

**STOP AIDS NOW!**  
**Gender Development Project**

**“That is how many women  
here survive”**

**Baseline Report Kenya  
2008**

## **Colophon**

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STOP AIDS NOW!  
Keizersgracht 390  
1016 GB Amsterdam-The Netherlands  
Project coordinator: Jennifer Bushee

Researched and written by: Kawango Agot, PhD, MPH &  
Susan Maua, BEd, MA

Data analyst: Mathews Onyango, MA, MPH

Editor: Ilse Flink, MA

Impact Research & Development Organisation  
Riddoch Road, Opposite Assisi Provincialate, Milimani  
P.O. Box 9171, Tel. 254-57-2020132,  
Kisumu, Kenya

More information can be obtained from: [jbushee@stopaidsnow.nl](mailto:jbushee@stopaidsnow.nl)

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## **Executive Summary**

Gender based discrimination plays a key role in fuelling the HIV pandemic. Not only are women more likely than men to contract HIV and other sexually transmitted infections due to their physiology, women face increasing levels of sexual violence in many parts of the world, and difficulties in negotiating safer sex due to gendered power imbalances. A growing body of research has been able to show a significant relationship between gender discriminatory beliefs and practices and increased HIV risk for both women and men (See Wingood and DiClemente 1998; Blanc 2001; Dunkle, 2006; Pulerwitz 2006). As a response to the rising prevalence of HIV amongst women and girls, a growing number of organisations are combating gender-based discrimination in order to address HIV/AIDS. The STOP AIDS NOW! (SAN!) partnership is one such organisation.

Specifically, STOP AIDS NOW! responds to the increased vulnerability of women and girls to HIV/AIDS through the Gender Development Project (GDP). Coordinated collaboratively in The Netherlands and in each project location, the GDP brings together community-based, non-governmental, and faith-based organisations working on HIV, human rights, women's empowerment and poverty reduction in Kenya and in Java and Papua, Indonesia. As part of the Project, the organisations take up local level HIV prevention strategies and interventions that promote egalitarian gender based attitudes, behaviours and norms and women's rights (SAN!, 2006).

SAN! has integrated a research initiative in the GDP in Kenya and Indonesia, specifically Java, to help determine the impact of the Project on the women and girls benefiting from the local activities the Project supports. SAN! commissioned Impact Research and Development Organisation (Impact-RDO), a research-oriented non-governmental organisation (NGO) based in Kisumu, Western Kenya, to carry out the research initiative in Kenya. An essential first step in this research initiative has been the baseline analysis. It provides an essential reference point for the evaluation of the Project.

At the most basic level, the results of the Kenyan baseline study are consistent with what has emerged from existent research on the relationship between gender-based attitudes, behaviours and norms and HIV risk. The baseline study showed positive associations between, on the one hand, the power and control women have in decision making in their sexual relationships, and on the other hand, their perceptions of being able to control condom use in their sexual relations, and the norms and attitudes they adopt towards condoms and their use. Contrary to the assumptions of much work being done in HIV prevention, however, the baseline study showed that, for the group participating in the research, HIV/AIDS knowledge does not have a significant relation with condom use intention. And given that condom use intention is a good predictor of actual condom use, we can surmise that HIV/AIDS knowledge, at least in the context of the GDP, cannot be assumed to lead in a straightforward way to increased condom use. This does not mean, however, that increased

HIV/AIDS knowledge does not, in general, play a role in a person's ability to protect him or herself from HIV infection.

The base line study confirmed that women in Kenya primarily act out lesser valued domestic and care-giver social roles. While women do have some decision making authority, it is limited to non-weighty, supposedly less important matters. Final decision making power lies with male partners, fathers or elder sons, and many of the women who participated in the study found this acceptable and "normal". Furthermore, the study revealed that domestic violence is common. It remains overwhelmingly unaddressed in general, and by the legal system specifically. When domestic violence *is* addressed, it tends to be addressed primarily as a private affair negotiated between the families directly affected. The baseline study also showed that a significant percentage of the women who participated accept physical violence as a justified form of punishment for behaviour on their part that their male partners find objectionable. In addition, the study showed that women and girls live in a constant gnawing fear of violence, be it domestic or at the hand of strangers.

According to the GDP baseline findings, higher risk factors for HIV infection included: being over the age of 40; being in a polygamous union or in monogamous union versus being unmarried, although being in a polygamous union presented a higher risk than being in a monogamous union; and being from a rural area (this last factor emerged, not from the quantitative data collected, but from the focus group discussions). Accordingly, the baseline findings showed that women above the age of 40 from rural areas who are in a polygamous relationship (and women in such relationships tend to be in rural areas) would be the most at risk. This group had lower scores with regard to actual condom use, lower condom use intentions and lower HIV/AIDS knowledge. Specifically, the results of the GDP baseline study in Kenya indicate that the women in question are in a very vulnerable position with regard to negotiating safer sex. Globally and in Kenya, rapidly increasing prevalence rates among young women 15-24 years of age indicate women in this age group have the highest risk of contracting HIV. The GDP baseline study challenged HIV risk assumptions based on the global state of affairs on HIV prevalence among women. The findings, however, are relatively consistent with previous research done in Kenya on HIV prevalence among different subgroups of women.

The above findings, along with other interesting outcomes, can be found in the following five chapters of this report: Introduction, Methodology, Results, Discussion and Recommendations. In the chapter on methodology, one may find an overview of the methods used to collect both qualitative and quantitative data, and information on how data were analysed and interpreted. The results chapter presents the specific findings that emerged from the study. The discussion chapter provides the interpretation of the results and a comparison of the qualitative and the quantitative data. The final chapter, the recommendations, provides advice on the end line measure.

## 1. Introduction

STOP AIDS NOW! is a partnership of five Dutch donor organisations: AIDS Fonds, Cordaid, Hivos, ICCO and Oxfam-Novib. As part of its efforts to contribute to improving the HIV policies and programs of its partners—through increased knowledge of successful strategies, interventions and practices—STOP AIDS NOW! takes up pilot projects on specific policy themes of relevance to the HIV pandemic. The Gender Development Project (GDP) focuses identifying promising approaches for transforming gender based attitudes behaviours and norms to address the rapid spread of HIV among women and girls in Kenya and Indonesia. The primary beneficiaries of the GDP are women and girls aged 15-60 years. Family members (spouses/partners, brothers, and parents) are secondary beneficiaries. The idea behind this choice of secondary beneficiaries is that the benefits of the interventions will spread beyond the individual women participating in the GDP activities to family members. In addition, several of the organisations participating in the Project directly take up GDP activities with the men and boys in the lives of the women and girls whom the groups target.

According to the Health and Demographic Survey conducted in Kenya in 2003 (KDHS, 2004), 7% of Kenyan adults were infected with HIV (8.7% women and 4.6% men). The gender disparity in prevalence was much wider in younger age groups, with 3% in 15-19 year-old women, compared to 0.4% in men of the same age, and 9% in women aged 20-24 years, compared to 2.4% in men in the same age bracket. Besides younger women, other subgroups of women who were more vulnerable to HIV included: widows (at 30.2%) and divorced or separated women (20.9%), compared with women who are currently in unions (at 8%). Also, prevalence was higher among women in polygamous marriages (at 11.4%) compared with women in monogamous unions (at 7.2%). Other risk factors for HIV infection among women were: 1) age at sexual debut (12.4% of women who initiated sex before age 15 years were infected, compared to 5% of men who also initiated sex before the same age of 15 years, and compared to women who initiated sex later – after age 20 years, of which only 6% were infected); 2) reporting two sexual partners 12 months prior to the survey (20.4% of women compared with 9.7% of men); and 3) reporting sex with non-marital, non-cohabiting partner (17.2% of the women compared to 4.7% of men).

All these key factors—widowhood, divorce or separation, polygamy, early initiation of sex, multiple sexual partnerships, and sex with non-spouse or non-cohabiting partner—have implications for HIV infection. For example, widowhood is associated with cultural practices such as sexual cleansing and inheritance. Divorce or separation can result from marital sexual violence. Multiple sexual partnerships characterise polygamy, and early initiation of sex is associated with long duration of potential exposure to HIV. With regard to sexual violence, the Demographic and Health Survey data indicate that recent physical violence (12 months prior to the survey) against women and girls in Kenya was high across several parameters. For example, violence was high among women and girls

of: different ages (26.3% among girls aged 15-19 years and 21.8% among women aged 40-49 years); different education level (24.5% among non-educated women and 15.9% among those with high school education or above); diverse marital status (31.0% among married women, 19.6% among divorced or separated women, and 17.7% among the never married); and diverse economic status (31.5% among those within the lowest wealth quintile and 17.5% among those falling within the highest quintile). Overall, 25.1% of women and girls aged 15-49 years reported physical violence in the year preceding the survey, with husbands accounting for 57.8% of the perpetrators.

It is with the backdrop of a generalised HIV epidemic and gender-based violence in Kenya that STOP AIDS NOW! is partnering with 25 organisations in the Country to implement small scale activities around the themes of gender, HIV/AIDS and human rights, such as discussion sessions, role plays, theatre activities, and peer education. The aim of the partnership is to transform gender attitudes, behaviours and norms as a means to reduce women's risk of acquiring HIV. In order to assess the effect of the planned interventions on transforming discriminatory gender norms, SAN! asked Impact-RDO to carry out both pre- and post-intervention evaluations with nine of the local partner organisations. The specific objectives of the research study were to collect, analyse and present baseline and end line information on:

1. Gender based attitudes, perceptions and beliefs on issues affecting women and girls;
2. The sexual and/or romantic relationships and power between men and women;
3. Forms of violence and how families and communities respond;
4. Intentional and actual condom use by women and girls; and
5. HIV/AIDS knowledge.

In line with these objectives, the specific tasks of Impact-RDO as a consulting research firm were to:

- Train representatives from the implementing organisations to equip them with skills to train others to conduct focused group discussions and administer questionnaires.
- Review and adapt with the representatives from the implementing organisations the qualitative and quantitative tools provided by STOP AIDS NOW! for data collection, and translate them into appropriate local languages.
- Provide light supervision during the qualitative and quantitative data collection exercises for both baseline and end line phases.
- Carry out the analysis of baseline and end line data.
- Draft baseline and end line reports.

## **2. Methodology**

This chapter describes the main methods used to conduct the baseline study. First, it describes how the training was organized for the representatives of the organisations. Second, it provides, by means of a table, brief information on the nine partners that participated in the research initiative. Third, it provides content on the actual data collection and the data analysis.

### **2.1 Training for Data Collection**

Between 30th August and 1st September 2007, Impact RDO trained 18 representatives from the nine implementing organisations (two representatives from each) participating in the research initiative in qualitative and quantitative data collection methods. In addition to equipping the organisations, through their representatives, to train local data collectors, important rationales behind this training were to adapt the questionnaire, make the research initiative more participatory, and give the partners more ownership with regard to the Project. Making the data collection more participatory also proved to be more efficient than training external researchers for data collection. To make sure that the training was useful to all the participants, the training involved the following:

1. A review of ethical principles of conducting research with human participants;
2. A review of questionnaire items, focus group discussion guides and in-depth interview guides (to be used for the end line measure);
3. A pilot test of the questionnaire and FGD guidelines with young women from a local NGO to assess the applicability of the questionnaire to the local context; and
4. Preparation of data collection and transcription plans.

Upon returning to their respective stations, the organisational representatives (having through the training session become trainers themselves) identified a group of women to train on data collection techniques (the Research Assistants, recruited outside the target group for the research), using the aforementioned tools provided. The training and the data collection by the groups were done on various dates between September and December 2007. The study covered diverse locations across four provinces: Nyanza, Nairobi, Central and Rift Valley (North Rift).

As not all 25 partners could be included in the baseline study, the table below depicts the nine partners that were selected to take part in the study. More information on the local partners is available in Appendix 1. Appendix 2 gives an overview of the criteria used to select the participating partners

**Table 1: Partners participating in baseline study**

<b>Partner</b>	<b>Location</b>
Help Self Help Centre (HSHC)	Naromoru, Nyeri District, Central Province
Young Women Campaign Against AIDS (YWCAA)	Mukuru Slums, Nairobi
Women in the Fishing Industry Project (WIFIP)	Ojola, Kisumu District, Nyanza Province
Community Mobilization for Economic Development and Advancement (C-MEDA)	Manyatta “B” Slums and other rural locations in Kisumu District, Nyanza Province
Citizens Coalition for Constitutional Change (4Cs)	Dunga beach and St. Stephens, Kisumu District, Nyanza Province
Kenya Female Advisory Organisation (KEFEADO)	Dunga beach and St. Stephens, Kisumu District, Nyanza Province
Community Aid International (CAI)	Bondo District, Nyanza Province
Anglican Church of Kenya, Eldoret (ACK-Eldoret)	Leseru, West Pokot District, Rift Valley Province
Kenya AIDS NGO Consortium (KANCO)	Mlolongo Trucking Center, Nairobi
Women’s Shadow Parliament, Kenya (WSP-K)	Ndhiwa Constituency, Nyanza Province

## 2.2 Data Collection Instruments

Two methods of data collection were used: focus group discussions (FGDs) and a structured questionnaire. STOP AIDS NOW! designed the questionnaire. The content was partly based on the following validated theories and scales:

1. The Sexual Relationship Power Scale (Pulerwitz, 2000)
2. The Gender Equitable Male Scale (Pulerwitz et al, 2006)
3. The Theory of Planned Behaviour (Fishbein & Ayzon, 1975)

After a thorough literature review, these three scales turned out most closely to relate to the Project’s indicators relevant for the baseline study, namely: 1) gender based attitudes, perceptions and beliefs on issues affecting women and girls; 2) the sexual and/or romantic relationships and power between men and women; 3) forms of violence and how families and communities respond; 4) intentional and actual condom use by women and girls; 5) HIV/AIDS knowledge. To enhance the internal validity of the questionnaire, the various indicators were measured with constructs from the scales and theory mentioned above. The Sexual Relationship Power Scale and the Gender Equitable Male Scale, designed by Pulerwitz *et al.* (2000; 2006) were used to determine gender based attitudes,

perceptions and beliefs and were integrated into the questionnaire with the following constructs: decision making dominance (referring to who makes the decisions within the relationship); gender norms (which “gender inequitable” norms do the women live by); and control (how much control do women perceive to have within their relationships). In turn, intentional and actual condom use were measured by using constructs from the Theory of Planned Behaviour (Glanz, 2002). Attitudes and self efficacy with regard to condom use were measured because various research initiatives have shown them to be important predictors of condom use. Self-efficacy is defined here as “people's beliefs about their capabilities to produce designated levels of performance that exercise influence over events that affect their lives” (Bandura, 1994). Furthermore, intentions to use a condom were measured because they are, according to the Theory of Planned Behaviour, the primary determinant of actual condom use. To make sure that all constructs of the Theory of Planned Behaviour were covered, actual condom use was also measured.

Besides focusing on the above constructs and indicators, the questionnaire also solicited information on the background profiles of the respondents. This included amongst others, age, educational background, religious background and questions on marital status.

The FGDs were led through use of a focus group guide developed by Impact RDO. The partners had the liberty to add topics to the guide that they perceived to be relevant for their target groups. The FGD guide focused primarily on the indicators that were difficult to quantify and were thus inappropriate for the questionnaire, i.e., indicator three on forms of violence and how families and communities respond and indicator. Nonetheless, the FGD guide was also meant as an addition to the questionnaires, and thus also focused on gender based attitudes, perceptions and beliefs on issues affecting women and girls, and the sexual and/or romantic relationships and power between men and women.

Both the questionnaire and the FGD guide were translated into Dholuo (for groups in Nyanza Province), Kiswahili (for groups in Rift Valley and Nairobi provinces) and Kikuyu (for groups in Central Province). English was used in schools and for other groups where participants preferred the language.

### **2.3 Data Collection Procedures**

The questionnaires were intended to be administered to women and girls between 15 and 60 years of age, and completed on or close to the day of the launch or commencement of the intervention. It was highly important that none of the women and girls taking part in the baseline study had been exposed prior to a GDP activity.

The intervention and the evaluation exercises were described to the participants, and those who wanted to participate in the research were directed to the research team for further description and group consent. Participants were then taken through the process of filling out self-administered questionnaires. Those who had reading or writing difficulties were assisted by the Research Assistants (RAs). The RAs were recruited from outside the target group to ensure participants answered the sensitive questions openly, and to preserve confidentiality of information collected. The participants then filled out their choices privately, or with assistance in cases of reading or writing difficulty or inability. When the process was over, completed questionnaires were dropped off in a central box within the room, collected by the researchers, and surrendered to the partner organisation for mailing to Impact-RDO for data cleaning, entry and analysis.

The qualitative data were collected through FGD sessions with girls of various youth groups, high school students, members of women's groups and culture custodians. Most sessions began with a description of the study to the entire group, emphasising, amongst others, principles of ethical research, confidentiality of the information and voluntariness of participation. Questions and issues arising were then addressed. This was followed by individual consenting. To be eligible, participants also had to consent to being tape-recorded. Completed tapes were transcribed verbatim by the note-takers, and reviewed for accuracy and completeness by the moderators of the respective sessions. In two instances, taping was not properly done, so the note takers expanded the notes. Where the local language was used, transcriptions and translations into English were done concurrently. A summary describing each process was written to provide a general impression on the exercise. The tapes, notes, transcripts and summaries were then submitted to Impact-RDO for analysis.

### **2.3 Data Analysis**

Quantitative data were entered into SPSS computer package version 12 (SPSS Inc., 1998, Chicago IL) and later transferred to SAS version 9.1.3 computer package (SAS Institute 2000-2004) for data management and analysis. Analysis involved simple descriptive statistics including: proportions and percentages for categorical variables, and means, medians and ranges for continuous variables; a factor analysis to detect the appropriateness of the questionnaire given the cultural context; and linear regression analyses to detect correlations between factors. The results were summarized in tabular formats, accompanied by brief narratives.

Textual information from FGDs was recorded in field note books and also audio taped. Data from the audio tapes were transcribed verbatim, and when the tape was faulty, notes were expanded by the note-taker upon arrival from the field. FGD transcripts were read several times, first for familiarity with the information collected and then to identify and extract key views, knowledge, attitudes and practices regarding each question. The findings for each question were sorted in terms of frequency of mention, and interpreted within the context of the GDP goals.

### 3. Results

After discussion with the local partners in the research initiative and corresponding adaptation of the data collection instruments, the base line sought to discover the following from the participants: their attitudes, perceptions and beliefs about the gender roles of men and women in their communities (including of children); gender based violence and issues around safety and security of women and girls; the power relations between men and women in families; actual and intentional condom use; and HIV/AIDS knowledge, including key sources of such knowledge. The results for both quantitative and qualitative data collected are presented in the following paragraphs. The quantitative results are presented according to the order of the questionnaire, while for FGD results, the format of the guide has been followed, dividing this section into three main parts (general questions about the community, safety and security of women and girls, and marriage and relationships between husbands and wives), following by responses for each set of questions.

#### 3.1 Quantitative Results

The following paragraphs depict the main results that arose from the questionnaires. This includes, amongst others, a description of the sample, an overview of the factor analysis that was conducted and the main correlations that were found.

##### 3.1.1 Description of the Sample

In total, 1,474 questionnaires were administered by the organisations to the women and girls taking part in the baseline study, as follows:

**Table 2: Total number of questionnaires administered**

Organisation	# Questionnaires
HSHC	53
YWCAA	50
WIFIP	139
CMEDA	66
4Cs	103
KEFEADO	103
CAI	153
ACK-Eldoret	269
KANCO	175
WSP-K	464

The median age of respondents was 28 years (range 9-82 years). There was no information on age or date of birth for 210 respondents. About 71.2% were in some form of relationship, 24.2% were single and not in any form of sexual or romantic relationship. Sixty percent of the respondents were married, among whom 70.9% were in monogamous unions while 29% were in polygamous unions. Eight of the participants (0.6%) were widowed. There was no information on relationship status among 109 respondents. The median duration in relationship among those who reported being in some relationship was 12 years. Three hundred and seventy two respondents who were otherwise in relationships did not give information on the duration of their relationship.

Most of the participants had at least secondary education and above (54.7%) with 6.8% reporting university education. This means that women had much higher education levels compared to the national level, which is 23% for some secondary education (KDHS, 2004). Seventy of the respondents did not give information on the highest level of education. Equally, their partners also had much higher education, with 55.4% having at least some secondary education, and 14.4% have university education compared to the national level for men, which is 27% for secondary level of education (KDHS, 2004). Stratified by name of organisation, it seems that the majority of the highly educated women came from only two groups: WSP - Kenya in Ndhiwa, Nyanza Province and KANCO in Mlolongo, Nairobi Province. WSP - Kenya accounted for 59% of the University graduates, KANCO accounted for 20%, while the other seven organisations split the remaining 21%.

A majority of participants (91.6%) identified themselves as belonging to the Christian faith while the rest – 6% and 2.2% – were Muslims and traditionalists, respectively. Data on religion was lacking for 40 respondents. Most participants funded for themselves with own income, 26.7% got financial support from husbands or partners, while the rest reported receiving support from other relatives (16%), social service/welfare (4.3%); other – undisclosed sources (0.9%). Fifteen-percent reported no income while there was no data on income from 118 respondents.

Majority of respondents (64.5%) had children. About 55% reported use of some form of contraception, particularly male condoms (34.9%), injectables (23.8%), pills (12.8%), norplant (8%), tubal ligation (3.9%), intrauterine devices (3%), and spermicides (4.5%). Tables 2a and 2b summarize the distribution of participants by demographic and socio economic characteristics.

**Table 2a: Distribution of respondents by age**

ATTRIBUTE	MEDIAN	MIN	MAX	Missing cases
Age (in completed years)	26	14	78	210
Duration at current relationship	7 years	1 month	49 years	372

**Table 2b: Distribution of respondents by other attributes**

<b>ATTRIBUTE</b>	<b>NUMBER</b>	<b>PERCENT</b>
Ever attendance of Gender Development Project activities		
Yes	66	4.6
No	1375	95.2
Missing	33	2.2
Highest Education level		
Primary	540	38.5
Secondary	768	54.7
University	95	6.8
Missing	71	4.8
Highest Education level of Partner		
Primary	267	30.2
Secondary	489	55.4
University	127	14.4
Missing	591	40.2
Religion		
Muslim	86	6.0
Christian	1316	91.6
Traditional	32	2.2
Missing	37	2.5
Main Source of Income		
Money from own work	486	35.7
No income	213	15.7
Other	12	1.0
Social service/welfare	59	4.3
Support from husband/partner	364	26.7
Support from other relatives	219	16.1
Missing	118	8.0
Relationship Status		
In a relationship	207	15.2
Married monogamous	582	42.6
Married polygamous	238	17.4
Other (widowed, etc)	8	0.6
Single	330	24.2
Missing	109	7.4
Whether participant had children		

ATTRIBUTE	NUMBER	PERCENT
Yes	855	64.5
No	487	35.5
Missing	102	6.9
Contraceptive use		
Yes	698	64.5
No	311	35.5
Missing	207	14.1
Type of Contraceptives used		
Birth control pills	88	12.8
Condoms	240	34.9
Spermicides	31	4.5
IUD	19	2.8
Injectables	164	23.8
Natural methods	61	8.8
Norplant	55	8.0
Tubal ligation	27	39.2
Missing	786	53.4

### 3.1.2 Exploratory Factor Analysis

Although validated scales and theories were used to measure the five main indicators of the project, it was still necessary to subject the variables to a factor analysis so as to make sure the variables measured the intended constructs (decision making dominance, control, gender norms, condom use intentions, attitudes towards condom use, self efficacy regarding condom use, actual condom use, and knowledge on HIV/AIDS) which are directly linked to the five indicators. In total, seven factors emerged as labelled in Table 3 below. This implies the questionnaire was valid for all the constructs because actual condom use did not have to be subjected to a factor analysis as it was only measured with one variable. The table also shows the standardized means, standard deviations, minimum and maximum values of the factor scores, as well as the number of cases (N) involved in the creation of each factor score.

**Table 3: Standardized factor scores**

	N	Mean	Std Dev	Minimum	Maximum
Decision making	767	-1E-15	1	-1.681	10.246
Control	824	-3E-16	1	-2.610	2.199
Gender norms	1283	4E-15	1	-2.567	2.012
Condom norms & attitudes	1319	-9E-15	1	-2.169	1.421
Self efficacy on condom use	1325	-6E-15	1	-2.218	1.283
Condom use intention	1345	3E-16	1	-1.770	1.085
HIV/AIDS Knowledge	1321	4E-15	1	-3.250	0.894

### 3.1.3 Descriptive Statistics per Factor

#### Decision-making Dominance & Control

Respondents who were in some form of relationship or marital unions were asked several questions relating to their practices and beliefs about the relationship. Specific statements were posed, and respondents were asked if they strongly agreed, agreed, undecided (no opinion), disagreed or strongly disagreed with the statement. Participants were also asked who in their relationship (respondent, partner or both) was responsible for certain decisions.

In general, respondents tended to disagree with the statements: partner tells respondent who to spend time with (32.4% disagree and 22.5% strongly disagree); when with partner, respondent is pretty quiet (37.4% disagree and 27.4% strongly disagree); when respondent does what partner doesn't approve of, he hits her (33.4% disagree and 30.82% strongly disagree); and, it is important that partner disciplines respondent (27.7% disagree and 31.9% strongly disagree). A relatively high percentage also tended to agree with some of these statements (i.e., 20.9 % agreed that it is important for the partner to discipline the respondent). Another relatively high percentage also tended to agree or strongly agree with the following statement: partner won't let respondent wear certain things (29.2% agree and 20.8% strongly agree), and that partner always wants to know where respondent is (39.2% agree and 21.9% strongly agree).

Regarding who has more say on aspects and decisions in a relationship, the majority of the respondents reported that both partner and respondent (rather than either respondent or partner individually) have a say on: what they do together (65.4%); how often they see one another (55.0%); whether to use condoms (50.2%); and whether they have sex or not (50.8). In contrast to this, the majority (55.5%) felt that their partners had more power in their relationship as opposed to themselves alone or themselves and their partners together.

### Domestic Gender Norms

Participants were presented with thirteen statements relating to gender norms in a domestic/sexual relationship, and asked whether they strongly agreed, agreed, disagreed, strongly disagreed with, or were undecided about the statements. Most participants tended to agree with the statements: a woman's most important role is to take care of her home and cook for her family (31.9% agree and 36.3% strongly agree); changing napkins/diapers, bathing, and feeding the children are the mother's responsibility (31.5% agree and 37.9% strongly agree); and it is important that a father is present in the lives of his children, even if he is no longer with the mother (33.4% agree and 42.6% strongly agree). Participants tended to disagree with the statements: it is the man who should decide whether to have sex (28.7% disagree and 34.6% strongly disagree); a man needs other women (19.5% disagree and 42.8% strongly disagree); there are times when a woman deserves to be beaten/hit (25.1% disagree and 43.3% strongly disagree); and it is ok for a man to beat/hit his wife if she won't have sex with him (26.1% disagree and 58.3% strongly disagree). Although the biggest percentage of respondents tended to disagree with the statement, "a woman should tolerate violence in order to keep her family together" (18.6% disagree and 37.4% strongly disagree), there were still relatively high percentages (18.5 % and 20.2 %) that tended to strongly agree and agree, respectively.

### Condom Norms and Attitudes

Participants were asked seven questions to measure their attitudes and norms regarding condom use. Questions included soliciting participants' thoughts on how using condoms, themselves or their partners, would make them feel, and how their condom use would be supported by people most important to them. About 53% agreed that using condoms would make them feel comfortable or very comfortable, but a sizeable proportion (about 48%) were either undecided, would feel uncomfortable or very uncomfortable using condoms. Close to 60% felt that encouraging their partners to use condoms would make them feel comfortable or very comfortable. In addition, the majority tended to report that most people important to them would want them to use condoms, and that it is expected of them to use condoms.

### Self-efficacy regarding Condom Use

Variables collected to measure self efficacy on condom use included questions about whether participants felt confident to use condoms if they wanted to, whether they thought using a condom was easy and beneficial, and that the decision to use condoms did not lie beyond their control. Self efficacy is, according the Theory of Planned behaviour, an important determinant of actual condom use. The more self efficacy the greater the chance is that one will use a condom.

The majority of the respondents (73.5%) agreed or strongly agreed that they would be confident enough to use condoms if they wanted to, while 7.2% were undecided. The rest (19.3%) disagreed or strongly disagreed that they would be comfortable enough to use condoms if they wanted to. A little over half of the respondents (58%) felt using condoms would be easy or very easy, and that using a condom would be beneficial.

#### Actual Condom Use

Regarding actual condom use, respondents were asked (on a scale of 1-5, 1 indicating always and 5 indicating never) how often they had used a condom during sexual intercourse in the past six months. Twenty-three percent reported consistent use of condoms in the six months preceding the survey, 18.6% reported condom use in nearly all sexual encounters, 19.2% were undecided or rarely used condoms, and 38.7% reported never using condoms in any sexual encounter six months preceding the survey.

#### Knowledge of HIV/AIDS

Ten statements related to knowledge of HIV/AIDS were read and participants asked whether they agreed, disagreed with the statement, or did not know. These variables were meant to measure knowledge of HIV/AIDS and included questions such as: whether a person can be infected with HIV but still look healthy; questions on modes of transmission of HIV; risk factors for HIV; HIV progression; positive living; and whether there is a cure for HIV. The results show that most respondents had sufficient knowledge of HIV/AIDS. All the questions were answered correctly by more than 60% of the respondents. In some cases 93.6% answered the question correctly.

#### **3.1.4 Regression Analysis**

A bivariate regression analysis was conducted to analyse the relation between two variables (the outcome/dependent variable and the independent variable). Furthermore, a multivariate regression was applied to measure the effect of various independent variables on the outcome variable—to be able to detect which specific variables had the most influence on the outcome variable, and correct for specific effect-modifiers or confounders (variables interrupting the effect of another variable) (Field, 2005). In the case of this study, the regression used condom use and HIV knowledge as the main outcome variables because it was interesting (for the research initiative of the GDP) to find out how other factors, like decision making dominance, correlate with these variables. With regard to condom use, the specific factors that were examined were: self efficacy regarding condom use; condom use intentions; and actual condom use. For all the logistic regression analyses a significance level  $\alpha = 0.005$  ( $p < 0.005$ ) was used.

### Self-efficacy regarding Condom Use

At bivariate level, there was a highly significant positive correlation between self efficacy and decision making dominance, control, gender norm, condom norms and attitudes and condom use intention ( $p < .0001$ ). Amongst these factors, condom norms & attitudes and condom use intentions had the strongest positive relationship with self efficacy. In turn, there was also a significant positive correlation with HIV/AIDS knowledge ( $p = 0.0153$ ), though not as high as the former factors. However, there were no significant differences in self efficacy between those aged less than 19 years and those aged 30–40 years compared to those aged 20-30 years ( $p = 0.1915$  and  $0.3155$  respectively). Those aged 40 years and above had significantly less self efficacy compared to those aged 20-30 years ( $p < .0001$ ).

Compared to those with primary level of education, those with secondary and tertiary levels of education scored significantly higher in self efficacy ( $p = 0.0263$ ,  $p < .0001$ , respectively). Similarly, respondents whose partners had secondary and tertiary levels of education scored significantly higher on the self efficacy scale compared to those whose partners had primary level of education ( $p = 0.0004$ ,  $< .0001$ , respectively).

In terms of relationship status, those 'in a relationship' or single had significantly higher scores on the self efficacy scale compared to those who were in monogamous marital unions ( $p < .0001$ ,  $0.002$ ). There were no significant differences in self efficacy scores between those belonging to Islamic denomination and traditional religion compared to those Christian denomination ( $p = 0.6665$ ,  $0.0996$  respectively). A table summarizing these bivariate regression results is shown in appendix 5a.

In a multivariate context gender norms, condom norms and attitudes, condom use intention and respondents age remained significant independent predictors of self efficacy ( $p = 0.0048$ ,  $< .0001$ ,  $< .0001$ ,  $0.0040$ , respectively). The results are shown in Appendix 6.

There was a moderately significant difference in standardised mean self efficacy scores between those aged 40 years and above, and those aged 20-30 years. Those aged 40 years and above had significantly lower standardized self efficacy scores ( $p = 0.0040$ ) compared to those aged 20-30 years. Within the multivariate context, partner's educational level could no longer be seen as a significant predictor of self efficacy ( $p = 0.1176$ ).

### Intention to Use a Condom

There were highly significant positive associations between decision making power, control, gender and condom norms and attitudes ( $p < .0001$ ,  $0.0002$ ,  $< 0.0001$  and  $< 0.0001$ , respectively). HIV/AIDS knowledge on the other hand did not have a significant relation with condom use intention ( $p = 0.3554$ ). Compared with those aged 20-29, respondents aged 19 years and below had

significantly higher scores on condom use intention ( $p=0.0175$ ) while those aged 30-40 years and 40+ years had significantly lower standardized scores on condom use intentions ( $p=0.0152$  and  $p=0.0364$ , respectively).

Regarding education, there were significant differences in standardized condom use intention scores. Compared to respondents with primary level of education, those with tertiary level of education had significantly higher scores on standardized condom use intentions ( $p<.0001$ ). There were no differences in standardized condom use intention scores between respondents with primary level of education and those with secondary level of education ( $p=0.129$ ). Respondents whose partners had secondary or tertiary levels of education had significantly higher scores of condom use intention compared to respondents whose partners had primary levels of education ( $p=0.0045$  and  $<.0001$ , respectively).

In terms of religious affiliation, those who reported traditional religious affiliation had significantly lower condom use intention scores compared to Christians while there were no significant differences in mean condom use intention scores between Muslims and Christians ( $p=0.0148$ ,  $0.7161$ , respectively). Regarding relationship status, those who were in single or in a romantic relationship had higher condom use intention scores compared to those in monogamous marital status ( $p=0.0017$ ,  $<.0001$ ). There were no significant differences in condom use intention scores between those who were in polygamous unions compared to those who were in monogamous unions ( $p=0.2993$ ), although there was a trend towards lower condom use intention scores among those in polygamous unions compared to those in monogamous marital unions. The results are presented in Appendix 5b.

Adjusting for all factors as well as demographic variables in a multivariate regression model, only condom norms and attitudes and being single remained statistically significant and positively correlated with condom use intention ( $p<.0001$  and  $0.0022$ , respectively). The multivariate regression results for condom use intention are presented in Appendix 6.

#### Actual Condom Use in the Previous Six Months

There was a highly significant positive association between condom use frequency in the previous six months preceding the survey and decision making power, control, gender norms, condom norms and attitudes, and condom use intention ( $p<.0001$ ). There was no statistically significant relationship between condom use frequency in the previous six months and HIV/AIDS knowledge score ( $p=0.1749$ ). Those aged 40 years and above had, on average significantly lower frequency of condom use compared to those aged 20-29 years ( $p=0.0155$ ). There was marginally significant difference in condom use frequency between those aged 20-29 years and those aged 30-40 years ( $=0.0545$ ) and between those aged 20-29 years and those aged 19 years or below ( $p=0.0465$ ).

Compared to those with primary level of education, respondents with tertiary level of education and those whose partners had tertiary level of education had significantly higher condom use frequency ( $p < .0001$ ). There were no differences in condom use frequency between respondents with secondary level of education and those with primary level of education ( $p = 0.1915$ ) and those whose partners had secondary level of education compared to those whose partners had primary level of education ( $0.0608$ ). Those in polygamous marital unions had significantly lower condom use frequency compared to those in monogamous marital unions ( $p = 0.0232$ ). Those in a relationship or single had significantly higher condom use frequency compared to those in monogamous marital unions ( $p = 0.0002$  and  $< .0001$ , respectively). Regarding religious affiliation, no significant difference in condom use frequency between Muslims compared to Christians and traditionalists compared to Christians ( $p = 0.1619$  and  $0.755$ ). The bivariate results are presented in Appendix 5d.

Controlling for all the factors, demographics and sex frequency in the last six months, condom norms and attitudes, condom use intention, type of relationship and religion were the best predictors of condom use frequency. There was a positive, highly significant relationship between condom norms and attitudes and condom use intention and condom use frequency ( $p < .0001$  and  $0.0084$ , respectively). Those in polygamous unions had significantly lower condom use frequency compared to the those in married, monogamous unions ( $0.0016$ ) while the single had significantly higher condom use frequency compared to those in monogamous unions ( $p < .0001$ ).

#### HIV/AIDS Knowledge

There was a highly significant positive association between HIV/AIDS knowledge score and control as well as gender norms ( $p = 0.004$  and  $< .0001$ , respectively). Those aged 40 years and above had significantly lower standardized mean HIV/AIDS knowledge score compared to those aged 20-29 years ( $p < .0001$ ). There were no significant differences in mean HIV/AIDS knowledge score between those aged 20-29 and those aged less than 19 years and those aged 30-40 years ( $p = 0.3564$  and  $0.8022$ , respectively).

Regarding education level, there were highly significant differences in standardized mean HIV/AIDS knowledge scores between those with secondary level of education compared to those with primary level of education. However, contrary to expectation, there were no significant differences in HIV/AIDS knowledge score between those with tertiary level of education compared with those with primary level of education ( $p = 0.7978$ ) and the relationship tended to be negative. Similarly, those whose partners had secondary level of education had significantly higher standardized mean HIV/AIDS knowledge score compared to those whose partners had primary level of education. There were no significant differences in standardized mean HIV/AIDS knowledge score between those whose partners had tertiary level of education and those whose partners had primary level of education ( $p = 0.1478$ ).

Compared to those in monogamous marital unions, those in polygamous unions had a significantly lower standardized mean HIV/AIDS knowledge score ( $p=0.001$ ). There was no association between HIV/AIDS knowledge score and condom norms and attitudes ( $p=0.2529$ ) and between Muslims and Christians and traditionalists and Christians ( $p=0.2704$  and  $0.5624$ , respectively). The bivariate results are presented in Appendix 5c.

In a multivariate context, gender norms, age, respondent's education level, partner's education level and type of romantic relationship were the best predictors of HIV/AIDS knowledge score. With every one standard deviation increase in gender norm, HIV/AIDS knowledge score increased by about 0.22 standard deviations ( $p<.0001$ ). Average HIV/AIDS knowledge score for respondents aged 40 years and above was about 0.39 standard deviations lower than those aged 20-29 years ( $p=0.0007$ ). Those with tertiary level of education had significantly lower mean HIV/AIDS knowledge score compared to those with primary level of education. HIV/AIDS knowledge scores among those with tertiary level education was on average 0.39 standard deviations lower than those with primary level of education ( $p=0.0099$ ). There was no significant difference in HIV/AIDS knowledge score between those with secondary level of education compared to those with primary level of education.

Regarding marital status, those who were in polygamous unions had significantly lower HIV/AIDS knowledge score compared to those who were in monogamous unions. On average, their knowledge score was 0.33 standard deviations lower than those in monogamous unions ( $p=0.0034$ ). Similarly, those single also had significantly lower knowledge scores compared to those in monogamous unions. They were about 0.36 standard deviations lower on average compared to those in monogamous unions ( $p=0.0124$ ). These results are summarized in Appendix 6.

### **3.2 Qualitative Results**

The FGD guidelines sought to explore three areas of gender issues: part one comprised of general questions about the community in terms of how different members spend their time; how they help each other; how they make decisions; and how they get information. The expectation was that this part would elucidate interesting information on gender norms. Part two explored issues of safety and security of women and girls within their communities related to Gender Based Violence (GBV). Part three focused on issues around marriage and relationships between husbands and wives. The expectation was that this part would elucidate information on power within sexual and/or romantic relationships. In the following sections, the results for each of these parts are presented.

### 3.2.1 General Questions about the Community

Seven sets of questions were asked in this section. One set focused on how men, women and children spend their time, including the social activities they engage in, who makes decisions on where and when children go to school, and whether or not children work at home.

#### What men do

By and large, there were similarities in what was reported for men in urban settings and those in rural settings. To earn a living for self and family, men in urban areas were reported to engage mostly in casual labour, while those in rural areas work mostly in farms and also in the livestock and fishing industries. A significant proportion of respondents were of the view that men today do very little work. As one respondent explained:

“When talking about men, there are men we are staying with here. They are just like dead, because they don’t bring you anything. Most of the time it is you looking for food and everything while he is seated eating what he wants, but does not help by working. His work is to sit, walk, eat and bathe but never asks where these things come from and never contributes even 100 shillings (\$1.60) to buy sugar. When he comes in, he asks, “What is ready in the house? What are we eating today? Give me something to eat.” But he does not know where these things come from. My people [referring to other participants], men are killing us.”

This and other views show that most men have abdicated their traditional responsibility of providing for the family and have instead become dependent on the women. More specifically, virtually all focus groups reported that most men spend their time in bars or community centres (shopping and market) drinking, taking marijuana and khat, looking for other women, or engaging in chit-chat around political and relational topics.

#### What women do

Women, on the other hand, were reported to spend most of their time doing assorted household chores, ranging from taking care of the children and other members of the household, keeping the house clean and orderly, and doing laundry for the family. In addition, women in rural areas also work the farms, fetch water and firewood, tend animals and milk cows (reported only in West Pokot), as well as look after the property of their husbands who are working in the cities. Respondents in Nairobi observed that many educated and working (and presumably empowered) women have also taken over hitherto male responsibilities, and rent, bills, children’s school/college fees, house furnishings are paid by the women of the house, in addition to taking charge of kitchen expenses. Appendix 7a contains selected quotations from rural and urban settings that highlight the multiplicity of tasks women in different parts of the country shoulder.

With regard to social activities, women spend time attending church activities, welfare group meetings, markets, or occasionally hanging out with friends or neighbours. All respondents agreed women are busier now than they were five years ago, citing increasing numbers of single women with

families to care for, more women getting into business and paid jobs, and still doing most of household chores. In addition, economic hardships are necessitating the need to lend a hand to or take over from their husbands in providing for the family. As a respondent put it:

“Nowadays, if you don’t have money to put up a business, it is very difficult. Some of us knock from door to door asking [the owners of these houses] to do their laundry or clean the house. If there is no laundry, we meet with someone, negotiate, he tells you he’ll give you two hundred shillings (\$3.50). With those two hundred shillings, you will purchase traditional brew from a local brewer at one hundred and fifty shillings. So, you will get that man, go sleep with him, he gives you the 200 shillings. You will buy the alcohol, which is cheaper than the food because if you go to the market, that money will not be enough. So you would rather buy the alcohol so that those who build houses [work in construction sites] when they come, these young men will drink the alcohol because it is cheap. So you get the money to buy food and other things, and even remain with some change to buy some more alcohol to add [to the stock]. If the alcohol is over and you do not have enough money to buy more because you used more in the house than normal, you look for another man again and start again. That is how many women here survive.”

#### What children do

Children were reported to spend most of their time playing and going to school. Older ones also help with domestic chores and farm work (rural areas only) after school. There was clear division of labour; boys looked after animals or ran errands, with plenty of time in between to play, while girls helped in fetching water and firewood, cleaning the house, caring for younger siblings, doing laundry for other members of the family, and cooking. With free primary education in Kenya, almost all children are enrolled in school. However, many do not go to school beyond standard/grade eight, and some drop out of school earlier. Consequently, some children get involved in odd jobs for pay. Below is an excerpt from a respondent that illustrates this trend:

“Some collect metals and plastics and they go sell. Some are also employed for low wages. They leave school to engage in various types of labour – as maids or do other house jobs; others chisel local stones to make gravel; others harvest sand by the rivers. And those near the beaches leave school to go fishing or to trade in fish.”

In general, children’s chores are also sub-divided into feminine and masculine roles. In the homes, the girl child still does more work than the boy.

### **3.2.2 Decision-making Dominance within Relationships**

At the family level, both men and women were cited as taking various types of responsibilities in decision-making. It emerged, however, that in households where men are available, they make most of the decisions either singly and then inform the rest of the family members, or consult with their wives and sometimes grown up children before concluding on a course of action that involves the whole family. But in instances when the husbands are working away from home, women make more decisions, particularly those that do not come with substantial changes in managing family affairs. In some cases, women are expected to consult with first born sons, brothers or parents of the husband. Furthermore, it was observed that a significant number of households are currently being headed by

single women, who are solely responsible for making most decisions affecting their families, and may consult with male members of the extended family or community leaders only if they choose to do so.

A respondent illustrates this trend:

“In homes, everyone can make decisions. Like in our area, mostly here in Kieni, most homes do not have husbands, and single mothers are the dominant, so women are the heads of their families. Maybe it’s only a lover they are staying with, and so it is her house. Those who are married, they can both decide because they should agree on things together. I can say it is okay this way. If my partner says it is not, we can talk and agree so that both decide. If he refuses and says he must decide alone, he can go.”

The slant of the responses nonetheless demonstrated that in many Kenyan ethnic communities, men are perceived to have almost exclusive rights to decision-making in the home and the community, especially those that involve weighty matters such as sale of land or domestic animals, and marriage of the children. Consequently, the overarching feeling among the respondents was that it may be a woman’s right only to make decisions concerning non-weighty matters in the home, such as “kitchen issues.” While the women concurred that they are busier than men and that most men have offloaded their responsibilities to their wives, most of them still preferred to leave the decision-making in the men’s domain. A respondent maintained that:

“Women had specified roles and should leave decision making to the men or their husbands.”

Another respondent remarked:

“Normally, the way we are brought up is that the man is the head of the family.....most of the time, a mother can make a decision as a parent but whatever the father says really has a lot of weight”

It is worth noting there was some disparity in perceptions of roles in decision making between the women in the rural settings and those in the urban ones. While rural women felt decision-making should be left to the men, their counterparts in the urban set ups felt women should take an active role in decision making. In the event that the decision maker (the man) was away, the rural women still preferred that an older son or brother- in-law should take over. Although respondents had earlier stated that women have taken over a lot of responsibilities from the men, they (the women) still seem to shy away from decision making.

### **3.2.3 Safety and Security for Women and Girls**

Respondents agreed that safety and security of women and girls are serious concerns in Kenya today. They felt the incidence of rape has become so common that women and girls are often looking over their shoulders as they walk most roads, lanes and paths:

“Women who go out for chores for example fetching water at the lake or river and even those who go home late in the evening from the market are more vulnerable. Women can’t just do their work in peace without fear.”

A relatively new development in the country is the apparently increasing report of robberies during which women and girls are gang raped. According to one respondent:

“It’s not enough that you are concerned about being raped when walking even on the streets of your neighbourhood; you are also worried when you go to sleep in case robbers break in to steal and rape.”

Girls also reported that young men in groups often make sexual comments as they walk past, and all participants knew of women or girls who had been physically abused by their male partners.

Circumstances believed to be causing insecurity for women and girls include: idleness and peer pressure among young men that push them to rape; popular Western media showing sexual scenes or overt pornography, which allegedly plants sex into the heads of men; and the opening of economic and professional spaces to women. In addition, participants reported there is limited time to chaperone daughters due to over-commitment with economic activities. Some parents are accused of sending their daughters to the streets or bars to solicit for paid sex to augment family income. There was a general agreement that one of the key reasons why gender-based violence (GBV) is on the rise is because women and girls do not know their rights. Victims do not know where to go for help or what to do, they are intimidated by parents or guardians and made to keep silent, and the judicial system hardly prosecutes offenders. Victims and/or family members feel it is a waste of time reporting to the authorities. Many lamented that, more often than not, the police or the magistrates are bribed, and offenders get released and return to the same neighbourhoods where they committed the crime. In addition, the victims and/or their families fear revenge when the culprits are released without charge.

#### Specific forms of violence against women and girls

Domestic violence topped the list in terms of frequency of mention. Even young and unmarried school girls cited vivid examples of wife battering. This was attributed to several factors, key among which were forced or arranged marriages (often of young girls to much older men), financial burdens that pushes men to let out their frustrations on women, extra marital affairs by either partner, failure to contribute to running the house, and external interferences, especially by in-laws. Respondents also felt that failure to accord girls equal opportunities with boys, especially in education and professional training, is a form of GBV because they (girls) are being denied an opportunity to be self reliant in the future. Overworking women and girls, including house girls, was also seen as a form of GBV, as was the payment of dowry, which makes men feel they own the wives and could therefore do whatever they like to them. Singled out also were female genital cutting, widow inheritance, and incest, especially by a father to a daughter. In Appendices 7c and 7d are excerpts from some respondents on incest.

In terms of practices that the community feels are sexually inappropriate, abusive or violent, rape and incest were most frequently cited. Others included sexual harassment. A youth out of school said that:

” We have boobs (breasts) and utapata mutu (you will find someone) will just be on you all the time. Anataka akushike (he wants to touch you), akufanye nini (do whatever to you), and you are not willing. There is also sexual harassment when you are in need of a job, and you are so desperate, and you really need that job by going with [having sex] him (the employer).”

Respondents defined forced sex or sexual harassment as having sex with someone without consent. Forms of sexual abuse included: being forced into sex to secure a job, promotion or favour; sexual manipulation, such as using sex to evade an issue or win support or approval from a partner (i.e., resorting to seduction and sex to shut up the wife and/or cover up a mistake); marital and non-marital rape; and coercion or seduction of house girls by the men of the house. Other forms are indecent touching, or making suggestive signs or remarks to someone who is not your partner.

Regarding when and where sexual violence occurs, most discussants said anytime anywhere: on the way to/from the market, job, farm, school, river to collect water, bush to collect firewood; in the offices, schools and colleges after hours; in deserted areas, lodgings and neighbourhoods; during social events like funeral discos (disco matanga) and other festivities; and even within the homes. The perpetrators are mostly men of all ages; those abusing alcohol and other intoxicating substances; teachers, students and bosses; cooks, house or shamba (farm) boys and watchmen; neighbours; family friends, uncles, fathers and boyfriends (date rape); and strangers, including gang rape during robbery. Although respondents agreed that most incidents go unreported, culprits of the few that get known are reported to the police for legal action, or assistant chiefs and other village elders for arbitration. Some are made to pay fines to the parents of the girl (emphasis ours to point out the parents are the ones appeased, not the victim), while some are forced to marry the girl, especially if pregnancy resulted from the rape. In cases of known incest, both were expected to go through a cleansing ceremony. A few mentioned mass action and mob justice, especially in instances where previous cases had been taken forward for legal action, and the perpetrators were released without charge.

One respondent felt that women exposed their daughters to sexual violence when they decide to travel and believe they leave their children in the safe custody of the fathers. She said:

“It is not good for a wife to leave her daughter in the same house with the father. Worse if she is a step daughter. Worse also if there are uncles or other grown up males in the house. It would be better to go with her or leave her with a female relative or friend. Otherwise she is leaving her in trouble. When she is not there, when the husband feels like having [sex with] his wife he blacks out and goes for the daughter.”

Reasons for feeling less safe or at risk include: taking alcohol; associating with particular types of people; the times one walks the streets; being an orphan, because men tend to take advantage of them; being a young girl, because one cannot defend oneself or are easily cheated; making and/or selling traditional brews, because of the type of men who frequent the businesses; being a sex worker, because one gets involved with unknown people, some of whom are dangerous and/or may not want to pay for the service; being a poor girl, because one is easily lured into sex by money or gifts; being married to a substance abuser; being single and those living alone; and being a house girl.

Most respondents felt sexual violence has worsened, especially rape, and attribute this mainly to the current dressing code, increased prevalence of incest, frustrating legal processes where perpetrators are taken in only to buy their release, and to HIV positive people who are engaging in “wanton spread” of the disease. But, some felt hopeful that the incidence is likely to go down now that Kenya modified its laws and has started giving tough sentences to perpetrators. They also believed that even if some HIV positive people engage in wanton spread of HIV, fear of the disease is probably keeping away some potential sexual abusers from carrying out their plans, and that the increasing number of educated women is slowly translating into a critical mass of women who are empowered and who know and act on their rights.

#### Are women to blame for sexual violence?

On the question of whether women are sometimes to blame for sexual violence meted against them, there was consensus that the dressing code is responsible. Older respondents had these expressions: they leave their stomachs outside; they put on skirts with slits up to the buttocks; they walk naked; the clothes are so transparent you even see their insides; they leave their breasts dangling out for all to see; they leave their chests and backs bare; and that their bodies are left open as if for public exhibition. Only one respondent held a different style of discourse, stating:

“I think the problem is with men, not the dressing style, because if a man can rape a two year old child... if a man can rape a grandmother who is well over 60 years, where does the dressing come in? So, I think shida ni kwa (the problem is with) men. A very small percentage is caused by dressing, but we know they go to an extent of raping a one month old baby or 70 to 90 year-old grandmother! Ah-ah (shaking her head). No, no, it is not just dressing; it is something in their head that we women may never understand.”

Others situations where women are to blame for sexual violence are: when they accept money or gifts, including alcohol, from strangers or those they know but who are not their sexual partners; habitual walking out late; frequenting nightclubs and discos; going to a single man’s house alone; being in an isolated place with a man; and teasing / taunting a man using covert sexual overture.

### Responses to violence

In terms of coping with violence against family or friends, women said they would educate the victims on how to be careful to avoid a repeat, report the matter to the Chief or his/her assistant, just be there for the victims, or hold demonstrations if widespread and the court has failed to take action. It was reported that the community rarely took action:

“When the fighting or beating exceeds the ‘normal’ rate, then call the two to sort it out” or “call the police if the fighting gets too much.”

Community responses also included calling for family/clan meetings, making the culprit pay hospital bills and other associated costs, or counselling the victim. Given such haphazard family and community response to violence, respondents felt that many women were not able to cope. One, they are disappointed when they see perpetrators go free. Two, they do not speak out due to stigma and/or if offenders are family members. Three, they are forced to withdraw cases if offenders are husbands or other known people, for fear of being ostracized or thrown out of the home. Participants lamented that women even protect their husbands when they (the husbands) rape their own daughters, and instead blame the daughters for fabricating the story(ies) or being responsible for circumstances that made them get raped.

### **3.2.4 Marriage and Relationships between Husbands and Wives**

In this section, twenty-three sets of questions were asked on issues ranging from marriage, domestic violence and the rights of husbands and wives, and family and community responses to gender-based violence. The results are presented here below:

#### Practice of and decisions around marriage

All the 23 FGDs concurred that polygamy was still relatively common, especially in Nyanza, and that parental roles in marriage arrangements are decreasing. Even though a majority of respondents concur that the age at which girls get married is becoming higher, due to education and career development, forced marriages still occur among 10-15 year-olds. This situation was cited mostly among groups convened by ACK in West Pokot. A respondent observed:

“Some get their girls married off because they need the money; because in some situations they have many children but no money to educate them. They marry off the girls to get money to educate the boys. Later if the marriage becomes difficult, the women just stay because the parents will not have the money to refund the dowry that had been paid.”

Respondents in all venues agreed most girls and boys initiate sex before they get married, with younger ones claiming that men and women would like to know if a partner is sexually functional before they enter into a long-term relationship. Terms like “tasting first” or “trying first” were used. And a respondent noted:

“You ask? Before she goes she already knows whether the man is sugary or salty.”

One respondent mused that only 1% of boys and 2% of girls are virgins at marriage. In communities where males traditionally get circumcised at around age 15, a respondent noted:

“They (the boys) get out of control [after being circumcised]; they believe they are now men and should have a lot of sex.”

### Women’s education and traditions

A question to explore the views of the respondents on education of women found that educated women are admired as being able to decide whether or not to get married, remain in a marriage, or have children—with or without getting married. Working women were also seen to help their parents more than men, and parents are thus valuing educating girls more and more. They are also able to take care of their families better than if they have to rely on their husbands for everything. But, the flip side was the feeling that educated women were not marriageable because they have no respect for their husbands. In fact, women said that some husbands do not allow their wives to work even if educated, fearing they would challenge their (the husband’s) authority in the family, so an increasing number of women are choosing to remain single. A respondent said that:

“You know most homes are of single mothers and even our daughters are not getting married these days, they are at home. They feel marriage is a bother.”

Some men also fear that their wives would start sexual affairs if they mix with other men in the course of work. Others viewed educating girls as bad investment for the family since they relocate to the husbands’ homes upon marriage, “and take with them all your school and college fees.”

### Conflicts in marriage

A question was asked about causes of conflicts in marriage. Views ranged from: lack of communication between spouses and between parents and children (mostly girls); disagreements about disciplining children; lack of trust/ suspicion of infidelity by one or both partner(s); interference by in-laws; drunkenness, holding wives responsible for mistakes made by the children; overburdening one partner with too many responsibilities; and denying a partner his/her conjugal rights.

As to whether a woman should question the husband, most respondents agreed that she should, but cautioned this should be done with respect, and should be based on facts, not gossip. Respondents also agreed a husband has no right to physically punish his wife. However, some said there were circumstances when beating a wife would be warranted, such as: refusing to admit a mistake; infidelity; talking back, being too outspoken, rude or disrespectful; drunkenness; mistreating his family or his children by another woman; being unable to take care of the family adequately; and denying him conjugal rights. A respondent said:

“Yes, he has a right [to beat me because] he removed me from my [my parents’] home and I am staying on their land therefore all my life is in his hands.”

In terms of emotional abuse by husbands, the following were mentioned: verbal abuse especially in public or in front of the children; having extra marital affairs; denying the wife the right to decision-making on issues affecting her or the children; excessive drinking and squandering family resources; allowing in-laws to run their marriage or life; and refusing to talk whenever there is a disagreement (referred to as cold war). It was felt that these are initiated or exacerbated by arranged marriages, stress associated with hard economic times, and the culture of silencing women's voices.

Regarding the question of whether a wife can turn down the husband's demand for sex, answers were mixed. Those who felt she cannot refuse argued that, "that thing is his, so how can you refuse," or that:

"Traditionally a woman has no right to refuse sex with the husband because this is the reason she came to that home. She must have a good reason like sickness to refuse.....Even if the women may feel tired or not in the mood for sex, the man will always insist and many cases of violence meted on the women for refusing sex are normal and acceptable."

Others felt wives can refuse, and reasoned that:

"If you explain well, he should understand, but if you make it habitual, then you may drive him away to look for sex elsewhere then you are the one to blame if he brings AIDS home."

Some felt that after a day's toil, many women are too tired to want sex, especially with an energetic man who came home to a cooked food and warm water for bathing after spending the whole afternoon chatting with friends, who went to bed at 9pm, and who is ready to "just jump on you" (anakurukia tu) as soon as you get into bed, with no "preparation" at all. Most respondents, old and young, agreed that it is rape if a wife refuses sex and the husband forces her. However, there are those who felt that there is no such a thing as marital rape, because husbands pay dowry for "that thing."

On the question of why some women stay in violent relationships and refuse to seek outside help, the discussions identified the following underlying factors: women normalize violence, with some blaming themselves for it; some are orphans and have nowhere else to turn to; most communities are both patriarchal and patrilocal, hence women do not want to leave their children behind to suffer, especially under the care of co-wives; some just love their men or are attracted to their wealth; others fear stigma if word gets out that they are being battered; some were married in churches and do not believe in divorce; there are those who are ashamed to return to their parents if they (the parents) had not supported the marriage in the first place, or because traditions do not accommodate women who have walked out of marriage to return to their maiden homes; others fear backlash from husbands if they seek outside help; and some fear that the in-laws would say they were not fit for their sons or brothers.

Participants expressed that there is general apathy among members of the community with response to violence against women. The public often blames the victims of sexual violence; and the negative attitudes of the communities at large also put the onus of care on the victims. As a result of this stigma, many cases go unreported. Even in cases where the perpetrators are known, nothing is done. One participant observed that:

“I know a woman whose daughter had been repeatedly raped by the father; she never wanted to talk about it. This is how some people react: silence! Keeping quiet, hoping things will change and the event forgotten. Family cases tend to be hushed up by the family members themselves to avoid exposing the victim or offender’s family to public embarrassment. This has caused the victims to suffer mental trauma in many cases as they are forced to continue living with the shame, and they have no voice.”

#### Girls and risk for HIV infection

Respondents agreed girls are more exposed to HIV than boys because: their male partners often have several other sexual partners; they are less educated and therefore less informed about HIV; they are poorer hence more open to sexual abuse by older richer men; they look after sick family members who are infected; and they are exposed to rape and other forms of sexual violence. Although believed to be less informed than boys of the same age, respondents agreed that with the many educational and training seminars the government and local NGOs provide, many girls are increasing their HIV knowledge base. In schools, HIV/AIDS is taught as part of the syllabus, and the information is augmented by AIDS clubs and other peer-led programs. In addition, information is also passed through the media, targeted talks and information, communication and education (IEC) materials (flyers, brochures and posters) in churches, health facilities, youth groups, during social events, and at voluntary HIV counselling and testing sites. It was felt that to be effective, specific programs should be implemented for and with girls in- and out-of-school, and should also involve boys and parents, where appropriate. The latter was viewed as important because of poor communication skills for discussing issues of sexuality with children, a factor cited as contributing to the vulnerability of girls to HIV. A respondent from Mukuru slums, Nairobi Province, stated that:

“Even you as a married woman, you are in the house settled [faithful] but your husband goes and meets with a dot com [girls or young women], sleeps with her and gets it [HIV], how will your staying at home help you? How will you say you can’t be infected because you don’t move [with men]? You will be infected. And then he will continue infecting other “dot coms.” Many married women like some of us here live in fear of getting HIV from their husbands.”

## 4. Discussion

This chapter discusses and compares the key baseline findings relevant for the end line measure.

### 4.1 Key Findings: Gender Norms, Decision-making power, Self-efficacy and Condom Use

“Negative” gender norms were mainly perceived by the respondents as having to take on inferior tasks in the house as opposed to men. Women felt that their major role was to clean, cook and take care of the family. Given what Kenyan society values, this role automatically puts them in a less advantageous social position than their male counterparts. The focus group discussions revealed similar results. Most of the women agreed the main role a woman should take up in the home is that of a care-taker and giver.

With regard to decision-making dominance, additional interesting results were found. Although the majority of the respondents felt most of the decision-making within the household was shared between the husband and the wife, a majority felt final decisive authority should be left up to males. This same pattern was also illustrated by the focus group discussions. The discussions revealed that, particularly within rural/ethnic settings, women have very little power within their relationships. Women adjust to being inferior to men at a very young age, and perceive it to be difficult to step out of this role.

Overall, the quantitative results demonstrate an important influence of gender norms and condom norms and attitudes on self-efficacy in relation to condoms (A clear relationship was found between condom norms and attitudes and self-efficacy), condom use intentions and actual condom use. With regard to self-efficacy, women above the age of 40 proved to have remarkably lower levels of self-efficacy than their younger counterparts. Condom use intentions and actual condom use were in line with the Theory of Planned Behaviour (positive attitudes and condom use norms have a positive effect on self-efficacy, intentions and actual use).

Actual condom use proved to be determined, in particular, by the type of relationship (monogamous, polygamous or single) one was in. To that end, being in a polygamous relationship was a strong negative determinant for condom use and being single had a positive effect on condom use. Being in a monogamous relationship had a positive, though remarkably smaller, effect on condom use.

The general level of HIV/AIDS knowledge was high amongst the respondents. However, those aged 40 and above had less knowledge than their younger counterparts. An odd finding, with respect to knowledge on HIV/AIDS, was that those with tertiary levels of education had lower levels of knowledge than those with primary levels of education. This is not in line with expectations, as

education levels are thought to have a positive influence on HIV/AIDS knowledge. Seeing as the general level of education amongst the respondents was higher than the national levels, it could be that a large proportion of the respondents gave a “socially accepted” answer rather than an “honest” answer, and this may have led to over-reporting of education. This issue needs to be taken into consideration when carrying out the final evaluation of the GDP.

A general conclusion that can be drawn from these quantitative and qualitative results is that women above the age of 40 that are in a polygamous relationship form a clear risk group that may need to be tackled separately. Not only was their HIV/AIDS knowledge found to be lower, they showed less frequent condom use; and had lower self-efficacy with regard to the use of condoms. This places them in a highly vulnerable position when it comes to HIV/AIDS.

#### **4.2 Key qualitative findings on gender based violence**

As far as safety is concerned, women and girls reported feeling unsafe everywhere, every time and from nearly every male. Women and girls face violence or fear violence—physical, sexual and psychological /emotional—from all quarters. If the reality corresponds to perceptions, the lack of safety for women and girls in Kenya has serious implications for HIV acquisition/transmission.

In line with the “blame the victim mentality”, women and girls (young and old) in this study believed that many of those who get raped deserve it because of their manner of dressing. This is a worrisome finding, in part because it has implications for whether women will engage the legal system in case of violence. If women feel they are the ones to blame for violence, the chances are likely to be lower that they will engage the legal system if they are themselves subjected to violence, or that they will support other women survivors of violence in responding through formal, legal channels. The focus group discussions also revealed the majority of the respondents do not agree marital rape exists. They concurred that in most marriages sex is performed in line with the man’s ‘timetable’, whether or not the woman is in agreement. The fact that Kenyan law does not recognize marital rape may partly be responsible for this finding.

There was agreement across the four provinces where data were collected that the court system does not deter rape (including marital rape). The process of collecting credible evidence is severely hindered, in part because women and girls are not in a position to produce such evidence, due to lack of knowledge of their rights but also because of social issues, especially shame. In addition, the police and the magistrates are very easily bribed into releasing the perpetrators without any charge, even when there is clear evidence incriminating the accused. Corruption of this sort discourages rape survivors from seeking legal redress, and at the same time makes it possible for the offenders to continue committing the same offense with impunity. Furthermore, the discussions revealed that most families and familial circumstances are not helpful. Fear of stigma, reproach, or rejection deter

women and girls heavily from disclosing violence to family members for. Fear of disclosure by girls specifically, notably in cases of incest, is linked back to the level of relationship they have with their parents or guardians, which according to respondents, are in most case lacking trust.

## 5. Recommendations for the End Line Measure

Some limitations of this baseline study need to be taken into account for the end line measure. First, the selection of adequate research assistants was at times problematic. In some cases, research assistants did not explain the questionnaire to the respondents question by question as instructed during the joint training. Often questions were misunderstood. In addition, one organisation decided to train only male interviewers. On the day of data collection women were too embarrassed to answer the questions; the interview meetings had to be rescheduled, and women were trained as interviewers. Considering these limitations, it is highly important to try to train the research assistants adequately for the end line, and where possible, it would be preferable to use the same assistants as during the baseline, since they are aware of the procedures.

Regarding the questionnaire, the background question on 'relationship status' appeared problematic because the choice of "in a relationship" or "single" was ambiguous: Those who were unmarried considered themselves single, even when they were in a relationship. This posed challenges for analysis of decision making dominance and control and for gathering information on reproduction and family planning data. Some respondents who said they were single actually answered questions on this decision making dominance and control, yet skipped questions on whether they had children and contraceptives. Some respondents who filled in that they were not in a relationship, even though they actually were, did not fill questions on this decision making dominance and control. An easy way to overcome these challenges for the end line would be to move the position of the question on relationship status to a different place in the questionnaire.

Some questions should be added to the questionnaire, while others should be removed. The questionnaire should ask the location of the respondents—to determine whether they are in a rural versus an urban setting—as the focus group discussions proved there were clear differences between women depending on their respective settings. Questions on the type of contraception respondents use and the total number of children they have were not of significant importance for the baseline, and could be removed for the end line. Shortening the questionnaire would result in a slightly shorter time investment for answering the questionnaire. Organisations that participated in the baseline complained the questionnaire was too long.

There are discrepancies between what people say, what they wish or hope for, and what they do. This is a limitation of the qualitative component of the research initiative. When dealing with such intricate issues as gender norms, people may report what they idealise or what is socially acceptable, instead of what they practice. A way to overcome this challenge is to triangulate data in the end line measure as well. Qualitative data should thus, at all times, be combined with quantitative data and vice versa.

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## **Appendices**

### **Appendix 1: Profiles of Participating Organisations**

HSHC is based in the Mt. Kenya region with its activities covering three districts: Meru, Nyeri and Laikipia. The main focus of the organisation is the management of natural resources and access and control over these resources by women. The main target for the group is approximately 65% women as direct beneficiaries and 20% children and 15% men as indirect beneficiaries. For this project, the organisation intends to target 50 families. The approach is to mount HIV education and information campaigns targeting women, men and youth on issues along the destigmatization-prevention-care mitigation continuum. They plan to use dramatized poems composed by girls as the main education and information dissemination tool in schools. They will also educate parents on property succession planning, and mobilize the community against gender-based abuses related to HIV/AIDS.

YWCAA is a national NGO currently operating in urban slums in Nairobi City. It is committed to enlightening the society about HIV/AIDS, and seeks to address HIV preventive measures through advocacy and awareness creation as a way of mitigating the impact of the scourge. The NGO focuses on youth and young women, especially bar waitresses/ illicit brewers who are mostly single mothers. For this intervention, the direct beneficiaries are women groups with 100 members while the indirect beneficiaries are 300 male partners/boy friends and parents/guardians. The objectives are to address the increased vulnerability of women and girls to HIV/AIDS through peer education; to strive towards gender equality by having boys/young men participate in seminars on human rights; and to empower women to know their rights, especially sexual rights and know how to protect and stand up for themselves. The plan is to develop appropriate IEC materials to disseminate at the community level; use edutainment video shows; and work with role models to carry out exercises that address issues around gender values and attitudes, as well as gender justice in the community.

WIFIP is based in western Kenya, and operates within selected districts of Nyanza and Western provinces. The NGO endeavors to empower women and other marginalized groups in the community to undertake viable social and economic initiatives through non-formal distance education and development programs. The main targets for this intervention are women groups, high school students and youth out of school, together totaling about 140 females. The focus is to facilitate and implement programs that promote sustainable social and economic development targeting women, girls and other marginalized groups in the fishing industry. The three approaches will be to: 1) develop appropriate behavior change communication messages by designing, developing, producing and distributing information, education and communication materials, 2) organize appropriate thematic/educative games and sports, and 3) promote VCT uptake as an avenue for behavioral counseling.

CMEDA has its activities implemented within the Lake Victoria region in the district of Siaya and the urban and peri-urban areas of Kisumu. It partners with women groups and CBOs which are basically managed by married women, widows and People Living with HIV/AIDS. The main targets for the intervention and evaluation are schools and three women groups in Ojola, Kisumu district. The objectives include promoting women's rights through paralegal training conducted in collaboration with local activists, as well as building the capacity of women towards economic empowerment. The methods of the intervention include facilitating skits and plays that pass appropriate messages to reinforce self esteem and positive self concept. The aim is to enable women and girls avoid physical and sexual abuse. In addition, they will carry out school based programs on motivational talks facilitated by successful women who have made it through difficulties. They also plan to distribute reading materials on gender and human rights issues.

4Cs / KEFEADO (the two organisations will work together for purposes of this research). 4Cs is a non-governmental, voluntary, non-partisan and not-for-profit social movement, with a vision of a Kenyan society that upholds practices that protect constitutionalism and democracy, where citizens participate in just governance, where human rights are protected and gender equity is ensured, where the interests of the disadvantaged are guaranteed, and where a sustainable wholesome development is promoted. Their thrust is towards the creation and maintenance of a new constitutional order in Kenya – a constitution that will guarantee a better society desired by all citizens through a democratic process that is popular, open, participatory and inclusive. In terms of targets for the intervention, the organisation aims to hold an average of 3 workshops and conduct FGDs and trainings, with a participation of 50 persons per activity. The objective is to promote the rights of women to control their sexuality in order to avoid cultural practices that lead to HIV infection, such as early marriages, coerced sexual intimacy, rape and widow cleansing rituals. The two approaches to the intervention are to build the capacity of: 1) community theatre groups to articulate gender and HIV/AIDS in the context of human rights, and 2) engage an HIV/AIDS consultant to facilitate workshops that enhance understanding of HIV/AIDS and gender issues within the groups. KEFEADO is an organisation based in Kisumu with its activities covering Kisumu, Nyando and Bondo Districts. The purpose is to promote gender equity, equal opportunity, and human rights for all Kenyas by providing holistic social, economic, legal/human rights development. The specific emphasis is on empowering women and their families through innovative rights-based approaches to address life's issues. The Gender Development Project activities are to be implemented in Nyando district, Nyanza Province, targeting mainly three secondary schools. The proposed approach is to expand communication and information space on issues around gender, leadership and HIV/AIDS in the target schools through discussions, role plays, theater performances, and cultural analysis and debates. KEFEADO will partner with 4Cs during the effect evaluation in Kisumu district. The two organisations trained their

research assistants separately but collected data together in two locations – St. Stephens' ACK Cathedral and two youth groups in Dunga beach.

CAI works in four provinces across the country. Over 80% of CAI programs are child- and women-centered. The organisation targets women groups and girls in high schools. The objectives of the intervention is to provide life skills development training for girls and boys, facilitate gender sensitive debates and discussions at group and community levels, train women and their leaders in leadership development, involve more women in gender and governance programs, and introduce forums in schools to champion girls' rights. They plan to use peer learning and education, and life skills development training as the main approaches to the intervention.

ACK ELDORET: A wing within the Anglican Church of Kenya, the Christian Community Services, is a faith-based organisation responsible for the implementation of development programs in the ACK diocese of Eldoret and Kitale, Rift Valley Province. It is a provincial organisation serving nine administrative districts of the North Rift, and uses forums and structures of parish councils, priests, evangelists, youth leaders, and mothers' union leaders as entry points to reach communities. The organisation will target about 1200 women and girls through schools and women and youth groups. The objectives are to equip and work with peer educators to: 1) transform staff attitudes towards women and girls and raise their knowledge and skills to appropriately respond to HIV/AIDS among women and girls, 2) use gender transformative exercises to raise knowledge of the women and girls about HIV prevention, 3) change community and individual attitudes on violence and discrimination against girls and women, and 4) empower women to know and act on their rights as autonomous human beings. The methods of intervention will include production and dissemination of IEC materials, collaboration with other stakeholders in lobbying and advocating for gender-related rights, and facilitating HIV prevention through debates and life planning skills training in schools.

KANCO is a national network of NGOs, CBOs and FBOs involved in HIV/AIDS activities in Kenya. It provides up to date HIV/AIDS information through four established resource centers in Nairobi, Mombasa, Nakuru and Kakamega. It is committed to building the capacity of members and other stakeholders to undertake various intervention activities. The main targets for this intervention are members of two women groups, and girls from three youth centers. Secondary targets include boys from these three youth centers, plus parents of the youth from the centers, both boys and girls. The objectives are to increase the capacity of women and girls to make choices and to transform those choices into desired actions and outcomes. The intervention will be done through advocacy and networking with partner organisations, production and distribution of IEC materials, and engagement with gender transformative exercises in the form of theatre and role plays, self reflective activities, debates, discussions, and workshops.

WSP-K is a non governmental organisation born out of the need to engender the political space in Kenya, with the broad objective of creating an enabling environment for women to effectively participate in the decision-making process in Kenya's political arena. To this end, the organisation is engaged with activities that empower women to be active agents in public life, as well as those that reduce barriers that prevent women's full and equal participation with men at both local and national levels. The organisation intends to reach 1 million women and another 2 million girls, men and boys through IEC materials and radio programs in the local FM radio stations. For this intervention, the organisation proposes to reach about 2,000 girls across several locations in Ndhiwa Constituency, Nyanza Province. The objectives are to: increase women's representation and participation in decision making on political issues, promote awareness and empowerment of women and girls to know their sexual rights so as to make informed decisions in matters relating to their sexuality, and engage provincial administration authorities, culture custodians, women leaders and opinion leaders to discuss issues and practices that undermine women's autonomy, such as the culture of widow inheritance. The organisation intends to achieve these objectives by organizing advocacy training workshops and campaigns against negative gender-based practices which retard women's progress in all spheres of life, specifically those that put them at increased risk of HIV acquisition and transmission.

**Appendix 2: Number of respondents interviewed by size of group/organisation**

Name of Civil Organisation	Number Interviewed	Intervention target	Members interviewed as % of target
4Cs / KEFEADO	103	240	42.9
ACK ELD	269	1200	22.4
CAI	153	153	100.0
C-MEDA	66	66	100.0
KANCO	175	180	97.2
HSHC	53	53	100.0
WIFIP	139	140	99.3
WSP-K	464	2000	23.2
YWCAA	50	50	100.0

### Appendix 3a: Decision-making dominance

VARIABLE	#	%	Factor loading
Who has more say about what partner and respondent do together			0.596
Partner	143	28.0	
Both Partner and respondent	334	65.4	
Respondent	33	6.5	
Who usually has more say about how often respondent and partner see one another			0.363
Partner	187	37.	
Both Partner and respondent	274	55.0	
Respondent	37	7.4	
Respondent has more to say about decisions than partner			-0.305
Strongly Agree	50	10.1	
Agree	94	18.9	
Undecided	55	11.1	
Disagree	195	39.2	
Strongly disagree	103	20.7	
In general, who does respondent think has more power in the relationship			0.614
Partner	279	55.5	
Both Partner and respondent	192	38.2	
Respondent	32	6.4	
Who usually has more say about whether you use condoms			0.455
Partner	136	28.6	
Both Partner and respondent	239	50.2	
Respondent	101	21.2	
Who usually has more say about whether respondent has sex			0.596
Partner	211	42.9	
Both Partner and respondent	250	50.8	
Respondent	31	6.3	

### Appendix 3b: Control in Relationship

VARIABLE	#	%	Factor loading
Partner tells respondent who to spend time with			0.472
Strongly Agree	70	13.9	
Agree	108	21.5	
Undecided	49	9.7	
Disagree	163	32.4	
Strongly disagree	113	22.5	
Partner won't let respondent wear certain things			0.444
Strongly Agree	104	20.8	
Agree	146	29.2	
Undecided	44	8.8	
Disagree	118	23.6	
Strongly disagree	88	17.6	
When with partner, respondent is pretty quiet			0.485
Strongly Agree	58	11.6	
Agree	88	17.6	
Undecided	30	6	
Disagree	187	37.4	
Strongly disagree	137	27.4	
When respondent does what partner doesn't approve of, he hits her			0.559
Strongly Agree	52	10.3	
Agree	98	19.5	
Undecided	30	6.0	
Disagree	168	33.4	
Strongly disagree	155	30.8	
Partner always wants to know where respondent is			0.458
Strongly Agree	110	21.9	
Agree	197	39.2	
Undecided	31	6.2	
Disagree	103	20.5	
Strongly disagree	62	12.3	
It is important that partner disciplines respondent			0.482
Strongly Agree	62	12.4	
Agree	105	20.9	
Undecided	36	7.2	
Disagree	139	27.7	
Strongly disagree	160	31.9	

### Appendix 3c: Domestic Gender Norms

VARIABLE	#	%	Factor loading
A woman's most important role is care of home and cook for family			0.589
Strongly Agree	299	36.3	
Agree	263	31.9	
Undecided	18	2.2	
Disagree	113	13.7	
Strongly disagree	131	15.9	
A couple should decide together whether to have children			-0.330
Strongly agree	694	50.9	
Agree	490	35.9	
Undecided	56	4.1	
Disagree	82	6.0	
Strongly disagree	42	3.1	
Changing napkins/diapers, bathing, and feeding the children are the mother's responsibility			0.610
Strongly Agree	312	37.9	
Agree	259	31.5	
Undecided	24	2.9	
Disagree	137	16.7	
Strongly disagree	91	11.1	
It is the man who should decide whether to have sex			0.594
Strongly Agree	89	11.0	
Agree	127	15.6	
Undecided	82	10.1	
Disagree	233	28.7	
Strongly disagree	281	34.6	
A man needs other women			0.564
Strongly Agree	111	13.7	
Agree	132	16.3	
Undecided	63	7.8	
Disagree	158	19.5	
Strongly disagree	347	42.8	
There are times when a woman deserves to be beaten/hit			0.538
Strongly Agree	66	8.0	
Agree	130	15.8	
Undecided	64	7.8	
Disagree	206	25.1	
Strongly disagree	356	43.3	
A woman should tolerate violence to keep her family together			0.568
Strongly Agree	151	18.5	
Agree	165	20.2	
Undecided	43	5.3	
Disagree	152	18.6	
Strongly disagree	305	37.4	
It is ok for a man to beat/hit his wife if she won't have sex with him			0.558
Strongly Agree	34	4.2	
Agree	52	6.4	
Undecided	41	5.0	
Disagree	213	26.1	
Strongly disagree	475	58.3	

**Appendix 3d: Condom Use Attitudes and Normative Beliefs**

VARIABLE	#	%	Factor loading
Respondent thinks using a condom would make her feel			0.769
Very comfortable	197	24.5	
Comfortable	225	28.0	
Undecided	146	18.1	
Uncomfortable	137	17.0	
Very uncomfortable	100	12.4	
Respondent thinks encouraging sexual partner to use a condom would make her feel			0.756
Very comfortable	229	28.5	
Comfortable	230	28.6	
Undecided	146	18.2	
Uncomfortable	99	12.3	
Very uncomfortable	100	12.4	
Respondent thinks using a condom would make her feel			0.798
Very good	207	25.7	
Good	262	32.6	
Undecided	141	17.5	
Bad	95	11.8	
Very bad	100	12.4	
Respondent thinks encouraging sexual partner to use a condom would make her feel			0.806
Very good	237	29.5	
Good	242	30.1	
Undecided	145	18.1	
Bad	85	10.6	
Very bad	94	11.7	
Respondent thinks most people important to her would want her to use a condom if I were to have sex			0.699
Very likely	269	33.5	
Likely	238	29.7	
Undecided	123	15.3	
Unlikely	81	10.1	
Very unlikely	91	11.4	
It is expected of Respondent to use a condom			0.725
Strongly Agree	273	33.8	
Agree	232	28.8	
Undecided	90	11.2	
Disagree	89	11.0	
Strongly disagree	123	15.2	

### Appendix 3e: Self Efficacy

VARIABLE	#	%	Factor loading
Respondent is confident that she could use a condom if she wanted			0.682
Strongly Agree	329	41.5	
Agree	254	32.0	
Undecided	57	7.2	
Disagree	64	8.1	
Strongly disagree	89	11.2	
For Respondent, using a condom is			0.796
Very easy	210	26.4	
Easy	241	30.3	
Don't know	101	12.7	
Difficult	126	15.8	
Very difficult	118	14.8	
For Respondent, using a condom is			0.827
Very beneficial	290	36.2	
Beneficial	261	32.6	
Undecided	88	11.0	
Worthless	75	9.4	
Very worthless	87	10.9	

**Appendix 3f: HIV/AIDS Knowledge**

	Response; number and (percent)			
	Disagree (%)	Agree (%)	Don't know (%)	Factor Loadings
A person can get infected with HIV by greeting or touching a person living with HIV and/or AIDS	776 (91.1)	42 (4.9)	34 (4.0)	0.49463
One can get HIV by sharing syringes/ razor blades with people who have HIV and/or AIDS	44 (5.2)	785 (93.6)	10 (1.2)	0.36425
Only prostitutes, homosexuals and people who abuse drugs get HIV.	656 (78)	126 (15.0)	59 (7.0)	0.51282
Most people with HIV immediately show signs of being sick.	537 (64)	232 (27.7)	70 (8.3)	0.43666
There is a cure for HIV and/or AIDS	614 (73.0)	155 (18.4)	72 (8.6)	0.30992

#### Appendix 4a: Bivariate Regression Results on Self efficacy

	$\beta$	SE	t	p
Decision making power	0.189	0.044	4.32	<.0001
Control	0.168	0.043	3.89	0.0001
Gender norms	0.273	0.044	6.22	<.0001
Condom norms & attitudes	0.768	0.029	26.36	<.0001
Condom use intention	0.646	0.034	18.89	<.0001
HIV/AIDS Knowledge	0.114	0.047	2.43	0.0153
Age (ref 20-29yrs)				
Less than 19 years	0.231	0.177	1.31	0.1915
30-40 years	-0.102	0.101	-1	0.3155
40+ years	-0.521	0.132	-3.96	<.0001
Education level (primary)				
Secondary	0.209	0.094	2.23	0.0263
Tertiary	0.757	0.155	4.87	<.0001
Partners educ level (ref 'primary')				
Secondary	0.360	0.100	3.6	0.0004
Tertiary	0.574	0.131	4.38	<.0001
Religion (ref 'Christian')				
Muslim	0.076	0.177	0.43	0.6665
Traditional	-0.502	0.304	-1.65	0.0996
Relationship (ref 'Married monog')				
Married polygamous	-0.140	0.126	-1.11	0.2672
In a relationship	0.547	0.113	4.85	<.0001
Single	0.480	0.154	3.11	0.002

**Appendix 4b: Bivariate Regression Results on Condom Use Intention**

	$\beta$	SE	T	p
Decision making power	0.187	0.045	4.14	<.0001
Control	0.168	0.045	3.74	0.0002
Gender norms	0.243	0.046	5.23	<.0001
Condom norms & attitudes	0.732	0.033	22.14	<.0001
HIV/AIDS Knowledge	0.045	0.049	0.93	0.3554
Age (ref 20-29yrs)				
Less than 19 years	0.454	0.190	2.39	0.0175
30-40 years	-0.260	0.107	-2.44	0.0152
40+ years	-0.286	0.136	-2.1	0.0364
Education level (ref 'primary')				
Secondary	0.148	0.097	1.52	0.129
Tertiary	0.688	0.165	4.18	<.0001
Partners educ level (ref 'primary')				
Secondary	0.294	0.103	2.85	0.0045
Tertiary	0.650	0.136	4.79	<.0001
Religion (ref 'Christian')				
Muslim	0.066	0.182	0.36	0.7161
Traditional	-0.701	0.287	-2.45	0.0148
Relationship (ref 'Married monog')				
Married polygamous	-0.133	0.128	-1.04	0.2993
In a relationship	0.650	0.117	5.58	<.0001
Single	0.500	0.158	3.16	0.0017

**Appendix 4c: Bivariate Regression Results on HIV/AIDS Knowledge Score**

	B	SE	T	P
Control	0.120	0.041	2.9	0.004
Gender norms	0.233	0.042	5.53	<.0001
Condom norms & attitudes	0.049	0.043	1.14	0.2529
Age (ref 20-29yrs)				
Less than 19 years	-0.154	0.167	-0.92	0.3564
30-40 years	-0.025	0.099	-0.25	0.8022
40+ years	-0.499	0.124	-4.03	<.0001
Education level (ref 'primary')				
Secondary	0.366	0.088	4.14	<.0001
Tertiary	-0.038	0.150	-0.26	0.7978
Partners educ level (ref 'primary')				
Secondary	0.384	0.095	4.06	<.0001
Tertiary	0.182	0.126	1.45	0.1478
Religion (ref 'Christian')				
Muslim	0.192	0.174	1.1	0.2704
Traditional	0.159	0.275	0.58	0.5624
Relationship (ref 'Married monog')				
Married polygamous	-0.393	0.118	-3.32	0.001
In a relationship	0.195	0.108	1.8	0.0727
Single	-0.319	0.151	-2.12	0.0348

**Appendix 4d: Bivariate Regression Results on Condom Use Frequency Last Six Months**

	$\beta$	SE	t	p
Decision making power	0.405	0.076	5.32	<.0001
Control	0.301	0.077	3.9	0.0001
Gender norms	0.400	0.080	5.01	<.0001
Condom norms & attitudes	1.141	0.063	18.11	<.0001
Condom use intention	0.916	0.070	13.16	<.0001
HIV/AIDS Knowledge	0.114	0.084	1.36	0.1749
Age (ref 20-29yrs)				
Less than 19 years	0.644	0.323	2	0.0465
30-40 years	-0.354	0.183	-1.93	0.0545
40+ years	-0.565	0.232	-2.43	0.0155
Education level (primary)				
Secondary	0.216	0.165	1.31	0.1915
Tertiary	1.401	0.272	5.16	<.0001
Partners educ level (ref 'primary')				
Secondary	0.332	0.176	1.88	0.0608
Tertiary	1.011	0.232	4.37	<.0001
Religion (ref 'Christian')				
Muslim	0.440	0.314	1.4	0.1619
Traditional	0.172	0.550	0.31	0.755
Relationship (ref 'Married monog')				
Married polygamous	-0.484	0.212	-2.28	0.0232
In a relationship	0.733	0.195	3.76	0.0002
Single	1.767	0.272	6.49	<.0001

## Appendix 5: Multivariate Regression

### Regression on Condom Use Efficacy

Factors/Variables	$\beta$	SE	t	P
Gender norms	0.097	0.027	8.04	0.0048
Condom norms and attitudes	0.607	0.035	214.75	<.0001
Condom use intention	0.192	0.035	28.08	<.0001
Age: 40+ versus 20-30	-0.149	0.068	-8.39	0.0040
Partners education: Tertiary vs primary	-0.090	0.070	-2.46	0.1176

### Regression on Condom Use Intention

Condom norms & attitudes	0.711	0.033	452.87	<.0001
Age (ref 20-29yrs)				
19 years and below	0.206	0.133	2.4	0.122
Religion (ref 'Christian')				
Muslim	-0.194	0.127	-2.35	0.1257
Relationship (ref 'Married monog')				
Single	0.259	0.084	9.52	0.0022

### Regression on HIV/AIDS knowledge Score

Gender norms	0.218	0.043	25.210	<.0001
Age (ref 20-29yrs)				
40+ years	-0.394	0.115	11.660	0.0007
Education level (ref 'primary')				
Tertiary	-0.387	0.149	6.710	0.0099
Partners educ level (ref 'primary')				
Secondary	0.196	0.083	5.540	0.0190
Relationship (ref 'Married monog')				
Married polygamous	-0.330	0.112	8.690	0.0034
Single	-0.362	0.144	6.290	0.0124

### Regression on condom use frequency previous six months

Condom norms & attitudes	0.921	0.086	114.87	<.0001
Condom use intention	0.223	0.084	7	0.0084
Religion (ref 'Christian')				
Traditional	0.707	0.452	2.45	0.1186
Relationship (ref 'Married monog')				
Married polygamous	-0.521	0.164	10.04	0.0016
Single	0.953	0.215	19.73	<.0001

## Appendix 6a: Selected Quotes on How Women Spend Their Day

From Ndhiwa, Nyanza Province (a rural setting):

My view is like this: according to the life of women here, when a woman wakes up, the first thing is to pray, then open the door, take a broom and sweep because at times you share the house with chicken so you remove their droppings. When I finish this, before I leave, I make breakfast for the children and their father. I give them, they dress and he goes to his business and the children go to school. They still leave me behind. When I am left behind I prepare myself to go to the shamba [farm] and stay there until about 12 noon because I have children coming from school for lunch. When I came back, if I didn't have vegetables at home, I pluck some from the shamba to cook for lunch before the children arrive. When the kids come back for lunch the vegetables are ready, they eat after which I start thinking of what to cook for supper. At first I ensure that there is water. I go to the river to fetch water, after which I go to look for vegetables for evening meal then fetch firewood. After completing this and ensuring that food and water are in the house, I leave for the market to sell home-made detergents. When the children are back from school they find things to start making dinner. I have a daughter whom I have trained. She will heat water and bathe the small children. So these are things that me as a woman I have to do. When night falls, I return home and find when my daughter has prepared the vegetables. I cook ugali (corn meal) and give them food. I also give my husband food if he is back. The children go to do sleep but the big ones do school work first. I then eat and go to sleep. But if my husband has not come, I sleep but my ears are alert because I will need to open the door and warm the food for him. These are what I do in a [normal] day.

From Mukuru, Nairobi (an urban slum setting):

If you have a small child like this one (gestures towards another respondent's child) and you want to go buy kales, potatoes, tomatoes and onions from the market to sell, you give the child piriton [an over the counter sedative], two or three tablets and then you can go. You do this because you don't have anyone to leave the baby with or money to pay a house girl. Your neighbors are also tired of taking care of your child everyday. So you give it piriton and when you came back and find that it is still asleep, you continue selling near the house. With the money you get [from the sale], you will have flour for the baby's porridge when it wakes up, and what you fail to sell you prepare a meal for the house.

From Obunga, Kisumu, Nyanza Province (urban slum setting):

You know, ....in feeding your family if you have a husband and he has refused to work and even that money for business is not available, it will force you to go find a man and sleep with him so that he can give you money to go feed the family. Because you don't have money for business [and] you don't have anything, what will you do? Some one calls you for two or three shillings, [4¢ or 5¢ -

probably not exact amount but to underscore the small amount they get paid for survival sex] you'll go have sex so that your children get food and sleep.

#### **Appendix 6b: Excerpts of Sexual Violence**

From Kisumu, Nyanza Province:

You can be walking on your way home from the market and then suddenly some man attacks you and you may not even know why. Sometimes someone you don't know just touches your breasts or buttocks as you pass him. Some idle young men also just like to make remarks and abuse girls and young women as they walk past. Sometimes they make [such] obscene remarks you feel embarrassed because sometimes you are with your mother or father.

From Bondo, Nyanza Province:

There are manipulations of the girls. Men take advantage as in the case of teachers and their students or pupils, even in class 4. Fishermen also will not allow the women to purchase fish unless they (the men) are given sexual favors. If your children are hungry and selling fish is your only source of money, you just agree even if you don't like it. If you refuse, they refuse to sell to you the fish or they give you at very high price so you go at a loss when you [re]sell.

### **Appendix 6c: Selected Quotes on Incest**

From Mukuru slums, Nairobi:

Concerning this issue we are talking about, there was a recent incident around this place, there was a father would sleep with the daughter. So one night when they had planned for a night out, the daughter refused, so they ended up having sex in the house when the mother was away. The girl was heard moaning that, “Ayii Daddy, why are you doing it so painfully like this today?” That is how neighbors got to learn what was going on. So issues of incest happen within our community and can go on for a long time before people know what is happening.

From Naromoru, Central Province:

A case happened last year where a father would have sex with his daughter then entice her with money so she does not to divulge this information to others. The issues only got exposed when the daughter got pregnant. When she could not hide it anymore, she confided in the mother and told her the truth. If there was no pregnancy, maybe no-one would have known.

## Appendix 7: Baseline Questionnaire Used-English

### ***Baseline Questionnaire***

#### **Introduction**

As a female participant of the Gender Development Project you are kindly requested to fill in this questionnaire before taking part in the activity that you have been invited to. With this questionnaire we would like to get an idea of some of your perceptions concerning the division of roles between men and women in a relationship, the community or at home and how you feel about the use of condoms and HIV/AIDS. Please carefully read the questions and follow the instructions that you will find in the questionnaire. If you have any doubts regarding the format or meaning of the questions you can turn to one of the activity coordinators or interviewers who will kindly assist you. Once you have filled in the questionnaires you can return it to one of the activity coordinators or interviewers. We hope that you are able to answer the questions as honestly as possible as the information given will be treated with maximum confidentiality. To ensure your agreement with this questionnaire, you are kindly requested to leave your signature. Please be reminded that your participation is truly voluntary so pulling out of the questionnaire is possible at all times.

Your cooperation and response will be greatly appreciated!

Signature respondent: \_\_\_\_\_

*(To be filled in by activity coordinator)*

Name of organisation:

Name of activity coordinator:

Date:

Location:

Respondent number:

Short description of the activity:

## SECTION 1

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The following section aims to collect general information about your background. Please encircle the answer that applies most to you or use the space provided to fill in your answer.

A. Have you attended any of the gender development project activities?

**Yes**     → The questionnaire ends here.

**No**   

B. Sex

**Male**     → The questionnaire ends here.

**Female\***   

C. Age (in years or date of birth): \_\_\_\_\_

D. Highest educational Level  
(completed:)

**Primary**     **Secondary**     **University**

**Other:** \_\_\_\_\_

E: What is your religion? **Muslim**     **Christian**     **Traditional**

**Other:** \_\_\_\_\_

F: What is your main source of income?

**Support from husband/partner**     **Support from other relatives**

**Money from own work**     **Social service/welfare**

**No income**     **Other:** \_\_\_\_\_

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\* Or living in the social role of a female.

- G. Relationship Status:**
- Married Monogamous**
- Married Polygamous**
- In a relationship  
(Sexual or romantic)**
- Single**  → Go to section 3
- Other:** \_\_\_\_\_

**H:** Duration of current relationship or marriage in years and/or months: \_\_\_\_\_

**I:** Do you have children: **Yes**  **No**

**J.** Do you use any form of contraception? **Yes**  **No**  (if No, go to L)

**K.** If yes, what type of contraception do you use?

- Birth control pills**  **Condoms**  **Spermicides**  **IUD**
- Injectables**  **Natural methods**  **Norplant**  **Tubal Ligation**
- Other:** \_\_\_\_\_ (If single, go to section 3)

**L:** Highest Educational **Primary**  **Secondary**  **University**

Level of Partner (completed) **Other:** \_\_\_\_\_

## SECTION 2

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The following statements refer to the **relationship** you have with your **main** partner. If you have indicated that you are single and momentarily not in a sexual nor a romantic relationship please go directly to section 3. If you are in a relationship or married (polygamous or monogamous) please fill in these questions.

*Please indicate by encircling to what extent you agree with the following statements. Your answers can be given in the form of 1 = Strongly Agree, 2=Agree, 3=Undecided, 4=Disagree and 5 =Strongly disagree.*

1. My partner tells me who I can spend time with.  
1(Strongly Agree) 2(Agree) 3(undecided) 4(disagree) 5(strongly disagree)
2. Most of the time we do what I want.  
1(Strongly Agree) 2(Agree) 3(undecided) 4(disagree) 5(strongly disagree)
3. My partner won't let me wear certain things.  
1(Strongly Agree) 2(Agree) 3(undecided) 4(disagree) 5(strongly disagree)
4. When my partner and I are together, I am pretty quiet.  
1(Strongly Agree) 2(Agree) 3(undecided) 4(disagree) 5(strongly disagree)
5. I have more to say about decisions than my partner does.  
1(Strongly Agree) 2(Agree) 3(undecided) 4(disagree) 5(strongly disagree)
6. When I do some thing that my partner doesn't approve of, he hits me.  
1(Strongly Agree) 2(Agree) 3(undecided) 4(disagree) 5(strongly disagree)
7. My partner always wants to know where I am.  
1(Strongly Agree) 2(Agree) 3(undecided) 4(disagree) 5(strongly disagree)
8. It is important that my partner disciplines me.  
1(Strongly Agree) 2(Agree) 3(undecided) 4(disagree) 5(strongly disagree)

The following items must answered in the following manner: 1 = My Partner, 2 = Both of Us, Equally and 3 = Me

9. Who usually has more say about what you do together?

1(My Partner) 2(Both of Us) 3(Me)

10. Who usually has more say about how often you see one another?

1(My Partner) 2(Both of Us) 3(Me)

11. In general, who do you think has more power in your relationship?

1(My Partner) 2(Both of Us) 3(Me)

12. Who usually has more say about whether you use condoms?

1(My Partner) 2(Both of Us) 3(Me)

13. Who usually has more say about whether you have sex?

1(My Partner) 2(Both of Us) 3(Me)

### SECTION 3

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The following section refers to your perceptions of the roles that men and women pursue in the domestic and sexual sphere. Please read the following statements carefully and indicate by encircling to what extent you agree/disagree with the statements. *Please use the following scale: 1 = Strongly Agree, 2=Agree, 3=Undecided, 4=Disagree and 5 =Strongly disagree.*

14. A woman's most important role is to take care of her home and cook for her family.

1(Strongly Agree) 2 (Agree) 3(undecided) 4(disagree) 5(strongly disagree)

15. Changing napkins/diapers, bathing, and feeding the children are the mother's responsibility.

1(Strongly Agree) 2(Agree) 3(undecided) 4(disagree) 5(strongly disagree)

16. A woman should have the final word about decisions in the home.

1(Strongly Agree) 2(Agree) 3(undecided) 4(disagree) 5(strongly disagree)

17. It is important that a father is present in the lives of his children, even if he is no longer with the mother.

1(Strongly Agree) 2(Agree) 3(undecided) 4(disagree) 5(strongly disagree)

18. Women who carry condoms on them are easily convinced to have sexual intercourse.  
1(Strongly Agree) 2(Agree) 3(undecided) 4(disagree) 5(strongly disagree)
19. It is a women's responsibility to avoid getting pregnant.  
1(Strongly Agree) 2(Agree) 3(undecided) 4(disagree) 5(strongly disagree)
20. A couple should decide together if they want to have children.  
1(Strongly Agree) 2(Agree) 3(undecided) 4(disagree) 5(strongly disagree)
21. It is the man who should decide whether to have sex.  
1(Strongly Agree) 2(Agree) 3(undecided) 4(disagree) 5(strongly disagree)
22. A man needs other women.  
1(Strongly Agree) 2(Agree) 3(undecided) 4(disagree) 5(strongly disagree)
23. Women need sex more than men do.  
1(Strongly Agree) 2(Agree) 3(undecided) 4(disagree) 5(strongly disagree)
24. There are times when a woman deserves to be beaten/hit.  
1(Strongly Agree) 2(Agree) 3(undecided) 4(disagree) 5(strongly disagree)
25. A woman should tolerate violence in order to keep her family together.  
1(Strongly Agree) 2(Agree) 3(undecided) 4(disagree) 5(strongly disagree)
26. It is ok for a man to beat/hit his wife if she won't have sex with him.  
1(Strongly Agree) 2(Agree) 3(undecided) 4(disagree) 5(strongly disagree)

#### SECTION 4

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The following statements refer to *your* attitudes and beliefs towards the use of condoms. Please circle to what extent you agree with the statements according to the scale that is indicated by each question.

27. I intend to use a condom when I have sex.

(1=very likely, 2=likely, 3=undecided, 4=unlikely, 5=very unlikely)

Very Likely            1        2        3        4        5            Very Unlikely

28. I think using a condom would make me feel

(1=very comfortable, 2=comfortable, 3=undecided, 4=uncomfortable, 5=very uncomfortable)

Very comfortable      1      2      3      4      5      Very uncomfortable

29. I think encouraging my sexual partner to use a condom would make me feel

(1=very comfortable, 2=comfortable, 3=undecided, 4=uncomfortable, 5=very uncomfortable)

Very comfortable      1   2      3      4      5      Very uncomfortable

30. I think using a condom would make me feel

(1=very good, 2=good, 3=undecided, 4=bad, 5=very bad)

Very good                      1      2      3      4      5      Very bad

31. I think encouraging my sexual partner to use a condom would make me feel

(1=very good, 2=good, 3=undecided, 4=bad, 5=very bad)

Very good                      1      2      3      4      5      Very bad

32. I think most people important to me would want me to use a condom if I were to have sex.

(1=very likely, 2=likely, 3=undecided, 4=unlikely, 5=very unlikely)

Very Likely      1   2      3      4      5      Very Unlikely

33. It is expected of me that I use a condom.

(1=strongly agree, 2=agree, 3=undecided, 4=disagree, 5=strongly disagree)

Strongly agree      1      2      3      4      5      Strongly disagree

34. I am confident that I could use a condom if I wanted to.

(1=strongly agree, 2=agree, 3=undecided, 4=disagree, 5=strongly disagree)

Strongly agree      1      2      3      4      5      Strongly disagree



## SECTION 5

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Lastly, we would like to ask you some questions about HIV/AIDS. Please indicate next to the statements (by means of a cross × or Tick ✓) whether you agree, disagree or don't know.

	Statement	Response		
		Disagree	Agree	Don't know
41.	A person can look healthy and yet is infected with HIV.			
42.	A person can get infected with HIV by greeting or touching a person living with HIV and/or AIDS			
43.	One can get HIV by sharing cups with people who have HIV and/or AIDS			
44.	One can get HIV by sharing syringes/ razor blades with people who have HIV and/or AIDS			
45.	A pregnant woman can pass on HIV to her unborn baby			
46.	Only prostitutes, homosexuals and people who abuse drugs get HIV.			
47.	Keeping in good physical condition can delay progression from HIV to AIDS			
48.	Most people with HIV immediately show signs of being sick.			
49.	Condoms reduce the risk of getting the HIV.			
50.	There is a cure for HIV and/or AIDS			

***Thank you very much for your participation!***

**Appendix 8: Focus Group Discussion Topic Guide Used-English**

**FOCUS GROUP TOPIC GUIDE ON GENDER BASED ISSUES FOR WOMEN AND GIRLS**

<b>Name of group interviewed:</b>		<b>Date:</b>	
Site:	Time discussion started:	Time ended:	
Participant summary:	No. women:	No. girls:	Total:
Name of facilitator(s):			

As participants arrive thank them warmly for coming, welcome them and put them at ease by friendly conversation. [When the group is complete] Introduce yourself and the record keeper and state the use of the tape recorder. Reaffirm from the members that they have come voluntarily to participate in the discussion and that they can still withdraw from the group if they wished to. Seek this consent by a show of hands.

**INTRODUCE TOPIC OF RESEARCH:**

I am interested in learning about some of the concerns and needs of people in this community. I'm especially interested in trying to understand some of the issues that women and girls have to deal with here. I hope that your answers to my questions will help improve services for women, girls, and families in this community. I expect our discussion to last about one-and a-half to two hours. Assure participants of confidentiality and explain what will happen to the data. Give an explanation on the need to record the discussion and ask for permission to record. [Inform about reimbursements or refreshments if you will be providing].

**AGREE ON GROUP NORMS AND CONFIDENTIALITY**

- Explain the session shall be in form of a discussion.
- Stress that there are no right or wrong answers.
- Ask participants to feel free to say what they think

- Ask the group to treat what others say as confidential
- Cell phone use and leaving the room while discussion is in progress etc.

***PART A: FIRST, I WOULD LIKE TO ASK YOU SOME GENERAL QUESTIONS ABOUT YOUR COMMUNITY:***

1. How do men spend time in your community? What are their daily chores?
2. How do women spend time in your community? What are their daily chores? What are their social activities? Do you think women are busier now than 5 years ago? Why?
3. How do children spend their time? Do they play? Are they in school? To what age? Who decides when and which school they go to? Are they working? At home or for pay?
4. Who is responsible for making decisions for this community? Who is responsible for making decisions in the family? What happens when the person making the decisions is not there? Who controls the resources in the community? In the family?
5. What people or groups in this community are involved in helping those most in need?
6. How do men get information about what is happening in the community? Who do men go to for help when they have problems?
7. How do women get information about what is happening in the community? Who do women go to for help when they have problems?

***PART B: NOW I'D LIKE TO ASK YOU SOME QUESTIONS ABOUT THE SAFETY AND SECURITY OF WOMEN AND GIRLS:***

8. Are you aware of problems with the safety and security of women and girls in this community? (Ask for examples. If no one speaks specifically about gender based violence (GBV), evaluate the group to decide whether you want to bring up the issue now or wait until the group has developed more comfort talking about these issues.)
9. What are the circumstances that cause problems of safety and security for women and girls in this community? (Ask for examples.) What has been done here to improve the safety of women and girls?
10. What about specific forms of violence against women and girls? What practices are considered sexually inappropriate, abusive, or violent in the community? Can

you give examples of sexual abuse in your community? (Examine definitions of forced sex/rape, sexual harassment, sexual manipulation, etc.)

**11.** When and where does sexual violence occur? .Does gender based violence occur in schools? If so, When? How? And who are the perpetrators. What can be done to improve this situation?

**12** Without mentioning names or indicating anyone specific, who are the perpetrators? What happens to the perpetrators (different consequences if the perpetrator is known/unknown)?

**13.** Without mentioning names or indicating anyone specific, which groups of women do you think feel the least safe, or feel at most risk for sexual violence? (Probe for widows, married women, single mothers, school girls etc.) Why?

**14.** Which groups of women do you think feel the most safe?

**15.** Has the problem of sexual violence gotten worse, better, or stayed the same in the last year? What particular types of sexual violence have gotten worse, better, or stayed the same? If there has been a change, what has caused it?

**16.** Without mentioning names or indicating anyone, do you know of women in this community who are forced to have sex when they don't want to? Where do these things happen? How do you know about them? What problems has this caused for these women? How does the community respond to this?

**17.** Is there ever a situation where a woman might be partially responsible or to blame (or at fault) for her rape/sexual assault? Would you help a woman in such a situation?

**18.** Is it possible that some women ask for sexual assault through their behaviors or attitudes? If a survivor is not crying or is not emotional after a rape, what do you think must have happened?

**19.** Do women look for help when they experience sexual violence? Do they tell anyone (family members, other women, health worker, community leader, police/security people/authorities, someone else)?

**20.** Do you think women and girls are more exposed to contracting HIV/AIDS? Why do you think so? Do women and girls get enough information about HIV/AIDS? Who provides this information? What can be done to improve this situation?

**21.** How do women cope with violence against their family members or friends? How do men cope with violence against their daughters, sisters, mothers, wives, friends?

22. How do families and communities cope with violence against women and girls?

23. How have people not been able to cope?

24. What are community responses when violence occurs? What is done to prevent violence? What is done to help survivors? How could these efforts be improved?

25. Do women's support networks exist to help survivors? What social and legal services exist to help address problems associated with violence (e.g., health, police, legal counseling, social counseling)? Who provides these services? How could these efforts be improved?

***PART C: THANK YOU FOR YOUR IMPORTANT FEEDBACK. I KNOW THESE ARE DIFFICULT QUESTIONS ABOUT TOPICS PEOPLE DON'T USUALLY TALK ABOUT. I'D LIKE TO PAUSE NOW AND ASK SOME QUESTIONS ABOUT MARRIAGE AND RELATIONSHIPS BETWEEN HUSBANDS AND WIVES:***

26. In your community, how is a traditional marriage done? Is there a bride price or dowry? If so, what exactly is the practice related to this?

27. At what age do women usually marry? Do women usually decide when to marry? Who to marry? At what age do men usually marry? Do men usually decide when to marry? Who to marry?

28. Do women usually wait until after marriage to have sex?

29. Do men usually wait until after marriage to have sex?

30. How many children do most couples want to have? What sex of children do most couples want to have? If husbands and wives disagree about the number of children, or sex of children, who has authority?

31. When women are pregnant in this community, do they usually see a health worker? Do they see a doctor? A nurse? A midwife or traditional birth attendant (TBA)? A traditional healer?

32. Do women usually decide when to get pregnant? What do women do when they are pregnant but they don't want to be?

33. What are the views on education of women, women working, and their ability to care for the family? Who makes decisions in the family about these things?

34. Are there traditional practices that hurt the welfare of women and/or girls? What happens when women and /or girls go against these practices?

- 35.** Are there traditional practices that hurt the welfare of men and/or boys? What happens when men and/or boys go against these practices?
- 36.** Do some men have more than one wife? Are all of the wives treated the same way?
- 37.** What kinds of conflicts occur in marriages and families and what are the reasons (e.g., fidelity in marriage, education/working wife, differences in socioeconomic status of both spouses, interference of in-laws with marital/family conflicts)? How are they resolved?
- 38.** There are men who treat their wives well and men who don't. What are some things that husbands do if they are treating their wives well? What are some things that might be examples of husbands treating their wives badly?
- 39.** There are women who treat their husbands well and women who don't. What are some of the things that wives do if they are treating their husbands well? What are some things that might be examples of wives treating their husbands badly?
- 40.** Do you believe that a wife should never question her husband?
- 41.** Does a husband have the right to physically punish his wife for any reason? Why would a husband hit his wife? Why would a wife hit her husband?
- 42.** Without mentioning names or indicating anyone specific, what types of physical and emotional abuse of women by their husbands are you aware of? Why do you think these happen?
- 43.** Without mentioning names or indicating anyone specific, what types of physical and emotional abuse men by their wives are you aware of? Why do you think these happen?
- 44.** When a husband insists on sex from his wife, does she have the right to refuse sex? If she does refuse and he forces her to have sex, is that rape?
- 45.** Why do you think most women who are in violent marriages do not seek any assistance (e.g., reasons such as break-up of family, family honor being affected, loss of economic support etc.)?  
Is your community doing anything to help? Who do you think will be the right person(s) to help women who are in abusive relationships?
- 46.** Without mentioning names or indicating anyone specific, do you know women who have been helped? If so, what type of assistance? Do you know men who have been helped? If so, what type of assistance?
- 47.** What can be done to prevent abuse and violence within families?

48. How can and how should this community protect family members from abusing each other?

49. What about NGOs and other community organizations? What about religious institutions? The government?

***PART D: LASTLY I WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT PROPERTY INHERITANCE IN YOUR COMMUNITY***

50. In your community, who decides on the inheritance of property? What is done to matrimonial properties when a husband dies? Are there cases when families lose their properties? If so, what role does community leaders play? What happens to children when a husband dies? In case both parents are dead, what happens to the girl child? [Help Self Help Center]

***PART D: LASTLY I WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT YOUR RELATIONSHIP WITH YOUR PARENTS/GUARDIANS***

50. On average how much time do you spend with your parents in a day?

What topics do you discuss most the time? (Probe for academic, boy-girl relationships, house chores, HIV/AIDS, dating/hanging out etc) What type of duties do boys do? Girls? What type of punishments do boys get? Girls? Why?

If you had an intimate relationship with the opposite sex, who would you talk to about it? Why? Has HIV/Aids information been adequately provided in your school? Who provides this information? What can be done to improve this situation? (CMEDA/KANCO)

***PART D: LASTLY I WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT BUSINESS ACTIVITIES AT THE BEACH.***

50. At the beach what activities are the men involved in? What kind of activities are the Women involved in? Are women allowed to fish? If not, why? What qualifies a woman at the beach to access fish from a boat owner? (Probe for negotiation for fish in other ways apart from cash)

51. Why are people more attracted to the beach than other settlements? How do they sustain their livelihoods at the beaches there after? What kind of social activities are common at the beaches? Do the people who come for business at the beach stay there? For how long? Do they come with their families; if not so how do they survive?

What other kind of economic activities are found in the beach? What do people do during fish bans? (WIFIP, WSP-K)

***CLOSING QUESTIONS:***

Before we finish, I would like to hear what you think should be done to end violence against women and girls in [...]?

What did you think about the subjects we have discussed? Do you think that this session covered issues that are important to women and girls? Do you think that this session covered issues that are important to men and boys?

***CLOSE THE DISCUSSION:***

Thank you all for your time and ideas. This has been extremely helpful. As I said in the beginning, the purpose of this discussion was to help me learn about what women want and what women need here. As more services are developed here, we want to be sure they help you address the problems you are facing. Please remember that you agreed to keep this discussion confidential. Please do not share with others the details of what was said here. People will be curious and you may have to say something—I suggest you tell them that I was asking questions about women and men and health issues, just gathering information—like I’m sure has happened before. Please do not give details of what was said here, so that we can try to preserve confidentiality and the safety of people who are exposed to violence.

How does that sound to you? Do you have questions for me? If anyone would like to speak with me in private, I will stay here after we end. Thank you for your help.