

**HIV/AIDS RISK MANAGEMENT AMONG WOMEN IN  
HETEROSEXUAL MARITAL UNIONS IN KIBERA INFORMAL  
SETTLEMENT SCHEME, NAIROBI**

**BY**

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**2007**

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## DECLARATION

This thesis is my original work and has not been presented for a degree in any other University

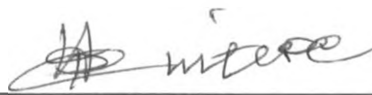


12/11/07

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



13/11/07

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**PROF. P. CHITERE**

## **DEDICATION**

Dedicated to my late father Kimeu Mutyauvyu

And

My children Mwende, Muthusi and Wandia

## ACKNOWLEDGEMENT

I am greatly indebted to my supervisors Profs.Preston Chitere and Charles Nzioka for their invaluable guidance and encouragement they gave me. They were totally committed to see this work accomplished.

I am particularly grateful to the former Chairman, Department of Sociology Prof. Gakuru for his encouragement to pursue graduate studies in spite of financial problems.

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Thanks to my many friends whose names cannot be listed here but gave me a lot of moral support.

## ABSTRACT

The main objective of this study was to investigate how power relationships in marital unions influences women's vulnerability to HIV infection. The main focus of HIV/AIDS programs to date has been the prevention of further transmission of the virus through promotion of mutual faithfulness, condom use and abstinence and more recently, the treatment of sexually transmitted infections. This study sought to address this issue by examining available HIV/AIDS prevention measures, specifically focusing on women in heterosexual marital unions. There is little information on prevalence rate among women in marital unions for the one reason that such unions are perceived to act as 'bumper zones' against infection. Persons in these unions are regarded as belonging to a very 'low-risk' group as opposed to homosexuals, drug users, prostitutes and truck drivers who are regarded as 'high-risk' groups. Ironically, there is glaring gender disparities in HIV/AIDS prevalence with more and more women getting infected. Gender inequality in particular has been blamed for the higher prevalence of AIDS among women than men.

Theoretically, the study adopted the socialist feminism perspective which holds that predominance of men in decision-making is a major cause of gender inequalities in all sectors including sexuality. This theory has been responsible for guiding some of the basic transformation in women's and men's lives and forms the basis for social policies and social action that can bring change. The study was also, guided by Health Belief Model in understanding perceptions surrounding choices of HIV Prevention options.

A sample of 100 women was selected for interviews in Kibera's both formal and informal settlement in Nairobi. The main tool of data collection was the interview schedule. Secondary data and Focus Group Discussions also supplemented the study. Study variables included personal characteristic like level of education, religious affiliation, income and family size. Other variables were safe sex practices, knowledge and risk perception of HIV/AIDS. Both descriptive and inferential statistics were used in analysis and presentation of the findings.

From the analysis, it was established that most women are unable to successfully negotiate for safer sex practices with their partners. Personal characteristics of the respondents were found to significantly influence their use of safer sex practices. Variables like level of education and income were key to women's empowerment, while economic disempowerment coupled with cultural pressures made it difficult for women to assert their wish for safer sex. Knowledge and risk perception of HIV/AIDS did not seem to significantly influence women's practice of safer sex.

The main policy implication here is the need for the government and other partners to come up with radical measures in formulating and implementing gender-sensitive legal protection of rights in the context of HIV/AIDS. Reproductive health rights are human rights and should be protected. There is need to focus more on respect, protection and fulfillment of human rights. It is recommended that more women should be involved in policy decision making at National AIDS Programs and also in grassroots organizations.

There is a pressing need to further explore and identify strategies, which are under a woman's control. However, the most efficient prevention strategies

are those that men have under their control. Thus every effort must continue to be made to change men's behavior by tackling men's attitudes and supporting projects which develop male peer educators for changing attitudes of men toward sex, gender and power.

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## INTRODUCTION

### 1.1 Introduction

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# CHAPTER ONE

## INTRODUCTION

### 1.1 Background

According to United Nations lead agency of AIDS (UNAIDS), an estimated 5 million people became infected with HIV around the world in 2001, 800,000 of them children. Over the next decade, without effective treatment and care, they will join the ranks of the more than 20 million people who have died of AIDS since the first clinical evidence of HIV/Aids was reported in 1981 (UNAIDS, 2002).

In sub-Saharan Africa HIV/AIDS marks a severe development crisis, as Africa remains by far the worst affected region in the world. Approximately 3.5 million new infections occurred in 2001, bringing to 28.5 million the total number of people living with HIV/AIDS in sub-Saharan Africa (UNAIDS, 2002). HIV/AIDS is now by far the leading cause of deaths in sub-Saharan Africa, and the fourth biggest global killer.

AIDS has unprecedented impact on regional and national developments as it kills many adults in the prime of their working and parenting lives, it decimates the workforce, fractures and impoverishes families, orphans millions and shreds the fabric of communities (World Bank, 2000). The magnitude of the problem and the current speed of expansion of the

HIV/AIDS pandemic make prevention of primary concern to save millions of people from the worst effects of HIV/AIDS (WCC, 2000).

In Kenya like, any other sub-Saharan African country, HIV is transmitted mainly through heterosexual contact. It has been found that HIV infection rates are higher among women than men (UNAIDS, 2000). Women's enhanced physiological risk of HIV infection is compounded by economic deprivation, lack of employment opportunities, poor access to education, training and information and socio-cultural norms and practices (UNAIDS, 2002).

The prevention of HIV transmission requires first and foremost that people be properly informed about the virus mode of transmission. Understanding these facts should enable people to make responsible choices that will prevent this transmission. Avoiding sexual behaviour, which leads to an increased exposure to HIV, can prevent sexual transmission of HIV. Some prevention options include sexual abstinence or mutual faithfulness in stable sexual relationships or proper and consistent use of latex condoms (WCC, 2000).

However, information alone is not enough to determine human behavior, which is related to socio-economic conditions and to cultural and traditional norms and values (WCC, 2000; Crewe, 2002). Most infections occur as a result of unprotected heterosexual intercourse. Women's low economic and social status limits their power to negotiate the use of condom, discuss fidelity with their partners or leave risky relationships. Such disempowerment increases their vulnerability to HIV. This restricted ability

to control one's own sexual safety comes not only from traditional societal values but also from physical technology and economic realities (Nzioka, 2000, UNAIDS, 2002). Studies have shown that even if women were educated about HIV/AIDS their economic dependence on men leaves them feeling "helpless" to negotiate safe sex (UNAIDS, 2002) sexual coercion and violence in all its forms inside and outside marriage increases the threat of HIV infection for women and girls.

Men have always dominated women in economic, social and cultural spheres of their lives and are historically recognized as authoritative decision makers in both private and public spheres (Nzomo, 1997). It is this social-cultural and economic lack of autonomy of women, which places them at the very heart of the HIV/AIDS Epidemic. In Africa, women account for 55% of all new cases of HIV. So far HIV prevention or safer sex education has focused mostly on condom use, which necessitates male compliance and the latter is not always available to women (Crewe, 2002).

According to AIDS CAP (1996), though Kenya could be potentially devastated by HIV/AIDS, the reality is that new infections are preventable with changes in sexual behavior. Effective and appropriate prevention campaigns could halve new HIV infections. The economics in favor of prevention are staggering, yet persuading people that effects are so terrible that it is worth paying a big personal price to stop; something they like doing very much, is itself an uphill task (Dixon, 1994).



## 1.2 Problem Statement

According to the Kenya National HIV/AIDS Strategic Plan, heterosexual contact accounts for 90% of the spread of HIV/AIDS. The other 10% is through mother-to-child-transmission and contact with infected blood. Available data shows that 80% - 90% of infections are among people aged 15 to 49 years (NACC, 2000). This group being the most economically productive one, the impact of HIV/AIDS will adversely affect Kenya's economic growth. It is estimated that Kenya's gross domestic product (GDP) may be reduced by 14.5% in the next ten years. Awareness on dangers posed by HIV/AIDS is high at 99% for both men and women but behavioral change on sexual matters is slow and is not matched with increased awareness (KDHS, 1998).

A lot of work has been done on HIV/AIDS including HIV/AIDS preventive measures, HIV/AIDS among the youth and HIV/AIDS among vulnerable groups. Several ways have been advocated for reducing the risk of HIV or avoiding it altogether. As World Health Organization says, that most effective way to prevent sexual transmission of HIV is to abstain or for two people who are uninfected to remain faithful to each other (Nixon, 1994).

Condom use has also been advocated for prevention of HIV/AIDS across board. Unmarried young people have been encouraged to tie the knot as a way of staying free from HIV/AIDS infection. This is because marriage has always been seen as a 'pure' institution devoid of certain calamities like HIV/AIDS infection. It is estimated that between 60% and 80% of infections among women occur in 'stable relationships.' The questions that beg for answers are; 'If marriage is a 'safe haven' from HIV infection, why then do we have more than 1.5 million orphans, majority of whom had both parents?

Why have women in marital unions continued to be infected by HIV/AIDS? While this scenario has presented itself in its naked form we have looked the other way. It is important that we re-evaluate whether the strategies being advocated in HIV/AIDS prevention are adequate in the context of marriage.

Due to men's dominance in socio-cultural, political and economic spheres, married women cannot question sexual behaviors of their spouses, even when they know it presents a risk of infection. Nzioka avers that marriage is not a 'safe haven' but a binding sexual union where the choices of women are limited by dominant cultural beliefs of subordination (Njeru, 1998, Nzioka, 2000).

Sexual inequality in marital unions legitimizes men's promiscuous behavior to the detriment of women's health. This is a social problem that needs to be addressed as it affects the society. For successful control of the virus, there is need to focus on preventive measures taken by women in marital unions. In most societies in Kenya, an entrenched gender inequality exists. Men's social, economic and political status eclipses that of women, double standards encourage multiple partners for men but not for women (UNAIDS, 2002). Such a scenario renders women powerless to negotiate for safer sex with their partners whether in marital unions or in casual relationships. This imbalance of power between men and women, where the latter remain subordinate to the former, weakens the fabric of family and community life. This imbalance of power is related to the failure of men to take responsibility for issues related to sexuality, reproduction and HIV/AIDS (WCC, 2002). If the anomaly in sexual matters is not addressed then health intervention measures will have very little impact on this group. Unless the

society dismantles social structures that perpetuate cultural biases that contribute to women's subordination and oppression, women will continue to be at risk of HIV infection.

From the foregoing, it is clear that gender inequality is a factor that creates a climate for the spread of HIV/AIDS. Preventive strategies are most effective when they take into account the role of gender inequalities in the epidemic, and when they help empower women against a wide variety of cultural and social inequalities that make them more vulnerable than males (UNAIDS, 2002).

While awareness and preventive measures against HIV infection are acknowledged by majority of Kenyans, there is a gap between knowing and doing. Studies on strategies married women adopt in HIV prevention are limited. This study therefore intends to explore the preventive measures women adopt in cases where their spouses have other sexual partners. The extent to which gender inequality impedes HIV prevention will be determined.

A study on gendered sexuality sheds light on vulnerability of women in heterosexual marital unions to practice safer sex. The study provides data on preventive measures if any taken by women to guard against HIV infection. It enables us understand how women in marriage see their vulnerability as well as provides data on the strategies they use in HIV/AIDS prevention in the context of marriage including the problems they face in negotiating for safer sex.

### **1.3 Objectives of the Study**

The overall objective of this study is to investigate how power relationships in marriage influences women's vulnerability to HIV infection.

Specifically, the study set out:

- a. To investigate how women in heterosexual marital unions perceive their own risk of HIV infection in marital unions.
- b. To investigate how women in heterosexual marital unions position themselves in regard to possible HIV infections.
- c. To explore how women deal with the possible risks of HIV infection in marital context.
- d. To find out whether women in heterosexual marital unions have the capacity to negotiate for safer sex.

To be able to generate the relevant data this study was guided by the following questions:

1. Do women in marital unions consider themselves at risk of HIV infection?
2. How does a gendered power differential influence the adoption of safer sex practices in marital unions?
3. Do women have the capacity to negotiate for safer sex within marital context?
4. What strategies do women use in dealing with the risk of HIV infection in marital unions?

## 1.4 Rationale of the Study

According to the Kenya Demographic Health Survey (1998), it is estimated that about 1.3 million adults and 90,000 children are HIV infected. It further says that virtually all men and women (99%) know of HIV/AIDS. However, though this knowledge is regarded as an important pre-requisite of behavioral change, it has not necessarily led to any tangible rapid change in attitude or behavior (KDHS, 1998). The incidence of infection reveals gender patterns, which point to women as being the dominant group in the demography of HIV infection. Women's enhanced physiological risk of HIV infection is compounded by economic deprivation and social cultural norms and practices (UNAIDS, 2002).

Preventive measures against HIV/AIDS like condom use, abstinence and faithfulness to one partner, have been promoted as safer sex practices. Yet there are underlying values and patterns of social interaction that create vulnerability of women to HIV/infection. This includes lack of social power for women to make responsible sexual decisions and lack of political power to change oppressive myths, cultural values and practices that perpetuate and exacerbate the powerlessness of women in the face of the pandemic (University of Pretoria, 2002)

In the face of these barriers to prevent HIV transmission from men to their spouses the need arises to address the underlying social-cultural and economic factors that deprive women of the power to protect themselves against HIV infection. Even when health education programs target women, they may have very little impact on HIV prevention as women lack empowerment to demand safer sex or refuse sex from their husbands. These

strategies are most effective when gender inequality in sexuality is taken into account.

This study was of great importance in finding out how women in heterosexual marital unions are protecting themselves from HIV infection against a wide variety of cultural and social inequalities that render them vulnerable. Already, there are an estimated 890,000 orphans in Kenya and huge numbers of children have also lost at least one parent to AIDS (UNAIDS, 2002). This is a clear indication that preventive or protection methods are wanting in marital unions. Therefore this study may help open the door to reviewing the current health interventions with a view to taking into consideration some of the cultural and traditional practices that are upheld by customary laws but which are detrimental in challenging the pandemic. The assumption that faithfulness will always be observed in marital unions is a myth as studies have shown elsewhere in Africa (Zimbabwe) (UNAIDS 2002).

### **1.5 The Scope of the Study**

This study was interested in HIV/AIDS risk management among women in heterosexual marital unions in Kibera informal settlement. The study focused on women who, by virtue of having a partner, it was assumed that they engaged in sexual intercourse. Of interest was finding out how socio-cultural and economic factors influence perceptions and actions in these heterosexual relationships. The study placed emphasis on heterosexual relations marital unions. Specifically, it focused on women in heterosexual marital unions in Kibera. The study looked at the strategies women in heterosexual marital unions employ in preventing HIV infections in cases where they are exposed. This would be of particular importance, as it

gauged whether women in such unions can rely upon the current health interventions in HIV prevention. The study examined awareness and risk perception of HIV/AIDS, and safer sex practices among the respondents.

The major focus of the study was to find out whether relationships exist between the hypothesized independent and dependent variables. The researcher attempted to find out whether personal characteristic like education income and number of children had any influence on safer sex practices. The study also examined whether knowledge and risk perception of HIV/AIDS has influenced the use of safer practices.

This study was limited to a small sample of 100 respondents. This was due to financial constraints, time and the fact that it was important that the researcher administered all the questionnaires. The population focused on by the study was targeted because the researcher felt that it had been ignored in HIV/AIDS prevention strategies due to the mythical 'safe haven' such unions are assumed to enjoy. This group is very important to target in HIV/AIDS prevention, as 1.5 million orphans is a crisis for any country, including Kenya.

# CHAPTER TWO

## LITERATURE REVIEW

### 2.1 Introduction

The main objective of this chapter is to review the works of different authors on existing gender relations *visa vis* HIV/AIDS prevention interventions. The literature review will specifically focus on preventive measures in relation to socio-cultural construction of gendered sexuality. This involves searching the literature by reading through books, journals and articles that talk about this topic. In order to understand critique and really benefit from previous research studies, Scutt (1992) says that it is a must to review the literature and this is dealt with in this chapter.

This chapter focuses on implications of gender relations on heterosexual marital unions. The differential power and authority relations between men and women in favor of the former are hypothesized to influence safer sex practices for the latter. As Chitere (1994) argues, many communities in Kenya are patrilineal and tend to downgrade women through existing gender disparities like gender based division of labor and decision-making. These gender disparities are responsible for disempowerment of women in heterosexual marital unions.

HIV/AIDS epidemic is among the greatest challenges confronting the global community. Although HIV/AIDS have now been identified in nearly all countries of the world, the prevalence or scale of infection



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HIV/AIDS epidemic is among the greatest challenges confronting the global community. Although HIV/AIDS have now been identified in nearly all countries of the world, the prevalence or scale of infection

varies widely both between and within countries. The virus reached global regions at different times and has spread faster or slower in various populations according to differing risk factors. Hence, even within one country, several epidemic patterns arise (Jackson, 2002).

An estimated 40 million people are infected with HIV/AIDS worldwide. Of the 5 million new HIV infections transmitted last year (2001), 3.5 million were in sub-Saharan Africa, where a total of 28.5 million people now live with the virus. By the year 2000, 22 million people had died while 68 million people are expected to die of AIDS by the year 2020 in the 45 countries most affected by the disease. Health officials in Eastern Europe and Central Asia believe that the opening of borders and drug trafficking are fuelling the spread of HIV/AIDS. Some 1 million people in the region are now said to be infected. Ukraine, with 250,000 HIV infections, is the most affected country in Eastern Europe, the region where AIDS is growing fastest. In the United States, there are estimated 950,000 people with HIV/AIDS, intravenous drug users accounting for 30% of all infections in the country (WHO/UNAIDS 2002).

Some countries, particularly in sub-Saharan Africa, AIDS has already exhibited visible demographic, social and economic impacts on the entire population (Ombeta, 1998). It poses the foremost threat to

development in the sub-Saharan Africa. Over 2.5 million Africans have already died as a result of HIV/AIDS epidemic. Much of Africa will enter or has already entered 21<sup>st</sup> century watching the gains of the 20<sup>th</sup> century evaporate (World Bank, 2000; UNAIDS, 2002). Worldwide, Africa leads in absolute numbers and increase of HIV/AIDS infection rates. Sub-Saharan Africa with just 10 per cent of world's population is home to approximately 60% of all people living with AIDS, accounting for over 11 million HIV cases (UNAIDS, 2002). In Africa, south of Sahara, the epidemic is focused in the Southern, Central and Eastern Africa, stretching from Uganda, through Kenya, Tanzania, Rwanda, and Burundi; further down south including Malawi, Botswana, Swaziland, Zimbabwe, Lesotho, Zambia, Namibia, Mozambique and South Africa. These countries are known as the 'HIV/AIDS Belt' (Anarfi, 1994; Mann et al., 1992). The disease is picking up speed in Central and West Africa, which until recently had maintained high but consistent rates of infection. There is an epidemic contrast between the sub-Saharan region and the Caribbean, and other regions/populations of the world. Worldwide, more men are infected and dying than women, but in Africa particularly sub-Saharan Africa, this trend is reversed. An estimated 54% of adults' infection by the year 2000 was women. In addition they are infected and die at a younger age than men (UNAIDS, 2002). Bi-directional heterosexual transmission is the predominant mode in Africa, otherwise known as

Pattern II countries. In developed nations, homosexuality and intravenous drug injections among the males are the main modes of transmission. These are categorized as the Pattern I countries. In the former category, HIV/AIDS prevalence among men and women are equal, where the ratio of infected men to women is 1:1. In the latter, the prevalence is as high as 19:1 (Mann et al, 1992; Carael, 1995; Buve et al., 2001). Up 50% of new mothers could die in the sub-Saharan African countries with the highest HIV prevalence rates. Of the 14 million children orphaned by AIDS worldwide, 80%, or 11million, are in sub-Saharan Africa.

World Bank avers that many HIV/AIDS victims died because the African leadership and its international partners have been slow to respond to the epidemic. The epidemic is no longer just a public health problem; it is a development crisis that calls on the World Bank, its development partners and African governments to make a new commitment in saving millions of people (World Bank, 2000). To date, more attention has been paid to HIV prevention, treatment of opportunistic infections and provision of Anti- retro Viral drugs (ARVs) than to the traditional culture that is responsible for pushing HIV/AIDS infection rates up among women.

The simplest national categorization of HIV/AIDS is into low, intermediate and high prevalence epidemics. Low level is taken as adult prevalence of below 1%; intermediate as below 5% and high

epidemic as prevalence of over 5% among the adults aged 15-49 years (W.H.O/UNAIDS, 2000). Looking at the epidemic patterns beyond this categorization, focus should be on nascent, concentrated and generalized epidemics. This analysis is useful for identifying high-risk environments within a country (region) enabling strategic interventions, through understanding the environmental risk factors for different population groups.

## **2.2 Kenya's HIV/AIDS Situation**

Kenya reported its first AIDS case in 1984 (NAS COP, 2005; Njue, 2000). AIDS is caused by Human Immune Deficiency Virus (HIV) that weakens the immune system, making the body susceptible to and unable to recover from other opportunistic diseases that lead to death through secondary infections.

By 1987, Kenya reported 1,299 AIDS cases. In 1990, there were 16,150 confirmed cases. In 1991, this rose to 25,702 and over 50,000 cases were confirmed in 1994. By September 1997, over 76,000 deaths were reported. There were over 1.32 million people already infected by HIV (NACC, 1997). The AIDS deaths in 1999 were over 180,000. Cumulative number of orphans by that year was 730,000 (UNAIDS, 2000). With a population of over 30 million, in year 2000, adults living with HIV/AIDS were over 2 million where 1.1 million women and

78,000 children were living with HIV/AIDS. People living with AIDS in Kenya translate to about 9.3% of the total population.

The prevalence rate of HIV is lower in rural areas, where about 80% of the total population lives than in urban areas. However, this presents an enormous problem because the greatest burden of HIV/AIDS infection is in the rural population. Urban residents have a significantly higher risk of HIV infection (10 per cent) than rural adult residents (6 per cent). Prevalence in urban women is 12 per cent compared with less than 8% of rural women (NCPD et al., 2003).

### **2.3 HIV/AIDS Prevention Measures**

There is growing consciousness that the one million Kenyans estimated to be currently infected with HIV will eventually die of AIDS or AIDS-related illnesses, that thousands of others will become infected in the coming years and that a set of inter-related social, economic and social crises for communities and the nation will develop unless swift and appropriate actions are pursued immediately (AIDS CAP, 1996). However, this trend can only be reversed if the interventions employed are broad and intense enough to encompass all groups at the risk of infection (World Bank, 2000).

In its Sessional Paper No.3 of 1999, the Kenya government outlines how it hopes to halt the current increase in the incidence of poverty and then eradicate it step by step. This plan, with the current HIV/AIDS pandemic may make no sense unless the government and other stakeholders place

HIV/AIDS at the center of development agenda. Successful proven approaches for HIV prevention have been identified but factors that render individuals and communities vulnerable need to be the main focus. Despite these important interventions, there remains a strong undercurrent of skepticism or down right opposition to more aggressive positions on HIV/AIDS prevention (AIDS CAP, 1996).

For a sustainable and expanded intervention, empowerment of vulnerable individuals and groups is crucial in bringing down HIV prevalence (UNAIDS, 2002). Most women in marital unions fall under the category of vulnerable persons evidenced by the number of orphans in Kenya estimated at 890,000 (UNAIDS, 2002). Experience has shown that once one parent has acquired HIV, the other is also likely to become infected.

#### **2.4 Gender Relations and HIV/AIDS Preventions**

The differential power and authority relations between men and women generally put the latter in a subordinate position in the society. This position of women has had a negative effect on the health of the women and in particular, prevention of HIV/AIDS infection. Andersen, (1997) sees social institutions and social attitudes as the basis for women's position in society. In such sexist societies, these institutions have created structured inequalities between men and women. The social and cultural importance attached to normative gender roles is such that women's ability to control their own reproductive behavior smacks of self-determination and freedom from male authority anathema to men in most societies (Huston, 1979).

Brydon and Chant (1989) have classified into three categories reasons why women's position in society is subordinate.

- (i) Factors relating to culture and ideology as they influence the normative roles to be played by men and women in a given society.
- (ii) Factors relating the nature of women's domestic role and a range of practical constraints operating at the level of the household which make it difficult for women to enter the labor market on the same basis as men.
- (iii) Factors relating to the actions and attitudes of employers and the state who commonly tailor their recruitment practices to the broad requirements of capital accumulation, sexual division of labor by which women have primary responsibility for 'reproductive' work (child care and domestic labor) is common throughout Third World. Because of gender embeddedness of the division of labor, female employment is usually regarded by men and indeed sometimes by women themselves as peripheral and/or undesirable (Scott, 1986). This lack of economic power by women reinforces the existing balance of gender roles and relations (Buvinic, 1984).

The commitment of finding women a place in decision-making has received considerable impetus from UN decade for women and is obviously an improvement on earlier modernization-oriented and gender blind approaches. However, there are still problems largely due to culturally stereotyped assumption about what women's roles are in decision-making.

Buvinic (1984) and Moser (1986) note that programs with strong welfare element in which women become the recipients of resources aimed at bettering their performance as wives and mothers only address women



'practical' needs but do nothing in terms of challenging women's traditional 'roles' and the balance of power between men and women. Because of the cultural dictates many interventions in HIV prevention may bear no fruits as they remain under the users (men) control (Hartmann, 1987). Other existing gender disparities are manifested through the following issues: -

(a) The Gender-Based Division of Labor

The basis of gender-based division of labor in Kenyan societies is as a result of social structure of society (Suda, 1999). According to (Andersen, 1997) gender is learned and enacted through gender roles which are patterns of behavior in which women and men engage, based on cultural expectations associated with their gender. This division of labor based on gender is a pervasive social factor, which devalues women's works (Nelson, 1996). This culturally dominant conception of gender distinct as hierarchical with 'masculine' on top, leads to high value being attributed to roles and activities perceived as masculine and a parallel devaluing of activities associated with femininity (Nelson, 1996).

The social and cultural importance attached to normative gender roles is such that women are sometimes prevented from working altogether, or at least are channeled into jobs, which may be undertaken in conjunction with their domestic responsibilities (Westwood, 1984). The desire to confine women to hearth and home is also a contributory factor to the great majority of women's in-come generating work being house-based (Moser, 1981). Even where women participate in labor force, they are paid less in the workplace than men. Their position in the family as mothers and housewives is often used as a justification for the fact that their earnings are

not as central to family welfare as those of the putative male bread winner; thus as secondary earners they do not need as large a wage or even need to work. Hoffnung (1989) notes that mothering is done at home outside the world of achievement, power and money. She further argues that this motherhood aspect has a limiting effect on women's public participation. Since housework and motherhood is unpaid, the work is devalued; furthermore, the workers who perform the unpaid housework are devalued and have low social status. Since wages are essential to obtaining the necessities of life the housewife is entirely dependent on others for her survival. Her social value further diminishes as it appears that she is unproductive (Oakley, 1974). This argument is supported by Hartmann (1981) who sees "the family as a primary arena in which men exercise their patriarchal power over women's labor...(and) that time spent on housework ...can be fruitfully used as a measure of power relations in the home'

From the foregoing, gender division of labor both expresses and promotes the subordination of women and as a result women remain economically disempowered.

We might assume that the increasing proportion of women in the paid labor force and the visibility of the women's movement would have created equality in which housework is divided. Recent studies, however, show that women still do most of the housework and, when men do housework, they do certain tasks like taking out the garbage and yard work (Aulette, 1994).

(b) The decision – making process

In most traditional African societies there are customary prohibitions against a woman's right to own or control economic resources. Although women's

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(b) The decision – making process

In most traditional African societies there are customary prohibitions against a woman's right to own or control economic resources. Although women's

earnings (mainly from subsistence farming) are smaller than men's, the latter still attempt to control the use of their wives' cash in what seems to be a deeper struggle to retain control over female labor. In some societies, the power of 'custom' can thwart a woman's attempt to gain economic independence (Hay and Stichter, 1984). Cultural practices such as the payment of dowry, predominantly male inheritance of land continue to limit women's participation in decision-making and freedom of choice in conjugal unions.

Njeru (1993) notes that African social institutions including the family have created structured inequalities between men and women within these institutions, there is a marked sexual divisions of labor and a strict normative gender role system such that women often have little or no power to exercise over their lifestyles. For example in pre-colonial times, Kikuyu women had their own gardens which fed their families, men had their own which women worked, the produce from which was either stored or sold. Kikuyu men were said to have made all major decisions about social, political and legal affairs and all decisions (Kenyatta, 1937). Though this has changed among the modern Kikuyu, this is not the case to women whose families' primary source of wealth comes from the production of cash crops (such as tea and coffee). These crops were introduced by the colonizers as men's crops and ever since have sporadically brought riches to their producers. In this way cash cropping seems to have reinforced patrilineal control. The tendency has been the increased diminution of women's work (Boserup, 1970). Such customary practices that discriminate against women on inheritance, will, divorce; property provision, child custody and maintenance have rendered

women merely passive decision implementers, under the jurisdiction of their husbands.

Studies have shown that where women are economically empowered, they are full participants in making decisions that affect them and their families yet when they are left out in decision-making, they are not able to use their full potential in development. Kiragu (2001) notes that by changing attitudes, we will recognize the benefit that will accrue from bringing into the mainstream of policy and participation of women whose potential has been largely untapped. She calls for change of those discriminatory social practices that elevate men to a higher position in society and has adverse effects on true partnership between women and men in as far as development of society are concerned.

Nobody describes the status of women better than does Jambo (2000 who focused on the oppressed women of Southern Sudan. She states “..... She is a daughter that is not allowed to go to school for her ‘bride price’ is far more important than her education. She is a wife for whom dowry was paid and therefore who has no voice in her matrimonial home. She is a silent partner that endures so much without complaints for divorce is a taboo and on the other hand culturally and traditionally, she continues to suffer from forced marriages, arranged marriages, wife inheritance and tribal clashes. Her education, training and public participation is discouraged and frustrated – indeed it is a miracle how she is still surviving!” Though this sounds outrageous, it is a typical reflection of many African communities which are predominantly patrilineal, meaning that authority, decision-making and control is in the hands of the man as being the father and the

head of the family (Jambo, 2001). Women make up a formidable backbone of their communities and are proportionately larger in number than men and thus should be given an order of impotence to participate effectively in the nation building.

The UN Convention for the Elimination of all forms of Discrimination Against Women (CEDAW) grew out of the understanding that the inequality and discrimination against women as a group had to be addressed specifically. This response had to be made in the overall understanding of the socio-cultural, political and economic factors that contribute to their inequality and the various ways in which this inequality is translated into the kinds of social phenomena we see today (Crewe, 2002). It is the particular social, political, economic and cultural position of women that brings the problems and complexities related to women's rights in the context of HIV/AIDS. Due to lack of power in decision-making women lack control over many issues that affect them.

## **2.5 Gendered – Sexuality**

Women have always occupied a relegated status in the society. They face all forms of coerced sex, harmful cultural practices, stigma and discrimination specifically in relation to HIV/AIDS. This is often exacerbated by the lack of criminal and civil law remedies for women who suffer all forms of violence and discrimination. These factors heighten their vulnerability and reserve, further limiting their ability to summon proactive challenges to the pandemic. Their inferior legal status in relation to marriage, inheritance guardianship, property ownership, maintenance and legal matters places them in a disadvantaged position politically, which in

turn compromises their ability to challenge such practices. These factors coupled by physiology of women render them more vulnerable to HIV infection because men leave their semen in the women's body. As a result men have been left to continue their domination and control over women's bodies (UNAIDS, 2002, Crewe (2002).

Nzioka (2000) argues that the disproportionately higher HIV incidence and prevalence rates among women is due to social and cultural constructions of gendered sexuality which have been reproduced partly through lay discourses and popular culture and reinforced through sexual practices which problematise the introduction, negotiation and sustained use of safer sex practices in heterosexual relationship.

Men have been traditionally regarded as requiring sexual variety for their physical health and adultery on the part of husbands was widely regarded as a regrettable but understandable foible. For women a single act of adultery by a wife was an unpardonable breach of the law of property and the idea of hereditary descent (Giddens, 1997). Therefore males are permitted a great deal of sexual autonomy irrespective of their marital status while women were permitted little or no sexuality (Bourdieu, 1993) Sexuality here can be seen as both an individual experience and cultural construct. Thus, on the one hand individuals strive to satisfy their curiosity, maximize their pleasure and explore the limits of sexuality, but on the other hand, the cultural construction of sexuality imbues sex with taboos. An individual sexuality is circumscribed by social and cultural expectation, even when they themselves think that they are acting naturally (Bourdieu, 1993).

The ideological parameters constructed by cultures state with whom, where when and how sex should be conducted. However, this does not seem to apply to both sexes, as the local norm points out that the male should not come to the marriage 'chaste' i.e. a virgin. On the contrary, he is encouraged to an early commencement of sexual activity; the man who comes to his wedding a virgin is 'suspicious and can be stigmatized as a homosexual or as impotent (Giddens, 1997). On the other hand, the prescription of female virginity before marriage is observed. Though Freud came to see sexuality as the core of all human experience and pursuit of its pleasure on the part of both sexes as desirable and necessary, female sexuality continued to be treated as the pathological origin of hysteria (Giddens, 1997). Their desires are not taken into considerations and their sexual lives are subordinated lives. Thus, culture has constructed social relations based on gender roles. These roles make masculine sexuality dominance and feminine sexuality repressed and marginalized from the symbolic order. As women cannot speak, they cannot gain a subjective nor give meaning to their life. Therefore, traditional definitions of sexuality see sex for women as passive and inhibited and sex for men as performance and action oriented (Anderson, 1997). However, Contemporary sexual attitudes represent some loosening of rigid judgments about sexual behavior but, predictably, these attitudes, too, are shaped by gender.

## **2.6 Sexuality in Marital Unions**

Sexuality in conjugal unions has been primarily associated with reproduction. This is changing with the current association with relationships of emotional intimacy and physical pleasure for individuals (D'Emilio and Freedman, 1988). Additionally due to economic crisis in



most developing countries, sexuality has become more commercialized and the tie between sexuality and reproduction has been loosened. However, sexuality as discussed earlier is gendered in these unions. The belief that sex in marriage is the norm to which other sexual activity is compared is widely held. For example, we use the words premarital sex and extramarital sex to describe sex between people who are not married to each other. The use of these terms illustrates how sex in marriage is the 'normal' reference point (Aulette, 1998). Most people believe that married people should have sexual relations only with each other (Reiss, 1986).

Same forces that structure gender relationships shape intimate or conjugal relationships. Men's greater control of resources thus influences their power in relationships with women. Studies have shown that the greater a woman's contribution to household income is, the more power she exercises in family decision making (Spitze, 1988).

Republic of Kenya, (2001) estimated the number of deaths caused by AIDS among young adults (age 15 to 49) to be 214,000 a year by 2000 and increasing it to 270,000 per year by 2005. Among these victims are women and men in marital unions. Globally, 11 million out of 14 million children who have lost one or both parents due to AIDS live in Sub-Saharan African (UNAIDS, 2002). This large number of orphans is a pointer to the extent to which the pandemic is entrenched in marital unions. A study conducted in Pumwani Maternity Hospital (PMH) in Nairobi showed that women lacked reliable information about HIV infection and are unaware how best to negotiate with their partners regarding protection like condom use (AIDSCAP, 1996). However, while health education and information will not in all cases eliminate HIV infection, it does appear that women economic

empowerment and decision-making is vital component in HIV prevention in marital unions. In this PMH case scenario the woman can neither protect herself from an HIV positive husband nor protect her husband from her own sero-positivity (AIDSCAP, 1996).

Studies have shown that men in marital unions have other sexual partners like young girls, who due to the seniority of the latter find it difficult to resist the former's sexual advances (UNAIDS, 2002). These young women also do have sexual relationships with their boyfriends who are their age mates. It is evident that large numbers of young people begin sexual activity at relatively early age, are not monogamous and do not use condoms regularly enough to ensure protection. Many girls and young women actually have little control over how, when and where sex takes place. A South Africa national youth survey showed that 33% of young women agree to sex because they are afraid of saying no to sex (UNAIDS, 2002).

According to KDHS (1998), 16% of married men had reported extramarital sexual activity in the last 12 months compared to 2% of married women in that year. From this scenario, it is evident that the woman in the marital union is at risk of contracting HIV from her supposedly 'faithful' husband.

## **2.7 Constitution of Marriage**

Marriage is a many-faceted social institution and can be defined in cross-cultural context. Anthropologists have described marriages as the process by which most households are formed, whether it is formal marriage recognized as legitimate by members of the community and/or state apparatus or whether it is an "illegitimate" or transient union (Keesing,

1985). While monogamy is the norm in developed countries, polygamy occurs in most African states and several parts of Asia and Middle East. Whether monogamous or polygamous, marriages are institutionalized by payment of bride wealth or by religious or civil ceremonies. The parties are entitled to certain rights and have responsibilities to each other. Marriage is meant primarily for the creation of children though other marriages are meant to consolidate wealth, create security over property or provide companionship for the couple (Kayongo–Male and Onyango, 1984).

The institution of marriage in the contemporary society has several components, which include legal, economic, emotional, sexual and political factors. Some of these are found at the macro-level but also have a powerful effect on the micro-level experience on individuals who enter into marriage with each other.

#### (a) Marriage as a legal contract

Even though we think of marriage as a private affair, a marriage contract actually gives more control to the government and less to the contracting partners than do other kinds of legal contracts. The government specifies the duties and rewards, not the parties who enter into the contract, the husband and wife. This means that the particular arrangements a couple makes are legally invalid if they conflict with the duties and privileges specified by public policy.

#### (b) Marriage as an economic arrangement

During the colonial period marriages were more likely to be arranged by a patriarch. A critical issue in his decision was the economic deal that could be struck with the parents of the prospective spouse of his son or daughter.

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Although the opinion of the potential bride and groom increasingly gained control over the decision as this unfolded throughout the 19<sup>th</sup> century, economics continued to play a role. The macro-level organization of class stratification is both expressed and maintained by the micro-level activities of individuals marrying one another (Carter & Glick, 1976).

#### (c) Marriage as a Sexual Relationship

Randal et al (1991) state, “the core of marital relationship is a claim to permanent and exclusive sexual possession of one’s partner”. Marriage laws require that in order to consummate a marriage one has to bring the wedding ritual to completion – a couple not only must have sex with one another, they must have a particular form of sex, intercourse. Social norms in many societies prohibit sex between people who are not married to one another. Sex is seen to be tightly bound to marriage, legally, ideologically, and for many people experientially. Therefore, marriage is at least partly defined by its link to sex (Reiss, 1986). Part of the meaning of commitment in marriage is often the promise of mutual sexual exclusivity, though the concept of commitment includes other aspects as well. For example permanence of marriage has historically been the essential component of commitment in marriage in cultures heavily influenced by Christian belief.

#### (d) Marriage as a political arena

Renzetti and Currain (1992) argue that marital relations are fundamentally power relations usually the power of husbands over wives. Fishman, (1978) and Berfer et al (1966) defined power, as the ability to impose ones definition of what is possible, what is right, what is rational, what is real. A research conducted on married couples about the division of power in their marriage showed that husbands usually had more power in their marriage

because they had the final say in more decisions (Aulette, 1994). It was also found that when wives brought more social resources to the marriage, like a higher education or income, they had a greater control over decisions than if they did not (Gillespie, 1971). In other words, women who had more resources had more power in their relationship with men.

Power appears to be an aspect of marriage that takes a variety of forms. Men have the upper hand in many instances, but marriages are an arena of struggle over power and the mechanisms by which power can be maintained or changed (Zubeida and Rita 1994; Brydon & Chant, 1989). Differences in power between women and men have become less overt at the macro-level in marriage law but remain salient and pervasive in every aspect of even the smallest issues of social interaction between husbands and wives.

According to Islam, law institutionalizes inequality within Islamic marriage. For example, there are separate articles for a man's rights vis-à-vis his wife, a wife's rights vis-à-vis her husband. On marriage a man has the right to total fidelity from his wife, obedience, the performance of domestic labor among others. A wife on the other hand cannot expect her husband to be faithful or obedient. Husbands therefore owe no moral duties to their wives and the alleged rights of women are in fact restrictions on their freedom (Brydon & Chant, 1989).

With the Judeo-Christian doctrine, insubordination of women is justified through the Holy Scriptures. Paul (in Ephesians, 5:23,25) says that in marriage, the husband is the head of the wife and must love his partner as Christ loves the church. The wife, on the other hand, is to submit herself to her husband in the same way that the Church is subject to Christ. These

verses have been used by Christians to justify the subordination of women in marriages. Nelson (1996) argues that the Catholic Church has played a major role in reinforcing and perpetuating the subordinate position of women in marriage. The major aspects of Catholicism affecting women include a glorification of motherhood and female suffering, personified in the image of the Virgin Mary and an encouragement to accept one's lot on earth in preparation for a better life in heaven.

Apostle Peter (1 Peter 3:7) advises husbands to try to understand the wives they live with, honoring them as physically weaker yet equally heirs with them for the grace of life. This could be interpreted to mean that men and women are equal in the eyes of God (Galatians 3:28). Therefore, stoic behavior is expected of Christian women as guardians of faith, virtue and the moral order and includes amongst other things, the silent endurance of unhappy marriages and financial penury. Women are encouraged to be good wives and above all to be 'good' mothers—"good" in this case meaning the demonstration of self-denial, passivity and resignation. The long-suffering mother, mainstay of the family, is a cultural heroine.

The above discussion has shown a number of ways in which the institution of marriage is a problematic one. Some theorists believe that marriage may be the key to creation and maintenance of gender inequality and the oppression of women and therefore the institution of marriage must be dismantled in order to restructure intimate relationships, especially those between women and men, more humanely and more equally. Engles (1970) believed that a marriage was a central factor in the oppression of women and as a result are not empowered to make decisions about their sexuality.

## 2.8 Summary of Literature Review

The differential power relationship between men and women is a dictate of patriarchy all over the world where the latter remains subordinate to the former. From the discussions above, women lack the ability to initiate, influence and implement decisions of both individual and family concern. This is clearly reflected in all aspects of a woman's life including sexuality, roles and activities, property ownership and decision-making among others.

It is also true that culture is a key determinant of socio-economic trends since they relate to gender relations. Patriarchal culture has influenced structures and value systems that uphold the unequal status of women. From the literature review it can be adduced that the same forces that structure these gender relationships are the same forces responsible for shaping conjugal relationships whether in marital, pre-marital or extra-marital. Retrogressive social norms and cultural practices including marital rape, widow inheritance and 'ndogo ndogo' phenomenon have endeared men as sole champions in sexual matters.

Therefore having seen that sexuality is gendered and women are disempowered to make decisions that affect their own health, it is of paramount importance to study how such women cope in situations like these. Prevention of HIV infection among women is a cardinal intervention, which would ensure the birth of "HIV free" babies and an "AIDS free" generation in Kenya. Unfortunately women are more vulnerable to HIV infection (UNICEF, 1998). It is worse for those women in marital unions



who have been 'left out' by health intervention strategies as they are thought to be safely protected from infection by the virtue of being in those union

The challenge of HIV and AIDS is to recognize the need to address not only what might be called the 'HIV specific' issues, such as HIV education programs and research into new barrier methods to prevent HIV transmission, but also the underlying socio-cultural and economic factors that deprive individuals of the power to protect themselves against HIV infections (Crewe, 2002). HIV prevention programs often need to be tailored to particular groups, which also include women in marital unions. Such strategies are most effective when they take into account the role of gender inequalities in the epidemic and when they help empower such women against a wide variety of cultural and social inequalities that make them more vulnerable than males. For example, in a study in Viet Nam, only 35% of women felt able to refuse their husbands sex, while a UNIFEM study on the impact of HIV/AIDS on communities in Zimbabwe revealed that, even if women were educated about HIV/AIDS, their economic dependence on men left them feeling 'helpless' to negotiate safer sex (UNAIDS, 2002).

A recent analysis of study samples from eight countries in sub-Saharan Africa found that attitudes towards condom use depended on the nature of relationships. In marital and regular relationships, many people said that they did not use condoms because they trusted their partners (UNAIDS, 2002). Culturally and socially men are allowed to have many sexual partners and as a result these preventive measures do not make a lot of impact in HIV preventions in marital unions.

## **2.9 Theoretical Framework**

Theory is an essential feature of sociological inquiry and any empirical study should be grounded on theory (Singleton et al, 1988). Theory helps us to understand and explain our social experience and it also helps to determine ways in which to resolve the problems we uncover. According to Hartsock, (1993), theory gives us a description of the problems we face, provides an analysis of the forces which maintain social life, defines the problems we should concentrate on, and acts a set of criteria for evaluating the strategies we develop. Hartsock (1993) argues that theory not only serves as guide to social change, it can itself become a force for change. Therefore the purpose of this section is to attempt to make a link between theory and the proposed study. The section focuses on three theoretical frameworks: Socialist Feminist Theory, Situational Approach Theory and Health Belief Model.

### **2.9.1 Socialist Feminist Theory**

This theoretical framework seeks to synthesize two major theoretical paradigms, Marxism and radical feminist. Socialist feminists present a radical feminist concern for gender inequality and the oppression of women. They draw from Marxist theory a concern for the economic factor in understanding the oppression of women (Aulette, 1994). Social feminist interprets the origins of women's oppression in the systems of capitalism and patriarchy. Whereas Marxists see the oppression of women as stemming primarily from capitalism, in which women are defined as the property of men and where the accumulation of profit necessitates the exploitation of women's labor, radical feminism analyses patriarchy as the primary cause of women's oppression and trace it to patriarchal control of female sexuality and to male domination in social institutions (Ritzer, 1992; Andersen, 1997).

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In an attempt to analyze these two perspectives the feminism theory combined them as capitalist patriarch by recognizing that capitalism is a patriarchal system of social organization.

The purpose of feminist theory is to help us understand the conditions in society and to envision the possibilities for bringing liberating social changes. Feminist theory is responsible for guiding some of the basic transformations in women and men's lives in recent years. It is the social and political thought that is behind much of feminist politics and forms the basis for social policies and social action that have driven change in society.

Feminism takes women's interest and perspectives seriously, believing that women are not inferior to men. Although feminists do not believe that women should be like men, they do believe that women's experiences, concerns and ideas are as valuable as those of men and should be treated with equal seriousness and respect.

In sub-Saharan Africa, male privilege and lack of advancement for women are basic to the society. Material, political and every other advantage that men have over women are made possible by a system of beliefs involving the notion that men are superior to women in the ideology of male superiority which is linked to, and is a product of patriarchy (Eisenstein, 1979). Socialist feminist theory argues that the predominance of men in decision-making is a major cause of gender inequalities, in all sectors and the premise that women's and men's positions in society are the result of social not natural or biological factors.

Patriarchy, by excluding the majority from decision-making, access to and control of resources goes against natural justice, is undemocratic and retards human development. Feminists note that there can be no sustainable development when women who constitute over half of the population of Africa have no opportunity to uphold their potential, when development programmes are gender unfriendly, when decisions about changing the lives of people are taken without the participation of half of the very lives that have to be changed.

For the purpose of this study, this theory will be used to explain the historical origin of women's oppression and individual and social cultural factors which are detrimental to women's health. The theory will also be used to examine sexuality in the context of gender relationships and show extend to which structured power relationships influence experiences of all groups of women and men.

### **2.9.2 Health Belief Model**

The Health Belief Model (HBM) was first advanced by Kals and Cobb (1966), and expounded on by Rosenstock (1966, 1974) and Kirscht (1974). The HBM is a psychological model that attempts to explain and predict health behaviors by focusing on the attitudes and beliefs of individuals. The HBM has been adapted to explore a variety of long and short-term health behaviors including sexual risk behaviors and the transmission of HIV/AIDS.

The main components of HBM include:

- (i) Perceived susceptibility i.e. one's subjective perception of the risk of contracting a health condition.
- (ii) Perceived severity: Feelings concerning the seriousness of contracting an illness or of leaving it untreated (including evaluations of both medical and clinical consequences and possible social consequences).
- (iii) Perceived barriers: The potential negative consequences including, physical, psychological and financial demands.

The determinants of the HBM are socially and culturally determined. The model maintains that the choice of a treatment or preventive action depends on the perceived probability of success of such an action. For instance, the perceived socio-economic costs of an action may prevent or facilitate the adoption of some disease control measures. More recently, though, researchers are suggesting that an individual perceived ability to successfully carry out a "health" strategy, such as using a condom consistently, greatly influences his/her decision and ability to enact and sustain a changed behavior (Bandura, 1989). The model enables one to understand perceptions surrounding choices of HIV prevention options. Similarly, the model can suitably be applied to households, which are units of analysis in this study.

### **2.9.3. The Situational Approach Theory**

Thomas and Znaniecki (1974) used the terms "situational approach" and "behavioral approach" almost interchangeably when propounding this theory. The basic arguments in the theory, which are of interest to this study, are:

- i). The idea of crisis.

- ii). The definition of the situation; socialization and attitudes.
- iii). The concept of social disorganization

The Situational Theory holds that human behavior occurs only under certain conditions. It further holds that there is nothing to define when people act as anticipated, but that when new influences appear to disrupt existing habits, and new stimuli demand attention, then the habitual situation is altered. When a group is unprepared for an experience (for example, deaths arising from a disease) then the phenomena assumes the aspect of “crisis” where a crisis is seen as a threat, a challenge, a strain on attention, a call to new action.

What may however, appear as a “crisis” to the observer may go unnoticed by the participants. The appearance of a new disease hitherto unknown to the people is likely to present itself as a “crisis” as the people have to find new ways of dealing with the disease. In this theory, “Crisis” is seen as the most significant of human experiences affecting the definition of individuals and groups, their behavior and finally influencing the content of culture and personality as well as direction of social change (Thomas et al 1974).

On the event of “crisis” (for example a disease) the decision to seek medical attention and who to consult may well depend on this perceived “crisis” so is the acceptance or failure to accept control measures. One major argument in the situation approach theory is that the behavior is situationally determined. The human situation and definition of the situation is seen to depend on Biological, psychological social, economic and cultural factors which singly or collectively determine subsequent behavior. Other factors like physical

environment, the relevant social norms and the behavior of others are also included.

Thomas et al ((1974) argue that attitudes can and actually are affected by our definition of the situation, where attitudes are seen as part of subjective behavior. In relation to disease, a certain culture may demand consultation with a medicine man. However, overtime, people may realize that the medicine man cannot cure the disease but the hospital can. This realization may lead to a redefinition of the situation such that if the same disease is suspected the sick person is taken to hospital for treatment. Thus, previous experiences can lead people to form certain constellations of attitudes as the situation demands. Similarly, in cases where faithfulness in married unions is elusive, there is need for redefinition of the situation to avoid HIV infection either by using condoms or abstaining from having sex with ones partner.

The acceptance and change of attitudes is not necessarily smooth. Whenever there are conflicting definitions of the situation (for example, how to protect one-self from contracting a disease) social disorganization takes place (where the concept means a decrease of influence of existing social rules of behavior upon the individual members of a group). Whenever there is perceived disorganization, the need for reorganization occurs and new definition of the situation may be accepted.

The situational approach theory sees human behavior as adjustable and human beings as always attempting to come to terms with or adjust to the situations in which they find themselves. In a situation where people find themselves confronted with a disease, the action they take to protect



themselves against the disease do not necessarily seem to come from the known scientific aspects of the disease.

The relevance of this theory to this study is that if women over time realize that being in marital unions is not guaranteed protection from HIV infection, then will form certain attitudes towards protecting themselves as the situation may demand. This may result in social disorganization that will eventually lead to reorganization of human socio-culture. This theory predicts that social-cultural factors, which inhibit women from protecting themselves from HIV infection, will be addressed.

## **2.10 Hypotheses**

A hypothesis is a conjectural statement of the relationship between two or more variables (Kerlinger, 1956). He premises that hypotheses are always in a declarative form and relate either generally or specifically one variable to another. The following hypotheses will be tested in this study:

1. A woman's personal characteristics influence her use of safer sex practices.
2. A woman's perception of her vulnerability to HIV/AIDS influences her use of safer sex practices.
3. Decision-making capacity of a woman about her reproductive health influences her use of safer sex practices.

## 2.11 Operational Definition of terms /Variables

The under listed variable/terms are used in this study in the sense in which they are defined.

### **Knowledge of HIV/AIDS:**

It is the level of awareness about HIV/AIDS. This awareness includes knowledge on transmission, prevention, treatment, testing and management of HIV/AIDS. The indicators for this variable also include other sexually transmitted infections and how they are transmitted and can be prevented. Indicators for sexually transmitted diseases included knowledge of these diseases (diagnosed), where treatment was sought and cost of treatment.

### **Safer sex practices:**

Is any sexual activity, which reduces the risk of transmission of HIV infection and other STDs. It therefore means having vaginal or anal sex using condom. Other forms of non-penetrative sexual activities including mutual masturbation, thigh sex, stroking, and massage and kissing are also considered safer sex practices. It also means 'saying no' and having sex that is pleasurable for both partners without risk of unwanted pregnancies and without pressure or abuse.

This variable is measured by the number of women in heterosexual marital unions able to use the following methods to avoid HIV/AIDS infection from their partners;

- (i) Condom use
- (ii) Abstinence

- (iii) Withdrawal
- (iv) Mutual Masturbation
- (v) Leaving risky relationships

### **Personal Characteristics:**

Personal characteristics of individual women include age, level of education number of children, length of marriage, independent source of income, partner's age, education, type of heterosexual union and occupation. This variable is used to measure whether these characteristics have an impact/influence on safer practices. For example, does a woman's level of education, income or religion influence her use of safer sex practices.

(a) **Age:** This was measured in terms of number of years lived and was categorized as; young ( $\leq 24$ ), middle aged (25-34), and older ( $>35$ )

(b) **Level of education:** This refers to the level of formal education attained by the respondent .It was measured by actual number of years one has spent in school. This was categorized as follows; 1) none 2) Primary education 3) Secondary 4) University/college.

(c) **Occupation:** This refers to the position the respondent held and was measured by different activities undertaken. It was categorized into the following; 1) Formal employment 2) Informal employment 3) Self – employment 4) Housewife.

(d) **Level of income:** It was measured in terms of monthly monetary earnings of the respondents and was categorized as 1) low income of less than ksh. 3999.

2) Medium income of between ksh.4000-6999

3) High income of more than ksh.7000.

(e) **Religion:** This refers to belief in existence of supernatural power. This was measured by asking the respondents the religious denominations she belonged to. It had the following categories; 1) Catholics 2) Protestant 3) Other religions (including Muslim and African Religions).

(f) **Size of the family:** This referred to the number of children the respondents had and it was categorized as follows: small family size of less than 2 children, medium family size of between 3-4 children and a large family size of more than 5 children.

(g) **Type of heterosexual marital union:** This refers to a married or cohabiting male and female couple that is assumed to have a normal sexual relationship. This was measured by asking the respondents the type of unions they were in. It was categorized into the following:

1) Traditional monogamous

2) Traditional polygamous

3) religious monogamous

4) Consensual union

**Decision-making Capacity:** As utilized in the study, it refers to the ability to initiate, influence and implement independent and constructive decisions on issues related to individual reproductive health with minimal hindrances.

This variable is measured by women's ability to be independent minded, assertive and ability to independently choose and plan their sexual lives.

This variable focus on woman's ability to:

- 1) Decide to use contraceptives without partner's consent.
- 2) Decide the number of children she wants to have.
- 3) Refuse to have unsafe sex with partner.
- 4) Introduce condom use to avoid HIV and other sexually transmitted infections.
- 5) Seek treatment in case of infection.
- 6) Leave risk relationship.
- 7) Go for HIV test.
- 8) Decision not to have sex when tired or not in the mood/refuse forced sex.
- 9) Initiate sex.

The above factors were categorized in terms of 1) Yes and 2) No

## CHAPTER THREE

### RESEARCH DESIGN AND METHODOLOGY

#### 3.1 Introduction

This chapter deals with the description of the study area in terms of the location and population. It also describes the sampling techniques that were used to identify and select the respondents from the whole population. Description of techniques used in gathering data and their analysis is also given in addition to the presentation of the problems encountered while gathering data.

#### 3.2 Research Site Description

This study was conducted in both the informal and formal settlement of Kibera Division of the Nairobi city. Kibera Division is located to the South West of the city, approximately seven kilometers from the center. The Kibera population was estimated to be 281,558 in 1999 population census. Where we have an informal settlement the houses are constructed of mud and wattle and roofed with corrugated sheets. The houses are built in rows and subdivided into rooms measuring 3 square meters and further subdivided by curtain to provide privacy.

Kibera division is divided into seven locations each administered by a chief. These locations are Kibera, Laini Saba, Langata, Karen, Mugumoini,

Nairobi West and Sera Ngombe. These locations are subdivided into 16 sub-locations and further into several villages, which are the smallest administrative units.

FIG I

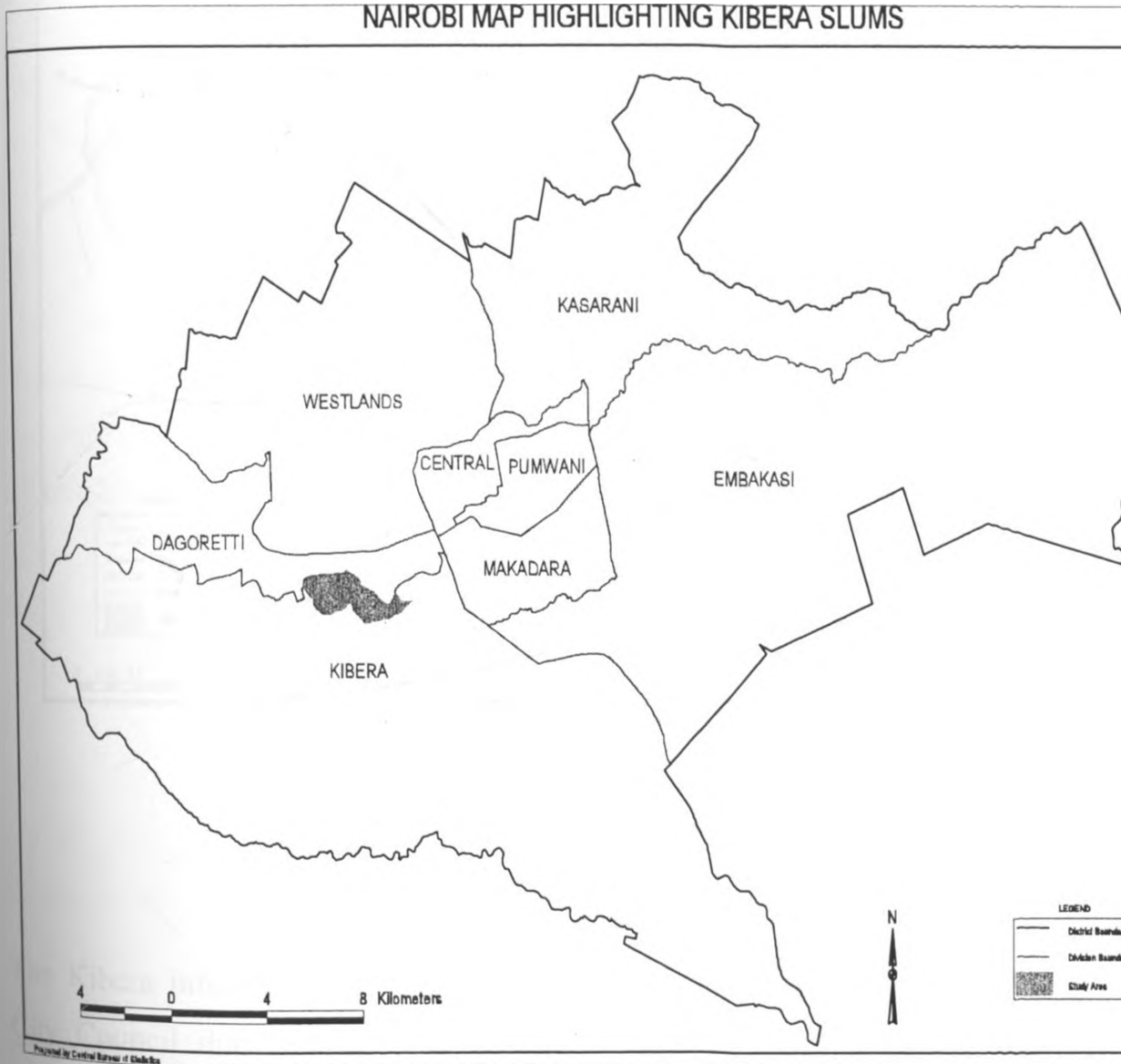
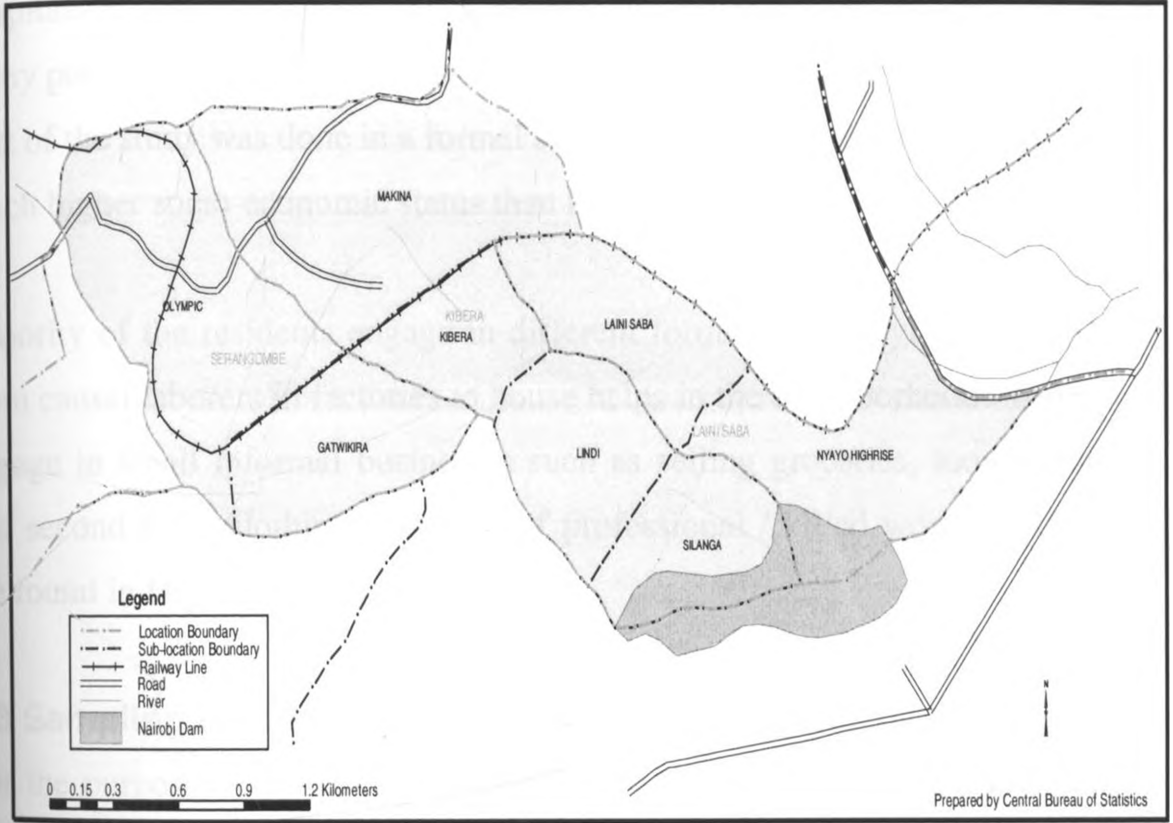


Fig.2

MAP OF KIBERA STUDY AREA



The Kibera informal settlement occupies government land. The Nairobi City Council does not provide services to the settlement. Water for example, is bought from kiosks, run by women. There are almost no sanitary services and those few pit latrines available are in deplorable conditions



because several households share them. Where these are not available people relieve themselves in polythene papers and throw them away nearby (flying toilets). Electricity is found in a few areas and most households use lantern lamps to light their houses. Private practitioners, NGOs and churches run health services. The city council clinics and government hospitals are in areas adjacent to Kibera and provide medical services to many people of Kibera.

Part of the study was done in a formal settlement village (Highrise) with a much higher socio-economic status than the rest.

Majority of the residents engage in different forms of employment ranging from casual laborers in factories to house helps in the neighborhood. Others engage in small informal businesses such as selling groceries, food kiosks and second hand clothing. Majority of professional / skilled workers (18%) are found in Highrise village.

### **3.3 Sampling Procedure and Sample Size**

For the purpose of collecting information with acceptable accuracy within the limited resources, time and finances, Kibera was selected purposively. Kibera is made up of seven locations and two of these were selected purposively. These locations are Laini Saba and Kibera with 18,645 and 28,479 households, respectively (CBS, 1999). These two locations happen to be very populous and typical of informal settlements. The two locations were selected due to their natural heterogeneity of people from various backgrounds. Since all the groups in Kibera are found in these two locations, the study sample was quite representative. There are six sub-locations in these two locations. From each location, one sub-location was sampled

randomly using the lottery technique. The randomly sampled sub-locations were Highrise and Kibera in Laini Saba and Kibera locations, respectively. From these two sub-locations, two villages were randomly selected from each sub-location. These were Kibera, Highrise, Kambi Muru and Silanga. Table 3.1 shows the sampled villages, number of households and the number of sampled units in each.

**Table 3.1 Population by number of households and sampled units**

Sampled Villages	No.of Households	No. of Sampled units
Kambi Muru	87	21
Kibera Village	93	23
Highrise Village	85	21
Silanga Village	143	35
<b>Total Sample</b>	<b>408</b>	<b>100</b>

Village elders were critical in providing for sampling frame by listing households in each of the villages. The study sample consisted of 100 respondents drawn from households in the four villages. In sampling households, each village was considered separately and households drawn proportionately from each sampled village. This means that the households were proportionately distributed to ensure that a sample of households proportionate to those in the village was selected. For example, Kibera village which had 93 households had 23 selected; Highrise which had 85 households had 21 selected. Kambi Muru had 21 selected out of 87 households while Silanga village with 143 households had 35 selected.

After distributing the households proportionately systematic random sampling was used to select the households from every village. This method consists of selecting every  $K^{\text{th}}$  case from a complete list of population (households) starting with a randomly chosen case. The units of analysis or rather the entities under study were women in heterosexual marital unions.

### **3.4 Techniques of Data Collection**

This study mainly relied on primary data and employed two different data collection methods. These were structured interviews, key and Focus Group Discussions (FGDs). These methods produced both qualitative and quantitative data.

### **3.5 Structured Interviews**

Interview schedule or questionnaire was the major tool for data collection in this study. This method of collecting data involves presentation of oral-verbal stimuli and reply in terms of oral-verbal responses. It requires that the interviewer has to collect the information personally from the sources concerned. He/she has to be on the spot and has to meet people from whom data have to be collected. This method of data collection was found to be viable due to the following;

- (i) More information and that too in greater depth can be obtained
- (ii) Interviewer by his own skill can overcome resistance, if any, of the respondents; the interview method can be made to yield an almost perfect sample of the general population
- (iii) Samples can be controlled more effectively as there arises no difficulty of the missing returns; non-response generally remains very low.

(iv) The interviewer can collect supplementary information about the respondents' personal characteristics and environment which is often of great value in interpreting results.

(v) The language of the interview can be adopted to the ability or educational level of the person interviewed and as such misinterpretations concerning questions can be avoided.

(vi) Personal information can as well be obtained easily under this method.

However, there are certain weaknesses of the interview method as mentioned below;

(i) It is a very expensive method, especially when large and widely spread geographical sample is taken.

(ii) Effective interview presupposes proper rapport with respondents that would facilitate free and frank responses. This is often a very difficult requirement.

(iii) There remains the possibility of the bias of the interviewer as well as that of the respondent; there also remains the headache of supervision and control of interviewers.

(iv) This method is relatively more time consuming, especially when the sample is large and re-calls upon the respondents are necessary.

(v) Interviewing at times may also introduce systematic errors.

Appropriate measures were taken to guard against the above weaknesses, viz; (a) the researcher took it upon herself to carry out all the interviews. With her experience she was able to develop rapport and therefore minimize some systematic errors.

(b) Every effort was made to create friendly atmosphere of trust and confidence, so that respondents felt at ease while talking to and discussing with the interviewer.

(c) The sample size was reasonably small (100 respondents) and easy to manage with technical competence. More so, data collection was not rushed but given ample time since the topic was a sensitive one.

After formulating the questions a pre-test in the field was done to assess and determine the suitability of the questionnaire and nature of responses. The questionnaire contained both open and close-ended questions in which case, the former are useful in that respondents are able to express their opinions and elicit spontaneous information. Pre-coded or closed ended questions, on the other hand, simplify both the process of recording down responses and data analysis. The information sought through the questionnaire included respondents personal characteristics, perception of HIV/AIDS, decision making capacity and safer sex practices.

The interview method of data collection was of great importance in that it directly addressed itself to the units of analysis. It was advantageous because certain aspects in the questionnaire required further explanation from the researcher. The researcher did the interviewing while an assistant from CBS was useful in identifying the clusters (villages) at the research site.

### **3.6 Focus Group Discussions**

Three Focus Group Discussions were held to collect qualitative data. Though each village of study was scheduled to hold one FGD, it was not possible to do so in one of the villages (this is explained below). The FGDs were composed of women in heterosexual unions only and the number of participants ranged from 10 to 12. Three FGDs were held in Kibera (10 participants), Kambi Muru (10 participants) and Silanga (12 participants): The

researcher with the help of research assistants carefully selected women who shared similar backgrounds like age, income, education among other characteristics. These women talked about their reproductive health including risk perception of HIV/AIDS, HIV testing and decision making in their homes. A schedule of discussion topics was used to guide these discussions.

FGDs were useful in providing specific insights into the issues further investigated through interview schedules. The information generated through this method of data collection was partly qualitative and could not be relied upon at the exclusion of other methods.

To supplement primary data, secondary data were collected from both published and unpublished materials were useful as secondary data and provided background information on the subject under study. The main source of this data were libraries in the Central Bureau of Statistics (CBS), RATN Resource Center (University of Nairobi Medical School), NACC, NASCOP, Departmental Library-Sociology at the University of Nairobi and media, especially newspapers, provided updated statistical information on the subject.

### **3.7 Limitations of the study**

Although this study adhered to scientific standards, my sample of 100 households out of 408 in the four villages was on the lower side. Probably if the sample was larger, more accurate data would have been generated.

A few of the respondents especially in Highrise village refused to be interviewed and argued that they had to get consent from their partners.

Others took a lot of time in rapport development as they treated the study with suspicion. A few just refused to be interviewed. In such cases systematic sampling was shelved as households were selected haphazardly. This was an error in sampling and may have affected the entire process of data collection.

During focus group discussions, some women gave their views on how to avoid HIV infection including being assertive. They claimed that once they knew their spouses' were unfaithful they would leave them. It is possible this may not happen but these women only wanted to be seen to be 'tough'. Other members of the group shied away from discussing this 'sensitive issue' and did not contribute in the discussions thereby withholding their opinions and hence denying this research important data.

In Highrise village, Focus Group Discussions was not held as per the schedule. It was virtually impossible to gather women here in a group. Residents in this cluster did not know their immediate door neighbors, do not talk to each other, and there is some kind of hostilities among some neighbors. This hampered group discussions as women here live individualized lives and do not trust each other. This may have affected the quality of the data as their input was important.

In one of the clusters majority of women were in formal employment and it was only possible to interview them on weekend afternoons. This compelled the study to be extended beyond schedule time.

However, in spite of all these shortcomings, the data collection exercise was a success and achieved maximum results.

### **3.8 Methods of Data Analysis**

Data analysis is the process of interpreting the survey data and helps in determining the statistical or descriptive relationship and explanations between hypothesized variables. In this study both descriptive and inferential statistics were used depending on the characteristics of variables and their levels of measurements.

#### **3.8.1 Descriptive Statistics**

This is a way of organizing and summarizing data such that they can be meaningfully understood and communicated. Descriptive statistics describe data in terms of measures as averages, levels, percentages, measures of central tendency e.g. mean, measures of dispersion e.g. standard deviation and measures of relations and association. In this study, various levels of measurements were adopted viz, nominal and ordinal levels. Nominal scales are arbitrary assigned to categories and serve merely as labels or names. Ordinal level of measurements was used in determining whether typical relations are “higher”, “greater”, “more greater” or “more difficult”, ordinal scale was rarely used in this study. Ratio scale was used especially in determining differences between respondents’ levels of income, number of children or number of years in marital unions.

The most used descriptive statistics in this study are the mean, the mode, percentages and the standard deviation. In particular, percentages have been greatly used in data interpretations. Multiplying each relative frequency by 100 created these percentages. By calculating percentages, the researcher was able to ‘standardize’ for sample size by indicating the number of



observations that would fall in each outcome of a variable tested if the total number of cases were 100.

### **3.8.2 Inferential Statistics**

Data analysis also involves the process of drawing conclusions about a population based upon observations of sample. It provides the method to be used for making inferences about a large group on the basis of small group findings. The inferential statistics tools that are used in this study include: -

(i) Cross-tabulations and (iii) Measures of association.

#### **(a) Cross-tabulation**

This is a systematic arrangement of statistical data in columns and rows. Under it, we classify each variable into two or more categories and then cross classify the variables in these sub-categories. We then look for interactions between them which may be symmetrical, reciprocal or asymmetrical. The data is presented in a logical sequence giving the shape of statistical tables which are useful in answering the questions of the problem under investigation. Cross- tabulation as a statistic of analysis prepares the ground for analysis and interpretation of the data. It has the ability to enable the reader to easily identify the patterns of association between the cross tabulated variables. Cross- tabulations in this study are used to determine whether an association exists between; 1.safer sex practice and personal characteristics 2.safer sex practice and risk perception 3. Safer sex practice and knowledge of HIV/AIDS.

## **CHAPTER FOUR**

### **DATA PRESENTATION**

#### **4.1 Introduction**

This Chapter presents the findings of the study and presentation and analysis of data will be done by using descriptive statistical methods. Frequencies, percentages and simple elaborative tables will be used in presentation of these findings. The first part of this presentation gives the background information detailing the characteristics of the respondents. The second part deals with levels of knowledge and risk perception of HIV/AIDS among respondents. The third and fourth parts deal with safer sex practices and decision- making among the respondents.

#### **4.2 Background characteristics of Respondents**

The data were collected from 100 respondents, all women in heterosexual marital unions. These respondents were drawn from four villages in Kibera viz, Kibera, Highrise, Kambi ya Muru and Silanga. To measure personal characteristics of the respondents, data on several subsidiary variables namely, age, income, level of education, religious affiliation, length of relationship and number of children, was collected. It is important to attempt to see whether these characteristics have any profound influence on use of safer sex practices.

##### **4.2.1 Age**

The age of respondents ranged from 20 to 48 years; with a mean age of 35 years and standard deviation of 6.1 years. The median was 32 years. Table

4.1 presents the distribution of the respondents by age category. As evident from the table, 96% of them were aged between 20 – 40 years which was considered childbearing age. Majority of the respondents (54%) aged between 25-34 were considered middle aged, 26% were young, while 30% aged 35+ years were considered older.

**Table 4.1: Distribution of Respondents by Age**

<b>Age in Years</b>	<b>Frequency</b>	<b>%</b>
20-24	16	16.0
25-29	26	26.0
30-34	28	28.0
35-39	19	19.0
40-44	8	8.0
45-49	3	3.0
<b>TOTAL</b>	<b>100</b>	<b>100.0</b>

#### **4.2.2 Level of Education**

Majority of the respondents had formal education and only 7% did not have any formal education. Table 4.2 shows that 53% of the respondents had acquired upper Primary education while 31% had secondary education and college graduates represented 9% of the study sample.

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**Table 4.2: Distribution of Respondents by Level of Education**

<b>Education Level</b>	<b>Frequency</b>	<b>%</b>
None/Adult literacy	7	7.0
Primary Education	53	53.0
Secondary	31	31.0
University	9	9.0
<b>Total</b>	<b>100</b>	<b>100</b>

### **4.2.3 Religious Affiliation**

This study found that majority of the respondents (64%) were Protestants followed by Catholics comprising 28%. Therefore, Protestantism and Catholicism were the major religious denominations among the population. The remaining 8% comprised of those belonging to other religions including Islam and African religions.

### **4.2.4 Respondents' Occupational Statuses**

Majority of the women interviewed were housewives who did not have their own independent income and were entirely dependent on their partners. This group represented 64% of the respondents whilst 18% represented professional/skilled women. Both skilled and unskilled represented 16% of the respondents. Majority of the professionals/skilled respondents were university/college graduates. Table 4.3 shows this distribution.

**Table 4.3: Distribution of Respondents by Occupational Statuses**

Occupation	Number	%
Professional/skilled	18	18.0
Skilled/semi-skilled	16	9.0
Housewife	64	64.0
Others	2	2.0
<b>Total</b>	<b>100</b>	<b>100%</b>

#### 4.2.5 Level of Income

From the total number of 100 respondents 18% had monthly income of less than ksh.5, 000. Another 11% earned over Ksh.10, 000 and these were found among the professionals and skilled. Majority of the respondents (63%) did not have income of their own. The table 4.4 presents detailed income distribution for the study sample.

**Table 4.4: Distribution of the Respondents by Levels of Income**

Income in Kshs.	Number	%
None	63	64.0
Less than 5,000	18	18.0
5,000 – 10,000	8	8.0
Over 10,000	11	11.0
<b>Total</b>	<b>100</b>	<b>100.0</b>

Based on the table 63% of the respondents had no income of their own. This could be explained by the fact that 52% of the respondents had only primary education and 5% did not have any formal education thereby contributing to their economic disempowerment. For the purpose of this study, those who earned less than ksh.5,000 (18%) were categorized as low income earners; those who earned between ksh.5,000 and ksh.10, 000 as medium income earners while those who earned over ksh.10, 000 were high income earners.

#### **4.2.6 Type of Heterosexual Union**

When asked whether they considered themselves married, 84% of the interviewees responded yes while 13%, though in heterosexual relations, did not consider themselves married. These were in loose consensual unions which hardly had any future plans for stabilization. Those who were in traditional monogamous union represented 48%, while 26% were in consensual unions and 13% in traditional polygamous marriage. Those in religious monogamous marriage represented 13%. Findings also showed that majority of those in polygamous unions had their co-wives staying upcountry. Again, 50% of those in consensual unions were 'second wives'; their partners had legal wives and chances of formalizing their unions were almost nil. The range of period of relationships for the study sample was between one and half and 30 years, with a mean of 9.15 years and standard deviation

of 6.46. The median period was 7 years.

**Table 4.5: Distribution of Respondents by type of Heterosexual Marital Union**

Type of union	Number	%
Tradition monogamous	48	48.0
Traditional polygamous	13	13.0
Religious monogamous	13	13.0
Consensual union	26	26.0
<b>Total</b>	<b>100</b>	<b>100.0</b>

#### **4.2.7 Family Sizes**

The number of children in marital unions ranged from 0 to 8 with 3% of respondents saying they did not have children. Majority of the respondents who had between 1 and 2 children represented 46% and were considered to have a small family while 34% had a medium family size of between 3-4 children. Respondents with between 5-8 children were considered to have large families and represented 17% of the study sample. Table 4.6 presents the distribution of the respondents by family sizes.



**Table 4.6: Distribution of Respondents according to their family sizes**

<b>Family size (children)</b>	<b>Number of Respondents</b>	<b>%</b>
<b>0-2</b>	49	49.0
<b>3-4</b>	34	34.0
<b>5-8</b>	17	17.0
<b>Total</b>	<b>100</b>	<b>100.0</b>

### **4.3 Knowledge of HIV/AIDS**

According to Oskamp and Thompson (1996), information that is relevant to HIV/AIDS transmission and prevention is an initial prerequisite of HIV/AIDS prevention behavior. They argue that to promote the initiation and maintenance of HIV/AIDS preventive behavior one should increase the levels of these factors. Therefore it was important to assess knowledge related to HIV/AIDS transmission and prevention.

#### **4.3.1 Source of Information about HIV/AIDS**

When respondents were asked if they ever heard about HIV/AIDS, all of them responded in the affirmative. Table 4.7 presents the distribution of respondents by source of information about HIV/AIDS. As evident from the table, radio was cited as the most common mode of transmission of HIV/AIDS information among the respondents; it was cited by 76% of the interviewees. While 51% of the respondents said that their source of information was through their friends or relatives, 41% indicated that that they received information from health workers. Newspapers/magazines emerged to be the least popular source of information with only 20% of the respondents saying that they received information from it.

**Table 4.7 Source of Information About HIV/AIDS**

Source	Frequency	Percent
Radio	76	76.0
Television	23	23.0
Newspaper/Magazine	20	20.0
Health Workers	41	41.0
Friends/Relatives	51	51.0
Churches/Mosques	32	32.0

Note: Do not add to 100%; respondents gave more than one source.

The above findings are in agreement with KDHS (1998) that more than 98% of Kenyans are aware of dangers posed by HIV/AIDS. Since knowledge is expected to enable people make responsible choices that would guard against HIV/AIDS infection, there was an attempt to establish the association between this knowledge and safer sex practices.

#### 4.3.2 Modes of Transmission of HIV/AIDS

The study also sought to establish the respondents' knowledge about HIV/AIDS transmission. The results showed that, overall, all respondents were aware of at least one method of transmission. Majority of the respondents (76%) said that transmission was through unprotected sex, 36% said it was through blood transfusion and only 1% said through mosquito bites. Table 4.8 synthesizes the various modes of HIV/AIDS transmission identified by the respondents. As evident from the table, other well supported modes of transmission included blood transfusion (36%), sex with multiple partners (27%), mother to child transmission and

**Table 4.8 Distribution of Respondents by knowledge of Transmission of HIV/AIDS**

<b>Transmission</b>	<b>Frequency No.</b>	<b>Percent</b>
Unprotected sex	76	76.0
Blood transfusion	36	36.0
Sex with multiple partners	27	27.0
Mother to child	22	22.0
Sex with prostitutes	3	3.0
Through kissing	5	5.0
Mosquito bites	1	1.0
Others	15	34.0

Note: Do not add to 100%; respondents identified more than one mode of transmission.

#### **4.3.3. Cure for HIV/AIDS**

When asked whether HIV/AIDS has any known cure majority (95%) indicated that it has no cure; 3% reported that it had a cure while 2% did not know.

#### **4.3.4 Anti-retroviral Drugs**

Concerning HIV/AIDS medicines, the results showed that 75% of the respondents had heard about HIV/AIDS medicines while 21% had not heard about them. However, specific knowledge about these medicines was lacking. As evident from table 4.9, only 20% of the respondents mentioned

anti-retroviral as HIV/AIDS drugs while 72% did not know any specific HIV/AIDS drugs. A few mentioned anti-diarrheas, herbs/immune boosters, and antibiotics as HIV/AIDS medicine. This suggests that knowledge on HIV/AIDS drugs was low among the respondents.

**Table 4.9 Distribution of Respondents by Specific Knowledge of HIV/AIDS Medicines**

<b>Types of medicines</b>	<b>Number</b>	<b>%</b>
Herbs/immune boosters	2	2.0
Antibiotics	2	2.0
Anti-diarrheas	1	1.0
Anti-retroviral	20	20.0
Do not know	72	72.0
Others	3	3.0
<b>Total</b>	<b>100</b>	<b>100.0</b>

In terms of information on where to get ARVs, the study found that this was lacking among the majority of the respondents as only 33% mentioned valid places (at hospitals/doctor). Based on Table 4.10, 41% did not have an idea where one could get them; two respondents went as far as saying that one could get ARVs from the market place. The subsidiary variable on level of information was categorized as >30%-low, between 30%-70% as medium and 71% as high. Conclusively, the level of information among the respondents is medium. The table below shows distribution of respondents according to their awareness of where one can get ARVs.

**Table 4.10 Respondents' level of Awareness of Where to Get ARVs**

<b>Where to get ARVs</b>	<b>Number</b>	<b>%</b>
Doc./hospital	33	33.0
Market place	2	2.0
Do not know	40	40.0
Other places	25	25.0
<b>Total</b>	<b>100</b>	<b>100.0</b>

### **4.3.5 Knowledge on how to Avoid Infection**

Majority of the respondents (58%) when asked how they could avoid getting HIV/AIDS said it was by remaining faithful to one partner while 45% said it was by using condoms. This question had multiple responses and each respondent mentioned at least two ways of avoiding infection. Table 4.11 shows that another 28% of the respondents said that avoiding multiple partners was another method of preventing infection while 20% listed abstaining from sex as a method for curtailing infection. Other methods given by respondents were avoiding sex with prostitutes (3%) and avoiding sex with homosexuals (2%).

**Table 4.11: Distribution of Respondents by Method of Avoiding Infection with HIV/AIDS**

Avoid getting AIDS	Frequency	%
Be faithful to one partner	58	58.0
Used condom	45	45.0
Avoid multiple partners	28	28.0
Abstained from sex	20	20.0
Avoid sex with prostitutes	3	3.0
Avoid sex with homosexuals	2	2.0
Others	7	7.0

Note: Do not total to 100%; respondents listed more than one.

#### 4.4 Perceptions About Risk of HIV/AIDS Infection

This study sought to establish whether women felt at risk of HIV/AIDS infection in their heterosexual unions. Perception of personal vulnerability to HIV/AIDS is a critical prerequisite for HIV/AIDS prevention. Responses to this question revealed that 37% of the respondents felt at risk of contracting HIV/AIDS. They cited several reasons as to why they felt at risk including their partners' having other sexual partners other than themselves. Majority of the respondents (63%) felt that they were safe from contracting any STIs including HIV/AIDS. However, 33% said they were certain their partners were cheating on them. Of the 37 respondents who said that they were at risk of contracting HIV/AIDS in their marital union, 40.6% felt the chances were great, 21.6% said the chances were moderate and 37.8% said the chances were small.

#### 4.4.1 Suspicion of Partners

To further probe their heterosexual relationships, the respondents were asked whether they suspected their partners of having sexual partners other than themselves in the recent past. If responses to these questions were yes, the participants were further asked how they manage the risk of HIV/AIDS infection from their partners. The results revealed that 33% of the respondents had suspected their partners and that less than half of these (45.5%) were certain that their partners had other sexual partners. Reasons for suspicion ranged from partners being alcoholic, coming home late, not being interested in sex with respondents to partners being caught red-handed cheating.

It is important at this stage to note that the researcher will be focusing more on respondents who had suspected their partners (33%) of having other sexual partners. Asked about what they did about their partners conduct, 51.4% of the 33 respondents who suspected their partners said that they discussed the issue of infidelity with their partners and some have since changed their sexual behaviors. Whereas 24.2% said that had done nothing 15.2% reported that they used a condom. As evident from Table 4.12, the remaining 9.1% of these indicated that they were abstaining from sex as sorted out the issue with their partners.

**Table 4.12 Distribution of the Respondents by Action Taken**

Action taken	Number	%
Discussed with partner	17	51.5%
Did nothing	8	24.2%
Used condom	5	15.2%
Abstained	3	9.1%
<b>Total</b>	<b>33</b>	<b>100.0</b>

#### 4.4.2 Sexually Transmitted Infections

This was a subsidiary variable used to measure risk perception and is an indicator of a possibility of HIV infection. Studies have demonstrated that where STIs rates are high, accompanying sores and ulcers facilitate transmission of HIV/AIDS (Kesby, 2000). The respondents were asked whether they ever contracted any sexually infectious diseases. Only seven (7%) said they did. Of these, three reported having suffered from syphilis while four suffered from gonorrhoea. Asked how they knew they were infected 4 of the seven respondents said they were diagnosed in Government health institution while the other 3 said they were diagnosed in private clinics. Responses on how they got infected showed that their regular partners infected 71.4 % of these respondents while the remaining 28.6% had been infected by casual partners. The findings show that the latter respondents were all in consensual relationships and had more than one partner at the time they got infected. For example, respondent E, 39, a mother of five (5) said that other than her regular partner she had another sexual partner purely for monetary benefits.



The results showed that 71.4% of those who contracted STIs informed their partners. Of this number 28.6% did so because they thought that their partners infected them while 42.9% informed them so that they could seek treatment together. The 28.6% of those who had been infected by casual partners revealed that they did not inform these partners about the infection because the sexual encounters were for only one night.

The data further showed that respondents' partners reacted differently when informed about the former's status. Whereas some of them got annoyed, others accused the respondents of unfaithfulness or simply refused to talk about it.

#### **4.5 Safe sex Practices Among by Key Informant**

Safer sex practice is the dependent variable and is measured by sexual practices, which reduce the risk of transmission of HIV/AIDS. Respondents were asked how risky sexual activities could be made safer. With some respondents offering more than one suggestion, 78% reported use of condom as one way of making high- risk activities safer, 43% identified being faithful to one partner and 7% suggested abstinence as a method for minimizing infection. Table 4.13 explains this narration.

**Table 4.13 Distribution of Respondents by Knowledge of Safe Sex**

**Practices**

Activities made safer	Frequency %
Using Condom	78.0
Faithful to one partner	43.0
Abstinence	7.0
Other	3.0

However, this knowledge on safer sex practices does not always translate into practical safer practices as evidenced by the following narration: Judy, 29, could not ask her partner to use a condom for fear of being beaten. In her own words;

“Women have no say in matters concerning their health and well being of their families, they have no power (*pumzi*) to talk and coil themselves at a corner in the house afraid of speaking to their spouses. How can I ask him to use a condom – ‘*hata wewe utaenda wapi na hawa watoto, si utakubali tu*’ - it is ridiculous to say no to unprotected sex, where would one take these children? You just surrender.”

Here, Judy’s immediate survival and that of her children is what takes center stage. In such circumstances, the respondent is denied the right to act upon what she knows about HIV/AIDS and safer sex and as a result exposes herself to the danger of HIV/AIDS infection.

As argued by Nzioka (2000), that the disproportionate higher HIV infection incidence and prevalence rates among women is due to social and cultural constructions of gendered sexuality where masculine sexuality dominates and that of feminine is suppressed. However, from the findings of this

study, women are challenging this power relation in families by asserting their power in protecting themselves against HIV infection. To some extent, this is a pointer that social conventions about sexuality are being challenged. The following cases attested to this unfolding power relationship in the family:-

Susan, 27, had been in a consensual union for one and a half years. She works with a United Nations body and has an income of over Kshs.50, 000, while her partner earns 230,000 per month. They do not yet have children. Susan said that they have always used a condom. Asked why they could not go for HIV test and stop using a condom, she had this to explain.

“I had a stable relationship and lived with a partner we were planning to get married, both of us had gone for HIV test, but I discovered that he was cheating on me. When I met my current partner, I insisted on using a condom until we formalize our marriage in about six months from now. When we met we decided to go for HIV test, we were both negative but right now, though we are committed to each other it is not like if we were married.”

Asked if they did not trust each other now though they lived like husband and wife what guarantee is there when they are legally married they would be able to trust one another, Susan responded casually as follows:

“May be there will be more commitment, I do not know! But I can never trust men, I know it is worse in marriage but we just take chances – there is no guarantee one’s partner will remain faithful. But

these are dangerous days and if you find out your partner is cheating on you, run very fast.” “[She meant leave the relationship as fast as one can]

Susan’s case was in agreement with Gillespie (1971) study which concluded that when women (wives) brought more social resources to marriage, like a higher education or income they had a greater control over decisions than if they did not. Women who had more resources had more power in their relationship with men.

Similar observation was made of Rose who was mesmerized by fear of getting infected. Rose, 31, and a company Secretary with one child is a graduate lawyer married to a professional civil servant of the same age. She said that she considers herself at risk of HIV/AIDS because the partner spends a lot of time away from home with friends drinking. She recounted her predicament.

“I do not suspect him of having other sexual partners but I am so afraid that he might one day.”

Rose said of her husband who she claimed travels a lot outside the country, sometimes for several months away.

“I am so afraid of getting infected that every time he comes home from abroad I insist on using a condom for the first one week after which we stop using.”

Rose said that they do not ever go for HIV test after using condoms for one week but felt psychologically satisfied that they could do without a condom. She thus said:

“I know it does not make sense to use a condom and then stop without going for HIV test. It is ridiculous but it gives me psychological

these are dangerous days and if you find out your partner is cheating on you, run very fast.” “[She meant leave the relationship as fast as one can]

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“I know it does not make sense to use a condom and then stop without going for HIV test. It is ridiculous but it gives me psychological

satisfaction”.

The above cases show how culture, economic power and perceptions are intermeshed in influencing safer sex practices.

Faith 27, a housewife and a mother of three had tearful narrative of her partner's conduct. Her anguish and hopelessness was expressed in these words:

“He does not even have the least respect for me. He brings his girlfriends in the house and I cannot ask him because he is very harsh and violent – ‘*Ni mkali sana*’. When I tried to ask him about his behavior he got so annoyed with me and asked me to give him ‘space’ to do whatever he wants to do with his life.”

Asked why she continued being in the relationship Faith responded as follows:

“I do not have fare to go to my parents’ upcountry. I am torn between taking with me my children and leaving them behind with their father. I do not have any income and I wonder how I will cater for their needs. See, they are already in bad health because their father does not spend his money on the family and I fear that if I leave them behind they will be neglected. But I am thinking of taking the youngest (one year old) with me.”

In the above scenarios, the issue of children is complicated by the fact that the respondent did not have her own income and therefore it was difficulty for her to move out of their relationships or even assert themselves. Where women are economically empowered they can assert herself as was found to be the case with Stella, a graduate aged 38, with three children and working

as a civil servant; had been married for 12 years. Out of 100 respondents interviewed, Stella was the only one who said she had completely abstained from having sex with her promiscuous, but well paid, partner. She narrated her story thus:

“When I discovered my partner was having an affair after a misunderstanding I decided never to have unprotected sex with him. We did not have sex for several months and I knew he was seeing another woman. Then one day he decided to have sex with me. When I challenged him that he could not have unprotected sex with me, he became wild. I explained that these are bad days for somebody to have extra-marital affairs; I meant bad days in that there is the killer disease – AIDS. He became so annoyed and after a struggle he asked furiously what I knew about AIDS. He said I just pretend to know so much yet I knew nothing! Then the bombshell came, he told me that without sex there would be no marriage.

We did not talk about it again for the one reason; there was no communication between us. Then after sometime he demanded to have sex with me and poor me as a result of previous threats, I gave in. Although he did not say it plainly, he pretended to extend an olive branch to me. This was short lived as he continued his weird behavior of coming in the morning. I decided to embark on finding out who was his lover. I discovered that before the current lover there was other two past ones and that, Emily was his current lover. When I talked to Emily she told me that she did not know that my partner had a family and that they had already broken up. When I asked her whether they used a condom she quipped, ‘Your man is very careless;

he refused to use a condom on the pretext that he could not do so with his future wife'. This discovery really broke my heart and I decided never to have unprotected sex with my partner. I wanted to visit a VCT but I was scared in case I was found to be positive, I imagined I would be so devastated and may be unable to cope.

After dropping Emily he got into another relationship. This time round he threatened to kick me out of the house and bring the other woman".

Asked why she did not leave the relationship, Stella had this to say:

"Twice, I packed to leave. But every time I explained to the children they would break into sobs and plead with me not to leave. I had decided to leave the children behind with their father, a decision I later considered unworkable. At this juncture I decided to seek legal advice. My lawyer advised me never to leave my matrimonial home otherwise I would be accused of abandonment; and if I had to leave I should always leave with the children.

When later my husband wanted to have sex with me, I said no. But he would not hear of it and he coerced me into having unprotected sex. Then after a few months the same process was repeated. I got so scared and traumatized with the idea that I could be HIV positive. Because of this fear, I developed so many psychological illnesses associated with HIV/AIDS. Convinced that I was HIV positive and that I had to live to see my children through to secondary school, I gathered courage and visited VCT center. To my amazement the testing kit showed that I was negative. Tears flowed freely as I could



not believe God had given me another lease of life. It was so unbelievable that I asked for a repeat of the test. The second test gave the same results. I cried uncontrollably swearing that I was never going to have unprotected sex again. Since then now five months, I have not had sex with my husband though he has tried to seduce me.”

Asked whether she shared her HIV status information with her husband Stella said she never did because the husband refused to talk to her and there was usually no communication between them whatsoever. But what guarantee was there that Stella would not be coerced into having sex unprotected with the husband since she said they still shared the same bed? Stella had this to say:

“I have one weapon, I will scream until the whole estate is woken up and since he fears embarrassment he will leave me alone”.

Asked what is the way forward for her relationship Stella quipped:

“I have children I care for so much and I have sacrificed my happiness for them. My husband can have all the fun he wants.

When he is through he will tell me and then we will talk from there.

If he wants us to resume our sexual lives then he will have to commit himself after which I will ask him to visit a VCT center.”

Stella had no intentions of leaving her husband. She said that she went through a traumatic experience and that was now over. According to her:

“If I did not leave when this problem started then I may never leave. I am a strong believer in marriage and I had a church wedding and in

my case my church does not allow divorce. If he divorces me fine, I would not mind it, but I will never initiate divorce.”

Pressed to state why she could not leave her abusive husband Stella had this to say:

Firstly, it is not easy for an African woman to leave her marriage due to its associated stigma. A woman is always held responsible for break up of her marriage no matter how mischievous the partner may be.

Secondly, children can force one to stay in an abusive relationship. In my case, I am not so economically empowered to give them good education and provide for their upkeep. African men are so irresponsible such that if a wife takes off with children they would never want to support them when they are with their mother. Even think of our courts, they are so slow and gender biased. I imagine my partner being given the custody of our children yet he is very irresponsible. My husband cannot kick me out of the house because he knows I will take him to court. He will also not divorce me because he fears if he is the one to initiate divorce he may lose the custody of the children and be forced to pay for their maintenance.”

Stella's scenario reveals the interplay between socio-cultural and economic factors that women continue to be subjected to in the context of HIV/AIDS. The traditional heterosexual relationship founded within a framework of patriarchy is characterized by gender defined power inequalities. And yet it is within the context of this unequal power relation that women are required to guard against HIV infection. Like in Stella's case most women are faced with the dilemma of keeping their marriages and leaving risky relationships.

### 4.5.1 Condom Use in Heterosexual Unions

Despite the attitude towards condom use, 34% of the respondents reported having used condom at one time with their current partners. They gave varied reasons for use of condoms as evident from table 4.14.

**Table 4.14 Percentage Distribution of Respondents by Reasons for Condoms Use**

Reasons for Condom use	Frequency	%
Prevent pregnancy	16	47.1
Prevent STI/HIV	10	29.4
Prevent both pregnancy & STIs	6	17.6
Partner insisted	2	5.9
<b>Total</b>	<b>34</b>	<b>100</b>

Most (47.1%) of those who used condom did so to prevent pregnancy (16%). Whereas 29.4% of the respondents reported that they used condom to prevent STIs/HIV 17.6% said that they use (d) a condom to prevent both pregnancy and STIs. The results showed that half of the condom users had done so before their relationship with partners stabilized. For example respondent D, 25, said that she used a condom with her partner for one year before they started living together as husband and wife. Even when they moved in together they continued using condom for six weeks and only stopped its use when her partner's parents visited hers to formalize the union.

Female condom is the only female controlled method barrier protection against HIV/AIDS and can be as effective as other barrier methods. As a result knowledge and use among the respondents were sought by this study. The results showed that knowledge of female condom was inextricably linked to levels of education. All respondents who had acquired University/College education were knowledgeable about female condom and only 20% of those with no formal education had heard about female condoms. Although majority of respondents (67%) had heard about female condom only 3% had made use of it. In fact though many respondents had heard about it very few had seen it, leave alone using it. Indeed, only one respondent said she uses the female condom consistently with her partner during every sexual activity. Another one interviewed said that she only uses a female condom with her irregular partner while another one said that she stopped using the female condom when her partner changed his sexual behavior, as she felt secure.

Not surprisingly, the number of respondents who did not know where to get female condoms was high standing at 71%. In any case, (33%) had not even heard of the female condom. Whereas 10% of these respondents said they could get female condoms from Government hospitals, 8% said from family planning clinics, 9% could get them from pharmacies while 2% said they would get them from VCT centers. Table 4.15 presents the distribution of respondents by knowledge of where to get the female condom from. As evident from the table, female condom and its use was widely ignored and therefore less understood. According to the findings of this study it can be concluded that knowledge on female condom was generally low.

**Table 4.15 Percentage Distribution of Respondents Source of Female Condom**

Where to get F.condom	Number	%
GOK hospital	10	10.0
Family planning	8	8.0
Pharmacies	9	9.0
VCT Centers	2	2.0
Do not know	71	71.0
<b>Total</b>	<b>100</b>	<b>100.0</b>

#### **4.6 HIV/AIDS Testing among Respondents**

The role played by HIV/AIDS testing and counseling in risk reduction programmes is an important one and is being promoted as a means of identifying the infected both for early medical intervention and prevention further infection. Those who are found to be negative are encouraged to stay alive. The study found that 49% of the respondents had not tested for HIV/AIDS compared to 51% who had been tested for HIV antibodies. Based on table 4.15, those who had taken the test reported doing so for varied reasons. Since majority of the women were at childbearing age, 82.3% of those who had done so during pre-natal visits, which are compulsory. This means that only 17.7% of the respondents who tested did so voluntarily. Whereas 5.9% said that they visited VCT centers because their partners had other sexual partners, 3.9% said they had several partners themselves while 5.9% had visited with their partners before starting to have unprotected sexual intercourse. The remaining 2.0% said that they had tested because they suffered from skin disorders. The testing results showed that even some

of those already using condoms in their unions did not know their HIV status but just assumed they are negative.

**Table 4.16 Percentage Distribution of Respondents by reasons for HIV Testing**

Reasons for Testing	Number	%
During pre-natal visits	42	82.3%
Partners had other sexual partners	3	5.9%
Prior to any sexual activity	3	5.9%
Selves had many sexual partners	2	3.9%
Got skin diseases	1	2.0%
<b>Total</b>	<b>51</b>	<b>100.0</b>

The 5.9% of the respondents who visited VCT due to their partners' sexual conduct said that their partners could not be informed because they could not agree to accompany them. This was due to fear of finding out that they were HIV positive. Respondent F argued that although her status was negative she did not know that of her partner, she expressed her disappointments thus:-

“There was no need for me to visit the VCT center, I cannot get my husband to do likewise or ask him to use a condom. I do not even want him to know that I visited VCT center for fear he might accuse me of unfaithfulness. I only suggested we visit a VCT center and he just kept quiet but I decided to go alone.”

For majority of women, unless forced by circumstances like pregnancy, they would be very scared to know their HIV status but worse still was the fact that their partners were more scared.

#### 4.6.1 Where to Take HIV/AIDS Test

Majority of the respondents seemed to know where to go for HIV testing. Based on table 4.17, 47% said they could visit GOK hospital/health center and 17% VCT Centers. While 7% said that one could visit a public sector institution, 2% identified private doctors and 7% government health centers as possible testing places. The remaining 20% were those who said that they did not know where to go for an HIV/AIDS test.

**Table 4. 17 Percentage Distributions of Respondents by Places to Test for HIV/AIDS**

<b>Place to test HIV/AIDS</b>	<b>Frequency</b>	<b>%</b>
GOK Hospital	47	47.0
VCT	17	17.0
Public sector inst.	7	7.0
GOK health Centers	7	7.0
Private Doctor	2	2.0
Do not know	20	20.0
<b>Total</b>	<b>100</b>	<b>100.0</b>

#### 4.7 Decision Making Capacity Among Respondents

From literature review and earlier findings in this study, there is evidence that men controlled sexual lives with their partners and that women exercised little or no control over their own sexual lives. This study attempted to find out the correlation between decision making capacity of women and practicing safe sex. Effects of gender inequality, socio-

economic conditions on the reproductive and sexual health of women have been highlighted. Evidence from this study show that majority of women interviewed could not have sex when they wanted and how they wanted it. For instance 61% of women reported that they could not initiate and could only have sex when their partners wanted. Respondents interviewed explained that it is uncultured for a woman to demand sex from a man. Umi, a mother of five (5) reported that she would never initiate sex because she felt embarrassed. She went further to say that those women who initiate sex have no shame – '*hawana haya*'. This is in agreement with Nzioka's (2000) assertion that women are passive recipients of male passion and have been socialized as such.

#### **4.7.1 Grounds for Refusal to have Sex with Partner**

Respondents were asked whether a wife was justified to refuse sex if partner had other sexual partners. While 83% of responded in the affirmative, 17% said a woman could not be justified. One respondent cited reasons like, 'a man always wants more and more and will always go for other women.' A second said, 'men have insatiable sexual urge'. A third noted that 'you cannot refuse to have sex with your husband because you are married for that, a wife has no power over her body'. These socio-cultural aspects are seen as impediment to women taking charge of their sexual lives and practicing safer sex.



**Table 4.18 Distribution of Respondents by Grounds for Refusing Sex**

Justification for refusing sex	Yes	No	Do not know	%
Partner infected with STI	91	4	5	100
Partner has other sexual partners	83	17		100
Tired/not in mood	77	18	5	100
At risk of HIV/AIDS	72	25	3	100

The respondents were further asked whether they felt at risk of contracting HIV from their partners they could say no to unprotected sex. The results showed that 72% would refuse to have unprotected sex while 25% said they would not. The remaining 3% said that they were not sure. As evident from table 4.17 when asked if being tired/ not in mood or if knowing that partner was infected with STI would lead to refusal to engage in unprotected sex, 77% and 91% of the respondents respectively responded in the affirmative.

#### **4.7.2 Sexual coercion**

This study showed that women go through unwanted sexual experiences in their heterosexual relationships. As stated earlier, 30% of women reported acts of sexual coercion in the recent past (in the last six months). Whereas 10% said that they were physically hurt or overpowered, 9% had been threatened to engage in sexual intercourse. Respondents said that they were forced into having sex because they were not in the mood, some cited fatigue and others said since they suspected their partners of having extra-marital affairs; they no longer felt the urge to have sex. Respondent C, 37, had this to say:-

“I do not ever feel like having sex, I do so much work, looking after my children and selling groceries. I only have sex as a duty towards my partner. It is even worse now, when I discovered he was having an affair I never want to have sex, you never know what he will bring to you (referring to HIV/AIDS). These days we even stay for as long as two months without sex and even then he has to force me”.

Like many other women, respondent C, did not see forced sex as marital rape. Focus group discussion participants believed that women had obligations to satisfy their partners' sexual passions whenever the latter wanted. Participants in one of the FGDs concurred with their fellow participant Rosemary, 34 year old, who said that men are over bearing in all areas of their (participants) lives and unless there are laws to protect women, the latter will continue to suffer.

The above scenario is attributed to the fact that there is no legislative right to non-consensual sex within marriage. Because of their powerlessness to make decision about their sexual lives coupled with the absence of legal right to refuse sex to their husbands, many women will continue to be at a greater risk for HIV infection.

#### **4.7.3 Decision on the Number of Children**

Further, study findings into reproductive and sexual health of women showed that 22% of the respondents could not decide on the number of children they wanted to have, not even jointly with their partners but the latter did. Based on table 4.18, 38% made joint decision with their partners compared to 35% who did so alone. Respondents (2%) who said it was God's decision on the number of children implied that they could not

interfere with nature, and therefore could not use contraceptives to limit/control the number of children.

**Table 4.18. Decision-making on the number of children**

<b>Decision by Whom</b>	<b>Frequency</b>	<b>Percent</b>
Partner	22	22.0
Respondent	35	35.0
Respondent & Partner	38	38.0
God	2	2.0
Others	3	3.0
<b>Total</b>	<b>100</b>	<b>100.0</b>

Where the male partner is the sole decision-maker this could be interpreted as violation of reproductive rights of their female partners. It is no surprise then that 43% of the respondents reported that they could not use contraceptives without partners' approval, while 35% had reported that they had the freedom to choose to use or not to use contraceptives.

# CHAPTER FIVE

## STATISTICAL ANALYSIS AND INTERPRETATION

### 5.1.0 Introduction

Many studies discussed in chapter two are of the view that the differential power and authority relation between men and women generally puts the latter in a subordinate position. It is argued that marital relations are fundamentally power relations usually power of husband over wives. Studies have further shown that where women are economically empowered they are likely to make or influence decisions that affect them including sexuality. This observation forms the basis of the first major hypothesis of this study, that personal characteristics influence use of safer sex practices.

This chapter deals with inferential analysis by examining and interpreting the relationship between safer sex practices and other selected variables. The dependent variable, as explained earlier refers to any sexual activity that reduces the risk of transmission of HIV/AIDS infection. This was measured by asking the respondents questions about their sexuality and risk management of HIV/AIDS infection. This was categorized as follows:

- 1) Those using condoms
- 2) Those abstaining
- 3) Those discussed with Partners
- 4) Those who did nothing.

### 5.2.0 Personal characteristics and safer sex practices

The analysis of the selected personal characteristics in relation to safer sex practices showed that certain variables profoundly influenced practice of safer sex among the respondents. These variables included level of education, economic status, children and decision - making capacity.

Respondents in higher socio-economic status in terms of income, education and occupation positively influenced decisions that affected them. For instance, they could decide the number of children to have and whether to use condoms or to abstain.

The underlying assumption of the first major hypothesis is that personal characteristics like the level of education and income determine a women's ability to practice safer sex when confronted with risk of HIV/AIDS infection. In this section we focus on education, level of income, religious affiliation, types of heterosexual union, family size and the respondents' occupational statuses.

### **5.2.1 Level of Education**

The aim was to find out whether any association existed between level of education and safer sex practices. The results are presented in Table 5.1

The table shows that none of the women with no formal education and those with lower primary education had abstained or used a condom due to partner's sexual conduct. Women with upper primary and secondary education who said that they used condom or abstained did this only temporarily. Once assured that their partners had changed their sexual behaviors, they resumed normal sexual relationship. This is in total contrast with women with higher level of education.

**Table 5.1 Relationship between Formal Education and Safer Sex Practices**

Level of Education.	Safer Sex Practices					Total %
	% used Condom	% Abstained	% discussed	% Did nothing	% Never Suspected	
None	0.0	0.0	5.9	0.0	10.4	<b>8.0</b>
Primary	20.0	66.7	47.1	62.5	53.7	<b>52.0</b>
Secondary	20.0	0.0	35.3	37.3	31.3	<b>31.0</b>
University/	60.0	33.3	11.8	0.0	4.5	<b>9.0</b>
<b>Total</b>	100	100.0	100.0	100.0	100.0	<b>100.0</b>
<b>Number</b>	<b>(5)</b>	<b>(3)</b>	<b>(17)</b>	<b>(8)</b>	<b>(67)</b>	<b>(100)</b>

Overall only 9% of respondents interviewed had University/College education and 44.4% of these had either abstained (11.1%) or use (d) a condom (33.3%) by the time of this research. It is also notable that respondents with university education took precaution in protecting themselves once alarmed by partner's sexual conduct.

Proportionally, respondents with University/College education who only represented 9% of all respondents and had suspected their partners seemed to take protection measures more seriously than those with lower education. Results of the study indicate that 8% of the respondents with both primary and secondary education had suspected their partners but did not take measures in protecting themselves. The case scenario described here echoes these findings.

Millie, 27 a graduate housewife, with one child was one of those using condoms in her heterosexual relationship with her graduate partner. She has been in a consensual union for six years. She told the researcher how her partner had been cheating on her with his ex-girlfriend and when she discovered she demanded they use a condom. The partner refused and for a year they were not sexually involved until the partner agreed to use a condom. Though her partner had changed his behavior, she insisted on condom use until she was certain she could trust him again, after which they would go for HIV/AIDS test.

### **5.2.2 Level of Income**

As evident from table 5.2, 80% of the respondents who used condom had income ranging between Ksh.5, 000 and over ksh.10, 000. Similarly 100% of the respondents who abstained had monthly income of Ksh. >5,000. On the other hand, 75% of the respondents who did nothing about their partners' sexual behavior had no income of their own. Respondents expressed fear of being beaten, denied financial assistance or quarreled if they questioned their partners' behavior.

What is emerging from the above discussion is that income is a very important factor in influencing sexual practices of a woman. Women with high income can challenge their partners' behaviors and assert themselves in demanding safe sex.

**Table 5.2 Relationship between Level of Income and Safer Sex Practices**

Level of income	Safer Sex Practices					Total %
	% discussed with partner	% Used condom	% abstained	% did nothing	Never suspected	
None	58.8	20.0	–	75.0	68.7	<b>63.0</b>
<5,000	23.5	–	33.3	–	19.4	<b>18.0</b>
Ksh. 5,000- 10,000	5.9	20.0	33.3	25.0	4.4	<b>8.0</b>
Over 10,000	11.7	60.0	33.3	–	7.5	<b>11.0</b>
<b>Total</b>	100	100	100	100	100	
<b>Number</b>	<b>(17)</b>	<b>(5)</b>	<b>(3)</b>	<b>(8)</b>	<b>(67)</b>	<b>(100)</b>

The above findings were further stressed by Jane’s experience. Aged 30, and a mother of four with secondary education and doing small business, Jane was a housewife when she suspected her husband of having extra-marital affair with his ex-girlfriend she suggested that they use a condom to protect herself from any infection. The partner responded harshly by telling her,

“If that is what is in your small mind, you will go to our rural home and stay there until your mind starts working properly”.

As a result, Jane was sent home for five months without any financial help as a punishment for questioning her partner’s sexual behavior.



Jane's account demonstrates women's lack of power to question, influence or control their partner's sexual behavior. This affirms Nzioka's (2000) argument that, for women to suggest that the man is careless in his sexual exploits and that this could present a risk of HIV infection to the wife could be construed to be a challenge to male authority. This could explain why 75% of the respondents who suspected their partners could not question their behaviors for fear of being economically deprived.

Income and education are intertwined variables, with significant influence on safer sex practices. Respondents with medium and higher income were found to be more assertive and more consistent in employment of preventive measures. The account of Lydia is an illustration of this. Lydia, 28, a graduate Economist with one child and income of over Kshs. 30,000 per month said that she uses a condom with her wedded partner. Lydia who was six months pregnant said she started using condoms when she was two months pregnant. According to her:

“I started using condoms when I was two months pregnant. I discovered that my husband was having an affair and I decided to protect the baby and myself from any infection. Though he has changed, I will continue using condoms until the baby is born.”

The above scenario was in contrast with Mary's hopelessness. Mary, 35, a mother of four was the third wife of a businessman. She had upper primary education and operated her husband's water kiosk. Her two co-wives stay in their rural homes. Mary reported that her husband was very promiscuous and had severally talked to him about changing his behavior by pointing out that his two brothers died of HIV/AIDS as well as her own brother. She said

that alcohol influences her partner's sexual behavior and it has become impossible to change his behavior. She had this to say:-

“Because my husband would not change his behavior I asked him to have his ‘fun’ outside and leave me alone but instead he accused me of wanting to have other men. Traumatized by the idea of getting infected with HIV/AIDS, I introduced condom use but only twice. She cheated her partner that she was preventing unwanted pregnancy but in actual fact she was using it as a preventive measure against HIV infection. After using it twice, the partner refused to use it any more. Disturbed by his behavior of ‘sleeping outside’, I decided to go for HIV test to know my status. Luckily I was found to be negative (the year was 2002)’.

“It was God’s protection, God had given me another lease on life, but I wondered how it was possible for me to stay negative while I lived with my husband in the same house. It looked awkward and did not make sense for me to know my HIV status. It dawned on me that there was nothing I was going to do to protect myself. If I had some income to bring up my children, I would have left this marriage long time ago, particularly when I tested negative. I only require Ksh. 20,000 to go to my parent’s home and start some small business.”

Mary, like many other women interviewed for the study found herself between a rock and hard ground. Having children and jobless what could she do! She could not leave her children and yet she could not take them with her and she decided to stay in the relationship she dreaded being in. Though they hardly had sex (may be six times a year), Mary felt at risk of

getting infected. Asked whether a wife is justified in refusing to have sex with her legally married partner when she knows her partner has sex with other women, Mary quoted from the bible as follows:

“The Bible says that a wife has no power over her body, likewise the man, but these days a wife can refuse to have sex with her partner if he is unfaithful. It is difficult for me to refuse because the children will hear the commotion”. She continued, “If you are under a man’s roof, you are under his instructions - *‘amri lazima ifuatwe’*”

The above narrative is in total agreement with similar observations by Nzioka (2000) that use of condoms, especially within marriage, will be acceptable to a small number and cannot prove to be a major force in prevention of HIV/AIDS in heterosexual unions. He avers that, while it is important for women to have influence on their husbands’ behavior and the right to protect themselves against husbands who risk infection, it is doubtful that most Kenyan women have either right.

### **5.2.3 Religious Affiliation**

Findings of the study showed that 36% of the respondents who felt at risk of getting infected and practiced safer sex were Protestants, while 21% were Catholics. For along time now, Catholic Church’s stand on condom use has been well known and this may have been instrumental in influencing condom use among the Catholics. Catholics shun use of condoms and advocate abstinence as the best method of practicing safer sex. This has been confirmed by the fact that 75% of respondents who abstained were Catholics. Protestants formed 60% of the respondents who used condoms while 20% of Catholics used them.

**Table 5.3. Relationship between Religious Affiliation and safer Sex Practices**

Religious Affiliation	Safer sex practices					Total %
	% used condom	% abstained	% discussed	% did nothing	% never Suspected	
Catholics	20.0	66.7	11.8	12.5	32.8	<b>28</b>
Protestants	60.0	33.3	82.4	87.5	58.2	<b>64</b>
Other Religions	20.0	0.0	5.8	0.0	9.0	<b>8</b>
<b>Total</b>	100	100	100	100	100	<b>100</b>
<b>Number</b>	<b>(5)</b>	<b>(3)</b>	<b>(17)</b>	<b>(8)</b>	<b>(67)</b>	<b>(100)</b>

From the above it is prudent to conclude that religious affiliation among the respondents has no influence on safer sex practices. This was confirmed by the focus group discussion participants who said that a woman is treated as a woman regardless of her religious background.

#### **5.2.4 Type of Heterosexual Union**

Respondents who considered themselves at risk of HIV infection because of partners' behaviors were in various types of heterosexual unions. It is important to relate the type of heterosexual union with the respondents' use of safe sex. The findings are presented in table 5.4.

**Table 5.4. Type of Union and Safer Sex Practices**

Type of Union	% discussed with Partner	% abstained	% used Condom	% did nothing	% never Suspected	Total %
Traditional Monogamous	29.4	33.3	0.0	62.5	55.2	48.0
Traditional Polygamous	11.7	33.3	0.0	12.5	13.4	13.0
Religious Monogamous	6.0	33.3	20.0	12.5	13.4	13.0
Consensual Union	52.9	0.0	60.0	12.5	12.0	21.0
Other	0.0	0.0	20.0	0.0	6.0	5.0
<b>Total</b>	100	100	100	100	100	100
<b>Number</b>	<b>(17)</b>	<b>(3)</b>	<b>(5)</b>	<b>(8)</b>	<b>(67)</b>	<b>(100)</b>

Based on the table, majority of respondents who used a condom were in consensual unions. They represented 60% of the total number of those who used condoms. On the other hand, the majority (62.5%) of those who did nothing about partners' conduct were in traditional monogamous. There seems to be some association between type of union and use of safer sex practices as is suggested by the table. Respondents in consensual unions were able to use condoms in spite of the same being rated as the most difficult preventive measures in heterosexual unions. Therefore the type of heterosexual union does influence safer sex practices

### 5.2.5 Family Size

From table 5.5, it can be observed that 80% of respondents who used condoms had between 0 and 2 children while 66.6% of the respondents who abstained had also the same number of children. This was considered a small family. Majority of respondents (41.2%) with between 3 and 4 children had discussed with their partners whilst 20% and 33.4% used condom and abstained respectively. The study found that none of the respondents with five children and more had practiced safe sex (abstinence/use of condom). This was considered a big family and majority of respondents (25%) did nothing about their partners' sexual behaviors. It is evident from the table that respondents with fewer children were keen to practice safe sex as compared to those with many children.

**Table 5.5 Distribution of Respondents by Family Size and Practice of Safer Sex.**

No.of children	Safer sex practices					Total %
	% discussed	% used condom	% abstained	% did nothing	% never Suspected	
0-2	58.8	80.0	66.6	37.5	44.8	<b>49.0</b>
3-4	41.2	20.0	33.4	37.5	31.4	<b>33.0</b>
5+	-	-	-	25.0	23.8	<b>18.0</b>
<b>Total</b>	100	100	100	100	100	<b>100.0</b>
<b>Number</b>	<b>17</b>	<b>5</b>	<b>3</b>	<b>8</b>	<b>67</b>	<b>100</b>

Further probe was done to determine why respondents continued to be in relationship they considered risky. Those who said it was because of

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3-4	41.2	20.0	33.4	37.5	31.4	<b>33.0</b>
5+	-	-	-	25.0	23.8	<b>18.0</b>
<b>Total</b>	100	100	100	100	100	<b>100.0</b>
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Further probe was done to determine why respondents continued to be in relationship they considered risky. Those who said it was because of

children represented 15% while 5% said they did not have anywhere to go. Respondents who could not leave risky relationships because of children accounted for 45.5% of the respondents. Other reasons for staying were religious and love for their partners.

Children seem to be a major factor in influencing sexual practices of women. For example, Judy, 29, a mother of five (5) and housewife and married as a second wife for 5 years had bluntly demonstrated this argument. She felt at risk of contracting HIV but could not ask her partner to use a condom for fear of being beaten. She pointed out that she could not bring up such an issue because the partner is harsh and stone-faced and hardly discusses anything with her. She wondered how she could say no to unprotected sex while she relied on her partner for her children's survival. The same scenario applies to Faith, a mother of three (3) and a housewife who was unable to leave her unfaithful and abusive partner as she could not take care of her children due to her economic status. Children therefore do contribute to their mothers continued stay in risk relationships impeding the latter's assertiveness in demanding for safe sex for fear of 'economic sanctions'.

#### **5.2.6. Respondents' Occupational Statuses**

Based on the results of this study, 11% of the respondents were professionals/skilled and their monthly income was over Ksh. 10,000. Housewifery was the major occupation of the majority of the respondents, representing 63%. Professionalism, which is otherwise interrelated with higher income returns, seemed to have had a major influence on practice of safer sex. Based on table 5.6, 60% of respondents who either used condom or abstained were in professional occupations. Some respondents, too sure of



their partners' promiscuous behaviors were not able to protect themselves for reasons to do with their economic empowerment. This was partly due to their economic occupations, which made them dependent on their partners for their upkeep and could not sustain themselves in cases of desertion by their partners.

**Table 5.6. Respondents' Occupation and Practice of safer Sex.**

<b>Occupation</b>	<b>% discussed</b>	<b>% used condom</b>	<b>% abstained</b>	<b>% did nothing</b>	<b>% never suspected</b>	<b>Total %</b>
Professional/skilled	5.9	60.0	33.3	12.5	17.9	<b>18.0</b>
Semi-skilled	5.9	0.0	33.3	0.0	14.5	<b>5.0</b>
Unskilled	5.9	0.0		25.0	11.9	<b>11.0</b>
Housewifery/others	82.3	40.0	33.3	62.5	65.7	<b>66.0</b>
<b>Total</b>	100	100	100	100	100	<b>100</b>
<b>Number</b>	<b>(17)</b>	<b>(5)</b>	<b>(3)</b>	<b>(8)</b>	<b>(67)</b>	<b>(100)</b>

From the above table it can be noted that majority of the respondents who used protection in terms of condom and by abstinence were either professional or skilled workers whose income was reasonably higher.

### **5.3.0 Knowledge of HIV/AIDS and Safer Sex Practices**

From the study findings it is notable that knowledge and awareness of HIV/AIDS was generally high. Each respondent knew at least one way of HIV/AIDS transmission. Even those who suspected their partners of having other sexual partners but did nothing about it were aware of means of

HIV/AIDS transmission. Of these, 87.5% mentioned unprotected sexual intercourse as one mode of transmission of HIV/AIDS while 25% mentioned sexual intercourse with multiple partners and 12.5% mentioned blood transfusion.

It is notable that even though respondents were aware of HIV/AIDS prevention methods, for example, use of condom and being faithful to one partner, some did not take measures to protect themselves from their anomalous partners, not even discussing infidelity with partners for fear of being beaten. Half of the respondents who did nothing about partner's conduct had each mentioned use of condom and avoiding multiple partners as ways of preventing HIV/AIDS. Table 5.6 samples the levels of awareness among the respondents. Knowledge on prevention, transmission, avoidance of infection and cure of HIV/AIDS is generally high, while that of AIDS medicine and their source is low. Knowledge of prevention and transmission of HIV/AIDS are two key components in fighting HIV infection.

**Table 5.7 Distributions of Respondents by Knowledge of HIV/AIDS**

Type of awareness	Level of Awareness	
	High	Low
Prevention	X	
Transmission	X	
Cure of AIDS	X	
AIDS Medicine		X
Source of ARVs		X
Avoiding infection	X	

From the above table, it can be adduced that awareness and knowledge of HIV/AIDS did not influence safe sex practices among the respondents.

### 5.4.0 Risk Perception and Safer Sex Practices

From study findings, 35% of respondents perceived themselves to be at risk of HIV/AIDS infection. However, about 6% of the respondents felt at risk due to their own sexual behaviors. Results showed that 15.1% of respondents exposed to HIV infection by their partners took protection by way of using condoms. Based on table 5.7, 9.1% at risk of infection had abstained whilst 51.5% discussed with their partners. On the other hand, 23.4% did not take any step to prevent infection. As seen elsewhere in this study most of those who suspected their partners and did nothing about it were housewives. Although 51.1% of respondents said that they discussed with their partners, not all the partners were agreeable in changing their sexual behaviors and some responded aggressively to the respondents' complaints as evidenced by the respondents' narratives.

**Table 5.8 Relationship between Risk perception and Safer Sex Practices**

<b>Risk Perception</b>	<b>% used condom</b>	<b>% abstained</b>	<b>% discussed</b>	<b>% did Nothing</b>
<b>Felt at Risk</b>	15.1	9.1	51.5	24.3
<b>Number</b>	5	3	17	8

Respondents in risky relationship were asked if they felt it important to introduce condom use. About 12% said it was not necessary while 22% saw it necessary but complained that their partners would never agree to use

condom. Further probe on safer sex practices revealed that 68% of respondents confronted with the risk of contracting HIV/AIDS would refuse to have unprotected sex while 25% said they would not refuse even when they risked infection.

Julian had this to say when asked why she continued being in risky relationship,

*“Uende wapi – kwetu? - Where do I go, to my parents? No, I cannot go to my parents, if I have AIDS I would give my mother the trouble of looking after me when I am sick.”*

Asked about introducing condom use, the respondent, by echoing another, retorted:

*“Men will never agree to use condoms and there is no way a wife will refuse to have sex with a husband because the latter is having extra marital affairs. She can only walk out. He will even ask you ‘Ni nini imekuleta kutoka kwenu? Dume wawili hawawezi kukaa zizi moja’ – What brought you here from your parents? Two bulls cannot stay in one pen. You cannot stay in one house if you refuse to have sex with your partner.”*

Mueni, a mother of one (1)son, had to cope with an extremely promiscuous partner. She had been married for 23 years. The partner had taken a younger wife with whom they had four (4) children. But the co-wife ran away from her promiscuous partner, leaving behind one child with Mueni. Mueni who had several times caught the partner red-handed including around the time of this study, said that she had talked to her husband and he is not about to change

Asked why she continued being in the relationship she put it thus:-

“A child needs inheritance and education from the father and I cannot take this away from him”

Mueni, who said she had overstayed in Nairobi due to lack of bus fare back home, described her partner as somebody who ‘naturally’ likes women. Mueni’s story was similar to Njeri’s. Aged 35 and a mother of five (5), Njeri described her husband as very promiscuous. She had discussed his conduct with him severally but seemed to have thrown in the towel. She said that every time she goes to her rural home and comes back to Nairobi unannounced, she finds a woman in their house with her partner.

The above scenarios are a pointer to the pre-existing patterns of sexual culture and gender inequalities rendering women incapable of questioning their partners’ sexual behaviors. Though Mueni’s co-wife ran away due to their partner’s behavior, she continued to hang in there, seemingly oblivious of lethal dangers she is exposed to. These three respondents are among many other women, who though aware of how HIV/AIDS is transmitted, have resigned themselves to fate by undermining the dangers posed by their partners’ sexual behaviors.

Speaking recently at the launch of the Global Coalition of Women and AIDS, Executive Director of Joint United Nations Programme on HIV/AIDS (UNAIDS), Dr. Peter Piot called for urgently needed female-controlled HIV prevention methods. He noted that women and girls are often powerless to abstain from sex or to insist on condom use. They may be coerced into unprotected sex or run the risk of being infected by husbands in societies

where it is common or acceptable for men to have more than one partner.

He continued to say that:

“While condoms have been proven effective in HIV prevention, their correct and consistent use rests with the male partner making it more difficult for women to negotiate safer sex. In fact most sexually transmitted HIV infection in female occur either inside marriage or in relationships women believe monogamous”

His observations seem to reinforce the findings in this study. For example Violet 25, a housewife married with four children had this to say when asked whether a woman is justified in refusing to have sex with her unfaithful partner:

“You cannot refuse to have sex with your partner because he will beat you up. Even when you know that he is having other sexual relationships with other women there is nothing a woman can do; because a woman is married for that (sex) – to satisfy the husband regardless of what he does.”

From the above discussion it is clear that risk perception of HIV/AIDS is not enough reason for use of safer sex practices. This is to some extent due to ignorance making many women undermine the risks involved in unprotected sex. Therefore the second hypothesis that a woman’s perception of her vulnerability to HIV infection does not automatically influence her use of safer sex practices including condoms, abstinence and leaving risky relationships. There are other factors at play that dictate a woman’s ability to practice safer sex and this includes her socio- economic status, level of education among others Therefore it is not just enough for a woman to know that she is at risk of HIV infection and take prevention measures, it takes

more than the perception of risk. This hypothesis therefore does not apply generally to women who perceive themselves to be at risk of HIV infection

### **5.5. Condom Use in Marital Unions**

As has been shown earlier in this study, few women were able to negotiate successfully for condom use. Most women reported that their partners never agree to use a condom in their sexual relationships. Due to gendered sexuality manifested through socio-cultural and economic factors most women did not have the ability or the courage to protect them in this way.

It is clear from the findings of this study that women feared introducing condom use or abstinence for fear of being accused of unfaithfulness themselves by partners. For instance, one respondent reported that though she had evidence her partner had sexual relationship with another woman (because she would find him in the other woman's house), she could not suggest condom use for fear of being told she was the one who was unfaithful. Therefore, it is no wonder that even when men knew so well they infected their partners they would still want to save their faces by accusing the latter of unfaithfulness.

Women interviewed in Focus Group Discussions pointed out that using a condom in marital union is not only sinful but also unacceptable. Condoms, they said, are seen as a sign of mistrust and worse if a woman suggested their use would be interpreted to challenge the masculinity in a man. More often condom use is associated with extra-marital sex and shunned by both men and women in marital unions. Though majority of women claimed that men would never agree to use a condom, a number of women felt that condoms were inappropriate within marriage and is only for use in illicit sex.

The twin problem of condom use, its sustainability and acceptance in heterosexual unions was a factor to contend with. There was the problem of continued use of condom as friendship gains ground and partners come to trust each other. Respondent D, 25, discussed earlier, reported that they could not continue using a condom as now they were wife and husband and could then trust each other. The ignorance in this scenario is the fact that past sexual relationships are not seen to pose any danger of HIV infection. This is brought about by the failure for the couples to know their HIV status before stopping condom use.

Findings of this study show that majority of women do not actually perceive the extent to which they could be exposed to the virus by their partners and as a result delay dealing with the issue of being at risk. Millie's story, told elsewhere in this study was a sharp contrast with respondent D's story. Millie already using a condom with a partner of six years was categorical that once satisfied her partner had changed his sexual behaviors; they would go for HIV test before discarding condom use. Here the question of risk perception is brought to the fore.

Eunice, 33, a housewife in a consensual union as a second wife and a mother of one (1) said that when she learned that the partner was cheating on her she abstained from sex for two months and only resumed sex once satisfied that the partner had changed. She told the researcher that she did not suggest HIV test because she did not think she could be infected and in any case she was afraid of finding out her HIV status. Again, this case brings to focus the extent to which people misperceive their risk of contracting HIV and the relationship between risk perception and risky practices. Even when respondents recognized the possibility of HIV infection they did not take



concrete initiative to address their need to deal with risk reduction. Though sexual practices of their partners place them at risk and could use condoms for a while, but they did not go further into finding out their HIV status before resuming unprotected sex.

Peninah, who operates between her rural home and Nairobi reported a similar scenario. Even though aware the partner had other sexual partners (and she knew three of them) she had never suggested condom use for fear that the partner would not agree.

With specific reference to the female condom, majority of women who considered themselves at risk of HIV infection expressed intentions to reduce its risk by using a female controlled method of barrier protection such as female condom or microbicides. At the mention of female condom by the researcher, most women were anxious to know how it works. They were particularly interested in knowing whether a partner can feel it during sexual intercourse. Mary, mentioned elsewhere in this study, whose partner discontinued condom (male) use and considered herself at risk of infection wondered whether she could use female condom without her partner's knowledge.

Feeling helpless and hopeless at their failure to change their partner's sexual behavior, some respondents, during focus group discussions asked why the government could not give them protection that was under their control. For example, they cited family planning methods, which they said they were able to use without their partner's knowledge. This was in spite of 95% of the respondents saying that AIDS is incurable. This was apparent ignorance

of the fact they if there was no cure for AIDS then the government could not provide an anti-AIDS drug.

It is worthy noting that condom (read female condom) promotion among female only targets single women or commercial sex workers leaving behind a vulnerable group of women in heterosexual unions. This may explain why 33% of the respondents had never heard of female condoms yet some lived in the same vicinity with/or were next door neighbors of distributors of female condoms. However, there is nothing to celebrate about female condom if it cannot be used without the partner's knowledge. Miriam, 35, a single mother of four (having left her partner of 12 years), and one of the three respondents using female condom convincingly said that her current partner did not know whether she used a female condom for every sexual encounter.

“Because of my children, I cannot take chances by engaging in risky behavior. I have always used a condom with my partner without his knowledge. This is a man with two wives and it is possible he has other girlfriends”.

Whether female condom can be used without the partner's knowledge is a subject for debate.

### **5.6. Decision- making Capacity and Safer Sex Practices**

From earlier findings in this study, there is evidence that men control sexual lives with their partners and women exercised little or no control over their own sexual lives. This study attempted to find out the correlation between decision making capacity of women and practicing safer sex. The results revealed that women were concerned about their partners' sexual behavior,

but also acknowledged the fact that their partners controlled their sexual lives. It is noted that 61% of the respondents did not have the capacity to initiate sex but their partners did; only 5% of respondents using condoms had the capacity to initiate sex and none of the respondents who had abstained had the capacity to initiate sex.

Participants in focus group discussions argued that it was a disgrace for a woman to initiate sex, as it was not in accordance with their culture. Therefore, the decision whether or when to have sex lies squarely with the men. In a focus group discussion, Umi, 40, argued that those women who initiate sex have no shame – '*hawana haya*'. This is in agreement with Nzioka's (2000) assertion that women are passive recipients of male passion and has been socialized as such. Because of their lack of social and economic power, many women and girls are unable to negotiate relationships based on abstinence, faithfulness and use of condom. Further, this is complicated by the socio-cultural aspects where women have been socialized to believe that "men have insatiable sexual urge" as one respondent put it when asked whether a wife is justified to refuse sex with an unfaithful partner.

Arguably, higher socio-economic conditions encourage active participation and independent rational decision making. Women with higher socio-economic status were instrumental in making decisions that affected their reproductive health including sex. This is a deviation from the traditional norms where women are expected to be 'noble and stoic' in fulfilling their partners' sexual demands. Women with no income were found to be less assertive and were not able to influence their spouses' sexual behaviors.

## CHAPTER SIX

### SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

#### 6.1 Summary and conclusion

This study sought to investigate how women in heterosexual unions deal with the risk of HIV/AIDS infection in their relationships with partners. Among other objectives, the study set out to find whether women in heterosexual unions consider themselves at risk of HIV/AIDS infection and how power imbalance in these relationships affect safer sex practices. The study findings are a challenge to the health strategies advocated for HIV prevention and which ignore socio-cultural factors that impede women from protecting themselves. Information alone, has been shown is not enough to determine human behavior as the latter is related to socio-economic conditions and cultural values.

The underlying assumption here was that personal characteristics, which included education, income, and number of children among others, have undeniable influence on safer sex practices. Proportionally women who had higher income and education practiced safer sex than those who did not have either. All women who were assertive and consistently used condoms or abstained had either higher income or higher education, or both. These findings tie very well with the proposition that where women bring home more income they have a lot of influence in decisions that affect them and their families. Housewifery characterized the larger part of the sample and it is from this group that a large number of women did not take steps in

protecting themselves from their unfaithful partners. Though aware of their partners' errand behaviors 8% of interviewees did not question their behaviors.

Limited access to education and economic opportunities coupled with having children had undermined women's bargaining power in negotiating for safer sex. Of respondents in unfaithful relationships 27% reported that they continued being in their relationship because of children. As Nzioka (2000) argues such a situation gives the male partner the power to control, regulate and direct the sexual life of the relationship. Where the wife or female partner has children and relies on the male partner for assistance, rights to discussion relating to her sexuality are often violated. Women of higher socio-economic status are able to make independent rational decisions including how they want their sexual lives shaped.

All the respondents were aware of at least one way of how HIV/AIDS is transmitted. They were also aware of how HIV/AIDS could be avoided. Generally, respondents had basic knowledge on HIV/AIDS but this could be limiting in that though 100% of respondents knew at least one way of how HIV is transmitted, they did not seem to know that one unprotected sexual encounter could spell doom for the rest of their lives.

Kamau (Nation Daily Newspaper, 26- 09 -03) argues that certain groups are more vulnerable to the HIV virus than others due to their inability to realize their civil, political, economic and cultural rights. Findings show that women have less access to information on HIV/AIDS thereby precluding them from discussing the same and taking preventive measures to protect

themselves. Of the respondents, 32% had not heard of female condoms and only 3% had used the same. This is pervasive discrimination on women in that the only barrier under their control is least promoted compared to other preventive measures.

The results showed that although 33% of respondents were aware their partners were unfaithful only 6% took protective measures, though some were temporary. Even when there was recognition of the possibility of risk many women shied away from facing this risk and instead distanced themselves from addressing their need for risk reduction by falling into the 'them, not us' syndrome. Respondents in marital unions did not seem to perceive the extent to which their partners were exposing them to HIV infection. Lack of risk perception was closely tied with condom usage. Findings from this study showed inconsistent use of condom. Condom use became irrelevant as relationships developed into steady partnerships ignoring past relationships that either partners may have been involved.

There was obvious element of ignorance and misconception in that past relationships of the partners were not put into consideration when it came to stabilizing heterosexual unions. Partners ignored the threat of HIV infection that past relationship could pose. There was notable inconsistency in condom use coupled with the failure to know one's status before discarding its use. Respondents did not go for HIV test before stopping condom use because they came to trust their partners and thus discontinued condom use without having known their HIV status. Level of awareness and respondents' risk perception of HIV/AIDS seem to be intertwined in influencing safer sex

practices. Respondents with deeper understanding of how HIV/AIDS is transmitted took protection measures more seriously than those who did not quite understand the dangers of risk behaviors. For instance, well-informed participants like Millie were very cautious in protecting themselves because she clearly understood how HIV/AIDS is transmitted.

## **Conclusion**

From a theoretical point of view, the findings show that Structural Approach adopted by this study, as its theoretical model is very viable, in its assumption that human behavior is adjustable and human beings are always attempting to come to terms with or adjust to the situations in which they find themselves. Confronted with the risk of HIV/AIDS infection, the social-cultural factors, which inhibit women from protecting themselves, are slowly being challenged. Gender inequality and violence, which is a key aspect in HIV/AIDS prevalence has gradually started to receive the attention of policy makers. There is now a major paradigm shift from general preventive methods of HIV/AIDS to more fundamentally focused causes of HIV/AIDS. The broader perspective is now on human rights (read women rights) violations which is partly responsible for higher prevalence of HIV/AIDS among women than men. On the other hand, the Health Belief Model enables one to understand perceptions surrounding choices and in this case of HIV prevention options, depending on the perceived probability of success of such an option. This model assumes that the perceived barriers to successful choices by women would be addressed.

Socialist feminist theory explains the culturally established constructions of female gender identity in a patriarchal society, which undermine woman's

capacity to question the status quo and to act 'rationally' in the face of HIV/AIDS.

## 6.2 Recommendations

On the basis of the findings of this study, the following recommendations are proposed:

1. Since materially deprived women risked the fear of income to feed their children higher than the remote possibility of the risk of HIV infection, there is urgent need to work towards empowering women economically. It is this economic dependence on men that has to be crushed first if we are to enhance women's right to safer sex and bring down the number of infections. It is often the poorest women who have the fewest choices.
2. Nevertheless women empowerment is not enough; men too must acknowledge their joint responsibility. Evidence from this study shows that prevailing social and cultural constructions of sexuality continue to shape gender identity and self images thereby placing more and more women at risk of HIV infection. This study therefore recommends that these social and cultural constructions gendered sexuality need to be challenged and disrupted. The society must be willing to redefine sexual roles in relation to HIV/AIDS epidemic.
3. The above recommendations may not have much impact without the backing of law. Legal interventions are required to bring to an end to violations of human rights by changing the underlying values and patterns of social interaction that create vulnerability to HIV/AIDS. Women should be protected from violent partners when they say no to unprotected sex. They



should also be able to stay in their matrimonial homes and get financial support from their partners even when they refuse to have sex with their partners. For all intend, women's right to safer sex and autonomy in all decisions on their bodies should be respected in support of Kamau (DN 26 – 09 – 03). It is suggested that conjugal rights be downgraded to conjugal privileges in this era of HIV/AIDS. In this regard, the rights-based approach in the context of HIV/AIDS is certainly to open the doors to reviewing some of the cultural and traditional practices that are upheld by customary law but which are detrimental in challenging the pandemic.

4. There is need to promote those strategies, which women have under their control. Few women (33%) interviewed for this study have heard about female condoms leave alone used them and there is need for their accessibility and availability. There have been studies on female condom to gauge its acceptability and effectiveness and there was conclusion that the overall balance view lies in its favor as a female controlled method of barrier protection. Working towards female condom promotion and increasing women's abilities to communicate assertively and effectively with sexual partners both should be promoted as prevention measure under women's control. Women's assertiveness includes initiating wanted sexual activities and discussing or insisting on using condoms. Lack of knowledge about female condom could be attributed to its association with commercial sex workers and single women with multiple sexual partners. There is need for awareness creation about female condom.

5. For the above recommendation to work well there is need to design programmes that are able to incorporate men. This would help in drawing

on men's perceived strengths in order to affirm forms of power that are not destructive and hierarchal. It would also be important to bring on board male role models involved in counseling and education processes thus men who live out a different norm of heterosexuality and who can be peer models.

### **6.3 Areas For Further Research**

Further research is suggested in the following areas:

1. AIDS and Human Rights. A case of Human Rights violation against women
2. Identify and incorporate the social context in prevention interventions
3. To assess the extent to which HIV/AIDS responses address gender. This will have the ultimate goal of empowering women and transforming gender relations.

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## APPENDIX: RESEARCH INSTRUMENT

### STUDY ON STRATEGIES ADOPTED BY WOMEN IN HETEROSEXUAL UNIONS IN HIV/AIDS PREVENTION

#### A. BACKGROUND INFORMATION

Date of interview \_\_\_\_\_

Household number \_\_\_\_\_

Village \_\_\_\_\_

Name of respondent \_\_\_\_\_

Sublocation \_\_\_\_\_

Location \_\_\_\_\_

Age of respondent in years \_\_\_\_\_

Level of Education \_\_\_\_\_

1. None
2. Lower primary
3. Upper primary
4. Secondary
5. University/college
6. Adult Literacy
7. Others (Specify).

Religious Affiliation

1. Traditionalism
2. Catholic
3. Protestant
4. Muslim
5. Others  
(Specify)

Ethnic background-----

1. Embu,
2. Kalenjin,
3. Kamba,
4. Kikuyu,
5. Kisii,
6. Luyha,
7. Luo,
8. Masai,
9. Meru,
10. Mijikenda/Swahili,
11. Somali,
- 12.

Taita/Taveta 13. Other (specify)

What is your occupation?

1. Professional (specify) 2.skilled (specify) 3. Semi-skilled 4. Unskilled 5. Housewife 6. Others (specify)

What is your monthly income?

- Less than 1 000 2. 1 000-5 000 3. 5 000-10 000 4. over10 000.

Would you describe yourself as married?

- Yes..... 2. No.....

How long have you been married to your current partner?

15. What type of marriage would you say you are in?

1. Traditional monogamous 2.Traditional polygamous 3.Religious monogamous 4.Religious polygamous 5. Consensual Union 6. Other (specify)

16. How many children do you have?

\_\_\_\_\_

17. Do you have any independent income from your partner?

1. Yes ..... 2. No.....

18. What is the age of your

partner? \_\_\_\_\_

19. What is your partner's occupation?

1. Professional (specify) 2. Skilled (specify) 3. Semi-skilled .

4. Unskilled 5. Do not know

20. What is his highest level of education?

1. Lower Primary 2. Upper Primary 3. Secondary 4.

College/University 5. Do not know

21. Approximately what is your partner's monthly income?

1. Less than 1000 2. 1000-5000 3. 5000-10000 4. over 10000

**B. perception of HIV/AIDS and other STIs**

22. Have you heard about AIDS?

Yes \_\_\_\_\_ No (go to qn 28) No response

23. From whom did you learn about HIV/AIDS?

1. Radio 2. Television 3. Newspaper/magazine 4. Health workers

5. Friends/Relatives 6. churches/mosques 8. Other (specify). (Tick all mentioned)

24. Do you know how HIV/AIDS is transmitted?

1. Through Unprotected Sexual Intercourse 2. Sexual intercourse with multiple partners 3. Sex with prostitutes 4. Homosexual conduct. 5. Mother to child

6. Kissing 7. Blood transfusion 8. Mosquito bites 9. Other (specify) (Record all mentioned)

25. Can AIDS be cured? 1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_ 3. Does not know \_\_\_\_\_

26. (a) Have you ever heard of medicines that people with AIDS can use to improve their health and slow down the progress of the disease?

Yes ..... 2. No. .... 3. Do not know .....  
4. No response .....

(b) If Yes (above) what are these medicines

1. Herbs/immune boosters 2. Health supplements/vitamins  
3. Antibiotics 4. anti-diarrheas 5. Anti-fungal 6. Anti-retroviral drugs  
7. Traditional medicine 8. Other (specify)

(c) If ARVs where can one get them?

Doctor/clinical officer at hospital 2. Traditional Healer 3. Herbalists  
Market 5. Other (specify)

27. What can you do to avoid getting HIV?

1. Abstain from sex 2. Use condoms 3. Avoid multiple sex partners  
4. Avoid sex with prostitutes 5. Be faithful to one partner 6. Avoid sex with homosexuals  
7. Other (specify)

28. Have you ever contracted any STI? 1. Yes .....

2. No(Go to qn 44) 3. Do not know

29. If Yes, (above) which of the diseases did you have?

1. Syphilis
2. Gonorrhoea
3. Genital warts
4. Other (specify)

30. How did you know you had the disease?

Diagnosed in Government Hospital/Health Center 2. Private clinic/Doctor

Mobile clinic 4. Other (specify).

31. Do you know how you got infected?

1. Yes.....
2. No.....
3. Do not know.....

32. If Yes, (above) explain how?

1. Infected by partner
2. Infected by casual partner
3. Do not know
4. Other (specify)

33. When you had disease(s) (from qn 28) did you inform your spouse?

Yes..... No.....

34. If you didn't, why?

1. Did not know how to inform him
2. Afraid of blame
3. He is violent
4. Other (specify)

35. If Yes why?

Thought he infected me

To avoid infecting him

To seek treatment together

36. If you did inform your spouse, how did you go about it? Explain

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

37. Did you encounter any problems in communicating this information to him?

Yes ..... 2. No.....

38. If Yes, what problems?

1. Fear

2. Taboo to discuss productive health

3. Other (specify)

39. What was your partner's reaction to your disclosure?

1. Angry with self

2. Accused me of unfaithfulness

3. Refused to talk about it

4. Threatened divorce

Other (specify)

40 (a) Did you seek advice/treatment together?



1. Yes..... 2. No.....

(b) If Yes, why?

---

---

(c) If No, why?

Partner refused

Own problem

41. What type of facility did you seek advice/treatment?

- 1. Government Hospital/Health center
- 2. Mission Hospital/Clinic
- 3. Private Hospital/ Clinic
- 4. Private Doctor
- 5. Herbalist/Traditional Pract
- 6. Other (specify)

42. Who met the costs?

- 1. Partner
- 2. Self
- 3. jointly self and partner
- 4. Other (specify)

43. How much did the treatment cost?

---

---

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**C. Risk Perception and Safer Sex Practices**

44. Do you consider yourself at risk of HIV/AIDS in your marriage?

Yes.....2. No.....(go to qn 44)

45. If Yes (above) what are your chances of contracting it?

1. Small
2. Moderate
3. Great

46. Why do you consider yourself (in qn 44 ) at risk?

1. Partner has other sexual partners
2. Self has many sexual partners
3. Do not use a condom
4. Other (specify)

47. If (qn 46 ) you do not consider yourself at risk can you give reasons?

1. Partner faithful
2. Have only one sexual partner
3. Use condoms
4. Limited number of sexual partners
5. Trust in God
6. Other (specify)

48. Have you ever suspected your partner of having other sexual partners?

1. Yes.....
2. No..... (Move to Q53)
3. Don't know

49. If Yes, what reason do you have to suspect him?

1. He is alcoholic
2. Comes home late
3. Not interested in sex with self
4. Other (specify)

50. What have you done about his conduct?

1. Discussed the issue with partner
2. Abstained from sex
3. started condom use.
4. Did nothing
5. Prayed to God
6. Other (specify).

51. If in (qn 50 ) you suspect your partner of having other sexual partners, do you think it is important to introduce condom use?

1. No..... 2. Yes ..... 3. Do not know  
.....

52. If your partner has not made changes in his sexual life why are you still in this relationship?

1. No where to go 2. Because of children 3. Love him 4.  
Other (Specify) \_\_\_\_\_

53. (a) Have you ever been forced into sexual activities by your partner?

Yes ..... 2. No..... (b) If Yes (above) how many times did this happen in the last six months?

(c) How did this happen?

1. Verbally threatened/blackmailed
2. Physically hurt or overpowered
3. Sweet-talked.
4. Bribed

54. What are possible ways of reducing the risk of transmission?

1. Being faithful to one partner
2. Using a condom
3. Abstaining
4. Others (specify)

55. Are the ways you have mentioned difficult to use?

1. Yes ..... (Explain)

---

2. No ..... (Explain)

---

3. Do not know

56. Do you know of (other sexual activities other than penetrative sex) which might be at the low risk end? Yes ..... No.

.....

57. If Yes (above) please name them

1. Rubbing each others thighs

2. Mutual masturbation

3. Talking dirty to each other on phone while masturbating

4. Stroking

5. Massage/kissing

6. Saying No

7. Other (specify)

58. Have you ever tried any of these methods?

1. Yes ..... 2. No.....

59. How do you think these methods could be promoted?

1. By discussing with partner

2. Empowering women

3 By educating women how t use them

4. By educating men

5. Other (specify)

60. How could high risk activities be made safer?

1. By using condom

2. Being faithful

3. Do not know

4. Other (specify)

61. Have you ever been tested to see if you have the AIDS Virus?

1. Yes ..... 2. No .....

62. (a)Do you know a place where you could go to get an AIDS test?

1. Yes ..... 2. No .....

(b)Where could you go?

1. Public sector

2. Government hospital

3. Government Health Centre

4. Government Dispensary

5. Private Doctor

6. Other (specify)

63. Do you think a wife is justified in refusing to have sex with her  
legally married partner?

1. When she knows her partner has a sexually transmitted disease?
2. She knows her partner has sex with other women?
3. She has recently given birth?
4. She is tired or not in the mood.

Has STD .....	1	2	3
Other women.....	1	2	3
Recent Birth .....	1	2	3
Tired/mood.....	1	2	3

64. Have you ever used a condom with the partner you are married to?

1. Yes ..... 2. No..... (Go to qn 69)

65. If yes (qn 64) what were the reasons for use?

Respondent wanted to prevent STI/HIV 2. Respondent wanted to prevent pregnancy 3. Respondent wanted to prevent both pregnancy/STI 4. Did not trust partner 5. Partner insisted 6. others (specify)

66. Who suggested the use of condom? 1. Partner 2. Wife 3. Joint decision

67. Was it easy to introduce its use?

1. Yes ..... 2. No.....

68. If No (above) what were the barriers?

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69. Have you ever heard of a female condom? 1. Yes .....  
2. No.....(Go to qn 75) 3. No response

70. Have you ever used a female condom? 1.Yes.. 2. No... 3. Do not know 4. No response.....

71. If Yes in above, with whom did you use the female condom with?  
1.Partner  
2.Irregular Partner  
3. Other (specify)

72. If the female condom was used with partner why was it used?  
Self suspected partner  
One partner was infected with STI  
Mutual agreement for protection from STI  
Other (specify)

73. How regularly do you use the female condom?  
For every sexual activity  
Twice per week  
Once per month

74. Which are places or persons where one can get female condoms? 1. Government Hospitals 2. Family planning clinics 3. Pharmacies 4. Shops/kiosks 5. VCT Centres 6.Private doctors 7.

Others (Specify)

75. Do you think it is good for a married woman like you to use condoms?

1. Yes..... 2. No.....(Give reasons for your answer)

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**(D) Decision –making Capacity of Women**

76. Do you personally ever initiate sex?

1. Yes..... 2. No.....

77. If yes (above) in what circumstances do you initiate sex?

1. When in the mood 2. When partner is unable to 3. After a long time  
4. other (specify)

78. Are there sometimes you cannot initiate sex?

Yes 2. No

79. If yes (above), explain under which circumstances you cannot.

When partner is in bad mood

When tired

When sick

Other (specify)

80. Do you find asking for safer sex difficult or easy? Explain your



answer

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81. Do you feel it is important to make changes in your sexual life?

Yes ..... No.....

82. If Yes, how do you intend to do this?

1. Abstain
2. Use condom
3. Ask partner to be faithful

83. If no, why?

1. Both of us faithful
2. Partner won't agree
3. Partner faithful
4. other (specify)

84. Who decides (ed) the number of children you should have?

1. Partner
2. Respondent
3. In-laws (Relatives)
4. Jointly respondent and partner

85. If you know you are at risk of contracting HIV from your partner, are you able to 'say NO' to unprotected sex? 1. Yes .....

(Explain) 2. No ..... (Give reasons)

86. Do you think your partner has extra-marital affairs because he has more money?

1. Yes .....
2. No.....

## **Focus Group Discussions Guide**

1. HIV/AIDS prevention methods available to women. Whether these methods are also available to women in marital unions.
2. Many people believe that if you are married you can not easily get infected with HIV/AIDS. What do you say about this?
3. What steps should a woman take when confronted with the risk of HIV/AIDS infection in her marriage?
4. Decision-making process in reproductive Health including decision to take HIV/AIDS test, number of children and when to have sex.