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Social context and drivers of intimate partner violence in rural Kenya: Implications for the health of pregnant women

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Abstract

More than half of rural Kenyan women experience intimate partner violence (IPV) in their lifetime. Beyond physical consequences, IPV indirectly worsens maternal health because pregnant women avoid antenatal care or HIV testing when they fear violent reprisal from partners. To develop an intervention to mitigate violence towards pregnant women, we conducted qualitative research in rural Kenya. Through eight focus group discussions, four with pregnant women (n=29), four with male partners (n=32), and in-depth interviews with service providers (n=20), we explored the social context of IPV using an ecological model. We found that women experienced physical and sexual IPV, but also economic violence like forced exile from the marital home or losing material support. Relationship triggers of IPV included perceived sexual infidelity or transgressing gender norms. Women described hiding antenatal HIV testing from partners, as testing was perceived as a sign of infidelity. Extended families were sometimes supportive, but often encouraged silence to protect the family image. The broader community viewed IPV as an intractable, common issue, which seemed to normalise its use. These results resonate with global IPV research showing that factors beyond the individual – gender roles in intimate partnerships, family dynamics, and community norms – shape high rates of violence.

Keywords

pregnancy; domestic violence; HIV/AIDS; gender; Kenya

Introduction

In the past decade, intimate partner violence (IPV) has emerged as a leading cause of morbidity and mortality for women of reproductive age (Coker 2007; Boy and Salihu 2004). Globally, between 15% to 71% of women experience IPV during their lifetime (Garcia-Moreno et al. 2006). Population-based studies in East Africa estimate that rates of IPV in the

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region are among the highest in the world (Garcia-Moreno et al. 2006). In Kenya, 47% of women reporting lifetime experience of violence from a husband or partner (Kenya National Bureau of Statistics (KNBS) 2010).

The health impacts of IPV on women of reproductive age include physical trauma and declines in reproductive health (Ellsberg et al. 2008; Garcia-Moreno et al. 2006). Psychological outcomes of IPV include depression, post-traumatic stress, and suicidal ideation (Ellsberg et al. 2008; Ishida et al. 2010; Pico-Alfonso et al. 2006). There is also evidence for a strong association between IPV and HIV risk, with HIV-positive women more likely to have experienced lifetime violence than HIV-negative counterparts (Fonck et al. 2005).

The prevalence of IPV during pregnancy in sub-Saharan Africa is also among the highest reported globally (Shamu et al. 2011). In urban Kenya, 28% of urban pregnant women reported lifetime IPV (Kiarie et al. 2006), but systematic reviews suggest that no studies to date have measured prevalence of IPV during pregnancy among Kenyan women (Devries et al. 2010). However, in neighbouring Uganda, between 13.5–27.7% of pregnant women report IPV during pregnancy (Devries et al. 2010; Kaye et al. 2006). Pregnant women exposed to violence are more likely to experience stress, depression, miscarriage, pre-term delivery, induced abortions, and stillbirths (Curry 1998; Okenwa, Lawoko, and Jansson 2011; Martin et al. 2006). Their infants are, in turn, more likely to experience low birth weight, illness, under-nutrition, and mortality (Rico et al. 2011; Valladares et al. 2002; Karamagi et al. 2007).

While the medical outcomes of IPV towards pregnant women are well-documented, little research from sub-Saharan Africa explores the drivers of IPV among pregnant women. One recent review found no studies from sub-Saharan African exploring risk factors for IPV during pregnancy (Taillieu and Brownridge 2010). Scholars have looked to qualitative research to interpret the multiple social factors that situate IPV (Boonzaier and van Schalkwyk 2011). We conducted formative qualitative research to explore the context and triggers of IPV in general and for pregnant women in rural Kenya. Findings from this research were ultimately used to develop a culturally-specific IPV intervention for the antenatal clinic setting.

Theoretical framework

We used an ecologic model to guide the analysis and write-up of data (Anderson 2010; Heise 1998). The ecological model suggests that personal, relationship, and community factors shape health outcomes, and is widely used in IPV research because it incorporates many complex factors that influence partner violence (WHO 2010). Within the ecological model, “personal” factors are the individual characteristics or behaviours that impact a person’s health. “Relationship” factors are the dyadic partnership issues that frame health outcomes. “Community” refers to the broader social or structural factors that impact on health.

Setting

In Nyanza Province, one of Kenya’s poorest regions, 59.5% of women have experienced emotional, physical, or sexual IPV in their lifetime (KNBS 2010). An estimated 14% of adults are HIV-infected, more than doubling national prevalence rates (NASCOP 2009). Antenatal services in Nyanza Province are typically located in primary health care clinics, which have been increasingly decentralised to better serve rural areas. While a large proportion of women in the province (96%) have at least one antenatal care visit during pregnancy, less than half (45.5%) access skilled birth attendance services (KNBS, 2010).

Methods

Data collection

We conducted formative research through in-depth interviews (IDI) and focus group discussions (FGD). Pregnant women (n=29) were recruited through an open announcement at four antenatal clinics, selected to represent a range of geographic communities from an ongoing study (Turan et al. 2011). Pregnant women were selected regardless of their own personal experience of violence, in an effort to protect participants from unintentional disclosure. Male partners and relatives of pregnant or postpartum women (n=32) were recruited in two separate communities (near, but not overlapping the antenatal clinics) through lay health workers familiar with the surrounding areas. Since male partners came from a different catchment area, this recruitment method minimised the chance that a pregnant woman's partners would learn of her participation in the research, potentially placing her at further risk of violence. All FGDs were conducted in a private room in the clinic. To encourage participant expression and deepen our analysis, we created FGDs that were homogeneous in terms of age; separate groups were organised for younger (roughly 18–30 years) and older (30 years and above) participants (Table 1).

FGDs were led by trained moderators, who were the same sex as participants and fluent in the local language. Semi-structured discussion guides were developed by the research team and explored several topics (Table 2). The topic of IPV during pregnancy was addressed, but FGD moderators were also encouraged to explore the social context and drivers of IPV generally, in preparation for developing an intervention for the antenatal clinic. Discussions were audio-recorded after obtaining participants' permission.

Lastly, we purposively sampled key informants (n=20) from three groups of service providers: non-governmental organisations; police and legal organisations; and public health organisations. IDIs were led by a Kenyan researcher and covered similar topics to the FGDs (Table 2).

Several steps were taken to ensure confidentiality and provide additional support for participants during the research. Study staff were trained to describe research as the social barriers to use of health services in the community. Interviews and focus groups did not include any questions asking participants about their personal experiences with HIV or IPV. Researchers asked participants not to talk directly about or disclose personal experiences of violence. If, despite this caution, a participant disclosed personal experiences, researchers encouraged them to speak about the situation privately. All participants were offered an information sheet containing contact information for local resources (counselling, legal advice, and health care). In cases of severe violence, researchers were trained to accompany the participant to the office of the most appropriate local resource for preventing or mitigating the impacts of IPV.

Data analysis

All data were transcribed verbatim in the language in which they were conducted and, as necessary, translated from the local language (Kiswahili or Dhuluo) into English by professional transcriptionists. To ensure accurate translation, each transcript was reviewed by the researcher who conducted the IDI or FGD, and queries were resolved through discussions among the researchers via phone or email. Researchers then added a brief report including personal reflections on how the IDI or FGD proceeded, observations, and notes about key themes. Word documents were password protected, to allow for electronic transmission via email among the research team.

Transcripts and researcher notes were managed in QSR Nvivo, using a coding framework developed by three research team members. An initial coding framework was developed based on several sources: the research questions, data collection themes, and current literature. Following the development of this initial framework, two authors coded all transcripts according to the identified 'broad codes', which represent wide thematic baskets of ideas (Miles and Huberman 1994). Next, the research team held a series of phone meetings to jointly develop 'fine codes' using a grounded theory approach (Hutchison, Johnston, and Breckon 2010). Two authors then applied the final list of 'fine codes' to two separate QSR Nvivo databases. A preliminary research report was created by printing out two sets of excerpts (from each database) related to each code, reviewing the text for any divergence of opinion, and summarising the views of participants alongside illustrative quotes.

This analytic report was reviewed by the entire research team, and to verify the findings, emerging themes were shared with service providers from the province during a 2-day workshop. This series of discussions refined our conclusions in preparation for translating the findings into a pilot intervention for the antenatal clinic setting. The purpose of verifying the findings with relevant local stakeholders was both a tool for bolstering the analytical rigor of the study (De Wet and Erasmus 2005), and a crucial method for ensuring that any future intervention around IPV in pregnancy would be responsive to the local setting, and therefore more sustainable (Agrawal 1995). Service providers were recruited using a snowball sampling method. The attendees included the research team, health workers, local government, and staff from regional organisations. While several stakeholders had specific expertise in violence in pregnancy, others were drawn more widely for their public health or multidisciplinary knowledge.

Ethics approval was granted by University of California San Francisco (CHR 10-00389) and the Kenya Medical Research Institute (SSC 1688). All interviews and discussions were conducted after signed informed consent, and anonymity of participants was protected throughout the research process.

Results

Several themes provide a deeper understanding of the social context of IPV in rural Kenya. We have organised the presentation of these themes according to an ecological framework (Heise, 1998). First, we identify types of violence experienced by women during pregnancy and the particular vulnerabilities of pregnant women. Next, at the intimate relationship level, we present data around relationship triggers of violence. We then examine the role of the extended family in perpetuating or protecting pregnant women from IPV. Lastly, we explore broader community and societal views on IPV.

Violence in pregnancy

Pregnancy as a time of economic dependency—Several participants described pregnant women as a particularly vulnerable group, due to their economic dependency on husbands to provide for them. A service provider, Doreen, explained that a pregnant client had most of her needs met by her violent husband and extended family: "She was beaten when she was pregnant but she stayed because the husband was from a well-off family and she was from a poor family - they were the ones who in fact meeting most of her needs."

A pregnant woman is in a particularly tenuous position when she is economically dependent on a partner for support. This also shapes a decision to remain silent as a strategy to cope with IPV. Men in one FGD described that pregnant women are especially reluctant to

disclose IPV at the antenatal clinic because recourse towards the husband would also cause suffering for them and their unborn child:

> Pregnant women don't say, when they come to the hospital, that they were beaten by their husbands because they feel that action can be taken against their husbands and they will suffer. So most of them stay silent. (Benjamin, age 28)

Forced sex and sexual coercion—Both pregnant women and male partners talked about sexual violence that occurs within marriage. One younger man described forced sex as almost an inevitable outcome of a woman refusing sex, stating that a man 'ends up' forcing his partner: "Sometimes the man wants to have sex but the woman doesn't have the desire so he ends up having sex by force. The forced sex will not bring about peace," (John, age 32). A service provider described that forced sex often occurs within marriage, even when a pregnant woman was recovering from recently giving birth:

> "Husbands can rape their wives, because sometimes the wife is sick, on her menses or still recovering from giving birth. When the man comes he wants sex and he says it is his right." (Rose, age 27)

Young women acknowledged that sexual coercion often occurs, or that physical abuse could occur if a woman refused to have sex:

> Mary (age 20): If you refuse to have sex it brings about beating.
>
> Amina (age 22): Sometimes you did not feel well and he insists and if you refuse then he says you have an affair and beating starts from that.

Relational triggers of violence

HIV testing without men's input—Although routine HIV testing during pregnancy is a standard of care in the study communities, men perpetrated physical violence in response to antenatal testing: "Women come that have been beaten by their husbands, beaten or slapped or kicked most because of HIV testing. Most husbands don't accept this," (Victor, service provider, age 35).

Part of the challenge of HIV testing lies in the issue of partner consent. Because most antenatal HIV testing occurs without a husband present, there is a sense that an important health decision has been made without a man's permission. Women are expected to consult their husbands on the type of action that should be taken when any member of the family needs medical care:

> Onyango (age 30): Pregnant women fear telling their husbands. If they are tested and found to be HIV infected it is not easy for her to go back home and explain to the husband …She just feels that if I tell my husband like that then he might even "send me away packing."
>
> John (age 22): Yes. This is because when the woman comes to the hospital to the [antenatal] clinic, she has not left the home directly for HIV testing. Since she has not gotten permission from the husband.

Failure to consult on health-related decisions may trigger violence, either towards the pregnant woman or towards health care providers. A service provider, Lucy (age 41), explained, "There is a husband to one of our clients who was assaulting the wife and also wanted to attack some of our staff because PMTCT (prevention of mother-to-child transmission) testing has been done without his consent." A reason that PMTCT testing may provoke male partner anger or violence is because men themselves may desire to avoid blame associated with being HIV-positive.

Several pregnant women agreed that following PMTCT testing, it is wiser to keep HIV status a secret, to avoid the potential rejection and anger that comes with partner disclosure:

> If I come from the test and I tell them I was found to be infected, he will say that is something he doesn't want anything to do with. It is just quarreling in the house. That is why I decided that if I am found to be infected, then I won't tell him. (June, age 25)

Perceived relationship infidelity—Both men and women in FGDs described infidelity as major triggers for IPV. A younger pregnant woman (Elizabeth, age 21) stated that "mostly what brings about problems in the family is the issue of extramarital affair. Women easily forgive husbands when they catch them (husbands) cheating … but, if a woman asks for an explanation the husband slaps her."

Women are at risk of IPV if they are perceived to have been sexually unfaithful, *or* if they ask their husband about his infidelity. One trigger of jealousy-related IPV is the wife refusing to have sex with her husband, which is seen as an indication of infidelity:

> If he has been away for long and insists on having sex, you have no option but to just give him even if you didn't want to have sex. Refusing to give him might only cause chaos. He might think that when he was away you also had another man and that is the reason you are denying him. It would just lead to more problems and he could end up beating you up. (Rebekah, age 34)

Women transgressing gender norms—An important theme in the discussions and interviews revolved around social norms and obligations for both husband and wife to perform specific gender roles. IPV seems to be triggered when women fail to meet expectations of being a 'good' wife, often described as respectful, obedient, and responsible. Men explained that women are expected to complete chores around the house, and will sometimes be 'disciplined' if they ignore these duties:

> I have told her to graze the cattle and ensure that they have water and when I come back I find that they are tethered in a place where there is no grass and they have not had water. I will get into the house angry. I take a cane and cane her thoroughly. (Peterlis, age 49)

Focus groups with women revealed the multitude of scenarios where a woman is perceived to be ignoring her duties as a wife:

> Esther (age 31): He asked you to press his clothes, and when he comes back and ready to leave then he realises you have not done that, so he gets mad.
>
> Alice (age 32): Or when he comes to the house with his friends and you treat him disrespectfully.
>
> Faith (age 37): Or if you refuse to cook for his friends.
>
> Sharon (age 32): When he comes home and finds the house very untidy, he might not like that and you will quarrel.

The majority of discussions around relationship conflict with younger men focused on the household decision-making process. If a woman deliberately goes against decisions the couple made together, a man might react with violence:

> A man might plan together with the wife on what to do, for example after harvesting you might agree that we are not going to sell a given part of our produce; we'll just keep it in store. You later learn that contrary to your agreement,

> the woman is selling the same behind your back. Such a case when you come back to the house you will beat her up straight away. (Simon, age 26)

Men transgressing gender norms—Partner conflict and violence also seemed to be triggered when men transgressed gender norms of 'the provider husband'. Across participant groups, men's role was seen as earning money and providing for the family. The inability of men to provide for the family was described as a trigger for violence: "What makes the women really angry is when a man has another woman … It is sort of anger that is immediate. It doesn't take time. Then the issue of provision of food also brings it about automatically." (Samuel, age 31)

Women in FGDs echoed the idea that money problems might escalate from marital conflict to outright violence, especially when men were perceived to be withholding economic support for children:

> Sometimes you know he has money where you have to buy maize meal, but he lets you stay hungry with the children. He comes late and when he ask you and finds you angry and you answer him badly then you end up fighting. (Ruth, age 33)

When men felt unable to provide for their family – particularly in comparison to how other men were providing - they described a situation of marital conflict:

> You might find that your income is low and your neighbor's income higher than yours and the kind of clothes he makes for the wife your wife does not have... It is said that it is the responsibility of man to provide these things, so if you have a temper then fighting will start in your home. You might beat up a woman until you break her arm. (George, age 41)

Thus, by questioning the financial choices of the man, a woman might inadvertently trigger IPV. One service provider, for example, described a client who was badly beaten after making demands that her husband provide food and school fees for their children.

Men described various responses that might occur as a result of the same trigger incident around money. In one discussion, men hypothesise the steps a man could take if his wife misspent household money:

> Or, if she has just used the money on useless things. Women are sometimes not serious and if what she did is not urgent- like the issue of sickness and clothes- then you will get angry automatically. If you realise that it is something important then you would understand. But if you are drunk then you will react badly. (Victor, age 46)

In this quote, alcohol is highlighted as a trigger of violence in a complex situation where resource constraints (only having money available for necessities such as medicine and clothes), and strict gender norms (requiring women to ask permission of husbands before spending household money) build towards violence.

Community views on violence

Belief in violence as unchangeable—Across FGDs and interviews, participants described accepting IPV as a normal, timeless tradition. Many participants described IPV as a consistent and unchangeable aspect of local culture:

> Grace (age 37): They say that a woman must be beaten.

> Sharon (age 32): There is even some belief that a woman must be beaten when she is still alive, such that if you don't beat her up then, you will have to somehow beat her even when she is dead.
>
> Esther (age 31): A woman must be beaten somehow, because it is a practice that has been there even before we were born.

Older men agreed with the sentiment that violence was a normal, accepted part of culture:

> When I was growing up I used to hear people saying that women have to be beaten and a woman cannot go to bed before being beaten up. Before she screams in that home then people don't sleep. So when they hear screams from there they just keep quiet because that is something they see as normal. That is their medicine and that is their prayer when they go to sleep. (Onyango, age 59)

The perception of violence was somewhat similar among younger participants. In a FGD with younger, pregnant women, one participant articulated the community tendency to justify IPV as a normal part of marriage: "Some people say that it [violence] is what entails marriage. Some people say that it is how people live," (Pauline, age 23).

Service providers tended to talk about IPV in terms of cultural practices that were outdated, but intractable problems of rural areas. One service provider described the 'ancient' beliefs held by fellow 'ignorant' community members:

> Others still reason the ancient way. Beating up a woman is actually a normal thing in the culture… Those ones are just ignorant; I have actually tried talking to them but they are just ignorant. (Kelvin, age 33)

This quote might as much illustrate the power differences between service providers and communities as suggest that violence is a normal occurrence. Nevertheless, a similar sense of the inevitable, unchangeable nature of IPV emerged as a key theme in many service provider interviews.

Families as a supportive resource or silencing party—The extended family serves as an important resource for women experiencing IPV by providing guidance to the couple. One participant explained that when women experience physical violence from partners, they can visit the paternal parents for safety and assistance: "When a man beats a woman, the woman runs to the father-in-law's house …In the father-in-law's house she is safe; she knows that she would get help," (Bonface, age 30). Younger women concurred that "if you are not able to handle a situation, then you go to his parents…Anything beyond the parents would be taken to the extended family." (Nelly, age 20).

One older man described regular family meetings that helped to relieve marital tension between himself and his wife. Younger men advocated for families to provide support and mediation, "If a man and woman suffer violence then they should get help from the people they live with in the home," (Dennis, age 25). However, Damaris, a service provider, described that the family is often biased in support of the perpetrator: "It is not something to be blown out of proportion- that can be discussed at family level… but family level who is discussing it is either the mother-in-law the father-in-law who are biased already!"

Pregnant women and service providers described the ways that extended family encourage women to keep silent about IPV as a way to protect the family's image: "Some of them believe that the domestic things need to be kept within the homestead. They feel by so doing they are protecting the family image," (Rachel, service provider). In one FGD, a woman explained that discussing violence risks bringing shame to the family image:

> Mercy (age 31): It doesn't portray a good image on the family- because it is required that if you are living together then you are one thing.
>
> Joyce (age 25): Then they [the family] just blatantly refuse and tell you that women do not have power to talk.

In a subtler way, mothers-in-law encourage younger women to stay silent about abuse by explaining that similar violence had been enacted towards themselves earlier in life. In a discussion with younger women, Violet (age 18) described: "So the old women, when you go to them after being beaten, they encourage you that even them they were beaten like that by your father-in-law; 'Even your father-in-law was doing this to me!'" None of the male partners in FGDs talked about the silencing role of extended families.

Towards critical reflection on violence—Some younger participants began to critically reflect on IPV in their community. During an FGD with younger men, one participant expressed the harm of cultural practices: "Customs like wife inheritance in our culture and traditions we just take them as things from the past. But they are hurting us," (Samuel, age 31). A young pregnant woman began reflecting on how unequal power shapes the dynamic around HIV partner disclosure:

> I feel the men see women as having less power than men do. Even if I come back and tell him that I have tested [HIV] positive, he will quarrel that I am the one who brought it. So that no one admits that he is the one who brought it. Just because he has more power than I have. (Joyce, age 25)

Ecological interpretation of key themes

An ecological interpretation of the key themes explored in this analysis is presented in Figure 1. Participants described multiple situations where IPV could be triggered by specific behaviours on the part of the woman or the husband. Extended family dynamics seemed to be protective or predictive of IPV. In the broader community, strict gender norms and a belief in normalcy of violence serve to legitimise its frequent use. It is important to note the intersecting nature of many of these issues (denoted by the dotted lines in Figure 1). Although the ecological model is a useful tool for organising the various drivers and risks for violence, particular topics may fit into more than one analytical category. For example, strict gender norms can be represented both at the community level and the intimate relationship level.

Discussion

Understanding the social context of IPV towards pregnant women and women of reproductive age is key for responding to violence in the health setting (Horn 2010). Although interventions for IPV during pregnancy have been developed in resource-rich settings (Parker et al. 1999; Tiwari et al. 2005), few exist in East Africa (Stockl, Watts, and Kilonzo Mwambo 2010). This research takes a first step towards developing targeted interventions for pregnant women by mapping the social context and drivers of IPV among women of reproductive age in rural Kenya.

The types of violence described by participants seem co-occur, making and it challenging to draw the line between arguments, partner conflict, and violence (Gage 2005). Both pregnant women and male partners described sexual coercion and forced sex as a part of married relationships. Sexual IPV has immense physical, psychological, and reproductive consequences (Jina and Thomas 2012; Martin et al. 2006), and in this setting is highly correlated with experiencing physical violence (Karamagi et al. 2006).

While current research on types of IPV tends to focus on physical, emotional, and sexual forms of violence, this study points out two additional forms of economic IPV for women in rural Kenya: being neglected financially by a partner or forced exile from the home. Male partner control over money is one form of relationship control, and is something that has been reported by pregnant women in other settings (Bacchus, Mezey, and Bewley 2004; Pallitto, Campbell, and O'Campo 2005). These types of violence might be particularly salient for pregnant and postpartum women who are especially vulnerable because of the financial pressures and household stress related to pregnancy (Jasinski 2001; Noel and Yam 1992). The findings of this study make it clear social context is central to understanding persistent IPV (Kaye et al. 2005).

Our findings support research showing that fears and experiences of IPV influence pregnant women's decisions regarding uptake of HIV services (Antelman et al. 2001; Kilewo et al. 2001). Indeed, throughout sub-Saharan Africa, the threat of violence has been documented as an important barrier to HIV-positive pregnant women disclosing their status to partners and accessing PMTCT services (Painter et al. 2004; Jasseron et al. 2011; Rujumba et al. 2012). Previous research in the Kenyan setting has shown that women who anticipate male partner stigma or violence are more than twice as likely to refuse antenatal HIV testing (Turan et al. 2011). Research in Uganda shows that following testing, HIV-negative pregnant women have troubles convincing partners of the need to test themselves as men often assume they are negative by proxy (Rujumba et al. 2012). Similar to our findings, HIV-positive women in Uganda failed to disclose for fear of abandonment or violence associated with "bringing HIV infection into the family" (Rujumba et al. 2012). This suggests that for HIV-positive pregnant women, as well as those of unknown or negative status, addressing IPV during antenatal care may improve HIV-related health behaviours.

We learned that a woman might be at risk of IPV if either partner fails to uphold traditional gender roles and norms that require men to be providers and women to be obedient (Dolan 2001). Similar to other studies (Jewkes, Levin, and Penn-Kekana 2002; Gage and Hutchinson 2006), participants justified use of male-to-female IPV when a woman was 'misbehaving' by making decisions on her own, consuming alcohol, or being sexually unfaithful. In other settings, women are victims of violence if they fail to meet prescribed responsibilities or if they challenge traditional norms of femininity by taking up new social or sexual roles (Jewkes, Levin, and Penn-Kekana 2002; Boonzaier and van Schalkwyk 2011). Similar to existing research, our study illustrates that IPV can be a powerful tool through which both men and women reinforce societal gender norms in an intimate setting (Go et al. 2003). Indeed, the act of violence is often used to consolidate or reassert a man's sense of power and control (Jewkes, Levin, and Penn-Kekana 2002; Miller 2003).

We found that a man's inability to provide financially, or a woman questioning his use of limited household resources, were important triggers of IPV, as has been found in other settings (Atkinson, Greenstein, and Lang 2005). This supports evidence that when a man's sense of masculinity is threatened, particularly in the context of rapidly shifting gender norms that empower women, he might react through violence (Koenig et al. 2003; Krishnan et al. 2010; Kaye et al. 2005). Men might be particularly vulnerable to these stresses when their female partner is pregnant or there is a new infant coming into the household (Newberger et al. 1992).

Limitations

The findings of this study should be reviewed in light of study design limitations. We asked participants to discuss IPV generally in their community, rather than cite specific incidents of violence, which limits our ability to understand individual cases of IPV. FGDs might have highlighted some voices more than others (Kitzinger 1995), though our analysis

attempted to address this limitation by searching out intra-group divergences in opinion. Researchers interested in the transferability of these findings to other study settings should note that this research was conducted in a single region of rural Nyanza Province, Kenya.

Implications for research and practice

Antenatal care provides a window of opportunity for women to have an ongoing relationship with health care providers, which might help women feel safe enough to seek support for IPV (O'Reilly, Beale, and Gillies 2010). Our data suggest that antenatal programmes should be alert to the violence and disclosure risks associated with HIV testing during pregnancy. Future programmes should consider complementing clinic services with community-based approaches (Raising Voices 2009), particularly those that encourage men to take on supportive roles in maternal health. Building interventions that address the social drivers of IPV in pregnancy is an urgent priority if the health sector is to gain ground in current efforts for maternal and child health.

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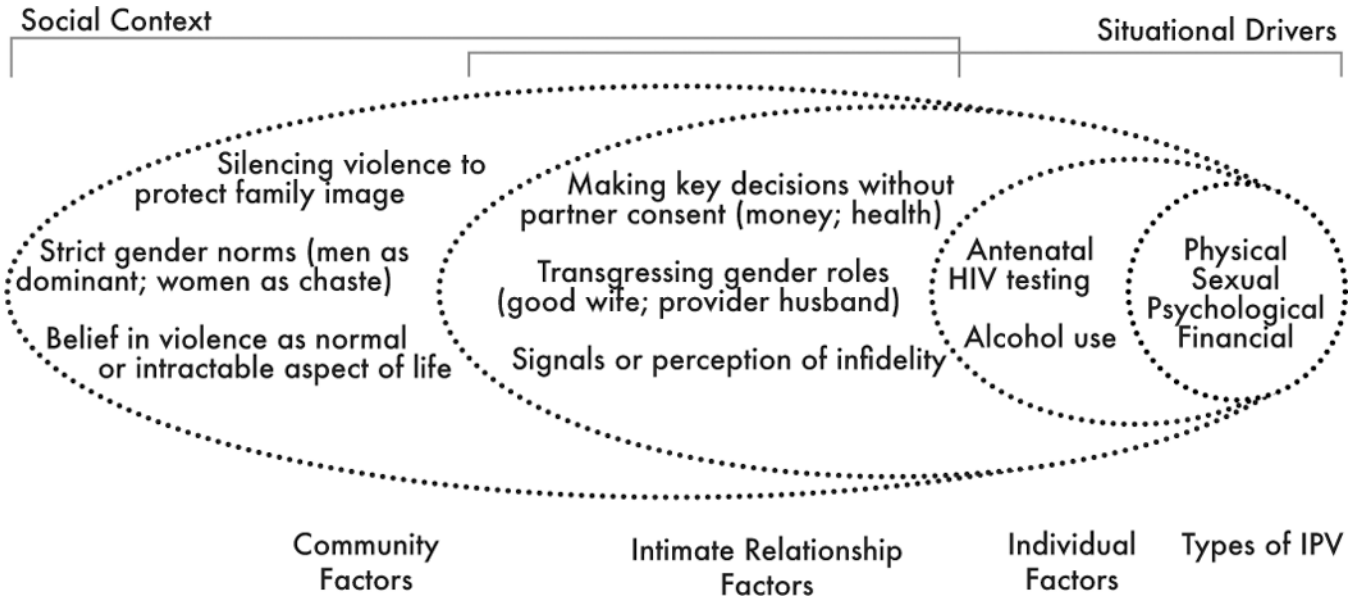

Figure 1.
Ecological interpretation of key findings

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Table 1

Characteristics of Study Participants

	Method	Group	Sub-Group	Sex	Age (Years)	Group size
Community Members	FGD	Pregnant Women	Younger	Female	18–32	7
	FGD	Pregnant Women	Younger	Female	18–31	8
	FGD	Pregnant Women	Older	Female	31–37	6
	FGD	Pregnant Women	Older	Female	30–35	8
	FGD	Male Partner	Older	Male	31–53	8
	FGD	Male Partner	Younger	Male	25–36	8
	FGD	Male Partner	Older	Male	39–59	8
	FGD	Male Partner	Younger	Male	18–29	8
Professionals & Para-professionals	IDI	Health Service Provider	Public Health Sector	Mixed	28–53	-
	IDI	Other Service Provider	Non-governmental organizations	Mixed	32–64	-
	IDI	Other Service Provider	Police and Legal sector	Mixed	38–50	-
	FGD	Service Provider	Mixed	Mixed	23–50	11

FGD, focus group discussion; IDI, in-depth interview

Table 2

Focus Group Discussion Topics

Theme	Sub-Theme	Example Questions
Social Context of IPV	Gender roles	What things are considered “men’s work” in this community? What things are considered “women’s work” in this community?
	Household decision-making	Who usually has the final say in typical decisions (money matters, raising children, use of health services,sex, fertility, contraception?
Drivers of IPV	Types of IPV	Do some women in this community sometimes experience violence? What types of violence? Who carries out the violence?
	Situational triggers of relationship conflict & violence	Which kind of things may make a husband angry at his wife? Which kind of things may make a wife angry at her husband?
	HIV testing & disclosure	Why do some pregnant women fear getting tested for HIV? What things can happen when a male partner finds out that a pregnant woman is HIV-positive?
Responses to IPV	Community responses	How do people in the community respond to violence against women? Do different people react in different ways?
	Help-seeking behaviors	What do women in the community who experience domestic violence usually do about it? Who do they tell?

IPV: intimate partner violence