DOMESTIC VIOLENCE AND WOMEN'S VULNERABILITY TO HIV INFECTION IN KINOO DIVISION, CENTRAL KENYA

BY

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DECLARATION

This project paper is my original work and has not been presented for award for any degree at any university.

..... Date 3rd November, 2010...

Mary Wanjiru Kiuma

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

..... Date 4/11/10

Prof. Simiyu Wandibba

DEDICATION

This project paper is dedicated to my spouse Kiuma and our two children, Kiguta and Nyawira. May you live to enjoy the sweet fruits of academic hardship.

TABLE OF CONTENTS

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I would like first and foremost to give Glory and Honour to the Almighty God for giving me good health and a sound mind to go through the Masters programme. Without Him I would not have made it; I thank Him for providing finances all through the two academic years.

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ABSTRACT

This was a study on domestic violence and women's vulnerability to HIV infection. The study was carried out in Kinoo Division, Central Kenya. It was done among women and men who were HIV infected and had enrolled in various HIV support groups. The study population was identified through their enrollment in the HIV support groups. The unit of analysis was the individual woman and man who was HIV positive. This was established based on the membership list of both private and public organizations that were located within Kinoo area, for example, World Vision, Lea Toto, Christian Children's Fund and Nyumbani. The sample population consisted of 100 respondents.

The study adopted a descriptive and cross-sectional research design. It combined both qualitative and quantitative methods of data collection. Data was collected using a structured questionnaire, key informant interviews, focus group discussions and secondary data. Qualitative data was analyzed through content analysis and the findings presented using verbatim quotes and anecdotes. Quantitative data was analyzed using the Excel computer software package, and the findings presented in tables of frequencies and percentages.

Cross-tabulated HIV sero-status with demographic and descriptive variables were used to examine confounds of the relationships between violence and HIV infection. Associations of different experiences of domestic violence with women's sero-status was examined and tested, for example, lifetime adult violence and current intimate partner violence.

The study found that women are more willing to come out in the open about their HIV status while the men are still hiding in denial and fear of confirming their status. The findings also showed that domestic violence increases women's vulnerability to HIV infection and that there is an intersection between domestic violence, gender inequality and HIV infection. It can, therefore, be concluded that double standards are practised both in the family and in the society. The men can move out with other women and get infected while it

is taboo for the women to do the same even when not sexually satisfied or deprived of their sexually rights by their matrimonial spouses.

CHAPTER ONE

BACKGROUND TO THE STUDY

1.1 Introduction

This was a study on domestic violence and women's vulnerability to HIV infection. The study was done in Kinoo Division, Central Kenya. It was done among women who were HIV infected and had enrolled themselves in various HIV support groups.

Twenty years ago, violence against women was not considered an issue worthy of international and national attention or concern. Victims of violence suffered in silence, with little public recognition of their plight. This began to change in the 1980s as women's groups organized locally and internationally to demand attention to the physical, psychological and economic abuse of women. Gradually, violence against women has come to be recognized as a legitimate human rights issue and as a significant threat to women's health and wellbeing (Garcia-Moreno and Watts 2000). There is increasing international consensus that the abuse of women and girls, regardless of where it occurs, should be considered as ''gender-based violence,'' as it largely stems from women's subordinate status in society compared to men (Ellsberg and Heise 2005).

Now that both international and local attention is focused on domestic violence, methodologically rigorous research is needed to guide the formulation and implementation of effective interventions, policies and prevention strategies. Until fairly recently, most of the research on violence consisted of anecdotal accounts or exploratory studies performed on non-representatives sample of women, such as those attending services for battered women. While such research has played a critical role in bringing to light issues of wife abuse, rape, trafficking, incest and other manifestations of domestic violence, it is less useful for understanding the dimensions or characteristics of abuse among the broader population.

Among the many types of violence women experience, domestic violence is the most far-reaching and prevalent. In communities throughout the world, women suffer physical, emotional, sexual and economic violence at the hands of their intimate partners.

Family secrecy, cultural norms, fear, shame, or the community's reluctance to get involved in what seems to be a domestic affair often protects domestic violence. Domestic violence severely impacts on women's physical and mental health, relationships and sense of security in the family and community. It also negatively affects the quality of relationships between women and men, the health and development of children, families and communities.

Domestic violence against women and the risk of HIV infection may largely be a result of gender and sexuality related inequality and stigma. Women are at risk of HIV due to the risk of domestic violence. Their husbands who abuse them, through domestic violence infect many women. Domestic violence and HIV need to be viewed as twin pandemics that feed into and off each other, with domestic violence being both a cause and a consequence of HIV (Maman et al. 2000). The fear of domestic violence and stigma associated with HIV acts as a barrier, along with many other factors related to women's marginalization and ability to access HIV prevention tools and services, including testing and counselling. Domestic violence greatly contributes to HIV vulnerability, with physical and sexual violence being extremely common in women's lives (Fisher and Foreit 2002).

1.2 Statement of the problem

Domestic violence and the human immunodeficiency virus (HIV) infection are problems of great public health worldwide, especially in Sub-Saharan Africa and much of the developing countries. This is due to their far reaching social, economic and public health consequences. The two problems have gender inequality and gender power imbalances as the driving force behind the "epidemics". HIV infection is mainly acquired through heterosexual relations, which themselves are greatly influenced by socio-cultural factors, underlying which are gender power imbalances. Unfortunately, gender relations, and gender issues in general, have not been given much emphasis, especially in efforts aimed at the prevention and control of HIV infection. There is, thus, need to mainstream gender relations in reproductive health. This research aims at emphasizing the intersection between domestic violence, gender inequality and HIV infection.

Worldwide, the majority of people infected with HIV come from Sub-Saharan Africa, most infections result from unprotected sex occurring in heterosexual relationships, and women are 6 times more likely be infected than men. Unequal power relationships puts women into a subordinate position that makes them socially and financially dependent on men, with limited access to resources, finances, employment, education and healthcare. Therefore, resulting in their vulnerability to domestic violence and HIV infection.

Domestic violence hurts us all. Women in abusive relationships cannot fully participate in community life. Their ability to share their energy, ideas, skills, talents and opinions with their families, communities, places of worship and in the political process is lost when their bodies and minds are consumed by domestic violence. Violence results in health problems, sadness, isolation, loss of income and self-esteem. Domestic violence is, therefore, not just a woman's problem but a concern of the whole community.

1.3 Research questions

1. To what extent does domestic violence make women vulnerable to HIV infection?
2. Is there an intersection between gender inequality, domestic violence and HIV infection?

1.4 Research objectives

1.4.1 General objective

The overall objective of this research was to explore the relationship between domestic violence and women's vulnerability to HIV infection.

1.4.2 Specific objectives

1. To examine the extent to which domestic violence increases women's vulnerability to HIV infection.
2. To establish the intersection between domestic violence, gender inequality and HIV infection.

1.5 Justification

Becoming informed about domestic violence is an important first step in addressing the problem. When more people understand and refuse to accept domestic violence, it becomes more and more difficult for the violence to continue happening. The research findings will, therefore, hopefully contribute to breaking the silence. It will highlight the relationship between domestic violence and women's vulnerability to HIV infection. Once the factors and impact of domestic violence are highlighted, policy makers and implementers should be able to intervene, in order to reduce incidents of the vice.

1.6 Scope and limitations

1.6.1 Scope

The study was done among women living in Kinoo, who were aged between 20 and 60 years. Cross-tabulated HIV serostatus with demographic and descriptive variables was used to examine confounds of the relationship between violence and HIV. Associations of the different experiences of domestic violence with women's HIV serostatus was examined and tested, for example, childhood sexual abuse, lifetime adult violence and current intimate partner violence.

1.6.2 Limitations

It was very difficult to have access to the HIV support groups. Some of the support group administrators thought that the topic was very sensitive and indulging into personal affairs. They, therefore, totally denied access to the groups. This made the study quite difficult to carry out, thus not being able to reach the expected number of respondents intended for the structured questionnaires and the focus group discussants within the stated work plan period. Therefore, causing the fieldwork period to take a longer time than planned for, causing a big delay in completing the research work.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This reviewed literature was obtained from various books and researches on domestic violence and women's vulnerability to HIV infection. The review revealed a range of issues pertaining to prevalence of intimate partner violence, social concepts of domestic violence, and agencies of domestic violence. The chapter also discusses the theoretical framework which guided the study.

2.2 Literature review

2.2.1 Social concepts of domestic violence

Gender comprises widely held beliefs, expectations, customs and practices within a society that define 'masculine' and 'feminine' attributes, behaviours and roles and responsibilities. Gender is an integral factor in determining an individual's vulnerability to HIV infection, his or her ability to access care, support or treatment, and the ability to cope when infected or affected by HIV (UNAIDS 2000).

Gender norms, for example, often dictate that women and girls should be ignorant and passive about sex, leaving them unable to negotiate safer sex or access appropriate services. Gender norms in many societies also reinforce a belief that men should seek multiple sexual partners, take risks and be self-reliant. These norms work against prevention messages that support fidelity and other protection measures from HIV infection. Some notions of masculinity also condone violence against women, which has a direct link with HIV vulnerability and homophobia, leading to stigmatization of men who have sex with men. Such men are more likely to hide their sexual behaviour and less likely to access HIV services (UNAIDS 2000).

Gender inequality both fuels and intensifies the impact of the HIV pandemic and is most effectively addressed at the national and community level. In the context of HIV

prevention, treatment, care and mitigation, this reinforces the need for interventions that are directed at individual people. Reducing gender inequality requires changing social norms, attitudes and behaviours through a comprehensive set of policies and strategies (UNAIDS 2000).

2.2.2 Prevalence of intimate partner violence

Research consistently demonstrates that a woman is more likely to be assaulted, injured, raped or killed by a current or former partner than by any other person. In fact, between 10% and 60% of women who have ever been married or partnered have experienced at least one incident of physical violence from a current or former intimate partner. Most studies estimate a lifetime prevalence of partner violence of between 20% and 50%. This shows that one out of three women has ever been assaulted or coerced by a man. Men who are dear to them have done 2% (Ellsberg and Heise 2005). WHO/WHD (2005) aver that most women who suffer physical or sexual abuse by a partner generally experience multiple acts over time, and such like abuses tend to co-occur in many relationships. At least 33% of women experience physical violence by a partner, 23% experience sexual violence while 41% experience both physical and sexual violence. These results suggest the importance of carrying out research on domestic violence.

2.2.3 Agencies of domestic violence

For many women and girls, sexual coercion and abuse are defining features of their lives. Forced sexual contact can take place at any time in a woman's life and includes a range of behaviours, from forcible rape to non-physical forms of pressure that compel girls and women to engage in sex against their will. The touchstone of coercion is that a woman lacks choice and faces severe physical, social, psychological and economic consequences if she resists sexual advances. Most of the non-consensual sex takes place among individuals who know each other, for example, spouses, family members, dating partners or acquaintances. In fact, much of the non-consensual sex takes place within consensual unions and includes a woman being compelled to have sex when she does not want it, or to engage in types of sexual activities that she finds degrading or humiliating. Much sexual coercion also takes place against children and adolescents in both industrial and

developing countries. Between one-third and two-thirds of known sexual assault victims are aged fifteen or younger, according to justice system statistics and information from rape crisis centres. On the other hand, 0-32% of women report, that they have experienced sexual abuse in childhood (Van der Stratten et al. 1998).

2.2.4 Domestic violence and women's vulnerability to HIV infection

Research indicates that violence may increase women's susceptibility to HIV infection. Studies carried out in Tanzania and South Africa found that seropositive women were more likely than seronegative peers to report physical partner abuse (Gielen et al. 2000). This indicates that women with violent or controlling partners are at increased risk of HIV infection. Abusive men are more likely to have HIV and impose risky sexual practices on their partners. There are also indications that disclosure of HIV status may put women at risk for violence (Gielen et al.1997).

Domestic violence is the most pervasive yet under-recognized human rights violation in the world. It is also a profound health problem that saps women's energy, compromises their physical and mental health and erodes their self-esteem (Vlahov et al. 1998). Apart from causing injury, violence increases women's long-term risk of a number of other health problems, including chronic pain, physical disability, drug and alcohol abuse and depression. Women with a history of physical or sexual abuse are also at increased risk for unintended pregnancy, sexually transmitted infections, including HIV/AIDS, and miscarriages (Kaye et al. 2002; Worth 1989).

Although both men and women can be victims as well as perpetrators of violence, most commonly committed is that against women and the nature of violence differs. Men are more likely to be killed or injured in wars or youth and gang-related violence than women are. They are more likely to be physically assaulted or killed on the street by a stranger. Men are also more likely to be the perpetrators of violence, regardless of the sex of the victim. In contrast, women are more likely to be physically assaulted or murdered by someone they know, often a family member or intimate partner. They are also at greater risk of being sexually assaulted or exploited either in childhood, adolescence or as

adults. Women are vulnerable to different types of violence at different moments in their lives. A spouse, parent or other family member frequently victimizes women (Ellsberg and Heise 2005:10-11).

Domestic violence has serious implications for prevention of mother-to-child HIV transmission (MTCT). Perceived risk of or existing violence may influence disclosure or partner notification by HIV positive women. It may also influence use of preventive measures for re-infection, such as negotiating use of barrier methods or abstinence, or choice between breastfeeding and formula feed options. Despite counselling, 10% experienced violence or disruption of relationships (Koenig and Moore 2000:103-109).

Behavioural modifications after knowing one's HIV sero-status include abstinence, use of barrier methods, avoidance of some sexual practices (such as dry sex) and non-breastfeeding of the child (or use of formula feeds) after birth. These may increase the risk of violence for women especially where there is poor couple communication or failed negotiation (Gaillard et al. 2002).

2.3 Theoretical framework

Although many theories have been put forward to explain domestic violence, radical feminism was used to guide this study. This is because it explains reasons why we have domestic violence in society, as well as its origin and prevalence. It sheds light on the existence of gender inequality in the society.

Radical feminist theory is described as being a ''paradigm'', roughly translated as a set of guiding assumptions or worldview, commonly shared within a group and serving to ward off recognition (Donovan 1985). This theory views all social relations through the prism of gender relations and holds in its neo-Marxist view, that men (the bourgeoisie) hold power advantages over women (the proletariat) in patriarchal societies and that all domestic violence is either male physical abuse to maintain that power advantage or female defensive violence, used for self-protection.

The radical feminist paradigm supports the notion that domestic violence is primarily a culturally supported enterprise and that female violence is always defensive and reactive. When women are instigators, in this view, it is a ''pre-emptive strike'', aimed at instigating an inevitable male attack (Donovan 1985). In contrast, male violence is not similarly contextualized and is always attributed to a broader social agenda. Men who assault their wives are actually living up to cultural prescriptions that are cherished in the African society, aggressiveness, male dominance and female subordination. Hence they are using physical force as a means of enforcing that dominance (Malcolm 1997).

Patriarchy is to blame for attitudes and acceptance of domestic violence, thus bringing about women's natural inferiority to men. This absolute relativism imposes perfect tolerance on women, including tolerance of sexism, homophobia, wage gap, violence against them, inadequate care, as well as class and racial injustices. Above all, women lack an institution that can take care of their specific needs, for example, where to report when abused by their intimate partners.

Radical feminism was relevant to the study because it sheds light on the male power over women and seeks to educate men to treat women with respect and dignity, and to accept differences and promote social justice. This may attempt to undo patriarchy without replacing it with matriarchy. It advocates for changes in the structuring of society, changing the attitudes of men to a state of equality in the power dynamics between men and women. It is about promoting a world in which women enjoy an equal share of the rights, privileges and power (Bromberg 1997). This framework helped me to explain the origin of and how gender inequalities are deeply ingrained in society.

2.4 Hypotheses

The study was guided by the following two hypotheses:

1. Domestic violence in Kinoo is a reflection of gender inequality in Gikuyu society.
2. Women with violent intimate partners are at increased risk of HIV infection.

2.5 Operationalization of variables

Domestic violence- physical, sexual, emotional or economic abuses between intimate partners. This was measured in terms of prevalence as indicated by whether one had encountered any of these forms of violence.

Inequality- social dominance of women by men. This was measured in terms of the unequal power relations between men and women in the society, dividing rights, privileges and power primarily by gender.

Intimate partners- a man and woman who were married or having a sexual relationship. This was measured in terms of whether a man and woman had been married, intended to marry or were co-habitating.

HIV- infection – the process of being exposed to and acquiring the human immunodeficiency virus. This was measured by whether one had undergone an HIV test or visited a VCT (voluntary counselling and testing) in the previous three months prior to the study.

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CHAPTER THREE

METHODOLOGY

This section describes the research site and design, study population, sample population, sampling procedure, data collection methods, data processing and analysis and ethical considerations.

3.1 Research site

3.1.1 Location

The study was done in Kinoo, a location 18km West of Nairobi, along the Nairobi-Naivasha dual carriage (Fig.3.1). The area enjoys proximity to the Capital City and an unpolluted environment. Administratively, Kinoo is in Kikuyu Division of Kiambu West District of the Central Province of Kenya. The district is divided into five administrative divisions, namely, Kikuyu, Kiambaa, Limuru, Lari and Githunguri.

3.1.2 Economic activities

Kinoo has a population density of about 45000 people (CBS 2001), which is comprised of about 30 per cent original dwellers, who are mainly farmers and business people. The farmers mainly practise subsistence farming because most of the farms, which were initially about two hectares, have been demarcated into small plots. Thus, the people practise zero-grazing, poultry and pig farming and mainly vegetable farming.

3.1.3 Socio-cultural aspects

Domestic violence in Kinoo is a reflection of gender inequality in the Gikuyu society. This is because of the deep-rooted partriachal culture, which views men as superior to women. Once a woman gets married, she is expected to be under the full control and authority of the man. The man, thus, exercises his authority fully as expected of him by society. Hence, men who assault their wives are actually living up to cultural prescriptions that are cherished in the Gikuyu society, for example, aggressiveness, male dominance and female subordination (Leakey 1977). Most of the time the men use physical force as a means of enforcing that dominance.

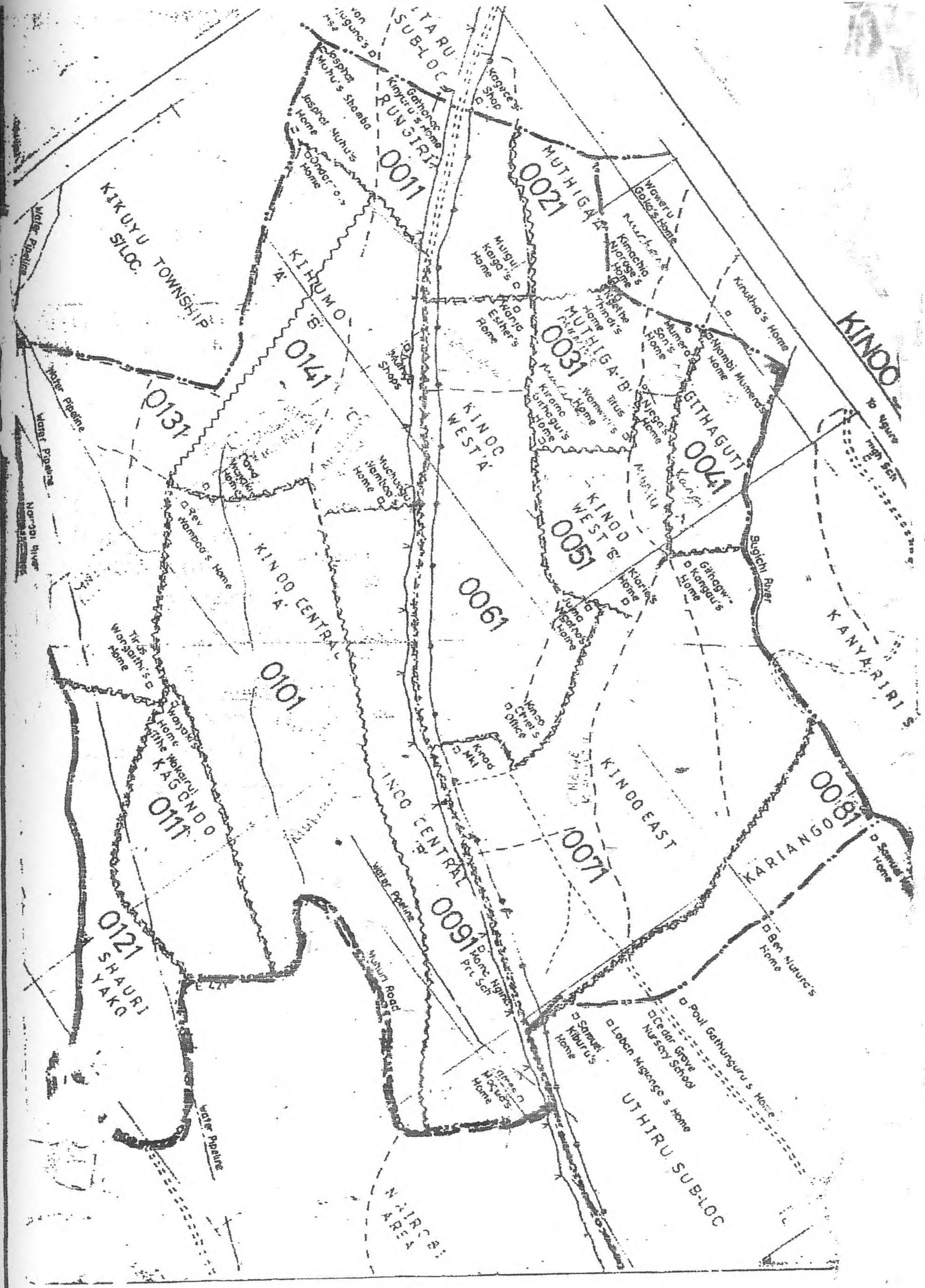

Fig. 3.1: Map of Kinoo Location.

3.2 Research design

The study adopted a descriptive and cross-sectional research design. It combined both qualitative and quantitative methods of data collection. Data was collected using a structured questionnaire, key informant interviews and focus group discussions. Qualitative data was analyzed through content analysis and the findings presented using verbatim quotes and anectodes. On the other hand, quantitative data was analyzed using the Excel computer software and the findings presented in tables of frequencies and percentages.

3.3 Study population

The study population included both men and women aged between 20 and 60 years, living in Kinoo and who were HIV infected. Their HIV status was identified through their enrollment in the HIV support groups. This age group is susceptible and vulnerable to domestic violence. Most women and men by the age of 20 have started having intimate dating partners and acquaintances or are engaged in preparation for marriage. The more elderly women and men have had a wealth of experience in marriage and various stages in life. Therefore, they may have experienced domestic violence in one way or another.

3.4 Sample population

The unit of analysis in the study was the individual woman or man who was HIV positive. This was established based on the membership lists of private and public organizations that are located within Kinoo area, for example, Nyumbani, Lea Toto, Christian Children's Fund, World Vision and Tumaini. For a group to qualify, it should have had at least 10 members and should have been in existence for at least 2 years. Members should have been in the group for at least 6 months and more. The target size was 100 respondents.

3.5 Sampling procedure

Non-probability sampling methods were used. A choice of 4 support groups was arbitrary and not based on any sampling theory with an expected confidence interval. No formular was used to calculate the sample size because the research design was not only based on survey method of data collection but also on qualitative methods of data collection.

Purposive sampling, which consists of units deliberately selected to provide specific information about the population, enabled the proper selection of the support groups to study depending on whether they had the requisite characteristics, for example, women of the required age group. This avoided selecting a support group by chance.

Snowball sampling, in which persons who had agreed to be interviewed recommended acquaintances for interviewing, was employed in selecting the study subjects. This involved the leaders who were the key individuals in the support groups to help identify at least three people having the requisite characteristics, for example, women who were HIV positive. These people were used as informants to identify others who qualified for inclusion in the sample. The second stage involved interviewing these persons, who in turn led to still more persons who were interviewed in the third stage, and so on.

3.6 Data collecting methods and tools

3.6.1 Survey

A structured questionnaire with open and closed-ended questions was administered to 20 respondents (Appendix 1). The questionnaire was self- administered. This was because respondents report socially undesirable behaviours and traits, like domestic violence, more willingly and accurately in self-administered questionnaires than they do in face-to- face interviews. Above all, anonymity gives people a sense of security and confidentiality.

3.6.2 Focus group discussions

Three focus group discussions were held, two groups for the women and one for the men. The discussants were selected on the basis of age, and were grouped into the following age groups: 20-30, 31-40 and 41-50, so as to ensure that there was free interaction and mutual understanding among them. A pocket tape-recorder was used to capture the discussions. This was downloaded into CDs then played and transcribed later. The method was used to capture new ideas and get consensus on issues emerging from key informant interviews and questionnaires. A focus group discussion guide (Appendix 2) was used to collect the data.

3.6.3 Key informant interviews

These were interviews with service providers. The providers included a pastor, police representative and nurse. This was because churches sponsor some of the support groups, while nurses provide the essential medical treatment and care to the support groups. On the other hand, the police receive cases of domestic violence quite often in the course of their duties. The interviews were recorded, downloaded into CDs then played and transcribed later. This yielded rich ethnographic data on the research questions. A key informant interview guide (Appendix 3) was used to collect the data.

3.6.4 Secondary sources

Secondary sources, for example, books, journals, newspapers, magazines and the internet, had already been used in the preparation of the proposal. They, however, continued to be used throughout the study.

3.7 Data processing and analysis

The data was analyzed and interpreted at the end of each day. Both qualitative and quantitative analyses were used. Close-ended questions were coded to enable all the

responses to be captured. Descriptive procedures were used to describe the collected data, for example, percentages and frequency distribution tables were used.

Analysis of the quantitative data was done using the Excel computer programme. This assisted in running the frequencies and cross tabulations to show the relationships between domestic violence and HIV infection. For the qualitative data, content analysis was done to provide emerging patterns and relations between the variables.

3.8 Ethical considerations

Due to the privacy highly recommended in research and the sensitive nature of the study, I had to get consent from the person in-charge of the support groups, before undertaking the research. For those run by the church, it was the pastor while for those run by the non-governmental organizations (NGOs) it was the administration. Though I come from the study area, I did not encounter any ethical dilemmas. However, since I was dealing with vulnerable people, I had to pose very official and convince the groups that the interviews were purely academic and would only be used for study purposes. Furthermore, I only collected data and interviewed those who gave their consent personally, assuring them that the information given would be kept confidential and that their identity would not be disclosed to those outside their organizational fold.

CHAPTER FOUR

DOMESTIC VIOLENCE AND WOMEN'S VULNERABILITY TO HIV INFECTION IN KINOO

4.1 Introduction

This chapter provides study findings on the socio-demographic characteristics of the respondents and women's vulnerability to HIV infection in the study area.

4.2 Socio-demographic characteristics of the respondents

4.2.1 Gender

From the research findings, women are most affected by domestic violence and HIV infection and willing to come out in the open about it. Seventy-five per cent of those interviewed were women while the men where only 25%. Since the study population included both men and women who were enrolled in support groups, this clearly shows that more women than men have enrolled while most men are still living in denial.

4.2.2 Age

The age groups enrolled in the support groups were between 20 and 50 years. 20-30 years had 30%, 31-40 years had 55% and 41-50 years 15%. This shows that those between 31 and 40 years are most affected probably because they have been married for many years, at least more than 5 years.

4.2.3 Marital status

Fifty per cent of the respondents were married, 20% separated, 20% single, 5% widowed and 5% co-habiting (Table 4.1).

Table 4.1: Marital status of respondents

Status	Frequency	Percentage
Married	10	50
Divorced	0	0
Separated	4	20
Single	4	20
Widowed	1	5
Cohabiting	1	5

Nevertheless, they were in the above status due to various reasons. Fifteen per cent were due to their HIV status, 10% wanted their children to have a figure father, 25% felt they wanted company, 20% had not declared married, 5% did not know why they were in that state, 5% is due to the death of their spouse, 10% due to violence and 25% did not answer the question (Table 4.2).

Table 4.2: Reasons for marital status

Reason for marital status	Frequency	Percentage
HIV positive	3	15
Figure father	2	10
Company	5	25
Not declared	4	20
Do not know	1	5
Violence	3	10
Not answered	5	25

4.2.4 Educational level

When asked their highest level of education, 40% had attended primary education, 40% secondary education, while only 20% had college education (Table 4.3). None of them had attended university education. This greatly impacted on their occupation showing that 30% were housewives, 5% farmers, 45% business people and 20% employed in various sectors, for example factory machine operators.

Table 4.3: Respondents' level of education

Level of education	Frequency	Percentage
Primary	8	40
Secondary	8	40
Tertiary	4	20

4.3 Domestic violence and women's vulnerability to HIV infection

All the respondents confessed that they had encountered one form or another of domestic violence. These included sexual (20%), physical (40%), economic (10%) and emotional (30%) (Table 4.4). Domestic violence is the most pervasive yet under recognized human rights violation in the world. It is also a profound health problem that saps women's energy, compromises their physical and mental health and erodes their self-esteem (Vlahov et al.1998). Women with a history of physical or sexual abuse are also at increased risk of unintended pregnancy, sexually transmitted infections, including HIV and AIDS and miscarriages (Kaye et al.2002; Worth 1989).

Table 4.4: Forms of domestic violence in Kinoo

Form	Frequency	Percentage
Sexual	4	20
Physical	8	40
Economic	2	10
Emotional	6	30

These proved that domestic violence increases vulnerability to HIV infection. Most of the women who were sexually violated said that they got bruises during forced sexual encounters by their spouses. This is called marital rape.

With 30% of women experiencing emotional violence, this also makes them vulnerable to HIV infection. This comes about in their pursuit to receive emotional attention. Two of the key informants, a pastor and a nurse, confirmed that these women go looking for a "crying shoulder" to lean on for consolation and affection during domestic violence. As they are being consoled, they often fall prey to the consoler, who is usually of the opposite sex. They might then engage in sexual activities with men whose HIV status is unknown. If the man is positive he transmits the infection to the woman.

Women who are victims of domestic violence usually go out to seek for consolation and affection, as they try to pour out their hearts on what they are going through. They often end up being lured into sexual intercourse. (Nurse)

Due to their (women) emotional pain, they often seek for a person who can give them time and listen to what they are going through in their marriages and relationships. They usually receive attention from the men, who sometimes take advantage of their vulnerable state, ending up in a sexual relationship. (Pastor)

Economic violence had been experienced by 10% of the respondents. One of the informants stated that:

After we have had a disagreement, which may end up in a quarrel, finally physical fight, the man will leave the house without leaving any money for buying food. This becomes double tragedy, physical and economic torture.

The woman who is a housewife is left stranded and has to go out to fend for herself and her children. This is especially the case when children start crying, an indication that they are hungry, and there is nothing in the house to cook. One woman disclosed that she had to look for a man friend who could offer financial support since she had no alternative. She then ended up becoming HIV positive.

One of the key informants, a police representative, stated that:

Most of the men in Kinoo are terrible drunkards who go home very late in the night. They misuse the family resources and are, therefore, not able to carry out their responsibilities. The women are not sexually satisfied due to the husbands' drunkenness. They then have to move out for sexual satisfaction. They end up acquiring the HIV virus.

Though 10% of the respondents are economically violated and have to live up with this violence due to poverty the police representative who was a key informant stated that:

> *Kinoo, which is in Kabete, the richest constituency in Kenya, has very wealthy men. They are, therefore, able to drink till late in the night as they misuse the family resources. The women, who have contributed to this wealth, complain bitterly. This usually ends up in disagreements and finally into physical fights. Not forgetting the sexual dissatisfaction, the women get tired of this regular domestic violence and finally plan on how to get rid of these useless and stubborn men. They then murder the men and inherit all the wealth. Upon the death of the husband, the woman who is now wealthy starts to seduce and move out with young boys who are sexually active and often HIV infected. The women then become HIV infected. The wealthy women then turn to the young boys whom they have employed as shamba boys, grounds men and shop attendants. They infect the young men who in turn go home and infect their young wives.*

Forty per cent of the respondents were primary level dropouts who ended up being housewives and totally dependent on their spouses. The dependency syndrome makes them vulnerable to HIV infection.

All the respondents had encountered at least one form of domestic violence, with 20% on a daily basis, 10% weekly, 45% monthly and 25% yearly (Table 4.5). This has caused 20% of them to opt for separation and another 5% to co-habituate. It should be pointed out that these women are in their prime age of between 20 and 50 years. This means they are sexually active, and need companionship, as well as economic and emotional satisfaction which can only be obtained from men who are either "single" or not stable in their marriages. When this happens, they risk being infected with the HIV virus.

Table 4.5: Frequency of violence

Frequency of violence	Frequency	Percentage
Daily	4	20
Weekly	2	10
Monthly	8	40
Yearly	6	30

4.4 The intersection between domestic violence, gender inequality and HIV infection

4.4.1 Introduction

Gender comprises widely held beliefs, expectations, customs and practices within a society that define "masculine' and 'feminine' attributes, behaviours, and roles and responsibilities. Gender is an integral factor in determining an individual's vulnerability to HIV infection and the ability to cope when infected or affected by HIV (UNAIDS 2000). Gender norms often dictate that women and girls should be ignorant and passive about sex leaving them unable to negotiate for safe sex (UNAIDS 2000).

All the respondents got infected through sex and 50% of them confirmed that they got infected after experiencing domestic violence in their marriage. This was during the time when they had separated after domestic violence. During the women's FGD, one respondent stated that:

> *One day, we had a heated quarrel with my husband, which ended up with him beating me thoroughly. I woke up the following morning, prepared my two children, packed a few clothes and went back to my parents' home. I stayed there for two years then he came and took us back to our marital home. Thinking all was well, we continued with our sexual life as before not thinking that there was need for us to be tested for HIV before embarking on our sexual relationship. I conceived after a few months and as usual during my antenatal clinics was tested for HIV, which turned out to be positive. I immediately knew that my husband had infected me since I had never had any sexual relationship for the two years I was away. Moreover, neighbours and friends told me stories of how he brought different women to our house when I was away. I automatically knew and*

confirmed that he must have been infected then and finally transmitted the infection to me. This was caused by the domestic violence and the subsequent two years' separation. More so, I could not question my husband about his behaviour during the period of separation because of the superiority complex as the head of the family.

This indicates that the patriarchal structure is still deep-rooted in Kinoo, where the women are seen as inferior to men. That is why the man could go for the wife after two years of separation, that is, it all depended on his discretion on whether the woman could come back to her marital home or not. Therefore, she is not an equal partner as is expected.

Though all the respondents had been tested for HIV, when asked whether their spouses had been tested, 40% of their husbands had not been tested due to various reasons. Fifteen per cent feared knowing their status, another 15 % because of denial that they may be infected, while 10% were separated from their wives. On the other hand, the women gave various reasons for undergoing the HIV test. Forty-five per cent were tested after falling sick every now and then, 30% just wanted to know their status, 20 % during their antenatal clinics, while 5 % did not know what prompted them to go for the test (Table 4.6).

Table 4.6: Reasons for respondents' HIV testing:

Reason	Frequency	Percentage
Falling sick	9	45
Desire to know status	6	30
Antenatal clinic	4	20
Do not know why	1	5

When asked whether they had informed their sexual partners about their HIV status, 75% said they had informed them while 25% had not. The 25 % who had not informed their partners gave various reasons for that. Twenty per cent said they had not disclosed their status for fear of being divorced or separated by their partners, a situation that would

adversely affect the children. Five per cent did not live with their husbands. Finally, the 20% who feared separation also confirmed that the separation would come after domestic violence being inflicted on them, which they feared and so opted to remain silent. The respondents narrated that:

> *I cannot disclose my status because he always says that women are prostitutes who go out and bring the HIV infection to their husbands. Even if men go out, they are never infected because they know how to go about these things.*

A nurse who was one of the key informants was quick to state that there is an intersection between domestic violence, gender inequality and HIV infection. When asked why there is domestic violence in Kinoo, she stated that the patriarchal structure, which is deep rooted, is a great contributor to this, leading to the HIV prevalence. She narrated that:

> *Men feel superior to their wives since they are the heads of the family. Moreover, men have always been the decision-makers in society, which has run down to the family level. They believe that they are always right, should not be questioned by any woman, especially on matters pertaining to their sexual decisions. They believe that they are polygamous by nature, therefore are allowed to move out with other women of their choice, while their wives should stay home and wait for their husbands. These men get infected out there then transmit the infection to their wives, who cannot question their husbands due to the fear of facing domestic violence.*

Poverty has also contributed to domestic violence, gender inequality and HIV infection. This could be because of the low level of education among the women, which has subsequently contributed to the lack of formal employment as a source of income. The research findings indicated that 40% of the respondents had attended primary school, 40% had secondary education and 20% had college level education, with none having

attended university. In terms of occupation, 30% were housewives, 5% small-scale farmers, 45% small-scale businesswomen and 20% others (Table 4.7).

Table 4.7: Respondents' occupation

Occupation	Frequency	Percentage
Housewives	6	30
Small-scale farmers	1	5
Small-scale business women	9	45
Others	4	20

This has contributed to their being poor and totally dependent on their husbands. This has brought about the dependency syndrome, making them prone to domestic violence and thus exposing them to HIV infection. Since they cannot make ends meet or feed their children without the contribution of the husband, the women may resort to extramarital relations.

Gender inequality makes the women not able to fight or demand for their rights. They do not have the power to negotiate for safe sex, for instance, use of the condom, even when they are aware that their spouses are moving out with other women. This may also cause re-infection in those already infected. Yet when the woman insists on condom use or denies the man sex, she is thoroughly beaten and denied money for buying food and for other necessities. One respondent narrated how her spouse once tore her underpants and baika when she insisted that he should use a condom, otherwise she would not allow him to have sex with her. She received a thorough beating and was then forced into having sex. This made her feel very humiliated, inferior to the man and used as a sex object.

CHAPTER FIVE
SUMMARY AND CONCLUTION

5.1 Summary

This was a study on domestic violence and women's vulnerability to HIV infection. The study was done in Kinoo Division, Central Kenya. It was done among women who were HIV infected and had enrolled themselves in various HIV support groups.

Gradually, violence against women has come to be recognized as a legitimate human rights issue and as a significant threat to women's health and well-being. (Garcia and Walts 2000). Among the many types of violence women experience, domestic violence is the most far-reaching and prevalent in Kinoo. Women suffer physical, emotional, sexual and economic violence at the hands of their intimate partners.

The study was guided by two research questions: to what extent does domestic violence make women vulnerable to HIV infection and is there any intersection between gender inequality, domestic violence and HIV infection? It adopted a descriptive, cross-sectional research design and combined both qualitative and quantitative methods of data collection. Data was collected using a structured questionnaire, key informant interviews and focus group discussions.

From the study findings, we can state that women are more willing to open up about their HIV status while the men are still hiding in denial and fear of confirming their status. Therefore, more women have enrolled in the support groups than the men. Women who are aged 25-40 years are most affected by domestic violence and hence most vulnerable to HIV infection.

The findings show that domestic violence increases women's vulnerability to HIV infection. All the respondents said that domestic violence was the root cause of their HIV infection. They experienced at least one form of violence or another, with physical, sexual and emotional violence being most prevalent. Though both men and women are at risk of being HIV infected, women are most vulnerable due to their low level of education. This leads to non-formal and lack of formal employment which creates a

dependency syndrome in which men take advantage of the women, thereby exposing them to HIV infection. Some of the women who experienced domestic violence went out in search of a "shoulder to cry and lean on", and ended up falling prey to men who were HIV infected. Others went back to their maternal homes for refuge after domestic violence and after coming back found their husbands had been infected and were subsequently infected by the husbands.

The study also found that there is an intersection between domestic violence, gender inequality and HIV infection. Some of the women who were infected by their spouses stated that they were not able to negotiate for safe sex, for example, condom use. Those who dared to negotiate, found the men totally unwilling and this led to further domestic violence like forced sex, tearing of the woman's underpants and physical violence. This demonstrates gender inequality in the family.

5.2 Conclusion

It can, therefore, be concluded that double standards are practised in the family and society. The men can move out with other women and get infected. On the other hand, it is a taboo for women to do so even when not sexually satisfied or deprived of their sexual rights by their matrimonial spouses. Due to patriarchy in the Gikuyu community, more men are educated than women. Therefore, men are formally employed while women are housewives or run small businesses, which cannot support the family. This makes them depend on the men, who take advantage of the imbalance and make the women feel inferior to them. This leads to frequent episodes of domestic violence in the family. Some of the women end up looking for other means of survival, from other men, ending up in the trap of HIV infection and, finally, transmitting it to the husband if he is not already infected.

It can also be concluded that there is an intersection between domestic violence, gender inequality, and HIV infection. This is because women are not able to negotiate for safe sex due to their inferiority complex and fear of domestic violence. This makes them vulnerable to HIV infection. Most women do not have the power to fight for their rights

and privileges in the society and at family levels. The more a woman becomes dependent on a man, the more she feels inferior to him. Hence making her vulnerable to domestic violence and HIV infection. Patriarchy, which is deep rooted in the Gikuyu community and greatly in-grained in Kinoo Division, has made gender inequality prevalent. Men practice immorality and get away with it unquestioned by the women, who suffer silently. They get infected and live with bitterness and the infection till death, yet, have nowhere to turn to for redress.

5.3 Recommendations

- Domestic violence should be brought to light by the victims, lobby groups, for example, Maendeleo ya Wanawake, and the government through the Ministry of Gender and Children.

- Perpetrators of domestic violence should be reported by the victims and charged in a court of law.

- The Ministry of Gender and Children, lobby groups, for example, Kenya Women League, and the church, should educate and enlighten the society on the causes, forms and effects of domestic violence in society.

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Appendix 1: Questionnaire

Hello,

My name is Mary. I am a student at the University of Nairobi doing my MA in Gender & Development Studies. Issues on domestic violence and HIV infection are on the increase in our society. Thus, for my final research project, I have chosen to deal with ''Domestic violence and how it contributes to women's vulnerability to HIV infection.''

You are one of the people who have been selected to contribute to this topic with your opinions and insights. Kindly take some time to respond. You need not write your name.

All responses will be held in confidence.

Thank you for your time.

Questionnaire No.....

Name of support group.....

Personal data.

1.Gender

Male..... Female.....

2. Date of birth DD..... MM..... YYYY.....Age.....

(Tick Appropriately)

4. Marital status

Married.... Divorced.... Separated.... Single.... Widowed....Co-habitating.....

5. Explain reasons for the status above.....

.....

6. Highest level of education.

Primary.... Secondary.... College.... University....

7. Occupation.

Housewife.... Farmer.... Businesswoman.... Other, specify....

8. Do you have children? Yes.... No....

9. If Yes, how many? ....

10. If No, why? ....

Knowledge of and attitude to domestic violence

11. Have you ever heard about domestic violence? Yes.... No....

12. Do you know what domestic violence is? Yes.... No....

13. If Yes, explain.....

.....

14. Have you ever encountered any form of domestic violence? Yes.... No....

15. If Yes, explain.....

.....

16. If Yes, how long ago? Less than 6 months ago.... Less than 1 year ago....
More than 1 year ago....Cannot recall....

17. Who inflicted the violence on you? Husband.... Boyfriend.... Father....
Other, specify....

18. What kind of violence was inflicted?
Sexual.... Physical.... Economic.... Emotional.... Not sure....

19. How frequently does this happen?
Everyday.... Weekly.... Monthly.... Yearly....

20. Have you ever disclosed this to anyone? Yes.... No....

21. If Yes, to who?
Parents.... Police.... Pastor.... Friend.... Neighbour....

22. If No, why? Explain.....

.....

23. What are your feelings about domestic violence?
Normal and okay.... Has always been there.... Bad and should be stopped....
Nothing can be done about it.... Should be made illegal....

Impact on health and HIV infection

24. Have you ever been tested for HIV infection? Yes.... No....
25. If Yes, why? Explain.....

    .....
26. If No, why not? Explain.....

    .....
27. If positive, how did you contract the infection? Explain.....

    .....
28. Has your husband or boyfriend been tested for HIV infection?

    Yes.... No....
29. If Yes, when? Explain.....
30. If No, why not? Explain.....
31. If positive, did you inform your husband or boyfriend? Yes.... No....
32. If No, why not? Explain.....

    .....
33. If Yes, why? Explain.....

    .....
34. How many sexual partners do you have? .....
35. Why? Explain.....

    .....

Appendix 2: Focus group discussion guide

1. What is domestic violence?
2. What do you know about domestic violence?
3. Have you ever experienced any form of domestic violence?
4. Who inflicted the violence on you?
5. What caused the violence to take place?
6. How did you feel about it?
7. To whom did you report the violence?
8. Do you think domestic violence should be acceptable in society?
9. What is the impact of domestic violence on a woman's health?
10. When women report about domestic violence, what action is taken?
11. What do you suggest should be done to end domestic violence?

Appendix 3: Key informant interview guide

1. What is domestic violence?
2. Why is it practised in Kinoo?
3. What are the common forms of domestic violence experienced by women in Kinoo?
4. What is your opinion on domestic violence?
5. Why are women vulnerable to HIV infection in Kinoo?
6. What is the reaction of women who experience domestic violence?
7. To whom are such cases reported?
8. Which category of women is most vulnerable to domestic violence and HIV infection?
9. Who are the perpetrators of domestic violence?
10. What do you think should be done to eliminate all forms of domestic violence?