

Full Length Research Paper

Male Spouse Perpetrated Psychological and Sexual Abuse among Pregnant Women in Nairobi, Kenya

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Abstract

The purpose of this comparative retrospective study was to evaluate the nature of male spouse-perpetrated gender based violence (GBV) during pregnancy. The objective was to establish whether diagnosis of HIV infection during pregnancy mitigates or exacerbates male spouse perpetrated psychological and sexual abuse during pregnancy. Case group comprising 96 HIV infected pregnant women, and comparison group (96 uninfected), all in their third trimester of pregnancy were interviewed upon consenting. A modified Conflict Tactics Scale 2 was administered to compare the two groups in terms of psychological aggression and sexual coercion. Results indicated prevalence and severity of male spouse perpetrated abuse to be higher for case group than comparison group across both psychological aggression and sexual coercion subscales. The odds of male spouse perpetrated violence was 6.64-fold higher in HIV positive pregnant women compared to HIV negative pregnant women (OR = 6.64, 95% CI 1.56-28.27, $p = 0.010$). Thus, diagnosis of pregnancy and absence of HIV infection was associated with mitigated occurrence and severity of male spouse perpetrated abuse, while diagnosis of HIV infection during pregnancy exacerbated the same. The investigator recommends immediate sensitization of health and social workers attending to pregnant women on the escalative effect of HIV positive diagnosis on male-spouse perpetrated violence. Intensive couple counseling and follow up care need to be specially designed and implemented for such couple whether they are concordant positive or discordant.

Keywords: Gender based violence, HIV, AIDS, Pregnancy, male spouse-perpetrated violence.

BACKGROUND LITERATURE REVIEW

The World Health Organization emphasizes that there is a lot of ground to cover in order to achieve universal maternal health by 2015 as envisaged by the Millennium Development Goal 5 (MDG 5) especially in Sub-Saharan Africa (WHO 2008). While the medical outcomes of gender based violence (GBV) towards pregnant women are well documented, little research from Kenya has explored the drivers of IPV among pregnant women (Hatcher et al., 2013).

In the context of co-existing GBV and vulnerable groups in the population, the focus of this research study

was to establish the effects of diagnosis of HIV infection during pregnancy on male spouse perpetrated violence. It is estimated that one in every three women around the globe have been beaten, coerced into sex or otherwise abused in her life (Ocha/Irin, 2005). The public health repercussions of this violence are that women suffer assault, rape, murder, unwanted genital trauma, sexually transmitted infection (STDs), psychological trauma and complication of pregnancy and childbearing amongst others (Ocha/Irin, 2005).

Although the World Health Organization estimates the prevalence of partner perpetrated violence during pregnancy to range between 4% to 32% worldwide, with rates being considerably higher in developing countries (WHO 2004), there is limited documented and published studies on this issue in Africa. In Kenya, 43% of women

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in the reproductive age of 15-49 years reported having experienced some form of gender-based violence in their lifetime, with 29% reporting an experience in the previous year. Some 16% of these girls and women reported having ever been sexually abused, with 13% of them reporting this to have happened in the last one year (KDHS, 2003).

In rural Ethiopia, 49% of ever-partnered women reported to have ever experienced physical violence by an intimate partner, rising to 59% ever experiencing sexual violence (WHO, 2006). In rural Tanzania, 47% of ever-partnered women have ever experienced physical violence by an intimate partner, while 31% reported to have ever experienced sexual violence (WHO, 2006). The UNFPA (2007) reported that in England and Wales, 40-60% of women experiencing domestic violence are abused during pregnancy and that 30% of all domestic abuses start during pregnancy.

Studies from diverse settings such as China, Peru, the USA, and Uganda have found that girls and women who have previously experienced sexual coercion are significantly less likely to use condoms, and more likely to experience genital tract infection symptoms, unintended pregnancy and a higher incidence of unsafe abortion (Gazmararian et al., 1995; Campbell et al., 2004). Lack of sexual autonomy and control stemming from actual or threatened violence, together with fear of repercussion from use of condoms or contraception, are direct pathways to unwanted pregnancy and increased risk of STIs (Kishor and Johnson, 2004).

Moreover, intimate partner violence has been found to be independently associated with HIV infection (Siemieniuk et al., 2010; Schechter et al., 2011). This is because not only have most sexual violence been found to be unprotected, but also vaginal lacerations and trauma increase the risk of transmitting the virus (Jansen et al., 2002). Victims of violence are more likely to engage in risk behaviors, such as injection drug use, which increase the risk of exposure to HIV (Abdool, 2001; Choi et al., 1998; Gilbert et al., 2002; Heise et al., 1999; Wyatt et al., 2002). As observed earlier intimate violence has been shown to be a risk factor for STIs, which, in turn, may increase the rate of HIV transmission (Thompson et al., 2002). Victims of violence are often unable to negotiate the use of a condom (Campbell et al., 2004; Davila and Brakley, 1999; Wingood and Clemente, 1997). Furthermore, proposing the use of condom may increase a woman's risk of being exposed to violence by her uncooperative partner. (Gielen et al., 2000). Several authors have indicated that violence or fear of violence may keep women from HIV testing and that violence may occur as a consequence of testing (Gielen et al., 2000; Heise et al., 2008; 2001; Maman et al., 2002).

WHO indicates that among the indirect causes that contribute to 20% of maternal deaths are diseases that complicate pregnancy such as malaria, anaemia and HIV. As observed earlier intimate violence has been shown to be a risk factor for STIs, which, in turn, may

increase the rate of HIV transmission (Thompson et al., 2002). Furthermore violence against women may result in unwanted pregnancy either through rape or by affecting a woman's ability to negotiate contraceptive use (WHO, 2008). Unwanted pregnancy before girls are biologically and psychologically sexually mature is associated with adverse health outcomes for both the mother and child. Research shows that the leading cause of death for 15 – 19 years old girls worldwide is complications from pregnancy and childbirth. Further, women are also vulnerable to contracting Sexually Transmitted Diseases (STDs) and HIV/AIDS because they are unable to negotiate for protection (WHO, 2006).

Violence usually goes by unnoticed. This is partly because people visiting health care services will rarely disclose spontaneously that they have undergone or carried out a violent act. Reasons for this are multiple. For instance, it is an unpleasant experience which the person feels uncomfortable remembering. Also a person experiencing domestic violence can be persuaded to introject the notion that she has suffered the violence because it is necessary or they deserved it. The specific objective of the study is as follow:

1. To compare HIV infected and uninfected pregnant women in occurrence of male spouse-perpetrated psychological aggression.
2. To compare HIV infected and uninfected pregnant women in occurrence of male spouse-perpetrated sexual coercion.

STUDY DESIGN AND METHODOLOGY

This study utilized a comparative retrospective research design that collected and analyzed quantitative data. The study was carried out within the city of Nairobi, the capital town of Kenya. Nairobi had a population of slightly over 3 million people according to the 2009 census (Central Bureau of Statistics, 2009). Nairobi city was chosen as the area of study because of its size (being the largest city in the country) and its geographical location (being approximately central) and its heterogeneous composition which is considered more representative of most of Kenya's ethnic and cultural groups compared to any other town in the country.

Within the city, the participants were recruited from two hospitals, namely the Kenyatta National Hospital (KNH) and Pumwani Maternity Hospital (PMH). These two hospitals were chosen because KNH is the major national public referral, teaching and research hospital in the country, while PMH is the largest maternity hospital in Kenya which also provides clinical teaching opportunity to both public and private tertiary educational institutions in Kenya.

In these two hospitals, a total of 96 HIV infected and 96 uninfected pregnant women who were attending for various antenatal services were traced. A modified Conflict Tactics Scale 2 (Murray et al., 2003) was

administered to the sample to capture issues of spousal psychological and sexual violence.

Pregnant women had to fulfill all of the following inclusion criteria;

1. Be in the third trimester of pregnancy (i.e. 7th, 8th and 9th month gestation)
2. Lived with her current male spouse for at least one year prior to commencement of this study.
3. Both herself and her spouse had known their mutual HIV statuses (as diagnosed by the hospital's screening tests) for at least four months prior to commencement of this study.
4. That her HIV status and that of her spouse were tested during the current pregnancy.
5. Both herself and her spouse had known about the presence of current pregnancy for at least four months prior to commencement of this study.
6. Gave informed voluntary consent to participate in the study

The completed and cleaned questionnaires were numbered and coded for ease of handling. Data were entered using STATA version 12 computer software. The data were using percentages, ratios, mean, standard deviation, correlation coefficient, chi square test and logistic regression analyses.

Ethical Considerations

The authority to conduct this research was obtained from the Ethic and Research Committees of the Kenyatta National Hospital and Pumwani Maternity Hospital. Confidentiality of study participants was ensured throughout the execution of this study. All the information obtained was used only for the purpose of this study. Study participants were required to give their own individual voluntary informed consent of participation in this study. For participants under the age of 18 years, both they and their parent or legal guardian gave consent.

RESULTS AND DISCUSSION

Demographic Characteristics of Study Participants

The table 1 below depicts the demographic characteristics of study participants

Discordance among Study Participants and their Spouses

This study established existence of couple discordance in terms of HIV statuses of partners. Thirteen (13.5%) of HIV infected pregnant women had male spouses that were HIV negative. Similarly, 4 (4.2%) of HIV negative pregnant women had spouses that were HIV positive

The difference between the case and comparison groups in terms of HIV status discordance of spouse was significant ($p < 0.001$).

The phenomenon of HIV status discordance among sexual partners is not new. Records of recent unpublished studies at the Comprehensive Care Centre of the Kenyatta National Hospital indicate that HIV discordance rates could be higher than previously thought, with discordance rates of 10% having been recorded. It is very important that such couples adhere to HIV prevention practice diligently, such as proper and consistent use of either male or female condom to ensure protection during sexual intercourse. This will protect the HIV negative partner from getting infected. Even in situations where couple HIV positive concordance exists, consistent and proper use of condom should be maintained to ensure that cross-infection with new clades of the Human Immunodeficiency virus does not occur between the couple.

The investigator also observed that several pregnant women could not be included in the sample due to the refusal of their male spouses to undergo routine antenatal HIV testing together with them as is required by the hospital protocol. In fact, the researcher observed some instances where, upon couples being requested to be screened for HIV, the male spouse walked out of the antenatal clinic, and some dragged their pregnant spouses along to seek services elsewhere. This observation is in tandem with the finding of a study in Zimbabwe by Shamu et al. (2012). In that study, it was established that men refused to take HIV test but expected to infer their HIV status from their partner's results. Participants and health workers reported that men saw having a baby was a way of knowing their own HIV status through their partner's HIV test result at the antenatal clinic.

Minor Psychological Aggression

As depicted in table 2 below, there were significant differences between the two groups in all the four items when they were asked whether these experiences had worsen or improved after the couples discovered the pregnancy and their HIV statuses ($p = 0.03, 0.02, 0.005$ and 0.002 respectively). Male spouses of HIV positive were reported to have abused their pregnant spouses more after HIV testing than those of the comparison group.

Severe Psychological Aggression

The results in Table 3 revealed that while the comparison group minimally endorsed these items (below 10% for all these four items), about a third of the HIV positive pregnant women endorsed each of these

Table 1. Demographic characteristics of participants

Demographic characteristic	HIV status		Chi square value	P value
	Positive	Negative		
Age in years				
19 yrs and below	7(7.3%)	7(7.3%)	0	1.00
20-24 yrs	23(24.0%)	15(15.6%)	2.10	0.15
25-29 yrs	18(18.8%)	30(31.3%)	4.0	0.046
30-34 yrs	22(22.9%)	22(22.9%)	0	1.00
35-39 yrs	15(15.6%)	10(10.4%)	1.15	0.28
40yrs and above	11(11.5%)	12(12.5%)	0.05	0.82
Religion				
Catholic	49(51.0%)	53(55.8%)	0.33	0.56
Protestant	23(24.2%)	27(28.1%)	0.43	0.51
Muslim	15(15.8%)	13(13.7%)	0.17	0.68
Traditional	9(9.5%)	3(3.2%)	NA	NA
Education level				
No formal education	9(9.4)	11(11.5%)	0.22	0.64
Primary school	16(16.7%)	14(14.6%)	0.16	0.69
Secondary school	42(43.8%)	50(50.1%)	1.34	0.25
College certificate	11(11.5%)	14(14.6%)	0.41	0.52
College diploma	12(12.5%)	5(5.2%)	3.16	0.08
Bachelors degree	5(5.2%)	2(2.1%)	NA	NA
Masters degree	1(1.0%)	0(0%)	NA	NA
Monthly income				
Own earnings	8(8.3%)	5(5.2%)	0.74	0.39
Spouse earnings	26(27.1%)	15(15.6%)	3.75	0.05
Combined earnings	62(64.6%)	76(79.2%)	5.04	0.03
Employment status				
Formal	22(22.9%)	22(22.9%)	0	1.00
Informal	48(50.0%)	62(64.6%)	0.66	0.44
Unemployed	26(27.1%)	12(12.5%)	6.43	0.01
Marital status				
Civil	13(13.5%)	7(7.3%)	2.0	0.16
Customary	30(31.3%)	30(31.3%)	0	1.00
Religious	29(30.2%)	30(31.5%)	0.02	0.88
Cohabiting	24(25.0%)	29(30.2%)	0.65	0.42

Table 2. Reported frequency after couple's knowledge of pregnancy and HIV status

Item	HIV positive		HIV negative		χ^2	P value
	Increased	Less	Increased	Less		
My partner insulted or swore at me	28(29.2%)	10(10.4%)	8(8.3%)	10(10.4%)	4.5	0.03
My partner shouted or yelled at me	35(36.5%)	11(11.5%)	16(16.7%)	16(16.7%)	5.7	0.02
My partner stomped out of the room or house or yard during a disagreement	21(21.9%)	7(7.3%)	10(10.4%)	17(17.7%)	8.1	0.005
My partner did something to spite me	54(56.3%)	5(5.2%)	9(9.4%)	6(6.3%)	9.4	0.002

Table 3. Endorsement of severe psychological aggression items according to HIV status

Item	HIV positive		HIV negative		χ^2	P value
	Once or more	Not happened	Once or more	Not happened		
My partner called me ugly	33(34.7%)	62(65.3%)	6(6.3%)	90(93.8%)	23.8	<0.001
My partner destroyed something belonging to me	31(32.3%)	65(67.7%)	5(5.2%)	91(94.8%)	23.1	<0.001
My partner accused me of being a lousy lover	32(33.3%)	64(66.7%)	9(9.4%)	87(90.6%)	16.4	<0.001
My partner threatened to hit or throw something at me	30(31.3%)	66(69.5%)	8(8.3%)	88(91.7%)	15.9	<0.001

Table 4. Frequency of occurrence of minor sexual coercion after couple's knowledge of pregnancy and their HIV status

	HIV positive		HIV negative		χ^2	P value
	Increased	Less	Increased	Less		
My partner made me have sex without a condom when we should have used it.	7(7.3%)	2(2.1%)		1(1.0%)		
My partner insisted that I have sex when I didn't want to (but did not use physical force)	14(14.6%)	20(20.8%)	34(35.4%)	14(14.6%)	7.2	0.007
My partner insisted I have oral or anal sex (but did not use physical force)	16(16.7%)	1(1.0%)	3(3.1%)			

items. Furthermore, when asked whether her subjection to this behavior by her spouse had been worsened, or mitigated by the couple's knowledge of pregnancy and HIV status, almost all case group participants who had endorsed them indicated that the situation had actually deteriorated.

The difference between the case and comparison groups in endorsement of severe psychological aggression were significant for all the items ($p < 0.001$, $\chi^2 = 23.8, 23.1, 16.4, 15.9$ respectively). This finding concurs with a study conducted in Rwanda by Ntaganira et al. (2008) in two urban antenatal clinics in Kigali and two rural antenatal clinics that HIV infection was associated with severe psychological violence among pregnant women.

Male Spouse Perpetrated Sexual Coercion

Table 4 findings of this study indicate that pregnant women who are negative (comparison group) were subjected by their spouse to engage in sexual intercourse when they did not want to, more than it happened to HIV positive pregnant women, though the spouse had not used force. This difference between case and comparison groups was found to be significant ($p = 0.04$).

Furthermore, when participants who had endorsed

this item were asked whether it had increased or decreased since the couple's knowledge of pregnancy and their HIV statuses, more (35%, $n = 34$) of HIV negative participants, compared to 14.6% ($n = 14$) of HIV positive participants indicated that it had increased. This difference between the two groups was also found to be significant ($p = 0.007$). These findings are in tandem with those of a study in rural Kenya by Hatcher et al. (2013). In that study that involved focus group discussions, both pregnant women and male partners described sexual coercion as part of married relationships. In Zimbabwe a study by Shamu et al. (2012) explored intimate partner sexual violence during pregnancy in the context of HIV reported that coercive or violent sex during pregnancy was common.

It is not clear whether Kenyan men understand and appreciate that this behavior of insisting on having sex with one's spouse, though not using threat or physical force, constitutes sexual coercion or abuse of the spouse. There has been a lot of discussion in social media on this issue, and particularly whether it is possible in reality for marital rape to occur. The investigator recommends that further future research be conducted on this issue. This should inform subsequent policy, legislation and public education, so that it becomes universally ingrained in the various cultures and subcultures in Kenya.

Table 5. Response to severe sexual coercion items according to HIV status

Item	HIV positive		HIV negative		χ^2	P value
	Once or more	Not happened	Once or more	Not happened		
My partner used force to make me have oral or anal sex	3(3.1%)	93(96.9%)	1(1.0%)	95(99.0%)	NA	NA
My partner used force (like hitting, holding down, or using a weapon) to make me have sex	1(1.0%)	95(98.9%)	0(0%)	96(100.0%)	NA	NA
My partner used threats to make me have oral or anal sex	12(12.5%)	84(87.5%)	1(1.0%)	95(99.0%)	*	0.003
My partner used threats to make me have sex	26(27.1%)	70(72.9%)	3(3.1%)	93(96.9%)	*	<0.001

Table 6. Summary of prevalence of various forms of male- spouse perpetrated GBV during pregnancy

GBV Sub-Scale	Prevalence		
	HIV Positive	HIV Negative	Mean
Minor psychological aggression	44.6%	24%	34.3%
Severe psychological aggression	32.8%	7.3%	20.1%
Minor sexual coercion	20.8%	18.1%	19.5%
Severe sexual coercion	10.9%	1.3%	6.1%
Mean Prevalence	27.3%	12.7%	20%

Severe Sexual Coercion

Table 5 findings indicate that in the severe sexual coercion subscale, there was higher endorsement rate in all these items by HIV infected pregnant women compared to those who were not infected. It was also observed that the majority of participants who endorsed these items reported that sexual coercion by their spouse had gotten worse during pregnancy. Furthermore, significant differences between case and comparison groups were found when participants were asked whether her spouse had used threats to make her have oral or anal sex ($p = 0.003$), and whether he had used threats to make her have sex ($p < 0.001$).

As observed earlier, research has indicated that sexual violence can result in HIV transmission. Not only is most sexual violence unprotected, but vaginal lacerations and trauma increase the risk of transmitting the virus (Jansen et al., 2002). Victims of violence are more likely to engage in risk behaviors, such as injection drug use, which may increase their risk of exposure to HIV (Abdool, 2001; Choi et al., 1998; Gilbert et al., 2002; Heise et al., 2008; Wyatt et al., 2002).

Summary of Prevalence of Spouse GBV during Pregnancy

Overall, the case group comprising of pregnant women living with HIV infection consistently reported higher prevalence of male spouse perpetrated across psychological and sexual coercion subscales (Table 6). Further, it was observed that 8 (8.3%) participants in case group knew of their HIV positive status, though they had never told their spouses, before the current pregnancy, and in spite of this they still went ahead to get pregnant. While the investigator found this perplexing, it was not surprising given the fairly high prevalence of male spouse perpetrated GBV among this group.

While making a recommendation for conduct of further future research on this finding, the investigator postulates that spouse perpetrated violence and fear of such violence could be the underlying factor. Thus, the assertion by Gielen et al. (2000); Heise et al. (2008); Maman et al. (2001) and Maman et al. (2002) show that violence or fear of violence may keep women from HIV testing, and that violence may occur as a consequence of testing could hold true for this finding. Moreover, intimate partner violence has been found to be

independently associated with HIV infection (Ghanotakis et al., 2012). This is because not only is most sexual violence been found to be unprotected, but also vaginal lacerations and trauma increase the risk of transmitting the virus (Jansen et al., 2002).

CONLUSSION

Diagnosis of HIV infection during pregnancy appears to escalate the occurrence and severity of male spouse perpetrated psychological and sexual abuse of female spouse.

RECOMMENDATIONS

Healthcare workers attending to pregnant women should immediately be sensitized on the escalative effect of couple or spouse HIV positive diagnosis on male-spouse perpetrated gender based violence on pregnant women. Intensive couple counseling and follow up care need to be specially designed and implemented for such couple whether they are concordant positive or discordant.

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