NATURE AND PREVALENCE OF GENDER BASED VIOLENCE EXPERIENCES BY HIV POSITIVE WOMEN ATTENDING MTRH AMPATH CLINIC, ELDORET

BY

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Declaration

Declaration by candidate:

This thesis is my original work and has not been presented for a degree in any other University. No part of this thesis may be produced without the prior written permission of the author and/or Moi University.

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Dedication

To the thousands of women who have fallen to the AIDS scourge, to the many more HIV infected women who continue to strongly live on and to those who, over the days and nights, dedicate their lives and minds towards overcoming the HIV/AIDS pandemic, I dedicate this work.

I hope that this is one more step closer to the ultimate solution in the fight against HIV/AIDS.

Acknowledgement

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Abstract

Title: The nature and prevalence of Gender Based Violence (GBV) experiences by HIV positive women attending MTRH AMPATH clinics, Eldoret.

Introduction: GBV is increasingly being cited as a cause and consequence of HIV infection. Prevalence of GBV as a consequence of HIV infection and nature of such GBV needs to be assessed in order to inform programs providing care to HIV positive women.

Objectives: This study sought to determine the nature and prevalence of GBV experienced by HIV infected women attending AMPATH MTRH clinic and to determine GBV and its relation to adherence to drugs and clinic attendance. Services provided by AMPATH program to victims of GBV were also determined.

Methods: This was a cross sectional study conducted between May and July 2009 involving randomly selected 368 HIV positive women attending AMPATH MTRH clinic. HIV positive women aged 18-49 years were included into the study. Demographic data, experiences of GBV, forms of GBV, frequency of missed clinic visits and drugs and services available for GBV victims at AMPATH were assessed.

Findings: 76% of HIV positive women reported history of GBV. Three forms of GBV were identified; physical, sexual and emotional. GBV was a consequence of disclosure of HIV positive status OR=8.7 and was significantly associated with poor adherence to clinic visits and drug p=0.001, OR=2.9. AMPATH program provides GBV support services but are underutilized by HIV positive patients because of unawareness by the patients, and GBV not being a core business hence less focus.

Conclusion: The high prevalence of physical, emotional and sexual GBV among the HIV positive women and its association with poor adherence to clinic visits and drugs emphasizes the need for screening of GBV and highlights the need to promote awareness hence utilization of the available services at AMPATH.

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List of Abbreviations/Acronyms

AED – Academy for Educational Development

AFR/SD – Africa Bureau Office of Sustainable Development

AIDS – Acquired Immunodeficiency Syndrome

AMPATH – Academic Model of Providing Access To Healthcare

AMRS – AMPATH Medical Record System

ANC – Antenatal Clinic

ANOVA – Analysis of Variance

ART – Antiretroviral Therapy

ARV – Antiretroviral drugs

CARE – Centre for Assault Recovery, Eldoret

CI – Confidence Interval

CT – Counseling and Testing

Dr. – Doctor

EP – Emotional and Physical violence

ES – Emotional and Sexual violence

GBV – Gender Based Violence

GOK – Government of Kenya

HAART – Highly Active Anti-retroviral Therapy

HCP – Health Care Provider

HIV – Human Immunodeficiency Virus

ID – Identification

IDPs – Internally Displaced Persons

IREC – Institutional Research and Ethics Committee

KDHS – Kenya Demographic Health Survey

LACE	– Legal Aids Centre, Eldoret
MOH	– Ministry of Health
MTRH	– Moi Teaching and Referral Hospital
NGO	– Non Governmental Organization
PEP	– Post Exposure Prophylaxis
PES	– Physical, Emotional and Sexual violence
PGH	– Post Graduate in Health
PMTCT	– Prevention of Mother-To-Child Transmission
PS	– Physical and Sexual violence
SPH	– School of Public Health
SPSS	– Statistical Package for Social Sciences
STI	– Sexually Transmitted Infection
STD	– Sexually Transmitted Diseases
TB	– Tuberculosis
UNAIDS	– United Nations Agency for International Development
UNDP	– United Nation Development Program
UNFPA	– United Nation Population Fund
USAID	– United States Agency for International Development
VCT	– Voluntary Counseling and Testing
WHO	– World Health Organization

Definition of Terms

Gender – It refers to the rules, norms, customs and practices through which the biological differences between males and females are interpreted and transformed into social differences between men and women, boys and girls. As a result, women/girls and men/boys are valued differently and have unequal opportunities and life chances.

Violence – It is aggressive behaviour that may be physically, sexually or emotionally abusive. In this context, violence is aggressive behaviour conducted by an individual to a HIV positive woman. Physically abusive behaviour is where one directly or indirectly ill treats causing physical injuries. This involves pushing, slapping, shoving, shaking, punching, kicking, squeezing and burning. Emotionally abusive behaviour is where there is mistreatment of a woman's self-worth which included verbal attacks, threats, taunts, mocking, yelling, exclusion, belittling and malicious rumours. Sexually abusive behaviour is considered mistreatment or the control of a woman sexually which included demand for sex using coercion, rape or the performance of certain sexual acts, forcing her to have sex with other people, treating her in a sexually derogatory manner or insisting on unsafe sex.

Gender Based Violence – This study uses the term to mean violence towards women and girls who are HIV positive because of their subordinate status in the society. The term in this context is used synonymously with 'violence against women'

Prevalence – It is the proportion of HIV positive women reporting at least one form of gender based violence among all the HIV positive women interviewed during the study period.

Nature – In this study, nature means form or type.

HIV positive – This is a person who is infected with Human Immunodeficiency Virus.

Partner - In this study the term partner is used to include husband or a man that the respondent has, had or been having an intimate relationship with.

CHAPTER: ONE

1.0 Introduction

1.1 Background

Gender-based violence (GBV) is a pervasive human rights issue with public health consequences.[1] Around the world, at least one in every three women has been beaten, coerced into sex, or otherwise abused.[2] GBV results in many negative consequences for women's emotional and physical health, it affects children and undermines the economic well-being of societies.

The growing body of evidence on violence and HIV/AIDS continues to confirm that violence is a lead factor in the "feminization" of the global AIDS epidemic and the disproportionately higher rates of HIV-infection among women and girls—who now represent at least half of those infected worldwide and about 60% of those infected in sub-Saharan Africa.[3,4,5,6] AMPATH, whose two third of its adult clients is women needs to determine these patterns and prevalence of GBV to be able to set up services to be provided that are specific to victims of GBV. School-related GBV is also being increasingly documented as a widespread barrier to girls being able to attain equal education.[7]

GBV can be classified in different ways according to the type of act of violence (e.g., physical, sexual, emotional or psychological violence); the relationship between the victim and perpetrator (e.g., current or former intimate partner violence, rape by stranger etc.); or according to when violence occurs during the lifecycle of a woman (pre-birth to reproductive age).[8,9]

Stigma and gender-based violence are widely recognized as two key factors that restrict the effectiveness of HIV prevention programs[10]. Both inhibit individuals from adopting risk-reducing behaviors and utilizing services for HIV prevention, treatment, care and support[11]. However, while stigma reduction is gaining traction on the ground through integration into HIV and AIDS programs, the issue of gender-based violence remains overlooked.

While HIV/AIDS treatment is crucial, GBV is prevalent among women in the African society due to women's social status in the community, which has a far deeper impact than the immediate harm caused by HIV[11]. GBV has devastating consequences for the women who experience it[12], and a traumatic effect on those who witness it, especially the HIV infected women seeking HIV/AIDS treatment, hence a driving force behind the epidemic.

Fear of violence is an undermining factor in terms of seeking HIV treatment. Women may hesitate to be tested for HIV or fail to return for the results because they are afraid that disclosing their HIV-positive status may result in physical violence, expulsion from their homes or social ostracism[12]. With AMPATH receiving most of its clients after testing at ANC or during hospitalization, there has been little attention directed to the views and opinions of women who test HIV positive regarding GBV.

It is against this background that this study sought to investigate on the nature and prevalence of gender based violence on HIV positive women attending AMPATH MTRH Clinic and how this has contributed to HIV positive women's adherence of drugs and clinic visits.

1.2 Problem Statement

While the full extent of GBV is not known, current research indicates that intimate partner violence ranges anywhere from 10-69% and that in some countries one in four women may experience sexual violence by an intimate partner in her lifetime[13]. Women represent one of the fastest growing groups being diagnosed with HIV infection[13-16]. By virtue of the circumstances under which they live, women at the highest risk for HIV infection may also be at risk for emotional, physical and sexual violence. HIV infection is relevant to GBV because it is primarily acquired through sexual relations, which themselves are greatly influenced by socio-cultural factors, underlying which are gender power imbalances. GBV, or the fear of it, may interfere with the ability to negotiate safer sex or refuse unwanted sex. Furthermore, violence against a woman can interfere with her ability to access treatment and care, maintain adherence to ARV treatment, or carry out her infant feeding choices. Evidence also exists that living with HIV can constitute a risk factor for GBV, with many people reporting experiences of violence following disclosure of HIV status, or even following admission that HIV testing has been sought. Thus a vicious cycle of increasing vulnerabilities to both GBV and HIV can be established[12].

Unpublished monthly reports from AMPATH have shown that women, constituting 65% of adults attending AMPATH clinics have higher rates of missed clinic visits compared to that of men. Results from other studies[16-18] which have shown relationship between poor adherence to clinic visits and drugs and GBV prompted this research to be done to determine GBV prevalence and how it affects the adherence to clinic visits and drugs on HIV positive women attending AMPATH MTRH clinic.

1.3 Justification

The links between HIV/AIDS and gender based violence are becoming increasingly apparent based on the findings of various studies on GBV and HIV conducted primarily in the United States and in Sub-Saharan Africa[16,18,20,21]. Findings show an increased risk of HIV/AIDS among women victims of gender based violence and also show that being HIV positive is a risk factor for GBV against women. This relationship has grave consequences for provision of quality HIV care in regards to clinical attendance, drugs adherence and prevention among the infected. With AMPATH's goal to achieve adherence level of 98%, there was need to determine if GBV as a factor was related to poor adherence of clinic visits and drugs, and if so what services are available to be provided to the GBV victims at AMPATH program.

This study therefore provides important information to health care providers and program leaders at AMPATH and other organizations that provide care to HIV positive women in regards to magnitude of GBV as a problem and some related effects to adherence and possible interventions within the program.

1.4 Objectives

The general objective of this study is to investigate the nature and prevalence of gender based violence among HIV positive women attending AMPATH MTRH clinic.

Specifically the study sets:

- To determine the nature of GBV among HIV infected women attending AMPATH MTRH clinic.

- To determine the prevalence of GBV among women attending AMPATH MTRH clinic.
- To determine the effect of GBV on adherence to drugs and clinic visits of women infected with HIV attending AMPATH MTRH Clinic.
- To determine services provided to GBV victims by AMPATH program

1.5 Research Question

- What percentage of randomly selected HIV positive women attending AMPATH MTRH clinic have ever experience gender based violence?
- What is the most common form of gender based violence?
- Does gender based violence have any effects on adherence to drugs and clinic visits among HIV infected women?
- What services do AMPATH program provide to the victims of gender based violence?

CHAPTER: TWO

2.0 Literature Review

2.1 Introduction

Gender-based violence is violence involving men and women, in which the female is usually the victim; and which is derived from unequal power relationships between men and women. Violence is directed specifically against a woman because she is a woman, or affects women disproportionately. It includes, but is not limited to physical, sexual, and psychological harm (including intimidation, suffering, coercion, and/or deprivation of liberty within the family, or within the general community). It includes that violence which is perpetrated or condoned by the state[22].

In 2004, the number of new HIV infections among women worldwide reached parity with that of men[23]. In some locales and among certain age groups, the percentage of females with HIV/AIDS has surpassed that of males. In sub-Saharan Africa, for example, females account for 76% of HIV infections among young people aged 15 to 24 years[24,25]. A number of biological, behavioral, and social factors contribute to the increased vulnerability of women, particularly young women, to HIV infection. This increase has been associated to GBV[25-29]. There is therefore a need to review this association within health care settings that care for HIV positive women.

2.2. Prevalence and Forms of GBV

GBV, specifically physical and sexual victimization of women, continues to affect the lives of many women in the United States and Sub-Saharan Africa[30]. The prevalence of lifetime GBV by a primary sexual partner is estimated to be 21% to 39% among women in the general population and clinical care settings, whereas during the most

recent 12-month period, GBV is estimated to range from 2% to 14%.[30-34] Among vulnerable populations such as minority women and women from low-income and low-education groups, estimates of lifetime GBV and GBV in the most recent 12-month period have been reported as high as 62% to 68% and 17% to 33%, respectively.[31,33,34,35] Furthermore, GBV among pregnant women and HIV-positive women has been estimated to range from 8% to 38%.[37,38,39]

A review of demographic health survey in 7 countries in sub-Saharan Africa showed the percentage of women (15–49 years) who had experienced physical violence was high in all countries, and ranged from around 30% in Malawi, Rwanda, and Zimbabwe; to about 50% in Cameroon, Kenya, and Zambia; and as high as 60% in Uganda. The percentages among ever married women showed a similar pattern (but were 2–6 percentage points higher)[22].

GBV can include physical, sexual, and psychological abuse by a person with whom the victim has had an intimate relationship with or by a stranger. Physical abuse can take the form of hitting, slapping, punching, or kicking.[38,39,42] Sexual abuse/forced or coercive sex includes rape within marriage or dating relationships, rape by strangers, unwanted sexual advances or harassment, forced marriage, denial of the right to use contraception or other measures to protect against sexually transmitted infections (STI), forced abortion, forced prostitution, and trafficking of people for the purpose of sexual exploitation. Childhood sexual abuse is sexual abuse that occurs before 18 years of age.[39] Psychological abuse includes belittling, humiliating, and intimidating an individual.[42]

2.3 Consequences of gender based violence

2.3.1 Gender-Based Violence as a Cause of HIV Infection

There is emerging evidence connecting the rapidly expanding HIV epidemic and GBV, particularly among young women.[38] A growing number of studies indicate that the first sexual experience of young women is often coerced,[39] and that such coercion is often viewed as a routine part of a relationship.[40]

Gender-based violence may increase a woman's risk for HIV infection through forced or coercive sex in several ways: 1) Physiology of the female genital tract makes women, especially young women, inherently more susceptible to HIV infection than men. 2) Women are twice more likely to acquire HIV from men during sexual intercourse than vice versa. 3) Forced or violent intercourse can cause abrasions and cuts, which facilitate entry of HIV through vaginal mucosa. 4) Forced sex limits a woman's ability to successfully negotiate HIV prevention behaviors such as condom use[41].

Several psychosocial factors also increase a woman's vulnerability to both sexual violence and HIV infection. These include age, alcohol or drug consumption, previous history of abuse, number of sex partners, involvement in sex work and educational level.[41] Though these factors have shown to be associated with GBV, the studies done have involved women from outside Kenya. This study aims at relating such psychosocial factors to GBV within an HIV care context in Western Kenya.

Several studies[39-43] link a history of childhood sexual abuse to an increase in HIV risk-taking behavior, including drug abuse, having a male partner at risk for HIV, having multiple partners', and exchanging sex for drugs, money, or shelter.

A study of racial and ethnic minority women in the United States found that those who had more sex partners, were unemployed, had more sexually transmitted infections, had a more severe history of physical and sexual trauma, were less educated and were more likely to be HIV infected.[27]

A study in South Africa and Tanzania found that experience of violence and controlling behavior from male partners was strongly associated with increased risk of HIV infection among women[41,42].

Rape, the most extreme form of forced sex[42], occurs in many different settings and situations, including intimate relationships, schools, health-care facilities, refugee camps, and during periods of armed conflict. A national survey in South Africa that included questions about experience of rape before the age of 15 found that schoolteachers were responsible for 32% of the disclosed adolescent rapes.[41] In Rwanda, where rape was used as a form of ethnic cleansing during the 1994 genocide, it is estimated that of the 250,000 women who were raped and are still alive, 70% are HIV infected.[31]

2.3.2 GBV as a consequence of HIV infection

Not only can gender-based violence lead to HIV infection, but it may also be a consequence of it. The risks associated with disclosure of HIV infection deter many women from revealing their serostatus[32,35]. Studies have shown that anywhere from 17% to 86% of women choose not to disclose their status for fear of abandonment, rejection, discrimination, violence, upsetting family members, and accusations of infidelity from their partners, families, and communities.[32,33]

In a review of 17 studies conducted in developing countries to assess the outcomes of disclosing HIV serostatus, 10 studies reported violence directed toward women as a reaction to disclosure at rates ranging from 3.5% to 14.6%.[25]. In a study conducted in the United States, 18% of HIV-positive women reported disclosure-related violence, including verbal abuse and physical assault.[32]. In another study conducted in the United States, 4% of HIV-positive women reported physical abuse after disclosure, and 45% reported experiencing emotional, physical, or sexual abuse some time after diagnosis.[35] Certain GBV risk factors are associated with experiences of abuse after HIV diagnosis, including prior history of abuse, drug use, lower socioeconomic status, younger age, length of time since diagnosis, and having a partner whose HIV status is negative or unknown.[39] Having known this from other studies done elsewhere, there is need to undertake a study within AMPATH, a comprehensive HIV care centre to determine the prevalence of GBV and factors associated with GBV in HIV positive women.

The research conducted on 1,366 South African[41] women attending health centers in Soweto and agreed to be tested for HIV and interviewed about their home lives

produced the following results; after being adjusted for factors that could distort the outcome, the figures showed that women who are beaten by their husbands or boyfriends were 48% more likely to become infected by HIV and miss treatment than those who were not. Those who were emotionally or financially dominated by their partners were 52% more likely to be infected than those who were not. A smaller study in Tanzania found that HIV positive women were over two and a half times more likely to have experienced violence from their partner than HIV negative women. [42]

Gender based violence and HIV/AIDS are also inextricably linked. The experience of violence affect the risk of HIV and other sexually transmitted infections (STIs) directly when it interferes with women's ability to negotiate condom use. Fear of violence not only hinders women ability to propose condom use but may also keep them from voluntary HIV/AIDS counseling and testing[39,40,41]. Furthermore, women may be at risk of violence after disclosing their HIV status to their partner, suggesting that domestic violence should be considered when formulating partner notification policies and HIV counseling.

A study conducted in Kenya to explore factors associated with physical and sexual wife abuse on a sample of 4,876 married women aged 15–49 years in the 2008-2009 Kenya Demographic Health Survey, showed that 40% of married women reported at least one type of violence; 36% were physical and 13% were sexual.[43]

Violence may also prevent women from accessing appropriate HIV information, being tested, disclosing their status, accessing services for their infants, and accessing

treatment, care, and support. In studies from sub-Saharan Africa that examine violence as an outcome of women's HIV status disclosure, among women who do disclose their HIV status, between 3% and 15% report negative reactions including blame, abandonment, anger, and violence.[35] In a Tanzania study of women accessing counseling and testing services, women reported fear of violence as a primary reason for not disclosing their sero-status to their partners.[42]

Alcohol also plays a major role in perpetuating the behaviors that increase both HIV infection and GBV. Studies indicate that intimate partner violence increases when the perpetrator has abused alcohol.[35,39,42] This study also look at alcohol abuse by the participant in relation to gender based violence both as a cause and as a consequence.

2.4. Health care providers and Gender-Based Violence

In the past decade an international consensus has gathered around the importance of recognizing gender-based violence as a critical public health issue, and as a barrier to women's use of health services[17]. As a result, the WHO and UNAIDS issued a policy statement in 2004, calling for interventions that take into account the different needs of women and men who access HIV services[18,19]. And the UN Commission on Human Rights in 2005 encouraged states "to ensure the availability to women and girls of comprehensive and accessible health-care services and programmes and to health-care providers who are knowledgeable and trained to recognize signs of violence against women and girls and to meet the needs of patients who have been subjected to violence, in order to minimize the adverse physical and psychological consequences of violence." [19]

2.5 Interventions Addressing Gender-Based Violence and HIV

Although awareness of the role of GBV in the HIV epidemic among women has grown, to date there have been few rigorously designed and evaluated interventions to address it.[33] Those in progress include microfinance interventions to increase women's self-efficacy, training, negotiation skills, and economic independence from men.[34] Other programs work with men and boys to address male gender norms that associate masculinity with risky behaviors such as having multiple partners, alcohol and drug use, the domination of women, and violence.[35] The impact of such interventions on HIV incidence or prevalence is not yet known. As a way to mitigate the likelihood of acquiring HIV infection following rape, some communities have established programs to provide post-exposure prophylaxis to survivors of sexual assault. This involves administering antiretroviral therapy within 72 hours of assault and over a period of days. This approach has been reported to be effective[33], although studies to date have not included data on untreated individuals as a comparison, so their interpretation is still problematic. This study examines AMPATH's approach in addressing GBV issues and how effective it has been.

2.6 GBV in Kenya following the 2007-2008 Post Election Crisis

It is difficult to gauge the number of cases of GBV that were reported and further it is important to note that even if this information is to become available from the Kenyan Police there is bound to be a low number of reported cases due to the obstacles that surround survivors of sexual violence.[44] Women who were interviewed during the Inter-Agency Rapid GBV Assessment suggested that even if a woman was raped, there would be significant impediments to disclosing the assault.[45] In Burnt Forest, women thought it highly unlikely that a survivor would report an incident because

reporting would not be viewed as a priority compared to other immediate concerns such as security, food, caring for children, etc.: *"in a crisis like this, your first thought is to care for your children, get settled down, you don't even think to report…you are trying to figure out how to live."*[44] In Eldoret, a female camp management representative who relayed that there were significant numbers of rapes of women displaced from Kapsabet to Eldoret explained that women who tried to report were told by the Kapsabet police *"this is an emergency situation and this is not the time to think about these issues."*[45] Women in a focus group in Kuresoi further explained that fear of abandonment by family members or other forms of stigma would likely discourage women from telling anyone about a case of rape. Those providing humanitarian response repeatedly echoed women's claims about the veil of silence surrounding sexual violence.[44] The pastor assisting IDPs in his church in Munyaka, Eldoret noted that there were threats of sexual harassment and rape during displacement, *"but here for someone to say that they have been raped would be really difficult."*[45]

CHAPTER: THREE

3.0 Research Methodology

3.1 Research Design

This was a cross-sectional study which was carried out between May and July 2009.

3.2 Study Setting

The research was conducted at AMPATH centre located within Moi Teaching and Referral Hospital (MTRH), Uasin-Gishu District, Western Kenya. AMPATH was initiated in 2001 as a joint partnership between Moi University School of Medicine (Eldoret, Kenya), the Indiana University School of Medicine (Indianapolis, USA), and the Moi Teaching and Referral Hospital (Eldoret, Kenya). The USAID-AMPATH Partnership was initiated in 2004 when AMPATH received ongoing funding through USAID and the United States Presidential Emergency Plan for AIDS Relief (PEPFAR). The initial goal of AMPATH was to establish an HIV care system to serve the needs of both urban and rural patients in western Kenya and to assess the barriers to and outcomes of antiretroviral therapy. Details of the development of this program have been described in detail elsewhere[46].

AMPATH has its headquarters located within the hospital (MTRH) with 25 sites and 24 satellite clinics spread throughout Western Kenya. At the headquarters there are 4 outpatient HIV care clinics; 3 for adults (Module 1, Module 2 and Module 3) and 1 pediatric clinic (Module 4). Each clinic operate independently, complete with a multidisciplinary team who run the care services all having main activity of prevention and treatment of HIV/AIDS. Patients in the care program are seen as outpatients and those who require admission are taken to the MTRH wards.

3.3 Target Population

The target population was HIV positive women seeking care in AMPATH MTRH clinic. The three sites included Module 1, Module 2 and Module 3 of the MTRH site in AMPATH centre. AMPATH had enrolled 14,257 adults at their MTRH sites at the time the study began in May 2009; 9,215 (65%) of them being women. Approximately 200 adult patients were being seen daily in each of these three clinics.

3.4 Study Sample

The sample size was determined through the approach based on precision rate and confidence level [47].

$$n = \frac{z^2 \, x \, p \, x \, q \, x \, N}{e^2 \, (N - 1) + z^2 \, x \, p \, x \, q}$$

Where;

e = acceptable error (the precision).

p = sample proportion, q = 1- q; since there is no study that has been statistically documented on prevalence of GBV 50% will be used by convention.

z = the value of the standard variation at a given confidence level and to be worked out from table showing area under Normal Curve;

n = desired sample size.

N = study population.

Taking; p=0.5

q = 0.5

e = 0.05

N = 9215

Z = 1.96 (as per table of area under the curve for the confidence level of 95%).

$$n = \frac{z^2 \, x \, p \, x \, q \, x \, N}{e^2 \, (N - 1) + z^2 \, x \, p \, x \, q}.$$

$$n = \frac{(1.96)^2 \, x \, 0.5 \, x \, 0.5 \, x \, 9215}{(0.05)^2 \, x \, (9215 - 1) + (1.96)^2 \, x \, 0.5 \, x \, 0.5}.$$

$$= \frac{8850.086}{23.9954} = 368.824 = 368.$$

The sample size was 368 women.

Table 1: Sample population at each of the three modules

	Module 1	Module 2	Module 3
Number of women registered in the AMRS Study population (N=9215)	3998 43.4%	2591 28.1%	2626 28.5%
Total number of women to be interviewed from each module; study sample (n=368)	160	103	105

3.5 Sampling Procedures

Inclusion and Exclusion Criteria

- **Inclusion**: HIV positive women receiving care in AMPATH MTRH Clinic and were 18 years and above.
- **Exclusion**: HIV positive women with mental disorders and those who were very sick were excluded from the study.

Participants in this study were randomly selected using the random number generator in Microsoft excel version 2003. A list of all the patients identification numbers were

obtained from each module, then a computer facility (random number generator in Ms. Excel) was used to randomly pick the study subjects from each module. The dates of their next visit were then generated from the AMPATH Medical Record System (AMRS). The health care providers were conveniently selected and were interviewed if they agreed to participate in the study.

3.6 Data Collection

Data was collected using interview guides and standardized interviewer administered questionnaires that were developed based on the objectives and the research questions for this study. The questionnaire contained both closed and open ended questions which were pre-tested on HIV positive women in Turbo health centre, one of the 25 AMPATH sites. The questions were related to HIV positive women's experience with gender based violence and how the experience has affected their adherence to drugs and clinic appointments. Pilot testing of the questionnaire was conducted by the researcher at Turbo clinic on 50 HIV positive women to assess the validity of the questions in the questionnaire. The questionnaire contained demographic information, HIV positive disclosure status, experiences of gender based violence and consequences of GBV.

Health care providers interviews focused on the common forms of gender based violence reported by clients being cared for in the institution and the institution's action/intervention on the gender based violence cases reported by the clients was sought from the health care providers. The study sought, from the health care providers' perspective if there were any effects of gender based violence in prevention of HIV and adherence to care.

3.7 Minimization of Selection Bias

Selection bias was reduced with the use of computer randomization of the participants. 368 random numbers of active women attending the three modules in MTRH, AMPATH site were selected. From the random numbers the next appointment dates were indicated against their AMPATH IDs. A standardized questionnaire was used for all participants. The questionnaire was pilot tested and standardized before its use in data collection.

3.8 Ethical consideration

Before commencing, the study was cleared by the School of Public Health. Approval was also sought from IREC before commencement. Permission to undertake the study in the selected clinic (MTRH Clinic) was obtained from the AMPATH administration. Written informed consent was obtained from women participating in the study. For those who could not read or write the participants' thumb print was placed on the signing space with the assistance of the research assistant. Information obtained was and is still stored under lock and key and only the researcher can access it. Although there were no adverse effects expected, women participating in the study were being requested to stay in the clinic for an extra 30 minutes above the usual clinic visit time. Participants were advised that "some of the topics discussed may be difficult to talk about, but many women have found it useful to have the opportunity to talk" Participants were told that they could end the interview at any time or skip any question they did not want to answer. Participants in this study were not compensated. At the end of the interview they were thanked for having participated.

3.9 Data Management

Data collected was processed by cleaning, coding, entry and analysis. Data cleaning involved removal of questions coded but were not answered in any questionnaire. Coding of qualitative data collected involved grouping into themes and ideas. Data collected using the questionnaire was coded and entered into SPSS version 16. Quantitative analysis was carried out using software SPSS version 16. Descriptive analysis was done using measures of central tendencies and dispersion. Pearson's chi-square and Fishers exact test were used to compare categorical variables which included; marital status, education level, main occupation, HIV positive disclosure status and experience of various forms of GBV.

Experiences of different forms of GBV (physical, sexual and emotional) were cross tabulated with demographic factors, HIV positive disclosure status and ever witnessed violence while they were children. Among those participants who had or has ever had a partner, a comparison was made between those who had experience GBV and those who had not.

Qualitative data from the semi-structure questionnaires were all typed into the Microsoft word document. The data was then grouped into subthemes, themes and ideas. Patterns were derived from the themes and ideas and were interpreted against the research objectives.

3.10 Limitations

Limitations to this study need to be acknowledged. The generalizability of the findings is limited to HIV positive women meeting the specific inclusion criteria of this study. GBV is a very sensitive issue that many who have experienced it are less likely to talk about as there is still a culture of silence surrounding it. This study relied on women's ability to recall violent experiences, and on participants' willingness to disclose this information. It is likely that violence, despite the high observed prevalence, might have been underreported. Analysis from this study are based on cross sectional data, precluding the ability to make any cause-effect interpretation.

CHAPTER: FOUR

4.0 Findings

The findings presented in this chapter are based on the qualitative and quantitative data collected during the interviews of 368 HIV positive women and 20 health care providers.

4.1 Demographic Factors

There were 368 women enrolled into the study, with their age ranging from 18–49years (Mean=30.9). High number, 360 (98%), of the participants had completed at least their primary school level of education. Majority of participants 169 (46%) resided in peri-urban area with the least in the rural area. Housewife 217(59%) was the main occupation with 16% involved in business. 78% reported ever married, with 6% in a polygamous marriage and 17% divorced or separated. The number of children the participants has ever had ranged from 0-9 children (mean=3 children).

Table 2: Demographic characteristics of the Respondents

Age	
mean	30.9
Range	18-49
Std. Deviation	8.2
Variable	**N (%)**
Marital status	
Single	81(22.5)
Married, monogamous	177(48.1)
Married, polygamous	21(5.7)
Divorced/Separated	62(16.8)
Widow	27(7.3)
Number of children	
0	28(7.6)
1-3	195(53.0)
4-6	106(28.8)
>7	39(10.6)
Level of education	
None	8(2.2)
Primary	193(52.4)
Secondary	116(31.5)
Tertiary	51(13.9)
Main Occupation	
Housewife	217(59.0)
Farmer	36(9.8)
Business lady	58(15.8)
Teacher	18(4.9)
Disciplined force	3(0.8)
Casual Worker	30(8.2)
Others	6(1.6)
Residence	
Urban	114(31.0)
Rural	85(23.1)
Peri-urban	169(45.9)
Tribe	
Kalenjin	108(29.3)
Kikuyu	40(10.9)
Luhya	98(26.6)
Luo	91(24.7)
Others	30(8.1)
Witnessed violence as a child	
Yes	262(71.2)
No	106(28.8)

4.2 Medical History

Most of the participants 78% have known their status for more than 3 years (mean=3.3years), having been tested in the hospital during inpatient admission or during antenatal care. 271 (74%) of the participants have disclosed their status. Of those who had disclosed their status 89% had disclosed to their partners, 40% to their siblings, 30% to their parents and 2% to their children. 52% had disclosed to more than one person. Fishers exact test indicated that there was a significant association between marital status and disclosure of HIV status ($\chi 2$ =18.96, df=4, p=0.001). Majority of the participants, 213(58%), reported not knowing their partners status. The high number attributed this to partners having not been tested or refusing to be tested after knowing their wives HIV positive status. The study found 88 (23%) of the participants had fled their previous places of residence and now staying with relatives or alone renting a house. Most of the movement 87% happened after disclosure of their status.

4.3 Forms of GBV

Those who reported physical abuse were 243(66%), of which 194(80%) of the abuse was perpetrated by their partner. Other perpetrators of physical violence included family members, neighbors, and strangers. Majority of participants, 168(69%) reported the violence having occurred after disclosure of HIV positive status p=<0.001, OR=8.7. Logistic regression showed that those who disclosed their HIV positive status were 3 times more likely to experience physical violence than those who had not. A total of 75(31%) reported physical violence before and after diagnosis. 37(15%) showed symptoms and signs of the attack including a loose of a tooth, missing fingers, a scar on the face, leg, hand and swollen face. Others, 7%, had

developed some disabilities; one eye that had become totally blind, loss of a hand because it had been chopped off, limping were among the disabilities reported.

The following quote exemplifies expression of physical violence:

> *After being diagnosed with HIV on admission to MTRH, my husband's drinking habit has worsened. He has been drinking every other day and tells his fellow drinkers that I infected him with HIV and soon he is going to die. I work as a casual in some neighboring estate as a day-house help. My husband and my 3 children depend on me to bring food at home and some extra money for my husband's liquor. At times I would get food as a pay for the work done. There was this day that I got home with food but no money. My husband kicked and punched me on the face in front of the children. The children cried and tried to help but the father kicked them too. I did not go to work the next day because I was in pain and my face was swollen. My AMPATH clinic visit 2 days after but could not come because my face was still swollen. I came in to the clinic a week later*

Majority of the participants 211(57%) reported having been emotionally abused. Emotional abuse reported included verbal attacks, threats, taunts, mocking, yelling, exclusion, belittling and malicious rumours. Most of the participants 188(89%) reported this abuse occurring after they had been diagnosed with HIV. A total of 173 (82%) of the abuse were perpetrated by the neighbors. Extended family members and workmates also contributed to the perpetration of emotional abuse of the participants. Some participants 54(16%) who have ever had a partner, were from a different tribe from their partners.

An example of emotional violence is expressed in the following quote:

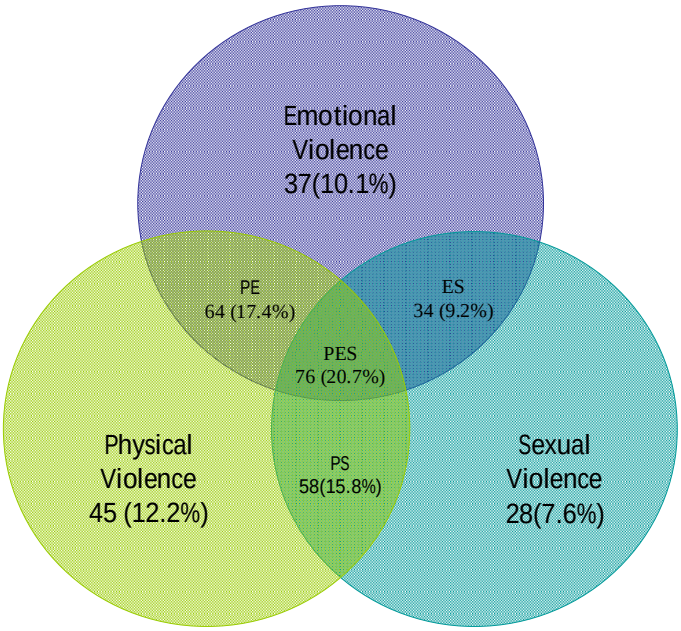
> *My late husband was a Kalenjin and I am a Luo. He died 6 months ago after being hospitalized for 1 month. I got to know his HIV positive status when the doctor asked me to take an HIV test as there was likelihood that I might also be positive following my husband's status. After his burial, I became an outcast in a place I had called home for 15 years. My in-laws would insult and yell whenever I walked by about how I had killed their son. I could not stand it anymore. I left and lived in a rental house in Langas estate. Though struggling to feed my 5 children, I am relieved to be out of my husband's family.*

A total of 196(53%) participants reported having ever been sexually abused. Sexual violence included demand for sex using coercion or the performance of certain sexual acts, forcing the participant to have sex with other people, treating her in a sexually derogatory manner or insisting on unsafe sex. Most of the cases of sexual abuse 122(62%) occurred before being diagnosed with HIV. Intimate partner was reported highest 110(56%) perpetrators of sexual violence followed by known relative or neighbors 80(41%). Policemen, unknown/strangers, workmate formed the remaining percentage 6(3%) of the perpetrators.

Sexual violence as a form of gender based violence is exemplified by the following quote:

> *My husband worked as a policeman before resigning a year ago. Rarely would you find him sober. He often comes home drunk and asks me to undress even when the children are in. He once came in to the house; luckily the children were out playing with friend, tored my blouse and pulled my skirt down and started having sex with me. I tried to protest and fight back but he held my hands firmly on the floor said that if I didn't want to have sex with him he can as well kill me. I kept quiet as not to attract the children attention……it was such a horrible situation.*

A number of women reported having experienced more than one form of GBV; 64 (17%) had experienced both physical and emotional violence, 34(9%) had experience both emotional and sexual violence and 58(16%) had experienced both physical and sexual violence. Some women, 76(21%) had experienced all the three forms of violence. Physical violence may have resulted into emotional violence and sexual violence may have resulted into physical violence. GBV experiences in this situation led to categorization of various forms of violence as shown in figure 1 for the purpose of analysis and clarity.



EP – Emotional and Physical Violence
ES – Emotional and Sexual Violence
PS – Physical and Sexual Violence
PES – Physical, Emotional and Sexual Violence

Figure 1: Venn diagram showing Relationship between Emotional, Physical and Sexual Violence

A participant who experienced all the three forms of violence intimated to me:

> *When I disclosed my status to my husband after antenatal testing, he beat me up and called me a prostitute. He forced me to have sex with him without any protection since I had infected him anyway. I had bruises all over my private part. In the morning I prepared myself and wanted to sneak to seek care but he found me when I wanted to leave the house. He slapped me and locked me up in the house. My husband came home drunk late that evening and asked me to leave his house and never to come back again. He also told me to take the child I was caring to my other lovers that I had been sleeping with. I left the house and went to stay with my sister who brought me to AMPATH. When I went back to where I used to call home to pick my clothes, my husband's family could not allow me into the house. They accused me of infecting their son with HIV. I still believe my husband is the one who infected me because he is always out at his workplace and comes home only over the weekends*

Table 3: Association between Demographic Factors and Gender based violence

Characteristic	Physical violence		Emotional violence		Sexual Violence	
	Yes	No	Yes	No	Yes	No
Mean age	31.3	29.8	30.6	31.1	31.1	30.6
Std. Deviation	8.3	7.8	8.2	8.3	7.9	8.6
p- value	**0.116**		**0.579**		**0.618**	
Education level	**N(%)**	**N(%)**	**N(%)**	**N(%)**	**N(%)**	**N(%)**
None	7(2.9)	1(0.8)	5(2.4)	3(1.9)	5(2.6)	3(1.7)
Primary	128(52.7)	65(52.0)	109(51.7)	84(53.5)	106(54.1)	87(50.6)
Secondary	74(30.5)	42(33.6)	62(29.4)	54(34.4)	58(29.6)	58(33.7)
Tertiary	34(14.0)	17(13.6)	35(16.6)	16(10.2)	27(13.8)	24(14.0)
p- value	**0.589**		**0.318**		**0.805**	
Marital status	**N(%)**	**N(%)**	**N(%)**	**N(%)**	**N(%)**	**N(%)**
Single	55(22.6)	26(20.8)	48(22.7)	33(21.0)	52(26.5)	29(16.9)
Married, monogamous	115(47.3)	62(49.6)	11(52.6)	66(42.0)	94(48.0)	83(48.3)
Married, polygamous	21(8.6)	0(0.0)	12(5.7)	9(5.7)	6(3.1)	15(8.7)
Divorced/Separated	31(12.8)	31(24.8)	31(19.7)	31(15.8)	31(15.8)	31(18.0)
Widow	21(8.6)	6(4.8)	9(4.3)	14(11.5)	13(6.6)	14(8.1)
p- value	**<0.001**		**0.042**		**0.047**	
Number of children	**N(%)**	**N(%)**	**N(%)**	**N(%)**	**N(%)**	**N(%)**
0	14(5.8)	14(14.2)	14(6.6)	14(8.9)	20(10.2)	8(4.7)
1-3	141(58.0)	54(43.2)	114(54.0)	81(51.6)	96(49.0)	99(57.6)
4-6	61(25.1)	45(36.0)	60(28.4)	46(29.3)	59(30.1)	47(27.3)
>7	27(11.1)	12(9.6)	23(10.9)	16(10.2)	21(10.7)	18(10.5)
p- value	**0.017**		**0.854**		**0.155**	
Residence	**N(%)**	**N(%)**	**N(%)**	**N(%)**	**N(%)**	**N(%)**
Urban	75(30.9)	39(31.2)	70(33.2)	44(28.0)	58(29.6)	56(32.6)
Rural	56(23.0)	29(23.2)	47(22.3)	38(24.2)	47(24.0)	38(22.1)
Peri-urban	112(46.1)	57(45.6)	94(44.5)	75(47.8)	91(46.4)	78(45.3)
p- value	**0.996**		**0.571**		**0.809**	
Witnessed violence as a child	**N(%)**	**N(%)**	**N(%)**	**N(%)**	**N(%)**	**N(%)**
Yes	179(73.7)	83(66.4)	151(71.6)	111(70.7)	142(72.4)	120(69.8)
No	64(26.3)	42(33.6)	60(28.4)	46(29.3)	52(27.6)	52(30.2)
p- value	**0.145**		**0.856**		**0.571**	
Main Occupation	**N(%)**	**N(%)**	**N(%)**	**N(%)**	**N(%)**	**N(%)**
Housewife	141(58.0)	76(60.8)	124(53.8)	93(59.2)	120(61.2)	97(56.4)
Farmer	20(8.2)	16(12.8)	22(10.4)	14(8.9)	16(8.2)	20(11.6)
Business lady	43(17.7)	15(12.0)	34(16.1)	24(15.3)	27(13.8)	31(18.0)
Teacher	8(3.3)	10(8.0)	10(4.7)	8(5.1)	10(5.1)	8(4.7)
Disciplined Forces	0(0.0)	3(2.4)	3(1.4)	0(0.0)	2(1.0)	1(0.6)
Casual worker	26(10.7)	4(3.2)	16(7.6)	14(8.9)	16(8.2)	14(8.1)
Other	5(2.1)	1(0.8)	2(0.9)	4(2.5)	5(2.6)	1(0.6)
p- value	**0.003**		**0.661**		**0.548**	

According to the data presented in Table 3 above, marital status was associated to gender based violence $p<0.05$. Main occupation ($p=0.03$) and number of children ($p=0.017$) was associated with physical violence. There was no association between GBV and age, education level, place of residence and ever witnessed violence while a child.

Logistic regression showed that those in married relationships were 2 times more likely to experience physical violence (OR=2.3). Those who are single are 3 times more likely to experience sexual violence (OR=2.9). There was no significant difference in those who had been married and those who were single inexperience of emotional violence.

Women who were married with no children were more likely to experience physical violence than those who were married and had children. Occupation (housewife) were more likely (OR=2.1) to experience physical violence that those who had employment.

4.4. Consequences of GBV

A total of 44(12%) participants reported having ever taken alcohol. Among them, 35(80%) took alcohol after being diagnosed to be HIV positive. 26(60%) took alcohol following abuse by the partner and to forget about what was going on in her life. There were 27(10%) participants among those who had ever experience at least one form of gender based violence that had stopped doing their normal working. Reasons given to this included loss of a right hand, complete blindness on one eye, missing fingers on the right hand, limping and chronic chest pain. 73% of the participants,

who had disclosed their status and experienced at least one form of GBV, had at one point missed a clinic visit or stopped taking drugs.

Effect of gender based violence is exemplified by the following quote:

"I had disclosed my status to my husband who refused to be tested. I had been seeking care at AMPATH for about 3 months but I had not told him about it. One day he found my drugs that I had hidden. He beat me up and poured all the drugs into the toilet together with my appointment card. I missed taking drugs for 3 weeks. I also missed my clinic appointment. An outreach worker came to my house and found my husband but I pretended I didn't know them, I even lied that I had never attended their clinic."

4.4.1 Violence during pregnancy

A total of 38 (11%) respondents among those who reported having experienced at least one form of violence reported experiencing it during pregnancy. Among them 19 (50%) reported giving birth to a normal baby, 7 (18%) reported giving birth to an underweight baby and 4 (10%) to still birth. Others, 8(22%) had miscarriage/abortion.

4.4.2 Missed clinic appointment

147(40%) of the participants reported having ever missed clinic appointment at least once. Among these 118(81%) reported these missed visits having been due to the violence that they had experienced.

4.4.3 Missed taking drugs

140(38%) of the study participants reported having ever missed to take their drugs. The drugs missed included anti-TBs and ARVs. Among those who had missed to take their drugs 106(76%) of them associated this to one or more forms of gender based violence met against them.

Those who had experience GBV were 3 times more likely to miss their clinic visit or miss taking drugs OR=2.9.

4.5 Response towards GBV

92(27%) of the participants interviewed and had experienced at least one form of gender based violence sought legal services against the perpetrator of the violence. Among those who sought the legal services 55% were not satisfied with the help they received from the legal service providers. Help provided by the legal persons/bodies included; prosecuting the perpetrator and compensation of the injuries caused. Those who were not satisfied with the legal help gave reasons including; the perpetrator was left free by the police, the court ruled out lack of enough evidence, being asked to settle the case at home and the perpetrator was asked to pay a small amount of money. Of those who had ever experience at least one form of GBV, 112(33%) reported having tried to defend themselves physically while 28% tried to escape. Among those who defended themselves 10% incurred injuries; fingers chopped off, cut on the hand, a cuts on the leg, a scar on the head and face and blind eye.

Some participants who never sought help did give reasons why they had not done so and included responses whose examples are given below;

"*The children were very young and I knew I could not bring them up alone. I did not want to take them to my parents*"

"*My mother would tell me that I should not leave my husband as it would reflect badly on her and my father*."

"*Family problems should be discussed within the family"*

Most participants commended AMPATH for providing care for the HIV patients but indicated that AMPATH should also try and help those who are experiencing GBV as this affects care.

4.6 Health Care Providers Interviews

Interviews were conducted on 20 health care providers in AMPATH centre with 12 (60%) of them being females. The health care providers working experience ranged from 1-7years with (mean=3.5). Those interviewed included; 6 heads of departments; (Clinical administration, Legal, Social Work, Psychosocial Support, Family Preservation Initiative Orphans and Vulnerable Children), 3 clinical officers, 3 nurses, 2 social work staff, 2 psychosocial support staff, 2 nutritionists and 2 outreach staff. Findings from interviews of the health care providers are as follows:

It was noted that AMPATH is currently providing GBV services though to a limited extent. Services provided include; psychosocial counseling which is carried out by the psychosocial department. Counseling sessions are done weekly (Thursday). Legal services were noted to be present at AMPATH and are provided by Legal Aid Centre Eldoret (LACE) department. AMPATH also works closely with the Centre for Assault Recovery – Eldoret (CARE) that is situated at MTRH, where patients experiencing GBV are referred. It was also mentioned that AMPATH shelter, situated in Elgon View, Eldoret acts as short term shelter for those patients who have run away from their homes. Post Exposure Prophylaxis (PEP) is also provided to clients who are suspected to have been exposed to HIV.

Most of the health care providers shared the same sentiments that HIV positive women are at a great risk for GBV. To better meet the needs of these women, the HCP felt that GBV screening should be offered as a component of routine care, ANC and in PMTCT services. HCP also indicated that GBV screening questions were not included on the patient encounter forms hence missing out on a number of cases.

Only 8(40%) of the health care providers interviewed reported having been approached by a GBV victim within their workplaces. Of those who had been approached by the GBV victims, they reported having physical and sexual forms of GBV being reported. Emotional violence was rarely reported by the clients. Some of these views are exemplified in the following quote:

A mother who had tested HIV positive at the ANC and referred to PMTCT came back 2 days later and said that the husband had beaten her up and asked her to look for where to stay but not their home. She was chased away from her matrimonial home by the husband and she was later housed at AMPATH shelter before moving in with a friend.

Procedure of how adherence was assessed at AMPATH was described by counselors: Counselors commonly monitor patients' adherence by counting the pills remaining from the last visit and asking questions if the patient has missed ART doses. A form, devised by AMPATH to assists counselors in discussing adherence-related issues with patients is completed by counselors. The form probes a wide range of reasons why a patient may not have taken their ART, including that the patient forgot, felt too ill,

experienced side effects, ran out of medication, was uncomfortable taking the pills in front of others, was disorganized, or had problems swallowing were listed.

When health care providers were asked if GBV had any effect on adherence to drugs and clinic visit, the response was generally anonymous; that GBV had a negative effect on adherence. Examples of such effects are expressed in the following quotes;

> *When a patient has to run away from her home there is likelihood that she may not remember to carry her drugs or even the clinic card. And if she has to seek refuge far away, the cost of travel to the clinic becomes an issue.*
>
> *In PMTCT the effect often is on the baby especially on issues of breastfeeding versus formula feeding. If the husband pours the formula or refuses to have the child fed with formula milk, the mother is forced to breastfeed the baby. At times, it is a pressure from mother-in-laws who would seclude one because they are not breastfeeding.*
>
> "*When a client knows that her spouse have tendencies of violence, they would rather not associate with AMPATH at all, hence missing out on care*".

There were a number of obstacles being faced by AMPATH in providing GBV services and included; GBV not being a core business for AMPATH and thus limited focus is in place on the same. Inadequate human resource (counselors, lawyers), number of patients currently being handled by AMPATH is so high and expertise to deal with GBV is inadequate in AMPATH. From health care providers interviews, women too were noted to be facing some obstacles in seeking GBV services because; women feel shy talking about their domestic affairs and a times feel the service providers may not understand; Lack of information and the knowhow and what to do in the event that they are violated; lack of support from police; women are sent away and told that domestic issues are dealt with by the family; cultural factors and social factors dictates that men are the breadwinners and in so doing women should comply

even if it means death. If one has children, it is hard to leave the children behind or even leave the matrimonial home. Women are required to provide reliable and accurate information before their cases are handled. In the case where the situation occurred during an affair this can prove to be a hindrance in getting legal justice to the women as they may not be able to provide evidence. An example of rape by a husband may not be taken seriously by legal persons.

CHAPTER: FIVE

5.0 Discussion

This study examined the forms of GBV experienced by HIV positive women attending AMPATH clinics and the impact of GBV-related experiences on adherence to clinic appointments and drugs. It also examines the services available for GBV victims within AMPATH Centre.

Three major findings arose from this cross sectional study; First, there is a high prevalence of gender based violence among the HIV positive women attending AMPATH, MTRH clinic. Second, three forms of GBV were identified; physical, emotional and sexual. GBV is impacting negatively on HIV positive patients' adherence to clinic appointment and drugs. Lastly, services available at AMPATH for GBV victims are underutilized by clients.

This study showed that 79% of the participants who were aged 18-49 years had experienced at least one form of GBV, with 53% having been sexually abused, 66% having been physically abused and 57% having been emotionally abused. The results from this study are higher compared to those collected during the Kenya Demographic Health Survey in 2008-2009[43] on the general population which showed that 39% of 15-49 year old women reported having experienced some form of gender based violence in their lifetime, with 16% of women reported having ever been sexually abused. Other studies[24,25,39,40] reported lower prevalence rate compared to those of this study. The higher prevalence reported here can be associated to the target population who were mainly HIV positive women.

Three forms of GBV (physical, emotional and sexual) were identified from this study. The findings revealed that HIV positive women are subjected to high level of physical violence by their partners. These results compared with those of a study carried out in South Africa[28,30] that found out that HIV positive women attending ANC clinic were more likely to be physically abused by their partners. Majority, (69%) of the physical violence experienced occurred after disclosure of the participants' HIV positive status, similar to a review of 17 other studies[17] that showed that violence directed towards women as a reaction to disclosure of HIV positive status ranged from 3.5 – 45%.

Four types of emotional violence were identified; verbal insults, humiliation/degrading, threatening and name calling. Results from this study are similar to those of a review of literature conducted by USAID[22] that showed a prevalence of between 22 – 60% of emotional abuse toward HIV positive women. These results thus show that HIV positive women are vulnerable to emotional violence at their neighborhoods and even at the family level. These finding can be due to stigma that people still associate with HIV/AIDS.

A prevalence of 53% on Sexual violence reported on this study was higher compared to results from other studies [1,3,5,39,40] that showed a prevalence rate of between 17-33%. The high prevalence could be attributed to the time when this occurred. This study focused on if the participant had ever experienced the violence, unlike other studies that looked at sexual violence in the last 12months or less. Intimate partner as a perpetrator of sexual violence was rated highest (56%) followed by known relative, neighbors and policemen similar to other studies that have specifically looked at

intimate partner as a perpetrator. This results are concerning particularly in the light of heightened risk for seroconversion for the perpetrator and reinfection of the women themselves.

GBV was an outcome of women's HIV status disclosure. Notably, those women who disclosed their status were 4 times more likely to be physically, emotionally or sexually abused. Although this association is consistent with prior studies[20,32], the percentage of women reporting actual abuse when disclosing their status was higher (12%) than those reported in previously. GBV prevented women from accessing appropriate HIV information, disclosing their status, and accessing treatment, care, and support. Similar to the study done in Tanzania[42], women accessing CT services, reported fear of violence as a primary reason for not disclosing their sero-status to their partners. These results are of concern in the light of promotion of positive living among PLWA.

Gender based violence was associated with marital status, main occupation of the participants and number of children depicting similar results as those of a study conducted by Gielen *et. al*[20] at the United States. This study showed that, women who were married were twice more likely to experience GBV than those who were single. Being married with no children would put an HIV positive woman at a risk of GBV. Women whose main occupation was housewife were more likely to experience physical violence that their counterparts who had an employment. This study lacked a standard measure socioeconomic status of the women, hence the results of this study cannot conclude based on the possibilities that those with employment are economically independent than housewives. This study did not show any association

between age, education level and ever witnessed violence during childhood. These results were different with various other studies that showed that women who were younger and had attained secondary school education were more likely to experience gender based violence that those who were older with less education.

Main finding of this study shows a strong association between experiences of GBV and poor adherence to clinic visits and drug adherence corroborating prior research[21,27,30]. With 73% who reported to have ever missed a clinic visit or missed taking drugs. Women who were experiencing GBV were 3 times more likely to miss their clinic visit or miss taking drugs that those who were not. This results are concerning, particularly when AMPATH program's objective is to achieve an adherence rate of upto 99% on its clients. A self report measure of adherence was used in this study hence results are higher than those reported in other studies[30] that combined both self report and pill count as a measure of adherence. However, it is worth noting that participants involved in this study, had not reported to the health care provider that the reason for their non adherence were related to GBV.

Health care providers are in a unique position to intervene in preventing and managing health consequences of gender based violence. This is because health facilities are one of the few public institutions that almost all women will come in contact with at some point in their lives, for pregnancy and delivery related care and contraception, or in process of seeking health care for their children. As noted from the study results and previous studies[33] the form being used to collect data for adherence counseling does not include questions about violence, including violence against women. Thus, some of the critical barriers to women's adherence to ART

remain undetected and unaddressed by healthcare workers hence undermining the facilities' ability to provide appropriate support to women who experience violence. GBV services are available at AMPATH though they are being underutilized by the clients. Underutilization is attributed to non referral by health care providers and lack of awareness on some of the available services by HIV positive clients.

5.1 Conclusion

This study sought to determine the nature and prevalence of GBV among HIV positive women attending AMPATH MTRH clinic. The study findings showed that GBV is prevalent among HIV positive women attending AMPATH MTRH clinic. HIV positive women were experiencing three forms of GBV; physical, emotional and sexual. Not surprisingly, HIV positive women experienced more than one form of violence, after disclosing their HIV positive status. GBV experience was associated with poor adherence of clinic visit and drug intake hence AMPATH can be much more effective in improving patient adherence if they addressed GBV issues. Though AMPATH had services available for GBV victims, these services were being underutilized.

5.2 Recommendations

- Screening of GBV at an early stage will be necessary in identifying victims of GBV. In so doing, inclusion of GBV experience questions on the encounter forms used for clinical care will be important. GBV should also be included among the list of possible reasons for assessing adherence on patients at AMPATH.

- Efforts to devise effective HIV prevention like HIV testing at ANC and at hospital admission must take into consideration whether the woman is in an abusive relationship
- Identification of GBV victims and referring them to relevant services available at AMPATH will be important in preventing further GBV and promoting utilization of the GBV services available at AMPATH.
- Creating awareness to all AMPATH clients on the available GBV services at AMPATH will be necessary to improve utilization of these services. Use of pamphlets or fliers to be issued to the patients would also help in creating awareness
- Further research to be conducted on the impact of GBV specifically on those experiencing multiple forms of GBV. Research on male partners to determine factors

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Appendix 1

Consent Form

Title: Nature and prevalence of gender based violence among HIV positive women attending AMPATH clinic, Western Kenya

Investigator
Kiplagat Jepchirchir
Moi University School of Public Health
P.O Box 4606
Eldoret
Kenya.
Tel: 0722 288 653

Purpose and background
This study aims to determine the nature and prevalence of gender based violence experienced by HIV positive women receiving care at AMPATH MTRH clinic. It is hoped that the results will be useful in developing appropriate care modalities for such women who have been victims of gender based violence.

Procedure
Randomly selected women receiving primary care from AMPATH will be interviewed using a semi-structured questionnaire. Health care providers will be interviewed using an interview guide. Health care providers will be chosen from among those who provide care to women clients at AMPATH MTRH clinic.

Benefits and Risks
There will be no direct benefits for those participating in this study; neither will there be any risks involved. If you agree to take part in this study, you will be asked to stay for about 30 minutes longer that your normal clinic time. Some of the topics in this questionnaire may be difficult to discuss, but many women have found it useful to have the opportunity to talk.

Confidentiality
All information will be used only for the purpose of the study. No name shall be attached to any information collected from this study.

Voluntary participation
Your participation in the study is voluntary and you are free to accept or not accept to take part in the study. You have the right to stop the interview at any time, or skip any questions that you don't want to answer.

Consent
I have read the above information/ I have been explained to in details about the study. I have asked questions and received answers and I agree to participate in the study.

Signature _____ Date _____

Signature of the interviewer _____ Date _____

Questionnaire

Interview Number _____ Date _____ Interviewer's No. _____

Hello my name is _____ I am from Moi University, School of Public Health. We are conducting a study to determine the nature and prevalence of gender based violence among HIV positive women attending AMPATH clinic, Eldoret. You have been chosen by chance to participate in the study. The answers you will give us in this session will enable HIV care providers to develop some modalities in handling cases of gender based violence. Further findings could also aid in development of materials to address gender based violence which will be of help to people who are at high risk of GBV.

I want to assure you that all your answers will be kept confidential. I will not keep the record of your name or address. Your participation in this study is voluntary. You have the right to stop the interview at any time, or skip any questions that you don't want to answer. There is no right or wrong answer. Some of the topics may be difficult to discuss, but many women have found it useful to have the opportunity to talk.

Do you have any questions?

The interview will take approximately 30 minutes to complete. Do you agree to be interviewed?

Thank you for agreeing to participation in this study.

A. Respondents Characteristics

1. Age ☐

2. Marital status

☐ Single ☐ Divorced/separated

☐ Married, monogamous ☐ Window

☐ Married, polygamous ☐ Woman to woman marriage

3. If polygamous, how many wives ☐

4. Number of children ☐

5. Tribe

☐ Kalenjin ☐ Kikuyu

☐ Luhya ☐ Luo

☐ Others (Specify)_____

6. Education level

☐ None ☐ Did not complete secondary

☐ Did not complete primary ☐ Completed Secondary

☐ Completed Primary

☐ Tertiary: University, College, institute of technology and polytechnics

7. Place of Residence ☐ Urban ☐ Rural

8. Occupation

☐ Housewife ☐ Teacher

☐ Farmer ☐ Disciplined forces

☐ Business lady ☐ Casual worker

☐ Others

9. Did you ever witness violence when you were a child ☐ Yes ☐ No

B. Partner's characteristics

10. Partner's age ☐

11. Partner's occupation

☐ None ☐ Teacher

☐ Farmer ☐ Disciplined forces

☐ Business man ☐ Casual worker

☐ Others

12. Education level

☐ None ☐ Did not complete secondary

☐ Did not complete primary ☐ Completed Secondary

☐ Completed Primary

☐ Tertiary: University, College, institute of technology and polytechnics

13. a) Does your partner take alcohol? ☐ Yes ☐ No

b) If yes, how often (*number of times in a week*) _____

14. Did your partner witness violence when he was a child ☐ Yes ☐ No

Medical History

15. When were you diagnosed with HIV? Year _____ Month _____

16. How did you get tested for HIV?

☐ Mobile VCT ☐ DCT

☐ Integrated VCT ☐ PITC

☐ PMTCT ☐ HCT

17. a) Have you disclosed your HIV status?

☐ Yes ☐ No

b) If yes, who have you disclosed to?

☐ Sibling ☐ Partner ☐ Parents

☐ Relative ☐ Children ☐ Others(*specify*) _____

c) What was their reaction? _____

18. a) Has your partner been tested? ☐ Yes ☐ No ☐ Don't know

b) If yes, when was he tested? ☐ Before you ☐ After you

c) What is their HIV status?

☐ Positive ☐ Negative ☐ Don't know

19. Place of residence before your HIV Disclosure

☐ Alone ☐ With Friend

☐ With partner ☐ With Sibling

☐ With parents

20. a) Place of residence after HIV disclosure? Is it the same as before disclosure?

☐ Yes ☐ No

b) If No, where are you staying now? _____

Now I am going to ask you questions relating to experiences of gender based violence. You may choose to answer or skip any of the questions asked. If you are not comfortable to answer, please don't answer. If at any time you will want to stop going on with the interview, let me know. Should I continue?

Type and characteristics of gender based violence

21. a) Have you ever been physically abused in your life? (*Physical abuse involves slapping, hitting, squeezing, punching, kicking, burning and harassment*)

☐ Yes ☐ No

b) If yes, was it before or after being diagnosed with HIV?

☐ Before ☐ After

c) How often does/did this happen ☐ Less often ☐ More often

d) Did you incur any injuries/disability from the violence? ☐ Yes ☐ No

e) Do you have any physical symptom resulting from violence? ☐ Yes ☐ No

f) If yes, indicate symptom_____

22. a) Have you ever been sexually abused in your life? (*Sexual abuse include rape, sexual assault, sexual coercion, unwanted sexual contact without intercourse, unwanted touching of a person's intimate parts, forcing an unwilling person to have sex with another person*)

☐ Yes ☐ No

b) If yes, was it before or after being diagnosed with HIV?

☐ Before ☐ After

c) Is your partner involved?

☐ Yes ☐ No

d) Would you talk to me about your sexual violence experience

_____

23. a) Have you ever been emotionally abused in your life? (*Emotional abuse include verbal attacks, threats, taunts, mocking, yelling, exclusion, and malicious rumours*)

☐ Yes ☐ No

b) If yes, was it before or after being diagnosed with HIV?

☐ Before ☐ After

c) Would you be able to recall an episode of how someone emotionally abused you and tell me how it happened? _____

24. a) Has any of the above mentioned forms of violence occurred during pregnancy?

☐ Yes ☐ No

b) Outcome of pregnancy

☐ Low birth weight ☐ Normal baby

☐ Miscarriage ☐ Still birth

☐ Abortion

The next stage will be questions related to consequences of gender based violence that you experienced. At this point, you are still free to answer or skip any questions you are not comfortable with. You can also still opt out of this interview.

Consequences of Gender based violence

25. a) Do you take alcohol?

☐ Yes ☐ No

b) If yes, when did you start taking alcohol?

☐ Before HIV +ve diagnosis ☐ After HIV +ve diagnosis

c) Is the alcohol intake related to violence after disclosing status?

☐ Yes ☐ No

26. a) Has this violence prevented you from working?

☐ Yes ☐ No

b) If yes, how? _____

27. a) Has this violence disrupted your work/ability to earn money?

☐ Yes ☐ No

b) If yes, how? _____

28. a) Has this violence disrupted your attendance to the clinic appointments?

☐ Yes ☐ No

b) If yes, how?_____

29. a) Has this violence disrupted your drug taking?

☐ Yes ☐ No

b) If yes, how?_____

30. a) Has this violence affected your family planning/HIV prevention methods?

☐ Yes ☐ No

b) If yes, how?_____

31. a) Has this violence caused any chronic health problems (*irritable bowel syndrome, GIT disorders, various chronic pain syndromes, hypertension, e.t.c.*)?

☐ Yes ☐ No

b) If yes, which problem?_____

The next stage will be questions related to your response to gender based violence that you experienced. You are still free to answer or skip any questions you are not comfortable in answering. You can also still opt out of this interview.

Respondent's response towards gender based violence

32. a) Who did you talk to about the violence that you are experienced?

☐ Clinician ☐ Partner

☐ Friend ☐ Parents

☐ Sibling ☐ Children

☐ Church Member ☐ Counselor

☐ Others (*Specify*) _____

b) Did any of the above intervene/tried to stop the violence?

☐ Yes ☐ No

33. a) Which services did you seek?

☐ Formal (police, judges) ☐ Informal (family, friends)

b) What was the response? _____

c) Were you satisfied with the response?

☐ Yes ☐ No

34. To reduce the violence, have you ever tried to defend yourself physically?

☐ Yes ☐ No

The next stage will be questions related to your community and how they view gender based violence. You are still free to answer or skip any questions you are not comfortable in answering. You can also still opt out of this interview.

Community perception

35. *In your community and elsewhere, people have different ideas about families and what is acceptable behavior for men and women in the home. I am going to read you a list of statements, and I would like you to tell me whether you generally agree or disagree with the statement. There is no right or wrong answer.*

Please rate it in the following 4 options

1. Agree 2. Disagree 3. Don't know 4. Refused/No answer

i. A good wife obeys her husband even if she disagrees_____
ii. Family problems should only be discussed with people in the family _____
iii. It is important for a man to show his wife/partner who is the boss _____
iv. A woman should be able to choose her own friends even if her husband disapproves _____
v. It's a wife's obligation to have sex with her husband even if she does not feel like it _____
vi. If a man mistreats his wife, others outside of the family should intervene _____

I want to give you a chance to give your recommendation both the AMPATH. What would you like to see changed or put in place to help victims of GBV?

Recommendations

36. In your opinion, what should AMPATH do to help victims of GBV? _____

I wish to thank you for participating in this survey and once again I wish to assure you that the information herein will be confidential and no forms contain any names

Appendix 2

Interview Guide

Purpose and background of the study

The purpose of this study is to determine the prevalence and effect of gender based violence among HIV positive women receiving care at AMPATH centre. It is hoped that the results will be useful in developing appropriate care modalities for such women experiencing gender based violence in their lives.

Key Informant Signature_____ Date _____

Interviewer's Signature/Name _____ Date _____

Key Informants Interview (AMPATH Care Providers)

Date _____

Gender _____

Designation _____

Years of experience _____

Gender Based Violence among HIV positive women

1. What role do you think AMPATH should play in addressing gender based violence? [*Probe on AMPATH role in: Prevention of GBV, GBV screening, treatment of victims including sexual assault (PEP), psychosocial counseling and referrals to other services*]

2. Is AMPATH providing these services? If so, which ones? What are the biggest gaps?

3. Do you think that women who are HIV positive are at a greater risk for GBV? If so, how can we better meet the needs of these women? Specifically, should GBV screening services be offered as a component of ANC or PMTCT services? Why or why not?

4. In the course of your working has there been any gender based violence cases reported by clients? If yes, how often?

5. Do you think GBV has any effects on clients' adherence to both clinic visits and drugs? If so, which effects? How do you screen for adherence in AMPATH?

6. What action do you take when a client reports gender based violence in her life?

7. Do you do any follow up of gender based violence cases?

8. Do you provide any support to the gender based violence survivors? If yes, which support?

9. What obstacles do AMPATH face in providing GBV services? What obstacles do women face in seeking GBV services in AMPATH?

Thank you!

Appendix 3

IREC Approval Letter

INSTITUTIONAL RESEARCH AND ETHICS COMMITTEE (IREC)

MOI TEACHING AND REFERRAL HOSPITAL
P.O. BOX 3
ELDORET
Tel: 33471/2/3

MOI UNIVERSITY
SCHOOL OF MEDICINE
P.O. BOX 4606
ELDORET
Tel: 33471/2/3

Reference: IREC/2008/51
Approval Number: 000357

13th November, 2008

Ms. Jepchirchir Kiplagat,
Moi University,
School of Public Health,
P.O. Box 4606,
ELDORET.

Dear Ms. Kiplagat,

RE: FORMAL APPROVAL

The Institutional Research and Ethics Committee has reviewed your research proposal titled:

"The Nature and Prevalence of Gender Based Violence Among HIV Positive Women Attending AMPATH Clinic, Western Kenya".

Your proposal has been granted a Formal Approval Number: **FAN: IREC 000357** on 11th November, 2008. You are therefore permitted to commence your investigations.

Note that this approval is for 1 year; it will thus expire on 10th November, 2009. If it is necessary to continue with this research beyond the expiry date, a request for continuation should be made in writing to IREC Secretariat two months prior to the expiry date.

You are required to submit progress report(s) regularly as dictated by your proposal. Furthermore, you must notify the Committee of any proposal change (s) or amendment (s), serious or unexpected outcomes related to the conduct of the study, or study termination for any reason. The Committee expects to receive a final report at the end of the study.

Yours Sincerely,

PROF. D. NGARE
CHAIRMAN
INSTITUTIONAL RESEARCH AND ETHICS COMMITTEE

cc: Director - MTRH
Dean - SOM
Dean - SPH
Dean - SOD

INSTITUTIONAL RESEARCH & ETHICS COMMITTEE
APPROVED
13 NOV 2008
P.O. Box 4606 ELDORET

Appendix 4

AMPATH Approval Letter

Academic Model Providing Access To Healthcare
P.O Box 4606 ELDORET
RESEARCH OFFICE

Ref: RES/STUD/3/2009 **March 17, 2009**

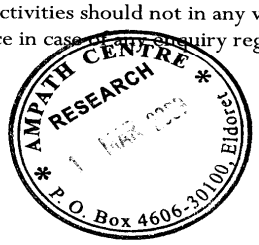
To: Module 1, 2, 3 and 4

Sir/Madam

RE: permission to conduct research at AMPATH

This is to kindly inform you that **Kiplagat S Jepchirchir**, an MPH student Moi University School of Public Health has been granted permission to conduct research at the AMPATH modules. Her study, *The nature and prevalence of gender based violence among HIV positive women attending AMPATH clinic in western Kenya* has been reviewed by IREC and assessed by the Research Office.

Her research activities should not in any way interfere with the care of patients. Please contact the Research Office in case of any enquiry regarding this matter.



Thank you,

K. Kirwa
Research Manager