Chapter 14
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Reproductive Health for Sustained Economic Development in Kenya

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ABSTRACT

The primary goal of this study was to examine how HIV positive women attending the Kericho County Referral Hospital Comprehensive Care Centre respond to domestic abuse. Available data indicate that 55% of women and 20% of men living with HIV infection experience intimate partner violence (IPV) and that 24% of women experience abuse by their partners after disclosing their HIV serostatus. IPV increases the risk of HIV acquisition and often interferes with victims' engagement in and adherence to HIV care. A descriptive cross-sectional research design was utilized. Between May and July 2013, 230 HIV positive women over the age of 15 were systematically sampled. To acquire qualitative and quantitative data, interview schedules and focus group discussions were employed. To determine frequencies and themes, content analysis was performed, and SPSS 20.0 and Microsoft Excel were used to enter and evaluate the data. Intimate partner violence (IPV) was experienced by 156 of the 230 women questioned. According to the survey, physical abuse (57.8%) was the most prevalent type of IPV, while sexual abuse (4.9%) was the least common. Furthermore, 25.6% of the women interviewed reported an increase in violence after being diagnosed with HIV. The majority of abused individuals (45.5%) left and talked to a friend (21.2%) in response to IPV. As a result, HIV and IPV are syndemic concerns that must be addressed in order for an HIV program to be successful. IPV was shown to have a substantial impact on HIV positive women attending Kericho District Hospital (KDH). There is a pressing requirement for IPV screening and management techniques to be included into the HIV prevention program at KDH, as well as IPV training for health practitioners. The CCC's health treatment should include trauma-informed care.

Keywords: HIV; women; partner violence; comprehensive care; Kericho County.

1. INTRODUCTION

Human immunodeficiency virus (HIV) is an infection that attacks the body's immune system. Acquired immunodeficiency syndrome (AIDS) is the most

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advanced stage of the disease. HIV targets the body's white blood cells, weakening the immune system. This makes it easier to get sick with diseases like tuberculosis, infections and some cancers. HIV is spread from the body fluids of an infected person, including blood, breast milk, semen and vaginal fluids. It is not spread by kisses, hugs or sharing food. It can also spread from a mother to her baby. HIV can be treated and prevented with antiretroviral therapy (ART). Untreated HIV can progress to AIDS, often after many years [1]. Yes. According to the Centers for Disease Control and Prevention (CDC), in 2018, 19% of the new HIV diagnoses in the United States and dependent areas were among women. In addition, 57% of women with HIV were Black/African American. The most common way that women get HIV is through sex with a male partner who has HIV without using a condom. Most women who have HIV know that they are HIV positive, but some women are not getting the HIV care and treatment they need. Intimate partner violence (IPV) can impact an individual's ability to engage in HIV care and adhere to treatment recommendations. A better understanding of this issue is needed to create an environment that supports engagement of individuals who experience IPV in care and fosters their emotional and physical well-being [2]. The Centers for Disease Control and Prevention [3] defines intimate partner violence (IPV) as actual or threatened physical or sexual violence or psychological or emotional abuse directed at a spouse, ex-spouse, current or former boyfriend or girlfriend, or current or former dating partner. Slaps, punches, kicks, and weapon attacks, as well as homicide, are examples of physical violence. IPV includes but is not limited to physical abuse. It is important to dispel any misconceptions that all individuals who experience IPV are women and are fragile, helpless, have low self-esteem, or fear for their lives daily, and that their abusers are all men who could easily be identified in a single interaction. Although these scenarios are true for some individuals, a one-size-fits-all approach does not hold true for IPV. Men also experience IPV, and IPV occurs in same-sex as well as heterosexual relationships [2]. Rape, coercion including use of physical force, verbal threats, and harassment to have sex constitutes sexual violence. Other examples include unwanted touching or physical advances that are accompanied by threats on the part of the perpetrator. Psychological violence, on the other hand, may include issues such as belittling the woman, preventing her from seeing family and friends, intimidation, withholding resources, preventing her from working or confiscating her earnings [4,5]. UNAIDS [5] reports that intimate partner violence constitutes physical violence, sexual violence and psychological violence.

The subject of violence against women living with HIV has been gaining interest within the international mainstream of HIV, gender and development. Studies have shown that globally, at least one in three women has been beaten, coerced into sex or abused in some other way — most often by someone she knows, including her husband or another male family member; one in four women has been abused during pregnancy [6]. Until recently, this form of violence, which affects females of all races, ethnic groups and classes, was viewed as a private matter, but studies in the last decade have recognized IPV as a human rights violation and a public health problem with legal, social, cultural, economic and psychological dimensions [7], (WHO, 2013); [6,8].

HIV/AIDS, on the other hand, is a pandemic that affects women more than men. According to UNAIDS [9], over 34 million adults worldwide have died from HIV/AIDS in their prime age. Quarraisha, Sengeziwe and Chery [10] note that approximately half of global HIV infections are accounted for by women, with sexual intercourse being the main mode of transmission. Quarraisha, Sengeziwe and Chery [10] further posited that HIV infection is 3-7 times higher in adolescent women in sub-Saharan Africa than in adolescent boys. High rates of infection among women can be attributed to a combination of biological and social factors; traditional, deep-rooted gender inequalities, including violence, are of particular importance [9,10].

A report in 2006 by UNAIDS indicated that approximately 46% of Kenyan women experience violence in their lifetime with one out of every four reported experiencing violence in the last year. Approximately 83% of the women and girls reported at least one form of physical abuse, and 46% reported episodes of sexual abuse. Two-thirds of omen reporting sexual and physical abuse noted abuse perpetrated by their husbands or close relatives. Approximately 26% experience emotional violence, 40% report physical abuse, and 16% report sexual abuse, often from current husbands [5].

An increasing number of studies associate IPV with HIV. Reports from studies in the USA reveal that women with HIV have more experiences of violence than those without HIV [3]. CDC [3] notes that a series of studies in the U.S. A show that the IPV rate among HIV-positive women was 55%, double the national rate. In Tanzania, HIV-positive women identified domestic violence as one of the most prevalent problems linked to HIV [11] Other studies confirm the high correlation between sexual and other forms of violence against women and girls and their chances of HIV infection [12], (Black 2011). Studies on the relationships between intimate partner violence, health status and use of health care by women have shown that women who have experienced violence are more likely than nonabused women to seek health care [12], (Black 2011). Research has shown that HIV-positive women report more lifetime violence than their HIV-negative counterparts do. IPV needs to be dealt with as an integral part of multispectral facto HIV responses. Seeking help, retaliating and leaving have been described in studies as steps taken by women to respond to a violent relationship [13]. In view of the paucity of data and interventions on IPV in women living with HIV in Kericho County, this study was conducted on how HIV-positive women respond to IPV.

2. METHODS

This research used a descriptive cross-sectional research design. The sample population was drawn from HIV-positive women aged 15 years and older attending the HIV/AIDS Comprehensive Care Center (CCC) at Kericho County Referral Hospital within the last 12 months between May and June 2013. Systematic sampling was used with Every woman attending the clinic was given a number, and all women assigned an even number were chosen to participate in the study. Data were collected through semistructured interview schedules

administered by recruited interviewers and focus group guides focusing on the demographic data and IPV experiences of women. Data on partner violence were collected using The Conflict Tactic Scale 2 (Straus, 2017) incorporated into the interview schedule. It is a 10-item instrument that asks a series of Yes/No questions aimed at measuring violence.

The rest of the interview schedule had open-ended questions focused on collecting qualitative data and in-depth information on the HIV/IPV relationship and responses to IPV. The interviews were also used to enroll participants for the focus group discussions. Four FGDs were conducted: two in the 15-34 age strata and two in the 35-54 age strata. Eight participants from each age stratum were identified during the interviews and contacted with appointed FGD. The FGDs were carried out by a trained session moderator and a session recorder. The focus group discussion (FGD) guide was used to collect further qualitative data on IPV and to corroborate the data collected from the interviews. The FGD guide focused on women's understanding of IPV, its existence and their knowledge of the responses to violence. The interview schedule was first pretested at the Kericho VCT Centre to come up with appropriate questions that were well understood by respondents. It was further translated into Swahili and Kalenjin.

Extensive training of interviewers on the objective and comprehensive recording of data was performed with an emphasis on reflexivity to minimize bias. This study incorporated both qualitative and quantitative methods. The data obtained from the interviews and FGDs were first cleaned by reading all text and checking for any redundancies, unimportant digressions and repetitions. Audio recordings were translated and transcribed into English, and important individual quotations were identified to be added to the results verbatim.

Demographic data and all answers to close-ended questions provided quantitative data, which were entered into a computer and analysed using SPSS program to generate frequencies and means. Content analysis was used to analyse all qualitative data from FGDs and open-ended questions. The identified categories were then entered into an SPSS 20.0 computer program to determine frequencies.

3. FINDINGS

3.1 Demographics

The demographic information on the 230 respondents interviewed and included in the FGD had a mean age of 31.75. Most of the women (65.8%) were in the 15-24 and 25-34 age brackets. There were more employed respondents (39.6%) than those who were housewives (33.5%) or self-employed (26.9%). A total of 36.1% of the respondents were currently married, with only 0.9% of them being single. Many of the participants had gone through either primary (38.3%) or secondary education (40%); however, 5.2% were illiterate.

3.2 Prevalence of IPV

The most common type of violence reported was physical violence. Emotional violence at most times seemed to go hand in hand with physical abuse. Sexual violence was the least common form of violence experienced by the participants. Out of the 230 respondents, 67.8% (156) had experienced some form of physical, emotional, or sexual abuse or all three.

3.3 Types of Violence

Table 1. Distribution of IPV among respondents

Type of IPV	Yes (%)	No (%)
Ever been emotionally abused?	56.5	43.5
Ever been physically abused?	57.8	42.2
Ever been sexually abused?	43.9	56.1

More than half of the women interviewed (56.5%) reported having experienced emotional violence, with 43.5% not having been emotionally abused, as illustrated above. The women reported having been threatened with harm as well as being humiliated in public by their partners.

"*If he finds me at the shops when he is drunk, he will shout all forms of abuse in front of everyone who is there. That is humiliating*." FGD, 15-24 age stratum.

Many of the women interviewed had undergone some form of physical violence, with 57.8% of the women reporting that they had been physically abused. A total of 42.2% of women had never experienced any kind of physical violence (see Table 1).

The results show that 43.9% of the women interviewed had experienced sexual abuse from their partner. The rest of the respondents had not been sexually abused, as illustrated in the frequency Table in Table 1. In summary, the most common form of IPV experienced by HIV-positive women attending the HIV clinic at Kericho District Hospital was physical violence, followed closely by emotional violence. The least common form of IPV experienced by the respondents was sexual violence.

3.4 Intervention Methods for IPV

A total of 45.5% of the respondents reported that they ran away from the relationship as an intervention from the abuse. A respondent from the FGD, 35-44 age stratum, noted the following:

"*Sometimes a woman decides to run away even before the husband arrives to avoid being beaten*."

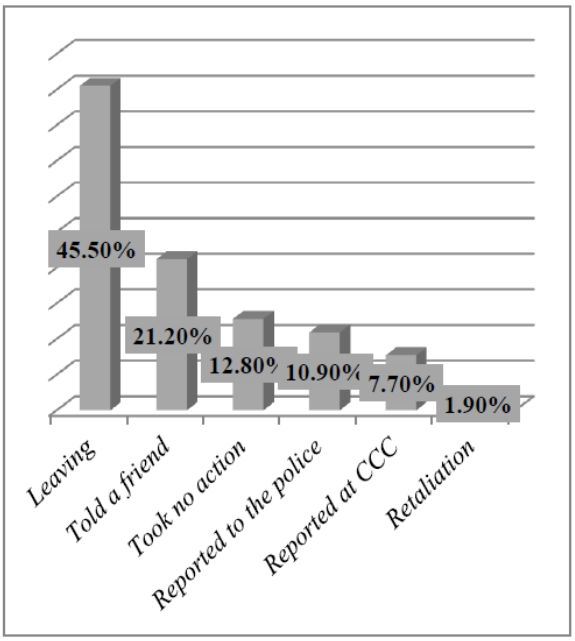

Fig. 1. Intervention Methods for IPV

A total of 21.2% of the respondents who had undergone abuse did not take any action after experiencing IPV. The predominant statement was that they had decided to tolerate the abuse mostly for the sake of their children.

"I have not done anything at all about him beating me because I don't know what will happen when I report him… what will happen to my children?" interview respondent, age 20, married.

A total of 12.8% of the respondents had shared with a friend the violence they had or were experiencing in their relationship. A total of 10.9% of the women reported to the police to ask for help after being abused. A total of 7.7% of the respondents said that they had reported at the CCC for help after experiencing violence. A total of 1.9% of the interviewed women had tried to fight back by physically trying to hurt their spouse when accosted with abuse.

"*I got very angry one day when he slapped me after an argument because after all, he was the one who had been unfaithful and brought this problem (HIV) to us... I bit him*" FGD, 15-24 age stratum.

3.5 Association between the Type of IPV and Intervention Response

A cross-tabulation and chi-square test of independence were performed to examine whether the association between the type of response and the kind of violence experienced was significant. The relationship between these variables was not significant $\chi 2$ (6, N=156) =1.52, p<.05).

Table 2. Association between response and type of violence experienced

Type of response	Type of violence			
	Emotional	**Physical**	**Sexual**	**Total**
Leaving	(27)39%	(24)30.98%	(20)24.64%	71
Took no action	(11)29.41%	(13)40.6%	(9)27.1%	33
Told a friend	(8) 40%	(5)25%	(7)34.5%	20
Reported to the police	(5) 29.4%	(6)39.3%	(6)39.3%	17
Others	(6) 40%	(4) 26.6%	(5)33.3%	15
Total	**57**	**53**	**46**	**156**

χ =21.52, N=156, α=.05

4. DISCUSSION

Any woman, whether HIV positive or negative, experiencing domestic violence has made a certain decision as a response to IPV. This study sought to determine how the women attending the Kericho HIV clinic responded after being abused and what made them take that particular response. Very few studies have been conducted on how women, in general, respond to violence by an intimate partner.

Most of the women left after an incident of abuse, as reported by 45.5% of the interviewees as well as by most women in the FGD. Leaving was also strongly associated with experiencing any form of violence. Most of them reported that they left for a while but went back until the next IPV incident. They reported that most of the time they went to their families but could not stay there because they felt that they were a burden or because they had left their children behind. Other times, the partner persuaded them to go back. There is a need for shelters for women who have been abused where counselling services and support can be administered in a safe and neutral environment. This has been an important health service lacking in Kenya. Leaving was also associated with the severity of injuries, with many women saying they feared for their lives or were afraid of more harm being inflicted on them. Many studies mainly conducted in the USA suggest that leaving a violent relationship is a process rather than a one-time event [14,15].

Not taking action was another popular response by HIV-positive women who had been abused, with 21.2% reporting that they did not do anything after being abused. Most of them reported that they had made a decision to tolerate the abuse. This is consistent with a report by FIDA that found that 29.6% had decided to persevere when accosted with violence. This could be explained by

cultural factors in which it is acceptable for women to be abused. A report on domestic violence in Northern Nigeria recommended that population-based intervention efforts were needed to reduce the level of HIV and violence against women [16]. They further noted that such programs needed to address the way violence against women was tolerated among many African communities. Poverty among women also influenced women's decision to tolerate IPV. Previous studies have shown that poverty leads to economic dependence, which makes it impossible to leave a violent partner (Cocker et al., 2000). This issue needs to be addressed if the fight against IPV is to be won. Another factor that influenced a woman to stay was the hope that her partner would change. This can be due to cultural and societal norms that expect women to persevere. Not taking any action was also weakly associated with having experienced physical violence. Previous research has reported that abused women were also twice as likely as nonabused women to report poor health and physical and mental health problems, even if the violence occurred years before [17].

More often, HIV-positive women who had been abused also talked to a friend concerning their IPV experience. This was a response taken by 12.8% of the participants. This was explained by the fact that women preferred another woman's advice, especially if they had had the same experiences. These women reported being more open and comfortable telling their friends about their experiences. Health programs geared towards violence against women could do well by incorporating programs that are women-centered and provide an atmosphere of understanding and support that enables women to report their abuse. Strategies for stopping IPV and supporting women who experience IPV should utilize peer support [18]. The 2013 WHO guidelines on responding to gender violence recommend that health care providers should provide and mobilize social support for abused women as part of women-centred care. Positive reactions of family and friends have been said to encourage more formal or professional help-seeking decisions, including the utilization of law enforcement, counsellors, crisis accommodation and financial support [19,20]. On the other hand, a view of domestic violence as a personal problem, often reinforced by community and perpetrator denial, as well as fear of retaliation and social ostracization, deters many women from confiding in others and seeking help [21], (WHO, 2006).

A few of the respondents (10.9%) had reported to an authority, which was the police in all the cases. This is almost consistent with the FIDA report, where it was found that 8.7% had reported to the police after undergoing violence. The women who reported to the police wanted to seek legal recourse following an act or acts of violence. When further explored in the FGD, participants reported that they rarely informed the police because they did not trust them. The FIDA report also found that police attitude towards GBV was mainly negative and discouraged women from reporting IPV incidences to them. This fact is common in many African countries where domestic violence victims expect little from the police—in many cases with good reason. Given this expectation, massive underreporting of domestic violence incidents to authorities is not surprising (Bowman C. G, 2003).

One attempt to address police reluctance to pursue domestic violence complaints through legal action has been the inclusion of a series of penalties in the South African Domestic Violence Act of 1998 for police officers who do not respond appropriately to domestic violence calls. Kenya should consider doing the same to improve its response to violence by the police. This can be achieved if the Domestic Violence Bill, which has already been gazette, is passed. On the other hand, respondents did not cite other authorities apart from the police compared to other studies where women had reported to elders or community-based organizations. This could be explained by the nonexistence of such organizations or lack of awareness.

A lower proportion of the respondents (7.7%) reported to the CCC concerning their IPV experience. This could be because the Kericho District CCC did not incorporate IPV programs in their health care provision. This underscores the importance of providing skilled counselling and supportive services for IPV at HIV Comprehensive Care Centers. This observation has also been made by a study in southwest Nigeria where lack of confidential treatment and counselling services hindered abused women from reporting at the HIV clinic [22]. This issue is of paramount importance because IPV causes more than physical consequences, but women also experience psychological stress, which is detrimental to their overall health.

Very few women (only 1.9%) had ever responded to IPV through retaliation. This is in contradiction to research conducted among American women that reports that women were more likely to respond by hitting back after physical abuse [23]. Cultural attitudes and gender norms that emphasize fear and reverence of male partners within a relationship may be the reason for few women retaliating. It is important that efforts include programs for gender tolerance and improved communication with rapid conflict resolution.

There was no significant association between the type of violence and the type of response. This could be explained by the fact that IPV comes with complexities individual to each woman. Burke et al. [24] found that women's accounts of their experiences of dealing with the abuse reflected movement through phases of nonrecognition, problem acknowledgement, consideration and selection of options, and use of safety strategies to remain free of abuse. A survey in the US showed that a majority of women who had been physically abused were more likely to leave the relationship.

There are multifaceted reasons that inform a woman's response to IPV, many of which have been mentioned above. Most of the women reported fear as a major contributor to the type of response taken by women attending the clinic. They cited fear for their lives, fear for further harm and fear of abandonment. Such reports of fear bring into light the amount of emotional turmoil that HIV-positive women experience before choosing to respond to violence. These women are in need of strategies that provide skilled counselling and psychological support. Some of the women reported feeling embarrassed if they were to seek help. The

WHO multicountry study on violence against women also observed that women sometimes did not seek help because they were ashamed.

5. CONCLUSION AND RECOMMENDATIONS

In recent times, HIV and IPV have been described as syndemic issues that need to be addressed for successful HIV programs. The findings in this study established that HIV-seropositive women attending Kericho District Hospital experience intimate partner violence, with physical violence and emotional violence being the most common types of IPV. They also experience significant sexual violence. Some of the HIV-positive women attending the Kericho Clinic also experienced increased violence after disclosure. More often, women at the Kericho District HIV clinic respond to violence in their life by leaving, while many others do not take any action at all. Confiding in close friends about IPV experiences was also a common response. Other responses to violence included reporting to the police and at the HIV clinic, with very few women retaliating.

Intimate partner violence, in addition to being a human right violation, has been clearly demonstrated as a risk factor for HIV and further affects health and stigmatization. Based on the overall results of this study, the following recommendations are called for: both government and nongovernmental organizations in Kericho County should make and implement policies, programs and services to effectively address the overlap between HIV/AIDS and violence against women. It is also important to include IPV screening at the Kericho District Hospital HIV clinic that incorporates trauma-informed care. Trauma-informed care is an approach that recognizes the presence of trauma symptoms and acknowledges the role that trauma plays in lives of people. Trauma-informed care may be indicated precisely because the study showed that some women who experienced IPV had obvious scars as a result of the violence.

COMPETING INTERESTS

Authors have declared that no competing interests exist.

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