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Original Article

RESPONSES TO INTIMATE PARTNER VIOLENCE BY HIV POSITIVE WOMEN ATTENDING KERICHO COUNTY REFERRAL HOSPITAL COMPREHENSIVE CARE CENTRE IN KERICHO, KENYA

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ABSTRACT

The main objective of this study was to describe how HIV positive women attending the Kericho County Referral Hospital Comprehensive Care Centre respond to intimate partner violence. The descriptive cross-sectional study design was used. A sample of 230 HIV positive women aged above 15 years was systematically sampled between May and July 2013. Interview schedules and focus group discussions were used to collect qualitative and quantitative data. Content analysis was done and SPSS 20.0 and Microsoft Excel used to enter and analyze the data to come up with frequencies and themes. Out of the 230 women interviewed, 156 had experienced intimate partner violence (IPV). The study found out that physical abuse (57.8%) was the most common form of IPV experienced while sexual abuse (4.9%) was the least experienced. In addition, 25.6% of the women interviewed reported an increase in violence after testing HIV positive. Most of the abused participants responded to IPV by leaving (45.5%) and talking to a friend (21.2%). Therefore, HIV and IPV are syndemic issues that have to be addressed for a successful HIV program. The HIV positive women attending Kericho District Hospital (KDH) noted to be significantly affected by IPV. There is an urgent need for the incorporation of IPV screening and management practices into the HIV program at KDH with the training of health providers on IPV. Trauma-informed care should be part of the health care provided at the CCC.

INTRODUCTION

Intimate Partner Violence (IPV) is defined by the Centers for Disease Control and Prevention (CDC, 2018) as actual or threatened physical or sexual violence or psychological or emotional abuse directed towards a spouse, ex-spouse, a current or former boyfriend or girlfriend, or current or former dating partner. Physical violence may include slaps, punches, kicks, and assaults with a weapon or even homicide. 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 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 (CDC, 2018; UNAIDS, 2006). The UNAIDS (2006) 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 on 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 (WHO, 2017). 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 (Joachim, 2000; WHO, 2013; WHO, 2017; Patrikar et al., 2017).

HIV/AIDS, on the other hand, is a pandemic that affects women more than men. According to UNAIDS (2015), over 34 million adults worldwide have died from HIV/AIDS in their prime age. Quarraisha, Sengeziwe and Chery (2010) note that about half of global HIV infections are accounted for by women with sexual intercourse being the main mode of transmission. Quarraisha, Sengeziwe and Chery (2010) further posit that HIV infection is 3-7 times higher in adolescent women in Sub-Saharan Africa compared to the adolescent boys. High rates of infection among women can be attributed to a combination of biological and social factors; the traditional, deep-rooted gender inequalities including violence are of particular importance (UNAIDS, 2015; Quarraisha, Sengeziwe, & Chery, 2010).

A report in 2006 by UNAIDS indicated that about 46% of Kenyan women experience violence in their lifetime with one out of every four reported experiencing violence in the last year. About 83% of the women and girls report a least one form of physical abuse and 46% episodes of sexual abuse. Two third of omen reporting sexual and physical abuse noted the abuse to perpetrated by their husbands or close relatives. About 26% experience emotional violence 40% report physical abuse and 16% sexual abuse often from current husbands (UNAIDS, 2006).

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 (CDC, 2014). CDC (2014) points out that a series of studies in the U.S.A show that 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 (Murray et al., 2006). Other studies confirm the high correlation between sexual and other forms of violence against women and girls and their chances of HIV infection (Ansara and Hindin, 2010; 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 non-abused women to seek health care (Ansara and Hindin, 2010; 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 response to a violent relationship (WHO, 2005) 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 the HIV positive woman responds to IPV.

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 HIV/AIDS comprehensive care center (CCC) at Kericho County Referral Hospital within the last 12 months between the months of May and June 2013. Systematic sampling was used with

every woman attending the clinic being given a number and all women assigned an even number were chosen to participate in the study. Data was collected through semi-structured interview schedules administered by recruited interviewers and focus group guide 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 to measure violence.

The rest of the interview schedule had open-ended questions focused on collecting qualitative data and in-depth information on 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 strata were identified during the interviews and contacted with appointed FGD. The FGDs were carried out by 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 on the responses to violence. The interview schedule was first pre-tested at the Kericho VCT Centre to come up with appropriate questions 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 done with an emphasis on reflexivity in order to minimize bias. This study incorporated both qualitative and quantitative methods. The data obtained from the interviews and FGDs were first cleaned through the reading of all text and checking for any redundancies, unimportant digressions and repetitions. Audio recordings were translated, transcribed into English, and important individual quotations identified to be added to the results in verbatim.

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

FINDINGS

Demographics

The demographic information on the 230 respondents interviewed and included in the FGD who 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%). 36.1% of the respondents were currently married with only 0.9% of them were single. Many of the participants had gone through either primary (38.3%) or secondary education (40%), however, 5.2% were illiterate.

Prevalence of IPV

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

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.

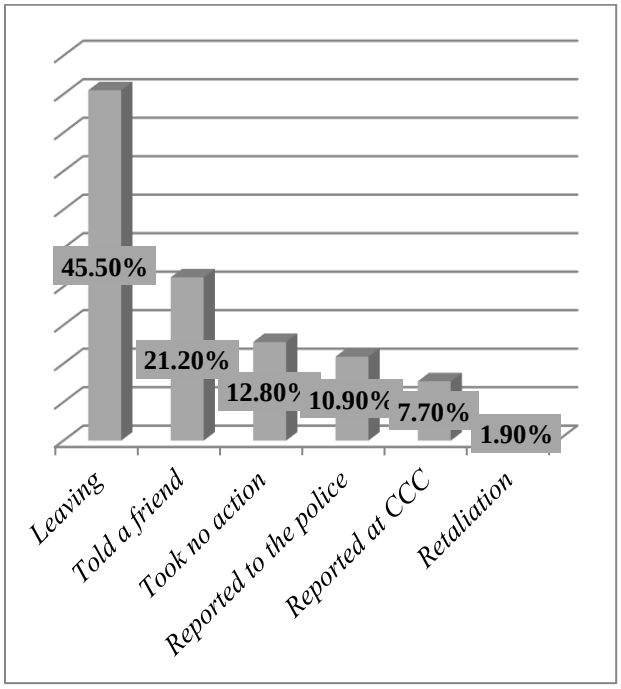
"*If he finds me at the shops when he is drunk, he will shout all forms of abuse in front of everyone who is there. That is humiliating*." FGD, 15-24 age stratum.

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. 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 on 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 form of IPV experienced by the respondents was sexual violence.

Intervention Methods to IPV

***Figure 1*: Intervention Methods to IPV**



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 that:

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

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.

12.8% of the respondents had shared with a friend about the violence they had or were experiencing in their relationship. 10.9% of the women had reported to the police to ask for help after being abused. 7.7% of the respondents said that they had reported at the CCC for help after experiencing violence. 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

Association between the type of IPV and Intervention Response

A cross-tabulation and Chisquare test of independence was done to examine if 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

DISCUSSION

Any woman whether HIV positive or negative experiencing domestic violence has taken a certain decision as a response to IPV. This study sought to find out 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 done 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 done in the USA suggest that leaving a violent relationship is a process rather than a one- time event (Kirkwood, 1992; Moss et al., 1997).

Not taking an 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 which 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 (Iliyasu et al., 2011). 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 led to economic dependence, which makes it impossible to leave a violent partner (Cocker et al., 2000). This is an issue that 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 their 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 non-abused women to report poor health and physical and mental health problems, even if the violence occurred years before (Garcia-Moreno et al., 2005).

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-centred

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 (Teti et al., 2007). 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 (Davis & Srinivasan, 1995; Goodkind et al., 2003). On the other hand, a view of domestic violence as a personal problem, often reinforced by the community and perpetrator denial, as well as fear of retaliation and socially ostracisation, deter many women from confiding in others and seeking help (Dominy & Radford, 1996, 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 the 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 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 non-existence of such organizations or lack of awareness.

A lower proportion of the respondents (7.7%) had reported to the CCC concerning their IPV experience. This could be due to the fact that 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 (Odunjirin, 1993). This issue is of paramount importance because IPV causes more than physical consequences but women also undergo 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 (Strauss et al., 2017). 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 (2001) found that women's accounts of their experiences of dealing with the abuse reflected movement through phases of non-recognition, 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 aforementioned. 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 HIV positive women undergo 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 multi-country study on violence against women also observed that women sometimes did not seek help because they were ashamed.

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 do experience intimate partner violence with physical violence and emotional violence being the most common types of IPV. They also experience significantly 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 the violence in their life by leaving while many others did 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's right violation has been clearly demonstrated as a risk factor for HIV and further affecting health and stigmatization. Based on the overall results of this study the following recommendations are called for: both government and non-governmental 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 the lives of people. Trauma-informed care may be indicated precisely because the study observed that some women who experienced IPV had obvious scars as a result of the violence.

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