pre-tested. Two research assistants

used were trained on how to do interviews and especially how to probe.

For key informants, the researcher conducted indepth interviews basing on the informants area of knowledge. Questions emerged spontaneously as the researcher guided the informant to his own areas of interest. However basic questions on women's HIV/AIDS preventive behaviour were asked first to give basis for interviews.

3.2.3.3 **Informal Interviews**

The subject matter in social sciences demands the study of human actions in their social situations. This is the reason why a researcher may be required to go beyond what he/she conceptualises prior to the fieldwork. In this case the researcher may get involved in casual conversations with the subject, steering him/her to areas of interest.

Informal interviews were used in this study to enrich the data gathered by use of other methods. As the researcher traversed the study area, he would meet different people who out of curiosity or interest would develop conversations with the researcher. From such conversations a lot of information was obtained.

In other cases those people near respondents or their neighbours would get interested and the researcher would let them articulate their views freely. This method proved very useful.

3.2.3.4 **Simple observations**

Simple observations were carried out in the community in general and respondents homes. This involved accurate watching and noting of phenomena. This helped capture some social, economic and cultural aspects which would have been vaguely perceived, unnoticed or even misrepresented by respondents.

The observations were noted down in the course of the interviews or later in situations where writing was discouraged if it was seen to interrupt the interview process.

3.2.3.5 Use of secondary data

In this method, use was made of records and studies to have the background knowledge of the problem being studied. Familiarization with works available in the field of HIV/AIDS and sexual behaviour change provided further orientation to this study. This method also involved and analysis of studies and other publications that provided historical and cultural information concerning the Maragoli way of life. Therefore there was extensive use of both public and private libraries.

3.2.4 DATA PRESENTATION AND ANALYSIS

The ultimate goal of data analysis is to summarise the study findings in a way which generates answers to research objectives. The study gathered both qualitative and quantitative data.

Quantitative data gathered was analysed using the statistical package for social sciences (SPSS- computer program). This program yielded descriptive statistics used in presentation, illustration and analysis of data. Such descriptive statistics included frequencies and percentages.

The qualitative data gathered was very detailed and massive. This necessitated its classification into various themes and sub-themes on the basis of their central focus for purposes of presentation and analysis.

On the whole, qualitative data analysis included presentation of quotes from different respondents and recording verbatim what some respondents said. Qualitative data were also analysed by inferences and discovery procedures as described by Spradley and Mccurdy (1975). This involved identification of both tacit and explicit cultural concepts and interpretation of issues related to marital sexuality among the Maragoli.

All the information gathered from the field is integrated in the interpretation which involves the search for broader meanings to answers given by linking them to available secondary data for purposes of making influences.

3.2.5 **PROBLEMS ENCOUNTERED IN THE FIELD**

Various problems were encountered during the data collection process. However, they were dealth with to ensure that they did not hinder the collection of data. One of the major problems was that this area has been visited by many research teams in the past. This is because some of the villages in Sabatia fall within CBS clusters. Due to this every year there are some research bodies conducting studies in the area. The most recent, and which was going on during the period of my data collection was a KEMRI project on Malaria. It was realised that some of the earlier researchers gave people empty promises as to the extent to which the research results would be of benefit to them. Some expressed their disinterest in researchers who had nothing to offer. Though it was not expressed in their disinterest in researchers who had nothing to offer. Though it was not easy to prevent this problem it was minimised being honest as possible to the people about how they can benefit without giving empty promises. One thing that worked to my advantage in this regard was the fact that I come from the area and people were more likely to trust me. They claimed that people who researched there in the past were accompanied with Europeans who took photographs and sold them for money. They thus felt that they were being exploited.

The second major problem was the sensitive nature of the subject. It was not easy for people to divulge information on AIDS especially that related to their own behaviour. This was especially so the case where in the households that respondents come from there were either suspected AIDS victims or cases of people reported to have died of AIDS. Such respondents treated the research team with a lot of suspicion. In some cases researchers faced a lot of hostility from members of such households where respondents also could completely refuse to cooperate. In some cases the researcher had to avoid interviewing some respondents who fell within the sample after having been discouraged by village elders due to the anticipated hostility.

There was also the problem of obtaining information from elderly women especially those over 35 years of age. They were likely to talk about AIDS but not their sexuality or that of their husbands. Being a young man it was not easy for such women to confide in the researcher. To be able to get more reliable data, the researcher had to hire female research assistants aged 33 and 34 years old. This ladies were trained by the researcher on how to conduct interviews and especially how to probe. After sampling procedure arrangements were made for them to interview those women whom it was anticipated that might not be collaborative with the researcher. The researcher himself concentrated more on younger women and key informants who showed willingness to divulge information. The progress of the research assistants was monitored and supervised. Research instruments were checked to ensure that the assistants were doing the required probing and recording.

It was extremely difficult to interview women respondents in the presence of other people especially their husbands. In some cases individuals found with respondents were very hesitant to part as the presence of the researcher was good reason enough to keep them around. The crucial need for confidentiality and the understanding that what one's response should be depends on the situation compelled the researcher to draw the respondents attention to need for privacy. Most respondents successfully excused themselves from the company of others. However, there were some husbands who insisted on hearing their wives responses to questions or refuse totally Ro them to be interviewed. However, such cases were few.

Several husbands raised questions as to why they were not being interviewed given their positions as household heads. Although the explanation was given to them that the study first intended to get the views of women before embarking on men, some men were not convinced. The researcher was forced to ask such husbands some questions. Though this was time wasting, the data gathered in this manner proved useful in shading more light on women's HIV/AIDS preventive behaviour and especially the male perspectives.

Organising focus group discussions was not easy. First and foremost there was the logistical problems. For instance, getting meeting points for the discussions was difficult. However, some church leaders assisted by providing their church premises as venues for discussions. Secondly, there was the problem of convincing people to participate. Some people expected to be given something in return. However, AIDS and health educators in this area were very instrumental in trying to identify willing participants and arranging for the discussions.

As a young man, it was not easy for the researcher to act as a moderator in female focus group discussions. Because of this a woman's group leader who is also an AIDS educator in this area acted as the moderator. She led the discussions and did the probing in areas which she had been instructed to do. The researcher occasionally would ask her to probe some areas that he felt needed probing as the progressed.

Inititally, some respondents in the discussions especially women were against the use of recorders. They argued that they would not like to be quoted anywhere. However, we managed to convince them that this tapes would be treated with a lot of confidence and would be destroyed after eliciting data from them. This made them cooperate although some were still suspicious.

Another big problem in the discussions was the tendency for some members to raise issues that were not of any importance to the subject. They occasionally touched on many issues most of which were irrelevant. It was sometimes very difficult to bring such women to discussing the relevant issue. This proved very time wasting.

CHAPTER FOUR

4.0 BASIC SOCIO-DEMOGRAPHIC CHARACTERISTICS OF MARRIED WOMEN

Certain basic socio-demographic characteristics of married women in Sabatia are discussed in this section with regard to their importance in understanding married women's knowledge of HIV/AIDS and their preventive behaviour. However, the extent to which such characteristics relate to married women's HIV/AIDS knowledge and preventive behaviour in Sabatia will be examined as the rest of the findings from the field are presented and discussed in proceeding sections of this chapter. The basic socio-demographic characteristics discussed here under include, age distribution, levels of education, marital duration, occupation, religion, type of marriage and number of children.

4.2.1 Age Distribution

Tables, 4.1 and 4.2 show the age distribution of their husbands respectively. Data in table 4.1 indicates that relatively few of the women in the population marry and have children before the age of 20. This may be attributed to the wide availability of and interest in education in the area (Oyosi 1995). This means that many young women of marriageable age are still in secondary school and are bound to postpone marriage until their education is completed.

However, well over 55 per cent of the married women are below the age of 30 as compared to about 41 percent of their husbands as indicated in table 4.2. Only about 3.2 percent of the women are also above the age of 45 years as compared to about 10 per cent of their husbands. This is an indication that generally a majority of this women are in their most reproductive stages of their lives where they are bound to be very sexually

active. This has implications for HIV/AIDS vulnerability (Onyango and Walji 1990). It can also be noted that the women are relatively younger than their husbands, meaning that in most cases women in this area marry older men. Ochola Ayayo (1991) notes that such a trend is common in most Kenyan communities. This trend may have implications for sexual decision making and freedom because the husbands are bound to have more sexual experience than their wives.

Table 4.1 **Age distribution of married women in the sample**

Age Cohorts	Frequency	%	Cum.%
Below 15		0.6	0.6
15 - 19	12	7.7	8.3
20 - 24	31	19.9	28.2
25 - 29	44	28.2	56.4
30 - 34	35	22.4	78.8
35 - 39	19	12.2	91.0
40 - 44	9	5.8	96.8
45 - 49	3	1.9	98.7
50 and above	2	1.3	100
Total	156	100	

Table 4.2 **Age distribution of husbands**

Age Cohorts	Frequency	%	Cum.%
Below 15	0	0	0
15 - 19	12	1.3	1.3
20 - 24	19	12.2	13.5
25 - 29	43	27.6	41.1
30 - 34	42	26.9	68.0
35 - 39	21	13.4	81.4
40 - 44	13	8.3	89.7
45 - 49	9	5.8	95.5
50 and above	7	4.5	100
Total	156	100	

4.2.2 ETHNIC COMPOSITION

Table 4.3 shows the ethnic composition of the sample of married women. A majority of married women in this area are predominantly of the Luhya ethnic group with almost all of them from the Maragoli sub-ethnic group. Despite the fact that migratory labour on the part of adult males in this area is widespread, (Oyosi 1995) however, most men and women seem to select their marriage partners from their own ethnic community or from closely related communities such as other Luhya groups. The husbands of married women in the sample all come from the Maragoli sub-ethnic group. This is not surprising given the limited availability of land for purchase or settlement, or employment in such a rural area. Key informant information shows that generally Maragoli men are still encouraged to marry fellow Maragoli women so that they can be able to interpret well and follow the cultural values and norms of the community in their roles as mothers, wives and daughters in-laws. As noted by Ulin et al (1993) such expectations may have implications for sexual decision making whereby women may be forced to comply with expectations that give their husbands superiority in sexual decision making.

Table 4.3 Ethnic composition

Ethnic Group	Frequency	Percentage
Maragoli Other Luhya Non Luhya	146 8 2	93.6 5.1 1.3
Total	156	100

4.2.3 Levels of Education

Education provides not only basic literacy but also higher level training to make possible utilisation of and advances in every aspect of life. Indeed education plays a great role in AIDS control. A literate population has a wider exposure to various sources of information about AIDS and this influences interpretation of such information and attitudes towards the epidemic. Tables 4.4 and 4.5 show the levels of education of the sample of married women and those of their husbands respectively.

In general, a majority of married women and their husbands have at least primary school level of education. However the men's level of education was slightly higher than that of the women. Only 5.1% of husbands had no formal education as compared to about 12.8% of the women. Only 19.2% of women had at least secondary education and above as compared to 28.2% of the husbands.

Whereas the levels of education of men is slightly higher than that of women, information from informal interviews attest to the fact that the practice of refusing to educate girls in this area is slowly being discarded. However there are still many cases where girls drop out of school due to teenage pregnancies and lack of school fees. A majority of such girls end up getting married.

The majority of men with higher educational levels in most cases move to towns in search of jobs and other opportunities that give them higher chances of controlling financial resources than their wives. It should also be noted that such men who move to towns are still young and sexually active hence at risk of HIV transmission putting their wives at home also at risk (Ochola Ayayo and Muganzi 1990).

Table 4.4 Levels of education of married women

Level of Education	Frequency	%	Cum. Of
None	20	12.8	12.8
Primary	106	68.0	80.8
Secondary	27	17.3	98.1
Post-Sec	3	1.9	100
Total	156	100	

Table 4.5 Levels of education of husbands

Level of Education	Frequency	%	Cum. Of
None	8	5.1	5.1
Primary	104	66.7	71.8
Secondary	38	24.4	96.2
Post-Sec	6	3.8	100
Total	156	100	

4.2.4 Duration of marriage

The data contained in table 4.6 shows that about 26.3% of women in the sample have been married for five years or less while about 21 percent have marriages that have endured for over 20 years. Information from focus group discussions and key informants are reveals that the marriages in which most respondents are currently in are first and not subsequent ones. This and the large number (proportion) of marriages which have endured 10 years (49.3%) however suggest that marital instability is not a very serious issue in this community. Studies have shown that sometimes the longer the marital unions the more likely that married women will take for granted their husband's sexual behaviour hence this could put hem at the risk of HIV infection. (See Ulin it al 1993).

Table 4.6 Duration of marriage

Duration in years	Frequency	%	Cum. %
1 - 5	41	26.3	26.3
6 - 10	38	24.4	50.7
11 - 15	25	16.0	66.7
16 - 20	20	12.8	79.5
21 - 25	16	10.3	89.8
26 - 30	8	5.1	94.9
31 - 35	5	3.2	98.1
36 plus	3	1.9	100

4.2.5 Religious Orientation

An overwhelming majority of women in Sabatia one Christians with about 84.6% of them being Protestants, while 12.8% are Catholic, while Muslims account for only 2.6%. Religion is very important in HIV/AIDS preventive issues including utilisation of condoms and other contraceptives (see Nzioka, 1994). As indicated, very few women in this area belong to the catholic church which has openly expressed disapproval of contraceptives use by propagating for abstinence(moral restraint), monogamy/faithfulness. Muslims, whose doctrines tend to be against contraceptive use also account for a very small percentage of women in this area.

4.2.6 Type of Marriage

A majority of women respondents (96.5) claimed to be in monogamous marriages. However, contrary to the general view held about African society, (see Davis 1963:7) polygamy is not common in this area. This finding is in line with that of Mburugu (1994:2) who contends that polygamy is on the decline as it has become unattractive for men to invest in women through polygamy so as to exploit labour of women and their children where family land is getting smaller and smaller. Informants attributed monogamy in this area to high cost of living and reduced land wealth which have drastically reduced the popularity of polygamy which was common in the history of the Maragoli. However, further inquiry revealed that men in this area avoid marrying a

second wife but would instead get involved in extra-marital sexual relations. Indeed Quawaisha (1996) contends that monogamy can give most married women an illusion of safety as far as HIV/AIDS transmission is concerned. Some women interviewed in this area revealed that they could not be certain that theirs were monogamous marriages because they sometimes suspected that their husbands would be keeping other women elsewhere especially in towns.

4.2.7 Number of children

The respondents interviewed had children varying from 1 to 16. This presents an average of 15. The modal number of children was 5.15 with a standard deviation of 3.27. Almost half of the respondents (47.79) had more than 4 children while the remaining 36.3% who had less than 4 children, most of them still in their child bearing age had not stopped giving birth. This implies that on average, there are large family sizes in the area of study. This is in line with the findings of Oyosi (1995). Some studies have shown a relationship between the desire to have many children with the utilisation of condoms and other contraceptives. (Ayayo 1991, Ndege 1990, Ulin et al 1993). Table 4.7 shows the distribution of respondents by the number of children. The data has been grouped to specify respondents with small size, moderate or large.

Table 4.7 Number of children

Number of Children	Frequency	%
Small 1 - 4	81	52.21
Moderate 5 - 8	55	35.40
Large - 9 - 16	20	12.39
TOTAL	156	100

4.2.8 Occupation

Table 4.8 and 4.9 show the tabulated representations of the occupations of married women and their husband's. The data shows that a majority of women (86.5 percent) are

mainly involved in agricultural activities with few of them considering themselves as housewives. However, the few who considered themselves as housewives did not necessarily depend entirely on their husbands's occupation since they got some income from agriculture. Indeed men appeared to be more involved in outdoor activities represented by paid employment, business and Jua Kali. This could be due to male control of financial capital than women. This higher economic capability is linked to men's social dominant social positions (Gita et al 1994).

Only 5.8% of women were in formal employment as compared to 31% of their husbands. In most cases formal employment is obtainable away from home. Due to the pressure on land the women left in the agricultural sector do not produce much. Thus men who are either in formal employment or involved in other outdoor activities are in a position to control more financial capital than their wives. This gives them higher economic and social positions compared to their wives. This may translate into women's economic dependance on their husbands and having an inferior social status. As Gupta (1994) notes women's economic dependence on husbands could have implications for sexual decision making and protection against HIV infection. GPA (1993) argues that concentration of women into occupations like agriculture reduces their exposure to information and also influences their perception of risk of HIV transmission.

Table 4.8 Main occupation of sample of married women

Occupation	Frequency	%
Formal employment Self employment Self help activities Agricultural activities	9 5 7 135	5.8 3.2 4.5 86.5
TOTAL	156	100

Table 4.9 Husbands main occupation

Occupation	Frequency	%
Formal employment	32	19.9
Business/Jua Kali	12	7.7
Odd jobs	17	10.9
Agricultural activities	96	61.5
TOTAL	156	100

CHAPTER FIVE

5.0 HIV/AIDS AWARENESS, KNOWLEDGE AND BELIEVES ABOUT VULNERABILITY

5.1 Awareness of HIV/AIDS

To measure the level of awareness of AIDS, respondents were specifically asked if they had ever heard or known anything about a disease called AIDS by the time of data collection. A large number of respondents reported to be aware of AIDS with 96% of them having heard of or known the existence of the disease. Only 4% of the respondents reported to have never heard of AIDS.

In this area the disease has been given local terms with which it is commonly referred to. Such terms include "Uvukimwi" (from the Swahili name Ukimwi), "Urutahona" (the incurable one), rwaveye kutsa (the new one), "ovoherizana" (the transmissible one) and urutivwa (the dreaded one). Married women mentioned such names to demonstrate their awareness of the disease.

From the local terms given to the disease there was some basic information amongst most respondents that AIDS is a dangerous transmissible disease that has got no cure. This findings are in line with other studies conducted in the general population in Kenya which indicate high awareness of HIV/AIDS (Ministry of Health 1996, Onyango and Walji 1990). However, as will be seen in proceeding sections, this general awareness about AIDS does not necessarily mean that married women in Sabatia have essential knowledge of AIDS. This is because awareness may not necessarily have a significant relation to knowledge as people can be aware of the disease but lack essential knowledge Nzioka 1994).

5.2 Causes of AIDS and knowledge of transmission

Asked what they thought causes AIDS, respondents tended to give responses that indicated an overlap between causes of AIDS and modes of transmission.

Only 16% of the respondents mentioned the HIV virus as the cause of AIDS. A significant number of respondents attributed causes of AIDS to behavioural patterns such as prostitution (64%) playing sex with HIV infected people (80%) contacts with AIDS patients (48%) and sexual deviation (immorality) 42%. AIDS was attributed to other causes such as witchcraft, curses and contaminated air all of which featured less frequently. This shows that respondents were not clear on the cause of AIDS as most seemed to be concerned more about how people get it rather than the virus behind it.

Knowledge of modes of transmission was measured by asking respondents how they thought AIDS was transmitted. Information on this subject was also obtained from group discussions. Table 5.1 shows the major modes of transmission mentioned spontaneously.

Most respondents tended to perceive AIDS to be a disease closely linked to sex and infections. Pre-natal transmission was only mentioned by 38.4% of the respondents in the sample. This indicates that the role of pre- natal transmission is unclear to most married women. Some studies have shown that in communities where child mortality is high, there is a high probability that pre-natal transmission of HIV will not be known to most women. (Ulin et al 1993). However for the case of Sabatia the reason may just be a gap in knowledge of transmission because the area has low child mortality (Oyosi 1995).

Whereas most respondents seemed to be aware of the major modes of transmission of HIV/AIDS the mention of mosquitos bites, curses, handshakes, witchcraft, breathing contaminated air shows that misconceptions about HIV/AIDS transmission still exist.

Table 5.1 Modes of transmission spontaneously mentioned by sample of married women

N = 149 for all responses

Mode of transmission	Frequency	%
Sexual Intercourse	143	96
Blood transfusion	89	60
Use of unsterilized needles	131	88.2
Mother to foetus	12	38.4
Kissing	31	21.2
Shaking hands	10	7.2
Contact with AIDS victims	29	19.6
Breathing victims air	12	8
Mosquitoes bites	27	7.8
Curses/witchcraft	5	3.4
Sharing utensils.	5	4.8

Focus group discussions revealed some various areas of consensus and contradiction on issues related to the transmission of AIDS. Women seemed to be well aware of the risk posed by sexual contact with an infected person and some offered striking explanations of how unwary partners may be infected. The more partners one has, they explained, the greater the risk of acquiring the disease and transmitting it to others. Some women demonstrated their understanding of this process;

> *"When men go with other women other than their wives, they think such women are safe when infact they go with the many other men who could have AIDS. When the man comes home he gives it to the wife" " AIDS can not be transmitted like cholera or typhoid, you get it through sex"*

Whereas explanations were constructed for the transmission of AIDS in a network of sexual relationships, there was a tendency for women to describe husbands as the link

between women on the outside and wives at home who were not expected to be involved in extra marital sexual relationships. The implication here is that it is the "other woman" and not the wife who is responsible for the sexual transmission of HIV/AIDS. In effect, men were often portrayed as vectors of the disease, oblivious of the consequences of their sexual adventures.

From time to time focus group participants acknowledged that extra-marital affairs of women who are married may also lead to sexual transmission of HIV/AIDS. However, most discussions supported the notion that "wives" or women in stable unions were less likely than their men to have liaisons outside the home. The role of sexual multiple partnership in transmission of AIDS seemed to be well understood by married women.

Whereas the role of infected blood in HIV transmission was well understood, there seemed to be misconceptions and exaggerations. There was extreme worry about injections that people get in the mushrooming private clinics in the area. Some respondents were concerned that incompetent nurses or doctors might use the same needle for infected and non-infected patients. Some confessed to having deliberately refused to go to hospital or to carrying their own injection needles every time they visit a health facility. A 52 year old woman expressed her fears when she retorted;

> *"When I go to the hospital, there are this young girls who sneer at me. I fear that one day these girls will give me AIDS through an injection. Soon I will refuse to be injected".*

In deed some respondents strongly believed that private physicians interested in maximizing profits re-used needles without sterilizing them. This was confirmed by some health personnel in the area.

Concerns about infected blood also surfaced in other ways ranging from the plausible to the impossible. Some women seemed to have given considerable thought to the risk of

transmission through Casual relations that might involve contact with infected blood or other body fluids such as kissing and transfer of saliva. However not all such women associated the risk of kissing to the presence of sores, or cuts which would allow passage of blood from infected to uninfected person. The same kind of reasoning applied to the risk of touching an open lesion or washing an open wound in water used by and HIV infected person. There seemed to be consensus to the assertion that blood is a channel of transmission but on the issues of saliva and casual contact that does not expose a person to blood, there were disagreements. Such segments of the discussions as below are typical of the divergent opinions expressed by women on this issue.

"If you swallow saliva from a man with AIDS then you get it"

"No to get AIDS through kissing you will have to have a cut in the mouth. Its not the saliva but the blood that gives people the disease"

It was strongly believed by some women that AIDS, infected persons would endanger other household members. They tried to give explanations by linking such transmission to drinking or washing in water contaminated by a person with AIDS, sharing food and eating utensils, sitting on a common chair or using the same toilet. However few women gave detailed support of how the blood or body fluids of the infected person might come to be on the contaminated article. Some concerns were raised about contaminated food and condoms as expressed in this segments;

"You can die of AIDS from infected meat the same way you can die of cholera"

"I don't trust this food Europeans put in tins. Sometimes it is expired, other times AIDS is put there deliberately to finish us"

"They say that this condoms used by young men have AIDS - they will be finished"

Spontaneous discussions raised the possibility that AIDS transmission might be a result of malevolent forces. Thus the issue of supernatural transmission emerged. A respondent in the discussions insisted that a person with AIDS may curse some one else to get it.

However, a majority of the other respondents disagreed with this kind of transmission. Some respondents also insisted that those who practice witchcraft could "transfer" the disease from one person to another. Such issues of natural causation of HIV/AIDS featured more frequently among women of no education or the elderly.

Causation and transmission of HIV/AIDS was also attributed to the violation of what the community considered to be cultural norms governing sexuality such as pre-marital sex and extra-marital sex. A 53 year old woman put it this way;

> *"AIDS is nothing but some form of punishment from God. People have become adulterous and promiscuous. This disease never used to be there. If you are immoral you just get it, it doesn't matter what you do"*

In discussions, vertical transmission of HIV from an infected mother to the unborn infant was rarely mentioned, spontaneously. Even when the researcher tried to ask probing questions concerning means of transmission, the danger of pre-natal transmission was seldom mentioned. When discussions turned to issues of vulnerability and consequences of AIDS for the family only then did a few women volunteer the information that unborn babies could be at risk. However they could not give adequate explanation as to how this comes about.

From this section we note that whereas misconceptions and confusion exists among married women on modes of transmission of HIV/AIDS, they featured less frequently than the major known modes of transmission. Married women in this area however wrestle with the logic of many fragments of information, some valid, others partly true or distortions of actual facts, others with no scientific basis. Some respondents expressed confusion or uncertainty in the face of so many conflicting notions;

> *" This disease is hard to understand. Sometimes they say prostitutes give it. Other times they say men other times blood and mosquitoes. I think nobody really*

knows what causes AIDS"

We note here that misconceptions and confusions about the mode of transmission of HIV/AIDS among women in this area featured more among the less educated women than those with no education. This supports the argument that education has an influence on both interpretation and utilisation of health information (Mbatia 1996). On the other hand younger women were more likely to have sufficient knowledge than the older ones such findings were also obtained by Ulin (1993) in a study among Haitian women. He attributed this to high level of mobility of younger women which exposes them to more information. At the same time he notes that married women who have a long duration of marriage may not be very curious in obtaining information about HIV/AIDS.

Generally the misconceptions about modes of transmission of HIV as this study reveals among married women is partly due to the fact that people are bombarded with a lot of information at the same time which they cant make sense out of (Nzioka 1994). However, it can best be said that married women in Sabatia have relatively high knowledge of HIV/AIDS transmission sources of HIV.

5.3 HIV/AIDS signs and symptoms

Married women were asked if they had seen or known anybody infected with the hi/aids virus. 52% of them confessed that they had, 16 per cent said that they had not while 32 percent said that they could not be certain/sure.

Those who admitted to have known/seen people with AIDS reported that they had seen them at hospitals and even within the Sabatia area. However, very few admitted that they were related to such people. It was revealed that many people have died of AIDS in the area but there is always tendency for family members not to disclose the nature of illness. The nature of illness is left to speculation and remains at the "rumour" level.

When asked how one recognizes a person with AIDS, some respondents listed classic

signs such as weight loss, diarrhoea, fever, sores, coughs, scaly and dry skin, loss of hair, fatigue. However, most respondents were quick to add that such signs alone cannot confirm that one has AIDS. This may be the reason why a significant number (32%) of women were not sure whether they had seen an AIDS victim or not. An individual showing such signs as mentioned above creates a lot of speculation.comments like this in the following segments of discussion are typical of women's responses to this issue;

" You can't just look at somebody and tell that they have AIDS, A doctor has to tell you"

" If a person has it anyone will notice within no time. Hair thins out, wounds develop on the body then you become thin"

" they say some people have it yet they look fat"

" I hear doctor's don't tell you when you have AIDS. They fear you will die before your time"

Whereas there seemed to be confusion among women on the issue, about 75 percent were aware that an individual can contract AIDS but just look healthy. They argued that a diagnosis of AIDS must be confirmed by a laboratory test or medical opinion but few also doubted the doctor's/physician's willingness to tell the patient the test results. In general we may venture to argue that a majority of married women in Sabatia are aware of the signs and symptoms of AIDS.

5.4 CONSEQUENCES OF HIV/AIDS AND WOMENS BELIEFS ABOUT VULNERABILITY

We have already shown that the level of awareness and knowledge of modes of transmission and signs and symptoms of HIV/AIDS among married women in Sabatia is relatively high. However, the response in manner of protection will depend on among other factors a clear understanding of the consequences of HIV infection, its preventive measures and personal beliefs about vulnerability. Corrorano (1992) argues that even if people have knowledge ofHIV/AIDS they may not necessarily take preventive measures

unless they are aware of such measures and consider themselves at risk. In this section we address ourselves to married women's understanding o the consequences of AIDS and whether they see themselves as being at risk or not. Women's knowledge of preventive measures will be dealt with in a later section.

5.4.1 Understanding of the consequences of HIV/AIDS

For most women, AIDS was seen as a disease to be feared for reasons that emerged with consistency in interviews and discussions. The consequences of AIDS were usually expressed in terms of invitable depth and the suffering the disease would cause to the family. Many spoke of the economic costs when the breadwinner dies, the breakup of the family unit, poverty, destitution, ostracism, abandonment and even the spread of the disease to other family members.

Concerns about the economic costs were echored by a majority of women. A 48 year old woman retorted;

> *" There is nothing as bad as AIDS. If you have somebody who provides for you and AIDS gets to him, the whole family is destroyed. No more food, those in school also stop"*

The misery in which children and women are subjected to when men die was also an issue of concern.

The possibility of social rejection as a consequence of AIDS arose severally. To some women, the disease is equated to epilepsy whose victims in this community were usually isolated and stigmatised. Women alluded to the stigma suffered by a person with AIDS which is also usually extended to the rest of the family members. Some feared AIDS because of what people may say afterwards upon their deaths. A segment of discussions as below is typical of women's concerns about this issue;

> *" I would not like to die strangely and have my children go through misery later when people ostracise them by telling them that their mother died of AIDS"*

The stigma attached to AIDS as expressed by this married woman has implications for both control, management and care of people with AIDS. It inhibits free discussions about the disease and also prevents people from willingly confessing they are HIV positive (Ngugi 1994) . Undignified burial was seen by some respondents as one of the consequences of AIDS. It was said that people who die of AIDS in this area are not given dignified burials. It is common for the dead in this community to be treated with a lot of respect and complete burial rites performed. For a confirmed HIV victim people even fear going near the body. In the words of one woman, "one is just planted like a cassava". Further inquiry revealed that a part from the fear that people who go near the body may contract the disease, people who die of the disease are viewed by a majority of people as immoral individuals. The treatment they get in death may be equated to what is done to those who commit suicide in the community.

There was little mention of the risk to the unborn child as a consequence of AIDS to the family. Very few women spontaneously mentioned peri-natal transmission as a consequence of AIDS to the family. This shows a gap in the knowledge of AIDS transmission and not acceptance of child mortality as a fact of life in this area. Oyosi (1995) has noted that child mortality in this community is low.

The pre-occupation with economic costs/loss and social consequences for abandoned children exceeded by far their other concerns, a reminder perhaps of many women's dependency for survival (Berer 1993). There was a tendency of women to hold almost similar views on the risks and consequences of AIDS, regardless of differences in characteristics such as age, education and occupation. We may venture to argue here that a majority of married women in Sabatia are aware of the consequences of HIV/AIDS may have on the family.

5.4.2 Beliefs about vulnerability

A sample of married women were asked whether they thought women like themselves could get AIDS. About 49 percent of them answered to the positive. This may be an indication that a majority of them see themselves as less likely to contract the disease.

When asked which persons are most likely to get AIDS, a majority of women (69%) said prostitutes, 36% mentioned those with many sexual partners, while 39% mention young people. Worth noting was that only 34 percent mentioned that anybody can get AIDS.

About which persons they thought were less likely to get AIDS, the responses were as summarized in table 5.2.

Table 5.2 Persons less likely to contract AIDS

N = 149 for all responses.

Persons	Frequency	%
Faithful people	86	58
Those with one partner	68	46
Young people	5	0.4
Children	53	36
Religious people	26	18
Married people	58	39
Old people	35	24
Those not promiscuous	64	43

The implication of this is that there is still a belief among a large number of married women that those people unlikely to get AIDS are those faithful to their partners. (Husbands). Such a belief can give them an illusion of safety from HIV infection.

In focus group discussion, women did not strongly concur that anyone can get AIDS. There were those who felt that there were exceptions to this rule. Some qualified their opinions by statments such as;

" Why get scared of AIDS when you do not fool around"

" If your husband is good you cant get it"

" It is immoral people who get it"

There was however cautious optism among many women about their safety. Although most tried to assert their own responsible behaviour and faithfulness there was less conviction about the latter. They always tried to alley an edge of doubt about their husbands.

There were some comments from married women which showed their painful awareness that one can never be sure of HIV status of her husband. However, individually it seemed that many women volunteered that their own husbands are faithful to them, but the underlying consensus seemed to be that men cannot be trusted. There were cases where women tried to personalize the issue of trust, by persistently stating that they themselves did not engage in extra-marital affairs but they had misgivings about their husbands. Interestingly, such women still considered their faithfulness as making them less vulnerable to the HIV virus. Such findings are consistent with the arguments of Berer (1993).

In reference to women in general, a majority of this married women tended to see women as being at risk. However the same women expressed their own confidence of safety in various ways. A majority expressed their confidence in their faithfulness and trust. Others expressed their confidence in religion as below;

" I am not afraid of AIDS because my husband is a Christian"

" God will not let me get AIDS unless I go around looking for it. Even if my

husband is promiscuous, God will protect me"

It was common for women who expressed fears of getting AIDS not to mention their husbands as the likely sources. When such women talked of their fears of contracting AIDS, they were most likely to refer to injections, mosquitoes, accidents and blood transfusions.

What emerges from this section is that although there is a general consensus among married women that women are at risk of getting AIDS, there is a tendency among individual married women to feel less vulnerable to the disease or doing their own vulnerability.

CHAPTER SIX

6.0 HIV PREVENTIVE STRATEGIES

6.1 The Curability of AIDS.

We sought to find out whether married women in this area are aware that there is no recognised cure of AIDS at the moment. While 79.5% of the sample of married women believed that there is no cure for AIDS, 10.4% said that it can be cured while at least 10.1% were not sure.

Well over half (54.5%) of those who believed that the disease is curable attributed such cure to traditional medicine. However, this respondents were not aware of any particular traditional healer who was known to cure AIDS. This did not stop them from giving some examples of people in the neighbouring district of Kakamega whom they alleged they had been informed that treat people with AIDS. Further more, they seemed not to be aware of any individual who had been healed by such medicine men.

Almost all the other remaining respondents who felt that AIDS is curable attributed such cure to spiritual healing. That through prayer, one can easily be cured of AIDS and gave some vivid examples of evangelists they claimed cure people with AIDS. Some even claimed to have witnessed HIV/AIDS victims confess that they had been cured by such evangelists. Only one woman mentioned KEMRON as a cure for the disease.

It is evident from the findings of this study that a majority of married women in this area are aware that there is no recognised cure for AIDS. For those who believe in traditional medicine and spirituality as being able to cure AIDS, the reason may not be necessarily lack of information and knowledge. As Reid (1995) notes, strong beliefs in spiritual

healing, traditional medicine and any other kind of supernatural healing may be retained by people regardless of accessibility to information that persistently stresses that AIDS is not curable. This may explain the findings of this study which show that almost all those who feel that there is a cure for AIDS attribute it either to traditional healing or traditional medicine. Such strong beliefs in traditional and spiritual healing were expressed by two women as below;

" *There is nothing God can not do. There is no disease he can not cure. God can finish all diseases"*

" *There are many diseases Europeans can't cure. AIDS had defeated them. This is where the medicine for the black man can beat them"*

A majority of those women who felt that AIDS is curable were most likely to be those with little or no education and those who were over 40 years of age. This may be understood in the sense that those with little or no education may not be accessible to information. At the same time, elderly people are most likely to be more religious as well as believe in traditional cure than younger people (Ulin et al 1993).

We have therefore shown here that although majority of women in this area are aware that AIDS is incurable, some misconceptions still exist such misconceptions may have implications for both management and control of AIDS in the sense that those who hold them may not treat the disease seriously.

6.2 Understanding of HIV/AIDS preventive measures.

Just as a majority of women were aware that AIDS has no cure, they were also aware that the disease is preventable. While 14.1% felt that the disease is not preventable, and 2.4% were not sure, about 83.5% felt that there are preventive measures that can be taken against HIV/AIDS infection.

Those who felt that the disease cannot be prevented seemed to show an expression of despair about HIV prevention which could be an indication of both the gap in general knowledge of AIDS, especially the modes of transmission and prevention and women's powerlessness. Such statements as below from interviews and discussions were typical of the feelings of some women about HIV/AIDS prevention;

- *The disease is like an accident you can't stop it'*
- *This is a punishment from God, only God can save us'*
- *Nobody has ever understood this disease, so who can't stop it'?*
- *People who have this disease do not have identification marks on their foreheads. You never know when you get it'*

Various methods of prevention were spontaneously mentioned as shown in table 6.1

Table 6.1 Modes of prevention mentioned spontaneously.

N=124 for all responses.

	Frequency	%
Monogamy/faithfulness	92	74.5
Condom use	50	41.0
Immunization	1	1.4
Prayer	24	20.0
Carrying needles to hospital	28	23.0
Avoiding injections	5	4.8
Avoiding small clinics	12	10.0
Avoiding blood tranfusion	14	12.0
Not sharing food with victims of AIDS	17	14.0
Avoiding company of people with AIDS.	24	20.0
Going to church/prayer.	22	18.0

The data in table 6.1 shows that a majority of women are aware that sticking to one

sexual partner (monogamy/faithfulness) is a means to protect one self from getting AIDS. Well over 74% of them mentioned faithfulness and monogamy as preventive measures. Less than half mentioned condoms as preventive strategies. Most of those who mentioned condoms were those below the age of 25 years and newly married. However as we will show in proceeding sections, this does not necessarily mean that such women use condoms.

It is worth noting that strategies that will ensure protection against transmission through contaminated blood featured though less prominently. In general, we may argue that despite of misconceptions, a majority of married women in this area are aware of the major modes of prevention of AIDS which include faithfulness and condom use. Whereas less than half believed that condoms can be used for protection, this may not imply that they lack information to the effect that condoms can be used, but it may be due to their attitudes and experiences about condom use in marrieage.

6.3 The Reported preventive strategies adopted by married women

Majority of married women in this area believe that AIDS can be prevented as we have shown in the previous section. A majority of women respondents (83%) reported to have taken preventive measures against infection while 17% said that they had not. However, we make a note of reservation here that even those who may not have taken any preventive measures against AIDS may have still said they have done so because they wanted to give the researcher a positive picture of themselves. They may have thought that this is what the researcher expected to hear. Therefore the percentage above may not really reflect the proportion of those who have taken measures against HIV infection.

Faithfulness to their husbands was the main preventive strategy reportedly to have been taken with almost all those women who said that they have taken preventive measures mentioning it.

Other preventive measurers mentioned included carrying needles to hospital, avoiding people with AIDS, avoiding quack doctors, prayer. No woman mentioned condoms as being used for HIV/AIDS prevention, this is an indication of the unpopularity of condom use in marriage.

6.4 WOMENS ROLE IN THE ADOPTION OF HIV/AIDS PREVENTIVE BEHAVIOUR

In this section we examine various factors which may have a bearing on married women's ability to adopt HIV preventive behaviour in their marital relationships as well as influence their husbands.

Whereas there are non-sexual modes of transmission of HIV/AIDS, we restrict ourselves to sexual behaviour with a view to identifying the conflicts and contradictions between old Maragoli norms of marital sexual behaviour and the new prescriptions for change. Among such prescriptions for change include mutual responsibility and the rights of either partner to protect themselves from HIV infection (Reid 1995). The rights and responsibilities of married women as they relate to various HIV/AIDS preventive aspects are discussed as thematised in the following sections;

6.4.1 Husband-Wife communication about AIDS

Husband-wife communication is an important tool of sexual negotiation. Through such communication a married woman can be able to express her desires, fears and opinions as regards HIV prevention to her husband (Elyne 1997). Without proper communication between husband and wife it becomes very difficult for a woman not only to adopt preventive behaviour herself but also to influence the husband to do the same.

We sought to find out whether married women in this community communicate/discuss with their husbands matters related to AIDS in particular. Of the 156 married women interviewed only 37 per cent reported that they do while a majority 63 percent said that they do not.

It was observed that those who reported that they discuss such matters were to be found among those with high school and post high school education as well as those with stable incomes evidenced by formal employment. Younger women with short marital durations were also likely to discuss such matters than older women. Such discussions were however rarely held as only 7% reported that they discuss oftenly. Such discussions were almost always initiated by men (62%), 18% by women and 20% by either men or women. The implication here is that for few cases where HIV/AIDS matters are discussed, it is always the husbands who initiate the discussions.

The overwhelming majority of women who reported that they do not discuss AIDS matters with their husbands gave various reasons for this as shown in table 6.2.

Table 6.2 Reasons for not discussing AIDS matters

N = 93 for all responses.

Reason	Frequency	%
A dreadful disease not to be discussed	37	40
Fear of contracting it.	20	22
Husband doesn't like to talk about it	37	34
Can create conflict / problems in marriage	43	47
Husband has not time to talk about it	31	34
Husband can be violent	11	12
There is nothing to discuss about it	12	13

From the spontaneous responses in table 6.2 we observe that mistrust/conflict in marriage was the major reason why married women did not talk to husbands about AIDS. A large number of women also fear that if you talk about AIDS then you could easily get it. For some either the husband had no time or did not like to talk about it. Violence from the husband come last among the reasons given for not discussing AIDS.

The issue of conflict and mistrust as a reason not to discuss AIDS in marriage was explored in detail. A woman who introduces matters of AIDS to husband, it was learned was portraying herself as one who is very experienced in sexual matters yet women who show a lot of knowledge in sexual matters are viewed negatively. One women put it clearly when she said;

> *"Married women should stick to their husbands and stop talking about things they know nothing about. They will be considered the know it all. They will tell who gives them lessons on AIDS"*

The above statement is significant for two reasons. For one it shows that even women themselves are sometimes made to believe that it is men who are knowledgeable in sexual matters . Secondly it shows that a woman who introduces matters of AIDS to the husband may be considered as having learnt them through promiscuity. This may be the reason why even those women who reported that they discuss AIDS matters with their husbands, it was always the husband who introduced the discussions. For purposes of maintaining "harmony and understating" in marriage women would rather not talk about AIDS.

Some women gave various reasons why they claimed that some men/husbands do not have time to discuss matters related to AIDS. Cases of alcohol taking in this area are common. Most husbands who are involved in 'Jua Kali' and other odd jobs usually take local brews almost on daily basis. The only time this men are

with their wives is at night when they are drunk. Such men are unlikely to introduce discussions on AIDS unless of course they are trying to accuse their wives of infidelity. Introducing AIDS matters to a drunk husband, some women claimed can lead to violence.

Some women also felt that to most husbands AIDS matters fall nowhere among their priorities. Most would say that they have no time to discuss such matters and go ahead to justify this by expressing their concerns about school fees, food etc. Most women were however in consensus that the main reason why men would not like to discuss AIDS matters is because such discussions may come close to or even end up discussing their extra-marital affairs.

For a majority of married women whose husbands work away from home communication about AIDS matters is also difficult. The occasions such husbands come home they are there for a short time. Introducing a topic on AIDS to such a husband could lead to problems of mistrust. One woman retorted;

> *"If a husband comes home from Nairobi and you start talking to him about AIDS he may think that you suspect him of moving with prostitutes back in Nairobi."*

From this findings we may observe that although a majority of married women in Sabatia may have certain desires and fears about HIV/prevention they hardly express them to their husbands. Most women would rather share such views and experiences with their female peers. Discussions about AIDS are seen as a source of conflict in marriage. There is also a general feeling among women that conflicts arising out of matters of sexuality are always blamed on them.

6.4.2 Wife's response to husband's infidelity

Central to the battle against AIDS is the need to empower women (Schoepf 1993). However as this study shows, this may only be achieved when wives have a major concern with their husband's other sexual relationships and when husbands are sufficiently apprehensive of that concern to change their behavioral patterns. Whereas both male and female infidelity is not uncommon in the Sabatia area, just as in most African communities (See Berer 1993) there was a general consensus among both men and women that husbands are the most likely culprits. Therefore what action would married women take if they suspected their husbands of unfaithfulness? Table 6.3 summarises some of the major actions that could be taken.

Table 6.3 likely actions to take when husband is unfaithful

N = 140 for all responses

Action	Frequency	%
No action	27	19.5
Don't know / not sure	15	11.0
Complain / confront him directly	44	31.5
Use third party relative to talk to him	74	53
Abandon / divorce him	14	10.5
Separate from him	18	13
Refuse to have sex with him	9	6.5

For most married women who may suspect their husbands to be unfaithful in this area, options are minimal. For most women the most likely option would be to approach a third party in confidence and request them to talk to the husband. Such persons should most likely be relatives who should be older than the husband. The next most likely option would be to directly complain/confront the husband, a strategy which as would be

seen in the proceeding section has negative consequences for the wife (see also Nzioka 1994). Abandonment, divorce, separation or sex denial were less likely options. Some respondents admitted that there was nothing they could do while others were not sure of what they could do. When the husband's unfaithfulness was associated with the risk of transmission of AIDS, the responses from married women as regards the action they would take changed slightly as shown in table 6.4. Some women reversed their positions as regards what action they would take. The number of those who initially felt that there was nothing they could do or were not sure of what they would do decreased significantly. At the same time more women seemed to express the idea that they could complain directly to their husbands than when the issue of AIDS had not been introduced hence the number of those who said they would use a third party reduced. Though small, the percentage of those women who reported that they could take steps sch as abandonment of the husband, divorce, separation and refusal to have sex with him increased. Some even dared to mention to use of condoms.

Table 6.4 Likely actions to take when husband puts wife at risk of AIDS infection

N= 140 for all responses.

Action	Frequency	%
No action	5	3.5
Don't Know / not sure	10	7.5
Complain / confront him directly	85	59.5
Use third party / relative to talk to him	68	49
Abandon / divorce him	28	20.5
Separate from him	32	23.5
Refuse to have sex with him	21	15.5
No response	13	9.5

Berer (1993) notes that even in societies where male infidelity has been taken as a fact of

life by married women, with the emergence of AIDS some have started to take steps that challenge male sexual domination. However there is always a limit to the actions they could take due to the resultant consequences hence reducing their ability to adopt appropriate HIV preventive behaviour as well as influence their husbands to do the same. This study shows that the same may be true of married women in Sabatia. In proceeding sections we examine in detail various married women's HIV preventive aspects and their rights in influencing sexual behaviour change.

6.4.3 Direct communication and insistence on fidelity

As discussed in section 6.4.1 of this chapter, married women in Sabatia rarely discuss matters related to AIDS with their husbands. As noted by Elyne (1997), this may present problems of communication about the need to adopt HIV/AIDS preventive behaviour where women are more likely to be disadvantaged than men.

In Sabatia however, a majority of married women expressed feelings that they should have a right to directly express their concerns about their husband's infidelity through such means as verbal communication as shown in the previous section. Data collected in this study showed that it is not easy for a majority of married women to take such a step. Infact there was a general consensus among them that a woman would be better of complaining about a husbands infidelity without introducing her concerns about AIDS to him. Such findings were also documented by Ulin et al (1993).

About 74% of women believed that married women in general had a right to verbally communicate to their husbands about their concerns about infidelity. Interestingly about 26% felt that w woman had not right to do that. Statements in support of such women's opinions showed their belief in Maragoli traditional values which restrained married women from confronting their husbands directly complaining of their infidelity. As expected tranditionaly, it is such women who were most likely to advocate for the use of a third party rather than expressing their concerns directly. Explaining the Maragoli traditional values related to marriage, Wagner (1949) noted that a woman who confronted

the husband directly accusing him of infidelity risked condemnation for being disrespectful.

Whereas we found that a majority of women felt that they had a right to show their concerns about their husbands infidelity directly and demand for faithfulness, such a right is usually denied. They may explain why very few of those who believed in such a right reported that in practice they can talk to their husbands about their infidelity let alone the fear of HIV/AIDS infection. This study established that the reasons for this stem from the likely negative reactions which such a step may elicit. Such reactions may not only come from the husband but also other members of the society especially the husband's immediate family members. Some of the major possible reactions mentioned are summarized in table 6.5

Table 6.5 Major possible reactions to married women's direct expression of concern about husband's infidelity

N = 136 for all responses

Reaction	Freqeuncy	Percentage
Husbands bitter denial	72	53
No change of behaviour	86	63.5
Change of behaviour	10	8
Denial of economic assistance	66	49
Condemnation from husbands family	52	38.5
Physical abuse	29	22
Forced separation / divorce	28	21
Worsening of behaviour	58	43

One of the most likely reactions from the husband is denial that they are involved in an extra-marital affair. Such findings have also been documented by Ulin et al (1993), Tuju (1996), Nzoka (1994) and Topouzis (1993) Women, as we learned, are not expected to

know about their husband's sexual behaviour outside the home. Even if a wife had proof of a husband's infidelity it is always very difficult for the husband to accept it. Statements such as the following were common in the discussion on this issue;

" Even if you catch him red-handed, he will always find ways of denying it"

Whereas verbal communication is meant to make the husband appreciate the wife's concerns about the need to change his behaviour, the feelings amongst most women was that behaviour will not change. A significant number indeed felt that behaviour would worsen. Those who held this view explained that some husband's infidelity would worsen because the husband either wants to silence the wife or prove that they are superior. The married women's passivity compared to the mens active role in the control of sexuality is very clear in these findings. This is consistent with the views of Ellis (1913), and Malinowski (1948). While women are expected to be passive, responsive and receptive in sexual dynamics, men are expected to be active and aggressive initiators of the sexual activities.

The inability to communicate to husbands about their infidelity and fear of risk of HIV infection was also attributed to denial of economic assistance. Whereas most studies show that power restructuring is becoming an important dynamic between husbands and wives due to the market economy, (ATRW 1992) the economic and social status of most Maragoli women is still low. The market economy in Maragoli has only managed to raise marital powers for few women in this area who can seek independence by opting out of the subordination by male heads. For example whereas the Maragoli women are expected to be submissive to their husbands even in matters of sexuality, we established that there are those very few women who are capable of buying their own land to which they have unlimited access and control. Such women are those relatively educated and they have the confidence and competence to free themselves from dependence on the Maragoli patriarchal structure. For majority Maragoli women who depend on their husbands for subsistence, the threat of denial of economic assistance makes them

complacent. Such women will not dare talk to their husbands about their infidelity and the need to change behaviour to avoid HIV/AIDS infection.

Interestingly it was noted that efforts by married women to directly express their concerns about their husbands infidelity may elicit negative reactions from the husbands family members. This comes about because the husband is most likely to confide in his relatives such as his elder sisters and aunts. More often than not such relatives will show disapproval of the wifes action and may have a very big influence on the husband to take drastic measures against the wife. To avoid living in a hostile social environment married women may remain silent about their husbands extra-marital sexual affairs at the risk of HIV/AIDS infection. It was learned that most husbands would always confide in their relatives to counter any attempts by their wives to report them to the very relatives.

Physical abuse forced separation and divorces were also mentioned as possible reactions though they elicited very low responses. This is consistent with the findings of Oyosi (1995) who documented that cases of physical abuse, divorce and separation or even divorce were low in this area. Some husbands would beat their wives who confront them with accusations of infidelity. They may also chase the wife from the home for some time. However few men divorce their wives especially when there has been a long marital duration, dowry paid and there are several children from the marriage. Although dowry payment as a practice is not very strong as in the past n this area (see Wagner 1949) it still binds a wife to the husband to an extent. Further more, contrary to the practice in the past, divorce of a wife may not necessarily be followed by the return of bridewealth to the husband immediately. Due to the importance given to the need for women to be married, women will always try their best to maintain harmony in the marriage to avoid divorce. Condoning a husbands infidelity is one of the ways of maintaining harmony in the marriage and reduces the wifes ability to influence adoption of HIV/AIDS preventive behaviour.

Whereas few women could talk to their husbands about their infidelity, data gathered

showed that introducing the issue of AIDS when talking to a husband about their extra-marital affairs was not easy. Mentioning AIDS it was learned could be very counterproductive. As Ulin et al (1993) notes, AIDS is a subject charged with emotion animating from suspicion and doubt to fear and anger (see also Nzioka 1994). A husband may accuse the wife of being unfaithful herself and at the risk of HIV infection. With the mention of AIDS some husbands it was learned would react very negatively and could even turn out to be violent. Further probing revealed that for most married women in this are even if the husband infects them with any other sexually transmitted diseases they will never tell him directly. They may seek treatment and remain silent about it or use a third party to warn the husband. The next section does not always work. This is because the husband may accuse the wife herself as the source of the disease.

In this section we have seen that the major reasons why married women would not directly communicate to their husbands about their infidelity and fear of HIV infection were their need to maintain their economic base, marital harmony and not challenge established norms tat govern husband wife relationships.

6.4.4 The use of a third party

It was considered opinion among most married women that the use of a third party was a better option in expressing their concerns about their husbands infidelity to them. This does not mean that it was necessarily an effective means but it was seen to be better than directly talking to him due to the reasons highlighted in the previous section. However more women volunteered the information that they would talk directly to their husbands if they were very sure of the risks of HIV/AIDS infection.

The strategy of the use of a third party is a remnant of the traditional Maragoli values.(see wagner 1949). A 71 year old key informant volunteered information that culturally among the Maragoli people it was unacceptable for a married women to confront her husband with accusations of infidelity. He retorted;

> *A good wife should approach an elderly person who is a kin to the husband and share with her/him her grievances. It is upon such a person to talk to the husband and warn him not to bring the disease in the home"*

The findings of this study showed that this strategy may not necessarily work for most married women who would wish their husbands to change their behaviour to avoid risk of HIV/AIDS infection. It was found out that this strategy may backfire whereby the husband would accuse the wife of exposing their private lives and not talking to him directly. Since the wives would not talk to their husbands directly, they suffer in silence at the risk of HIV infection from their husbands. At the same time, the use of a third party may not necessarily guarantee sexual behaviour change of the husband.

As indicated earlier, the normative structure among the Maragoli prescribes that the third party to be used be a kin to the husband. Findings of this study indicate that for the most part, relatives of the husband are more inclined to condone his extramarital affairs and that the older the relative the more likely that they would side with the husband. Such relatives may also not necessarily show their disapproval of the husbands behaviour but only express the wives concerns. It is also very easy for the husband to convince such a third party that the wife's concerns are not genuine.

Religious people such as church elders, pastors were seen by some women as possible substitutes for the husbands kinsmen as the people to be used to guide and advice the husband to change their sexual behaviour. This findings show the role the church can play in adoption of HIV/AIDS preventive behaviour. However as we found out in this study, the problem with this strategy was that whereas men may claim to belong to certain religious groups they in practice do not go to church. This finding is consistent with that of Ndege (1990) about the Maragoli people. Even if men go to church, they may not be very strong adherence compared to their wives to allow the religious people

to get involved into their private lives. Thus whereas women who do not believe n the role of relatives in the guiding and counseling their husbands may opt for the church, this study shows that there is a limit to the extent this strategy may work.

Conflicts in marriage arising from sexual matters in this area are sometimes brought to the attention of clan elders,village elders who convene "barazas" for resolution of such cases. Village elders (a magutu) take an active role in the settlement of such matters. Interestingly it was learned that rarely do matters of a husbands infidelity brought to such a level for resolution. Asked to comment on this one village elder "Ligutu" said;

> " *A husband's life outside the home is his own business provided he does not spoil peoples young daughters"*

More often than not it is always when a wife is accused of infidelity that such matters are brought to the attention of elders or when the husband goes with a married woman within the area and is accused by the husband. This shows a practice of condoning male infidelity hence most married women have no confidence in such a practice of resolution of marital conflict arising out of husbands infidelity.

Most married women aggrieved by husbands infidelity in this area may not venture to use "barazas" to warn their husbands to change behaviour in HIV/AIDS prevention. First and foremost, most married women regard their sexual lives as private and would not wish such matters to be brought to the scrutiny of the public. Secondly, taking the initiative to bring such matters to the public may destroy the harmony in the home. Thirdly and very significant was the issue of male superiority in the said "barazas". In such meetings it is likely that proceedings would be controlled by men who would most likely be biased against the women aggrieved. An AIDS educator in this area expressed her sentiments in this regard;

> " *In this area women feel that freedom is given to men to do whatever they*

want. Any problems that emanate from marital sexuality will always be blamed on the wife"

The findings as discussed in this section show a glim picture of the role of a third party in married women's ability to influence their husbands marital sexual behaviour in HIV/AIDS prevention.

6.4.5 Condom use insistence

Just as many studies such as documented by Ulin (1993), Nzioka (1994), Tuju (1996), Onyango and Walji (1991), this study also established that condoms are seldom used in marriage. That it was very difficult for a married woman to convince a husband to use a condom if one felt that their is need to do so. Indeed a married woman may never have any justifiable reason to request a husband to use a condom, not even for HIV prevention.

The few occasions where condoms are used by married couples in this area, they are more likely to be used for family planning purposes and not disease control (see Nzioka 1994). Women in particular had various concerns about the use of condoms namely their acceptability and effectiveness of condoms, for HIV prevention, a woman's right to ask a husband to use them and the kind of response that married women anticipated from the husbands.

Data gathered showed that almost all women had the information that condoms can be used for HIV protection. However, a significant number were concerned about their effectiveness. Some fearing transmission through saliva, doubted that condoms would be adequate protection. Others questioned the quality of condoms and the possibility of perforation and tears. A very small number alleged that infact condoms are laced with the HIV/AIDS virus. However, according to most women an even greater deterrent to condom use was the immoral attachment they have and the feelings that men canever accept to use them.

Majority of women's views indicated that for most part condoms are associated with immorality and casual sex. Very few women for example agreed that they could go looking for condoms even if they needed them. Those who felt that they could go looking for condoms suggested that their sources could be FP. clinics, F/F field workers rather than shops or chemists. One woman retorted;

" *You go to a chemist to buy condoms and everybody would think you are a prostitute"*

The differences of opinion that polarised womens focus group discussions showed the problems women face in attempting to request condom use as a means to protect themselves from HIV infection. The responses tended to follow a pattern in which women at first agreed that any woman has a right to protect herself from AIDS. But then they began to raise stringent conditions under which "any" woman could properly propose condoms.

A minority of women stated faltly that "you will never find a woman who would ask the husband to use condoms" However, for most women, they felt that some women had a right to ask their partners to use condoms. A criterion on which most agreed was that the woman was to be certain of her risk. That a woman who has a right is one who knows that her partner is "fooling around". Married women were however not expected to ask their hsubands to use condoms on them. Interestingly some married women said that a married woman who fears that her husband can get infected with AIDS should advice him to use condoms on the "other woman" becuase he cannot use them on herself.

Other women who were cosndered to have aright to ask for the use of condoms were prostitutes and school girls, neither of whom, they pointed out, would wish to be burdened with children. Women considered as those without a right were those in long term relationships (marriage) and those whose husbands may wish to have more children. Several women observed that christen women need not bring up the subject of condoms because Christian men do not have affairs with other women.

Two common elements that stand out in the criteria above are sexual freedom and fertility, traditional values now threatened by the risk of HIV/AIDS.

Looking at sexual freedom, we note that women who request the use of condoms may be in essence questioning their husband's fidelity and thus be challanging the validity of the double standard that has governed the marital relationship. For example an irony in the "rules" that some women suggested that should determine a woman's right to ask for condoms is that women are not supposed to know whether their husbands are frequenting prostitutes or having affairs with other women.

We established that fertility was a competing value that often overshadowed disease prevention as a priority in decisions about sexuality. (See also Ayayo 1991, and Ayayo and Muganzi 1990). First it was apparent that the link between condoms and contraception was more familiar than the link with disease prevention. Secondly focus group participants who tended to deny women the right to ask for condom use frequently turned to the rhetoric of family planning to find culturally acceptable metaphors to jusfity the use of condoms for AIDS prevention when children were not an issue. They felt that it was easier to convince a promiscuous husband to accept the use of condoms under the guise of family planning than confront the more threatening issue of AIDS prevention.

As the above suggest, married women in this area cannot be said to take lightly the public health prescriptions to use condoms as a precaution against AIDS. Some understand and can accept the preventive value of condoms, but there are costs, that for many outweigh the benefits. A side from their own misgivings about condoms and their safety, women were very skeptical and even apprehensive about the reaction of husbands to such a proposal. In group discussions they recommended that women in general should demand the use of condoms if they could not trust the fidelity of their partners. However, when asked how the same men would react, their opinions varied from the firm belief that "men who are not beasts" will agree, to an equally strong instance that few if any men will even

be willing to use condoms, especially with their wives.

Women who took the more negative stance on the issue of partner response to condoms were the more numerous and more vocal. For the most part their concerns centered on issues of denial and trust. They contended that men refuse to admit having other partners and instead turn the blame on their wives. They want to know why they are being asked whether it is because the woman herself is sick or her own behaviour is putting him at risk. Suggesting to a husband to sue condoms some women said, provokes him to accuse the woman of having other "husbands" the only reason he will allege, that she would make such a demand. If he wishes to take her request for condoms as evidence of infidelity he may respond with physical abuse, withdrawal of economic assistance/support or divorce.

Fear of physical abuse was not a major theme, but fear of abandonment or economic neglect and social condemnation was. It was found out that women in this area could easily be manipulated by men who had the power to deprive them of the resources for basic survival. Men who did not get what they wanted could retaliate by withholding money for food, clothing and childcare. Women who do not work have no right to make demands. Women with jobs may have such right because they have other options for themselves and their children. Reacting to the right of a woman to ask for the husbands use of a condom, one woman said;

> *"If the husband is making money and you are not, he never pays much attention ot you, but if both people are working, the woman is worth something. I have experienced this in my own house, and I realise that my husband would not treat me the way he does if I had a job"*

Comments such as the above take the problem of AIDS prevention to a more fundamental level, to the direct link between women fear and frustration in the face of the epidemic and their sense of powerlessness to control their own lives. For women in Sebatia,

money was much a symbol of freedom as it was a material resource for achieving independence from male domination. Without access to income they lacked the self esteem and the financial security to be full partners in critical decisions that could determine their chances of survival in the epidemic. One of such decisions is the right to demand the use of condoms for HIV/AIDS prevention.

6.4.6 Sex and Women's control of access to their bodies

Finding in this study reveal that majority of married women in Sabatia have no control over the access of their husbands to their bodies. Despite many comments that discovering a husbands infidelity would justify refusal to have sex with him due to the threat of AIDS, refusing sex still seemed to be a relatively new and even a frightening idea for most women. It was generally viewed as an unusual occurrence in marriage. It was evident that denying a husband sex may not be a very practical option but it was viewed by some women as a bargaining tactic to force a husband change his extra-marital behaviour.

Whereas a woman may give such reasons as illness, menstruation, fatigue or pregnancy as justification for refusing husbands sexual advance3s, the general opinion was that a married women can never have a sufficient reason to deny the husbands sex. Furthermore, the mention of fear of risk of HIV infection or husbands infidelity as reason not to have sex with him could be very counter productive.

When asked if they could refuse to have sex with their husbands if they suspected them of unfaithfulness, 18% of women said they could, 78% said that they could not while 4% were not sure. Those who said that they could not gave such reasons as forced sexual intercourse, physical abuse, abandonment, or lack of material support. The major reason was however that such a step may make him worsen his behaviour. It was generally believed that the husband will try to get sexual gratification elsewhere. Such statements as below from group discussions express this general feeling;

"Refusing sex does not help you. You will send him to prostitutes and he won't change".

When asked if they could refuse to have sex with their husbands if they feared that they could be infected with the HIV/AIDS virus, 30% of the women said that they could while 70% said that they could not. However discussions showed that some were confused over this issue as they felt that temporal sex refusal may protect them from their husbands. Further statements and comments from such women also showed that in practice they can not take this step due to the consequences that may follow. Toping the list among the consequences were possibility of abandonment, denial of economic assistance and subjecting the husband to more risk.

Interestingly, some women felt that it is a woman's duty to make sure that the husband has sexual gratification whatever their own feelings. Failure to do that was synonimous abdicating one's role as a wife. This and the fear of the breakup of the marriage, denial of economic assistance and subjecting the husband to more risk makes women lack control of access to their bodies.

6.5 MALE PERSPECTIVES OF WOMENS ROLE IN INFLUENCING HIV/AIDS PREVENTIVE BEHAVIOUR

6.5.1 Position of women in household decision making

The way husbands perceive the role of women in household decision making processes as Berer (1993) argues may also influence their perspectives on women role in sexual decision making and adoption of HIV/AIDS preventive behaviour. In general, their tended to be an ambivalent response from men. With respect to household duties a majority of men felt that it is wrong for wives to have extreme dependence on husband's authority for such everyday decisions as cooking and

child care.

They argued for example that once a husband provides money for household expenses, the wife has a right to decide how to spend it provided "she carried out her responsibilities to his satisfaction". However, the examples men gave to illustrate mens satisfaction belied their support for women's rights to make even ordinary decisions. The following segment from discussions is typical of the expressions of men on issues of household decision making;

> *" It is not always good for a husband to decide what the wife should cook. The wife should decide but she should ensure that what she cooks is what the husband would like to eat that day"*

Decision making thus frequently seemed to mean compliance on the part of the woman rather than actual independence.

Statements in support of joint decision making were similarly couched with terms that suggested that men are supposed to make decisions and women to agree. Decisions which husbands believed should be made in this fashion were such as those related to use of family planning, whether and where to send children to school and whom their children should associate with. While in general men wanted to be consulted about a service that required payment of fee, opinion favoured granting the wife the authority to act in emergencies with the understanding that she will inform him of her actions at a later date or time.

Interestingly some men believed that women should make their own decisions in household matters but they felt that husbands assume the authority because women expect that of them. One man quipped;

> *" Sometimes the husband becomes the sole decision maker because of the wife. Even if you try to decide things together, she always has it in her*

mind that your decision comes first. Whatever you do is right. Of course some women who are tough don't like that, but they think they are supposed to give you the right to act"

We may venture to argue here that generally men in this area do not believe in the women's authority in decision making in the household. Such a conception of decision making authority could be extended to sexual decision making.

6.5.2 Sexual freedom and women's rights

Majority of men spoke of monogamy as ideal, but they also accepted multiple sexual relationships as a fact of like,, at least for men. There was a tendency for them to take for granted a double standard that grants sexual freedom to men and denies women the right to question the husband's sexual activities. They frequently prefaced their remarks with "If " clauses for example. It was common to hear them say;

" *If a wife suspects the husband has another women'... or*
" *If she realises that you move dangerously... "*

What such statements imply is that it is not normal for women to know about their affairs but that they sometimes find out.

On the other hand, men were emphatic that a wife has no right to have other men. Although some men and women tended to speak from personal experience on many of the issues under discussion, men were less likely to believe or admit that their own wives might be unfaithful. When they alluded to the possibility of their wives infidelity; they did so in terms of a man's power to control a woman's behaviour. This finding is in contrast to the remarks of many married women that they (or women like themselves) could not trust their men, knew little or nothing

about their partners extra-marital activity and felt powerless to control their behaviour outside the home.

There was a tendency for men to describe women who showed concern about their husband's sexual activities as being desrespectiful. A good wife they claimed should concentrate on taking care of children and looking after the husband. One quipped;

" *When a wife starts to chase around the husband to find out what he does out there, she doesn't know what marriage is all about*"

For some men "loose or immoral" were the terms they used to describe women who expressed a lot of knowledge of sexual matters. As a 60 year old key informant said;

" *When a wife starts to know things about sex and love, then you know she is heading in the wrong direction. The next thing she will become is a prostitute*"

In general the way most men seem to perceive female sexual freedom is what the society expects of them. That women should not be assertive in sexual matters.

Men expected "loose women" to have multiple partners, but this norm did not apply to a married woman by custom or law. Men warned that even in marriage women were in need of surveillance and discipline as argued by one male focus group discussant;

" *When a man comes home he has to inquire from those around including neighbours to find out whether his wife acted in any immoral ways*"

Just as many women, men also seemed to be aware of the chain of transmission and men's position as the link between HIV infected women and their wives at

home. However, there was a tendency by some men to defend their freedom in this regard. Men's defends of their freedom seemed to show the influence of Maragoli values related to marriage and parenthood on their attitudes towards female sexuality. For instance some argued that when a wife is not able to conceive or give birth to sons there is nothing wrong for a husband to try and get the children elsewhere. However for some men, especially those with post-secondary education this was not a justification for men's extra-marital sexual relations. They seemed to be aware that such a problem may not necessarily be attributed to the wife alone. However the general consensus was that the society may condone such extra-marital sexual affairs on such grounds.

In this section we note that a majority of men in this area, irrespective of their educational levels and other individual characteristics tend to express opinions that indicate that women should not have sexual freedom. They tend not to recognise women's rights and responsibilities in challenging male sexual domination.

6.5.3 **The right to refuse sex**

The extent to which women are able to control access to their bodies is a critical element in their capacity to protect themselves from contracting AIDS. (Zorrilla 1993). Do men in this area believe that women should have control of access to their bodies?

Men tried to debate circumstances under which married women have a right to refuse sex and the reactions she might expect from the husband. Sharp differences of opinion polarised the discussions showing the struggle men have to resolve i.e. a basic contradiction between their right to demand compliance and the right for women to refuse.

One perspective more common among men was that wives who are well treated by their husbands actually have no reason to deny them sexual gratification. Well treatment of wives in this case was taken in most cases to mean material provision and financial assistance. For the most part however, some men tended to grant women the right to refuse sex under certain conditions. Such men who expressed a relatively confusing attitude would say "You have to try and understand the reason why she refuses"

However, the central position was that there are circumstances that justify a woman's refusal. Fatigue, ill health, and family planning were commonly mentioned but with little enthusiasm. For instance one man agreed that working hard all day might be an acceptable excuse but that "if the woman is not tired, has no work to do there is no reason to refuse. Other reasons mentioned albeit with little enthusiasm included hunger, unhappiness and financial neglect.

Although men made little direct reference, positive or negative to women's economic dependence, they acknowledged the unhappiness of those who feel neglected or abandoned by men seeking their own pleasure.

Even though participants in group discussions tended to agree that most men would overlook wive's occasional refusal, their comments also offered numerous examples of valid objections by a man to such decisions on the part of the woman. Frequent disclaimers such as "women have aright to refuse but ...." revealed the difficulty men were experiencing as they struggled to resolve competing issues of freedom and responsibility. There was clearly a limit to most husbands to tolerance of rejection.

Refusing sex because of a partners promiscuity provided a different kind of justification from refusal due to temporary indisposition like menstruation or fatigue. Almost without exception men concurred on the danger of sex with many

partners and agreed that women have a right to protect themselves from AIDS. Many men were aware of wife's concerns about the threat posed by the husband sexual freedom as in this man's comment below;

" *The wife can refuse to sleep with the husband is she notices that he goes with other women. She might think that if the husband has sex with another woman, he could get AIDS and give it to her. She could take the precaution of avoiding sex with him that day"*

The above statement is significant for various reasons. For one it represents the view of most male participants that when a married woman discovers that sexual contact with their husbands puts them at risk of HIV/AIDS they have a right to protect themselves. Even some men who earlier had condemned women who refuse sex for trivial reasons, when the issue was redefined to include possibility of HIV transmission, reversed their position. Secondly the issue of refusal now takes on a temporal dimension. The speaker above seems to suggest that a woman's decision to refuse sex is relatively recent, linked to the appearance of a new disease and a fear that did not exist in the past. Thirdly, the phrase "she can avoid sex on that day" raises a question about the understanding of transmission. It shows some lack of understanding about the nature of risk.

Those men who felt that women had a right to refuse sex with husbands who put them at risk of HIV infection also had reservations. They warned that such a strategy could easily backfire, lead the husband to accuse her of infidelity, and even give him reasons to be even more promiscuous. We noted in the previous sections that women also tended to have such fears. Some men openly expressed their opinions that refusing sex may ultimately threaten the stability of the whole family. Classic examples of such opinions are expressed in segments like below;

" *If the wife refuses sex, the husband could go with anybody who will give him AIDS which he will bring back home to the wife"*

" *The family can be destroyed when the husband leaves the wife because of sex. He may think that she has sex with another man. Yet the woman may be refusing for another reason"*

Many men tended to blame the wife for creating problems that could lead to HIV infection. Men's logical conclusion on this issue therefore seemed to be that a woman who refuses sex, in reality is increasing the chance that her husband will be infected by other women. By assuming the customary role of complaint, nurturing wife, she supposedly solves the problem with no cost to domestic harmony, helping to preserve the balance of power that sustains a man's sense of freedom. This perspective seems to be analogous to the anxiety which women in this study frequently expressed concerning the retaliatory behaviour of an angry husband who " can always go to other women".

6.5.4 How do married women protect themselves from HIV/ infection

Men in focus group discussions did not reach consensus on how married women should protect themselves from HIV infection especially from their husbands. When issues of the wives right to protection were raised the spontaneous discussions that emerged tended to centre on how married women can prevent infection from other sources other than their husbands. In such discussions that tended to put focus away from husbands men would give various protective prescriptions for married women. They stressed the need for wives to be faithful to their husbands. Few even ventured to mention the use of condoms as a last resort. They were also more likely to mention other non-sexual modes of prevention that are related to blood as a channel of transmission.

When discussions centered on the possibility of HIV infection from the husband various areas of agreement and disagreement emerged. Opinions on 'sex refusal' as an option for married women were the same as those discussed in the previous section (6.5.3). The general agreement was however that sex refusal may not

work. The insistence by some men that this method could be used by married women for HIV/AIDS prevention from their husbands was always supported by remarks that showed lack of knowledge of HIV transmission by such men. This is because they were likely to prescribe such a method but still insist that it could only be temporal.

Condom use came up as a possible option for HIV prevention with men expressing their opinions about its use by married women.
Discussions on condoms provoked controversy among men, just as it did among women. In general, men view condoms as unfortunate but sometimes necessary, alternative to giving up ones sexual freedom. However they almost all concurred that married women should not expect their husbands to use condoms on them.

Like the women, most men recognised the value of condoms in AIDS prevention, but some questioned their dependability and the right of married women to demand their use. In their remarks about condoms, just like the women, men frequently combined contraception and disease prevention and sometimes shifted the focus of discussion to family planning. Not surprisingly, they appeared more at ease putting the emphasis on contraception, rather than disease prevention. In fact some men suggested that a woman who is trying to convince a husband to use condoms "might be lucky" if she uses the argument that having fewer children will enable them to provide food and pay fees for those they already have. Most said that it would be "inappropriate" to attempt to use condoms if the couple did not have "enough" children. Thus, in the eyes of men, women who wish to avoid pregnancy may be "lucky" in convincing a husband to use condoms.

Most remarks on this topic also suggested that the longer the marital union, the less power women have to initiate behaviour change, because conjugal expectations are stronger and women therefore are under more constraint to ignore their husband' extra-marital behaviour. For instance men argued that along term

wife who suggests using condoms will by so doing, shatter the "understanding" that has sustained their marriage. To raise the issue seemed to many men like admission of guilt. A woman who has "good behaviour" and is faithful and respectful in the presence of her husband, will not ask, because she will not want him to think she is HIV positive or has another man. Men commonly remarked that if one partner brings up the subject after many years in a stable relationship, the other will have a right to begin "asking questions, since we are not used to using condoms". Men occasionally alluded to distrust and fear of disclosure that a woman might cause by raising the question of condoms but the possibility of inciting anger and retaliation were mentioned much less in discussion of condom use than in similar discussions of refusal to engage in sex.

Despite their negative attitude towards condom use, a majority of men felt that condom use may be appropriate for a wife whose husband has openly confessed to be HIV positive. However they were quick to add that some men may never want their wives to know about their HIV status. There were also expressions of misgivings about the dependability and ability of condoms to prevent infection.

Many men claimed to believe that with discretion and tact, women can induce men to reflect on their lifestyles and consider change of behaviour in order not to put their wives at risk of HIV infection. They admitted however that this is not easy. Avoiding the necessity of condom use for example they claimed may be sufficient incentive to convince a man to give up his extra-marital affairs, or he may be willing to use a condom if the alternative is loosing his wife. In either case, the men seemed to have been drawing from their knowledge of women's bargaining skill to make the point that at least some men can be convinced. One man offered his opinion;

> " *Men will have to do some thinking about their lives. They should avoid prostitutes. If their wives suggest they use*

condoms it is because they are aware AIDS is dreadful"

Some men acknowledged that women with no hope of influencing promiscuous husbands who could put them at risk of HIV infection could either leave them completely or temporarily to make a point that they have to change their behaviour. However, this argument is flawed for two reasons. For one, for many women without means of subsistence, there is no middle ground between living in the shadow of infection and both their own and children's destitution. Secondly temporal separation, even if it makes a husband change his behaviour may not guarantee safety to the wife because condoms may not be used when the wife goes back to the husband.

Whereas men were more likely to emphasise confrontation rather than collaboration the majority point of view was that men have to compromise if their wives discover their sexual exploits.

CHAPTER SEVEN

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

7.1 INTRODUCTION

The purpose of this chapter is to give a gist of the thesis by summarising the findings of the study, drawing conclusions and making recommendations. The chapter therefore draws heavily from the study findings, relating them to study objectives and hypotheses as highlighted in the proceeding sections.

7.2 AWARENESS AND KNOWLEDGE OF AIDS

The first objective of this study was to investigate the knowledge among married women concerning HIV/AIDS transmission and modes of prevention. The study found out that most married women in Sabatia are aware of the disease, its major modes of transmission and means of prevention. There was however evident confusion among many about modes of transmission, particularly casual contact. There also seemed to be little awareness or perhaps concern about peri-natal transmission. Few women were also bound to mention super-natural transmission. There were also evident exaggerations related to the knowledge of blood as a channel of transmission.

The study therefore concludes that HIV/AIDS education must continue to help people understand the major channels of transmission and recognise false or distorted information which may lead to unnecessary concern and unwarranted

discrimination against infected individuals. As cases of AIDS increase, the epidemic is becoming more visible and efforts to promote a realistic understanding of HIV infectiousness will be critical in preventing stigmatization and isolation of AIDS patients and their families. It is therefore recommended that;

- AIDs prevention programmes reinforce current HIV/AIDS education by placing greater emphasis on modes of transmission by dispelling myths concerning super-natural transmission, and increasing awareness of the danger of transmission to infants of HIV zero – positive mothers.
- That programmes evaluate all AIDS messages for accuracy, quality of presentation, and breath of dissemination. Programmes should pay particular attention of how individuals in the target population interpret the information they receive.

7.3 ATTITUDES CONCERNING PERSONAL VULNERABILITY AND PREVENTIVE STRATEGIES

The second objective of this study was to examine married women's attitudes concerning personal vulnerability and look into the action strategies they had adopted as away of prevention. Related to this objective the study hypothesized that knowledge of HIV/AIDS may not necessarily translate into adoption of effective HIV/AIDS preventive behaviour.

The study found out that married women in Sabatia were acutely aware of the seriousness of AIDS and its consequences. Where as they took the attitude that women in general are at greater risk of infection, there was a counter vailing tendency among individual married women to deny their own vulnerability. The attitude of such women was that having one sexual partner they had nothing to fear. As defined by this study, effective HIV/AIDS preventive behavior is one that would minimise the risk of contracting AIDS from various sources including the husband. The findings therefore confirm the hypothesized because through majority of married women were knowledgeable about AIDS, they seemed not to have taken any steps that would minimise the risks of HIV infection especially from their husbands. The study therefore recommends that;

- HIV/AIDS education messages should be very clear with information specifically packaged for married women stressing on mutual faithfulness. It should stress on the fact that faithfulness cannot guarantee safely unless it is mutual.

7.4 CAPACITY TO INFLUENCE HIV/AIDS PREVENTIVE BEHAVIOUR AND THE MALE PERSPECTIVES.

The third objective of this study was to explore married women's capability to influence marital sexual behaviour related to AIDS prevention and the male perspectives on women's role in sexual decision making and HIV/AIDS prevention.

This study established that for the most part married women in Sabatia have either low or no ability to influence marital sexual behaviour related to HIV/AIDS prevention. This

includes communicating to their husbands about AIDS, making the husbands appreciate their right and responsibility to protect themselves from infection, and insisting either on faithfulness of condom use as preventive strategies.

It was also noted that men were split between the right to demand compliance and their right to sexual freedom on one hand and the right of their wives to protect themselves from infection. Even with the risk of HIV/AIDS infection most men still show a lot of reluctance in allowing their wives to "interfere' in their role in controlling their wives sexual activities to make sure that they don't get the disease whereas some showed willingness to give their wives some authority in sexual matters, generally this was considered a completely as adomain of husbands.

This study therefore concludes that the complex issue of women's rights in marital relationships be a focal point of intervention. HIV/AIDS messages must be explicit about women's rights, sensitising women as well as men to actions, that women have a right, even a duty to take in order to protect themselves and their families. This strategy will require AIDS prevention programmes to incorporate opportunities for people to resolve the threat of AIDS. This study therefore recommends that;

- Married women in the target population participate with AIDS educators in developing communication strategies for negotiating safer sex.
- AIDS education include strategies in prevention messages which highlight gross gender communication on sexual risk.

- That communication strategies focus on both married men and women's rights in the marital sexual relationship.

7.5 BARRIES TO MARRIED WOMEN'S ABILITY TO INFLUENCE ADOPTION OF HIV/AIDS PREVENTIVE SEXUAL BEHAVIOUR

The fourth and last objective of this study was to identify factors that may hinder married womens abiity to influence marital sexual behaviour in HIV/AIDS prevention. In doing so, this study was guided by two hypotheses;

Firstly , that women's low economic status which leads to their dependence on husbands for subsistence has a bearing on their ability to influence adoption of effective HIV/AIDS preventive behaviour. Secondly, that the socio – cultural norms and values related to marriage, marital sexuality and parenthood have a bearing on married women's ability to influence adoption of HIV/AIDS preventive bahaviour.

The findings of this study show that the single most barrier to efforts by Maragoli women to effect positive behaviour change in HIV/AIDS prevention is their surbodinate status economically. This study has shown that there is a clear positive relationship between women's powerlessness and their dependence on their husbands for subsistence. Most of the preventive measures and mechanisms through which women can influence sexual behavior it was found depend to a large extent on their ability to be economically self sufficient. This findings confirm the first hypothesis above.

Another barrier was the negative association with condoms that women still hold. Whereas some had health concerns, most viewed condoms as a seed discord or distrust in marital relation, capable of causing psychological damage. Women who took this position worried that for them to insist on use of condoms they would raise suspicion of infidelility or HIV infection thus ruining the marriage and the home.

The study has also established that socio–cultural values and norms of sexual behaviour in Sabatia are an obstacle to married women's ability to influence HIV/AIDS preventive behaviour. Among the Maragoli, sexual freedom and the double standards that supports it represent deeply rooted gender differences in sexual decision making. Whereas the normative structure has seemed until recently to maintain the precarious balance of power between men and women, it cannot work with the advent of AIDS. When women try to influence husbands to change their sexual behaviour they will be challenging aspects of behaviour that have fallen traditionally in the dormain of men. At the same time they would be going against their traditional roles of good mothers, wives, and daughter in-laws. These findings confirm the second hypothesis above.

It is therefore the main conclusion of this study that HIV prevention, especially among married women can be achieved if both men and women come to grips with the need to change norms which control sexual relationships and deny women the right to determine their own sexual lives. Normative change calls for radical intervention in as it takes the problem of HIV/AIDS prevention beyond the individual behaviour to a societal level. At

the societal level it will require empowerment of women economically and the basic change in cultural definitions of sexuality and gender relations. This study therefore recommends that:

- National and international efforts to slow the spread of the disease in Kenya should give high priority to long-range goals of basic education and Training of women in income generating skills.

- Condom social-marketing programmes reinforce the message that condoms are safe and effective. They should emphasize the use of condoms in stable as well as casual relationships. The programmes should also make condoms accessible through community based distributors trained to provide realistic information and counselling.
- That HIV/AIDS Prevention Programs identify and train local leadership to conduct focused group discussion which addresses information needs and the resolution of conflict inherent in change. The local discussion leaders receive additional training and support to enable them to disseminate discussion techniques by becoming trainers of others.

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APPENDIX A

WOMENS HIV/AIDS KNOWLEDGE AND PREVENTIVE BEHAVIOUR

INTERVIEW SCHEDULE

Name of Location .....

Name of Sub-location .....

Questionnaire Number .....

Date of interview .....

1. Ethnic group.....

2. Age in years .....

3. Date of marriage. Enter exact number of years since date of marriage .....

4. Type of marriage

   1] Christian

   2] Traditional

   3] Eloped

   4] Muslim

   5] Cohabiting

   6] Other (specify)

5] Was bride wealth promised when you got married

   1] yes

   2] No

6. If yes was it paid?

   1] Yes

   2] No

7] Number of children

   1] Boys .....

   2] Girls .....

8] Level of education

1] None

2] 01 - 04

3] 05 - 08

4] 09 - 12

5] 13 - 14

6] 15 and above

9. What is the highest level of schooling you attained? .....

10. Any other type of education/training? .....

11. Adult education?

1] Yes

2] No

12. What is the age of your husband? .....

13. What level of education did he attain?

1] None

2] 01 - 04

3] 05 - 08

4] 09 - 12

5] 13 - 14

6] 15 and above

14. What do you do for a living? .....

15. What does your husband do for a living? .....

16. Have you everheard of a disease called AIDS?

1] Yes

2] No

17. Do you normally get information about this disease?

1] Yes

2] No

18. If yes, what are your sources of information about this disease?

1] ..... 4] .....

2] ..... 5] .....

3] ..... 6] .....

19. Do you believe that there is AIDS?

1] Yes

2] No

20. Do you believe that AIDS kills

1] Yes

2] No

21. Can a person who has AIDS disease be cured?

1] Yes

2] No

22. If yes what kind of cure can be used? .....

23. Can someone be infected with the AIDS virus and just look healthy?

1] Yes

2] No

3] Not sure

24. As far as you know, what are the symptoms of AIDS?

1] ..... 4] .....

2] ..... 5] .....

3] ..... 6] .....

25. Can someone infected with the AIDS virus but does not show symptoms infect other people?

1] Yes

2] No

3] Not sure

26. If yes, how? .....

If no, why? .....

27. Is it possible for people to prevent themselves from AIDS infection?

1] Yes

2] No

If yes, through which ways?

1] .....

2] .....

3] .....

4] .....

5] .....

6] .....

28. Do you know the ways through which an individual can get infected with the AIDS virus?

1] Yes

2] No

If yes, name them

1] .....

2] .....

3] .....

4] .....

5] .....

6] .....

29. Can anybody get infected with AIDS?

1] Yes

2] No

30. What kind of behaviour do you think is likely to expose an individual to the risk of contracting AIDS? .....

31. What kind of people are less likely to get infected with AIDS? .....

32. What kind of people are more likely to get infected with AIDS? .....

33. Have you ever seen or known anyone infected with AIDS?

1] Yes

2] No

34. If yes, where? Who? Were any of such people related to you? Specify relationship.

.....

35. Do you think it is necessary for married couples to take precautions in order to protect themselves from getting AIDS?

1] Yes

2] No

If yes, which precautions? .....

36. Do you yourself take any precautions to prevent yourself from getting AIDS?

1] Yes

2] No

37. If yes, which precautions?

1] .....

2] .....

3] .....

4] .....

5] .....

6] .....

38. If no why? .....

39. Do you have any fears that you could get infected with AIDS?

1] Yes

2] No

If yes, How? ..... if no, why ? .....

40. What would you do if you leant that your husband engages in sexual relations with other women? .....

41. What would you do if your husband's sexual behaviour puts you at the risk of HIV/AIDS infection? .....

42. Do you think it is good for a wife and husband to discuss matters related to AIDS disease?

1] Yes

2] No

If No, why ? .....

43. Do you personally discuss AIDS related issues with your husband?

1] Yes

2] No

44. If yes, who initiates such a discussion?

1] Self

2] Husband

3] Either wife or husband

Why? Explain.....

45. If No, why? Explain.....

46. Do you think a married woman has a right to complain directly to her husband if she learn that he has sexual relationships with other women?

1] Yes

2] No

If No, why? .....

47. Can you personally directly complain to your husband about his unfaithfulness?

.....

48. If yes, how would he react? .....

49. If No, why? Explain .....

50. Can you refuse to have sexual intercourse with your husband when you are not willing or when you suspect him of unfaithfulness? .....

1] Yes

2] No

51. If yes with what consequences? .....

52. If No, why? Explain .....

53. Can you yourself decide when to and when not to have sex with your husband?

1 Yes

2 No

54. If No, why? .....

55. What can you say about condoms?

Make choices as follows:

		Right	wrong
1]	Are good for protection against pregnancy	1	2
2]	Good for use by unmarried people	1	2
3]	Against my religion	1	2
4]	Offensive to husbands	1	2
5]	Can prevent AIDS if used well	1	2
6]	Good for use with husbands	1	2
7]	Too expensive	1	2

56. Can you go looking for condoms yourself?

1] Yes

2] No

57 If yes where? .....

58. If No, Why? .....

59. Do you use any family planning method?

1] Yes

2] No

60. If yes, who decided that you should go for the method?

1] Self

2] Husband

3] Both (wife and husband)

4] Other (specify)

61. Do you own land (wife alone)?

1] Yes

2] No

62. Do you have a bank account in your own name?

1] Yes

2] No

APPENDIX B

FOCUS GROUP DISCUSSION (FGD)GUIDE

(FOR MARRIED WOMEN AND MEN)

Moderator. A woman named MIDEVA is married to a man named AMADI. AMADI is working while MIDEVA is not. The couple have five children. The woman wanted to start using family planning methods but the husband has refused. The husband gives money for food in the house but it is he who decides what to be cooked. When the children are sick the husband must give permisionbefore MIDEVA can take them to hospital.

Guide Qn 1 WHAT DO YOU THINK OF THE WAY AMADI AND MIDEVA ARE LIVING?

Moderator. MIDEVA is very worried. She has earned that when AMADI goes to the market he often goes to the houses of other women whom he is having affairs with. She is afraid he will give her AIDS yet she dos not want to leave AMADI.

Guide Qn 2 WHAT DO YOU THINK THIS WOMAN SHOULD DO?

Guide Qn 3 IF THE WOMAN DOES WHAT YOU ARE SAYING HOW DO YOU THINK THE MAN WILL REACT?

Guide Qn 4 DO YOU THINK THAT THE WOMAN SHOULD TALK TO THE MAN ABOUT THE FEARS SHE HAS OF CONTRACTING AIDS HOW CAN SHE BRING UP THE SUBJECT?

Moderator. The woman in the story is afraid that her husband may give her AIDS because she

knows that he is having affairs with other women....

Guide Qn 5 HOW CAN SHE PROTECT HERSELF? HOW WILL THE MAN REACT?

Guide Qn 6 DOES THE WOMAN HAVE THE RIGHT TO ASK THE MAN TO USE CONDOMS? HOW CAN SHE ASK HIM? HOW WILL HE REACT?

Guide Qn 7 IF THE MAN DOES NOT WANT TO USE CONDOMS CAN THE WOMAN CONVINCE HIM? HOW?

Guide Qn 8 IN GENERAL, ARE WOMEN WILLING TO USE CONDOMS?

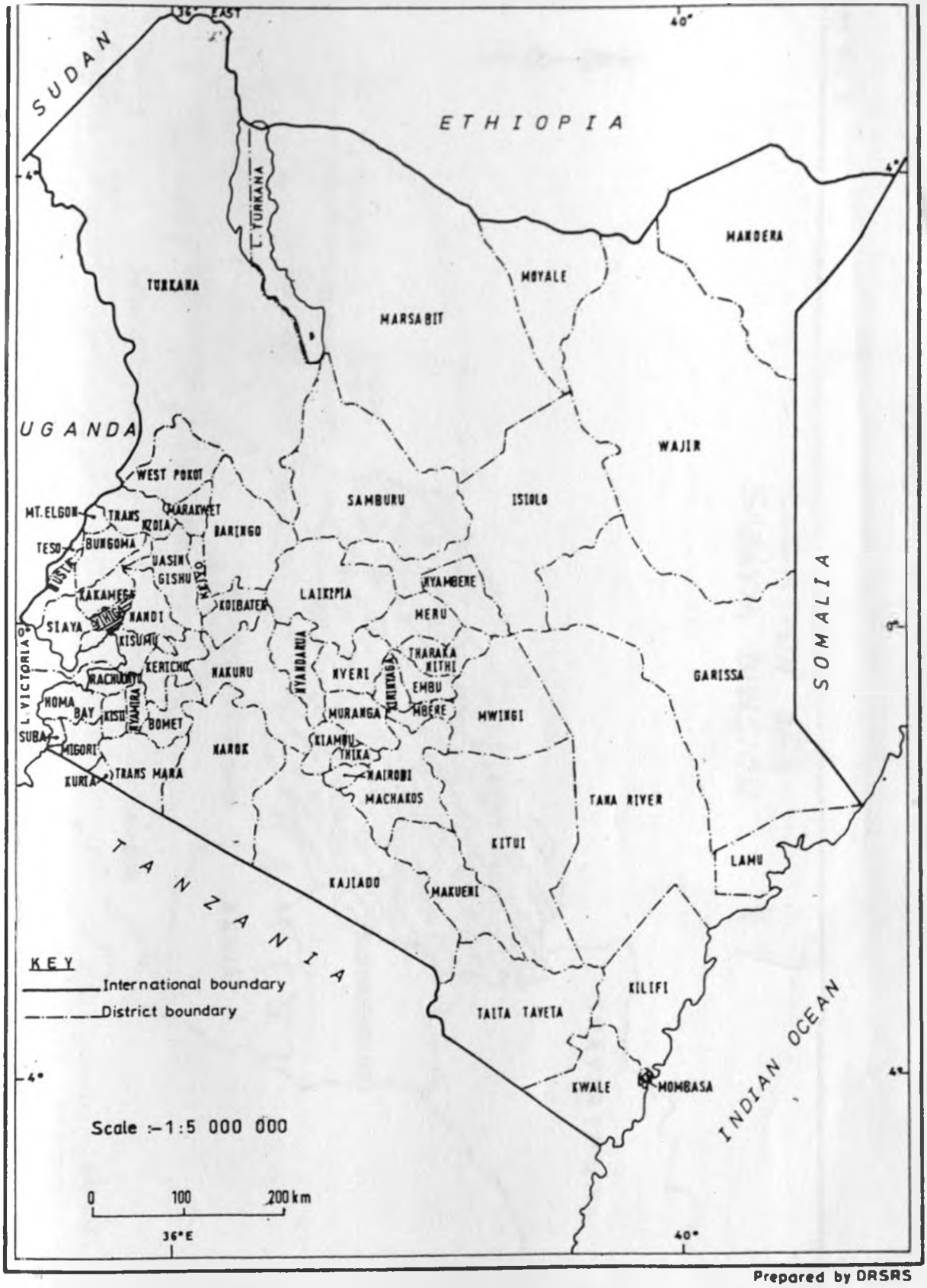
Guide Qn 9 ARE WOMEN ABLE TO OBTAIN(buy) CONDOMS ON THEIR OWN

Guide Qn 10 (Women only) YOU WOMEN KNOW WHAT AIDS IS ABOUT DO YOU BELIEVE YOU HAVE THE RESPONSIBILITY TO PROTECT YOURSELVES? TO PROTECT YOUR UNBORN BABIES? Please explain

Guide Qn 11 (men only) YOU MEN KNOW WHAT AIDS IS ABOUT. DO YOU FEEL THAT YOU HAVE A RESPONSIBILITY TO PROTECT YOURSELVES? YOUR WIVES? Please explain.

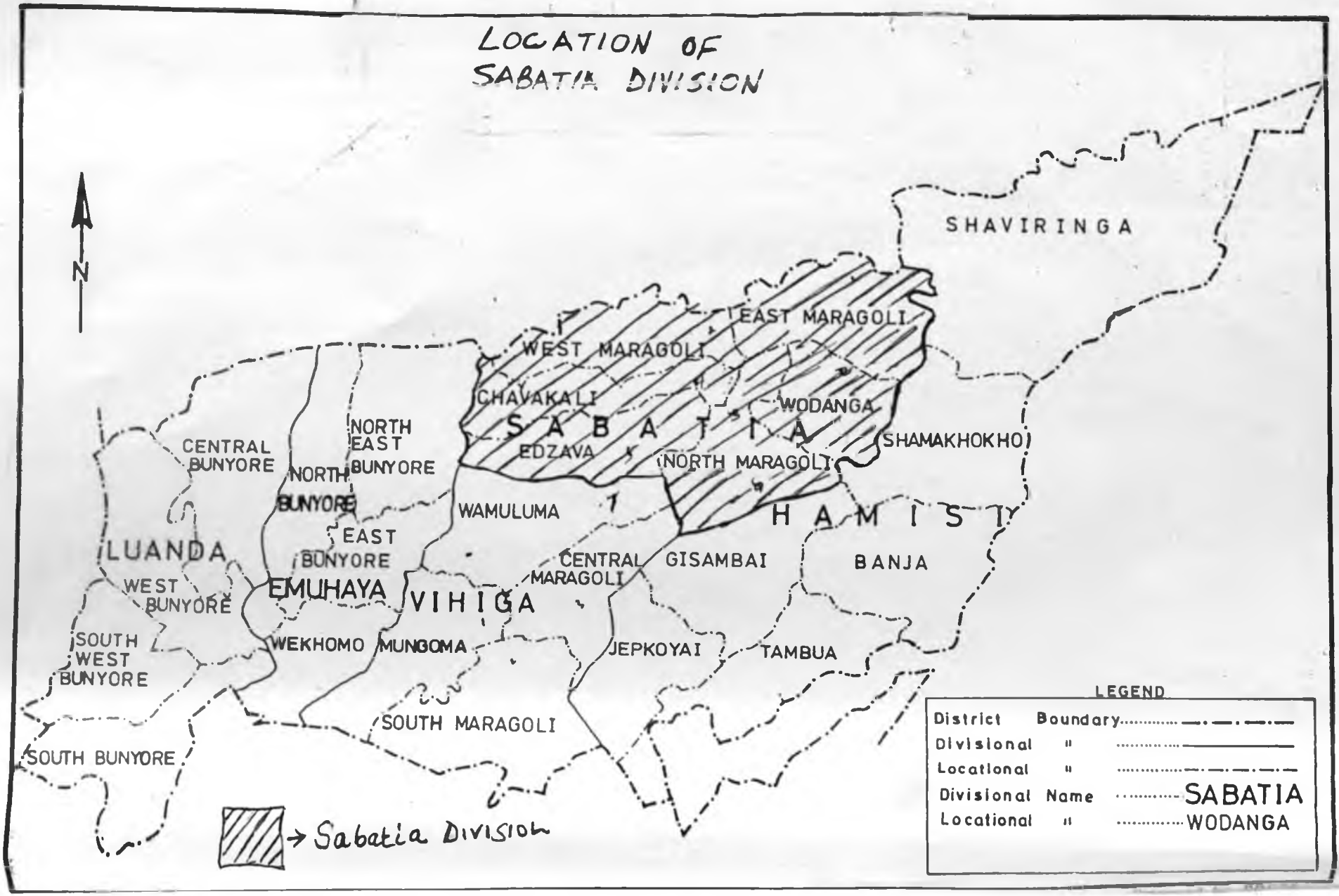
ndix C

LOCATION OF VIHIGA DISTRICT



Prepared by DASAS

Map No 2


LOCATION OF
SABATIA DIVISION
N
SHAVIRINGA
EAST MARAGOLI
WEST MARAGOLI
CHAVAKALI
S A B A T I A
WODANGA
EDZAVA
NORTH MARAGOLI
SHAMAKHOKHO
H A M I S I
CENTRAL BUNYORE
NORTH EAST BUNYORE
NORTH BUNYORE
EAST BUNYORE
WAMULUMA
LUANDA
CENTRAL MARAGOLI
GISAMBAI
BANJA
WEST BUNYORE
EMUHAYA
VIHIGA
SOUTH WEST BUNYORE
WEKHOMO
MUNGOMA
JEPKOYAI
TAMBUA
SOUTH MARAGOLI
SOUTH BUNYORE
→ Sabatia Division
LEGEND
District Boundary
Divisional "
Locational "
Divisional Name SABATIA
Locational " WODANGA