Published in final edited form as:
J Assoc Nurses AIDS Care. 2012 September ; 23(5): 442–453. doi:10.1016/j.jana.2011.09.006.

Grappling with HIV Transmission Risks: Narratives of Rural Women in Eastern Kenya Living with HIV

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Abstract

As people live longer and more productively with HIV infection, issues of agency in reducing HIV risk are particularly important for HIV-infected women living in high prevalence, under-resourced countries such as Kenya. Because of their gendered lives, in that being masculine is associated with dominance, while being feminine is associated with passiveness, women in rural Kenya must cope with continued HIV transmission risk even after knowing they are infected with HIV. In this narrative interview study, informed by theories of gender and post-colonial feminism, we examined personal accounts of HIV risk and risk reduction of 20 rural women in eastern Kenya who were living with HIV. From our analysis of the women's narratives, two major themes emerged: gender-based obstacles even in the context of a known HIV diagnosis, and struggles with economic pressures amid HIV risks. Implications for policy, programs, and research are discussed.

Keywords

HIV infection; HIV transmission; narrative; risk reduction; rural Kenya women

As Kenyans are living longer and more productively with HIV due to the scaling up of HIV treatment (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2010), the capacity to prevent HIV transmission is becoming ever more critical for Kenyan women living with HIV. HIV-infected women need to be able to minimize mother-to-child transmission and female-to-male sexual transmission, as well as protect themselves from infection with other

Conflict of Interest Statement The authors report no real or perceived vested interests that relate to this article (including relationships with pharmaceutical companies, biomedical device manufacturers, grantors, or other entities whose products or services are related to topics covered in this manuscript) that could be construed as a conflict of interest.

sexually transmitted diseases and HIV re-infection with potentially drug-resistant strains of the virus (Kozal et al., 2004). If they lack the capacity for re-infection risk reduction, HIV-infected women face possible treatment failure and resultant increases in viral load that make new transmissions more likely (Kozal et al., 2004; Kozal et al., 2006). HIV-infected women are also more likely to die early, increasing the orphan burden (UNAIDS, 2010). Unless issues of transmission are addressed in light of gender power relations that increase women's risk for re-infection, the gains made through antiretroviral (ARV) scaling up in sub-Saharan Africa will be threatened. The HIV transmission risks as experienced by Eastern Kenyan women living with HIV and their capacity to reduce those risks are the topics of this paper.

Study Design

In 2006, we conducted a qualitative narrative interview study with 40 HIV-infected women in Kenya to investigate the impact and daily challenges of living with HIV from their perspectives. Twenty participants were drawn from urban Nairobi; the other 20 resided rurally in Kenya's Eastern Province. The study's specific aims focused on events leading up to and following diagnosis, access to HIV care and treatment, and personal accounts of HIV risk and risk reduction. From this larger study, we report here about the rural women's HIV risk-related experiences. Results pertaining to the other specific aims can be found elsewhere (Kako, Karani, & Stevens, 2009; Kako, Stevens, & Karani, 2011).

We concentrate on the rural segment of our sample for this paper because in prior research with women in Kenya, marked differences were found regarding HIV risk depending on whether women resided in urban centers or rural areas. In comparison to cities, rural areas in Kenya have been described as having disproportionately higher potential for spread of HIV among women due to greater numbers of lifetime sexual partners among rural women (Voeten, Egesah, & Habbema, 2004), continuation of high-risk sexual behaviors by rural men despite increased awareness of HIV, and pervasive social norms that entitle men to concurrent sexual partners. Findings about sexual behavior and its association with socioeconomic deprivation have also differed depending on whether samples were taken from urban or rural environments in Kenya (Dodoo, Zulu, & Ezeh, 2007). More is also at stake in rural areas in regard to re-infection risk because access is generally relegated to first line ARV treatment in rural clinics (Kenya National Bureau of Statistics [KNBS], 2010). If re-infected with an ARV-resistant strain of HIV, rural women living in resource limited areas such as Kenya would need second or third line treatments, which are usually unavailable (Hamers et al., 2010).

Our study adds to the literature because we describe risk factors shaped by prevailing gender and socio-cultural structures. Utilizing ethnographic methodologies of narrative inquiry informed by post-colonial feminism and gender theory, we hoped to convey the particular risks faced by HIV-infected women from this little-studied region and the actions they take in response to those risks.

Background

Kenya continues to experience a generalized HIV epidemic with an estimated 6.3% of its adult population (ages 15–49 years) infected with HIV (KNBS, 2010). Rural areas bear the greatest burden as 70% of all Kenyans live rurally. Moreover, approximately one million of the 1.4 million people living with HIV in 2008 were located in rural areas. Kenya's gender disparity also characterizes the current epidemic; Kenyan women are twice as likely to be HIV-infected as their male counterparts: 8% and 4.3%, respectively (KNBS, 2010). Most prior risk prevention interventions have focused on primary prevention; few studies have

explored secondary HIV transmission risk among women who are already known to be living with HIV (Kozal et al., 2006).

Many surveys have documented that individuals in Kenya are knowledgeable about HIV; in general, they understand how the virus is transmitted and how transmission can be prevente (Kohler, Behrman, & Watkins, 2007). What is not so fully documented is how HIV-infected women perceive their personal risks, judge the sources and circumstances of those risks, and then make decisions about how they deal with HIV transmission risks in the context of their daily affairs. An appreciation of the complex contingencies that govern HIV-infected women's behaviors is essential for health care policy and programmatic responses to the epidemic. Expanded HIV prevention targeting those who are already infected must be grounded in an analysis of gender dynamics in local contexts (Piot, Bartos, Larson, Zewdie, & Mane, 2008).

Approaching a study of women and HIV in Kenya from a post-colonial feminist outlook means that we set aside a Western individualistic perspective for one that recognizes familial and communal factors influencing Kenyan women's health decisions. By employing post-colonial feminism thought, we are aware that women are not victims but partners in the fight against HIV with insights into their own health needs (Anderson & McCann, 2002). Rural Kenyan women living with HIV have untapped insights about the nature of obstacles preventing them from reducing HIV transmission. We believe applying egalitarian methodologies of narrative inquiry are crucial in eliciting women's voices about HIV transmission risk (Mkandawire-Valhmu, Rice, & Bathum, 2009). In utilizing these methodologies we recognize story telling as a means of sharing knowledge and the role it plays in the eastern Kenyan culture (Mbiti, 1990), and we recognize that women from rural eastern Kenya live in patriarchal societies in which gender power relations permeate their everyday lives. Narrative methods offer a forum for women to share insights about the realities that affect HIV transmission risk. Such insights are even more crucial as HIV shifts from a fatal illness to a chronic illness, lest the gains made by scaled-up ARV treatment be erased by emergent drug-resistant secondary infections that are more difficult and costly to treat.

Methods

Procedures

The first author recruited participants and conducted the interviews. She is a PhD-prepared native of Kenya, familiar with cultural expectations and everyday life in the country, and fluent in the three languages spoken in study areas: English, the official language of Kenya; Swahili, the national language more commonly spoken; and Kamba, an ethnic language of eastern Kenya.

Over a 2-week period in 2006, with assistance from staff at rural health care sites in Eastern Province, she approached individual women who were attending rural HIV clinics to ask if they might be interested in participating in the study. This recruitment strategy was continued until a sample of 20 rural-dwelling participants was obtained. Every woman over the age of 18 who was approached volunteered to be in the study. Informed consent was obtained in each woman's primary language. For their participation, women received a modest non-monetary gift of sugar, wheat flour, and cooking oil. All study procedures were approved by the appropriate U.S. based institutional review board, and by the Government of Kenya Ministry of Education, Science and Technology and the clinical sites where the study took place.

Each tape-recorded interview lasted about 90 minutes and took place on the day of recruitment in a private area of the clinic. The timing and location of data collection were designed around the needs of participants. Many had walked hours from their homes to reach the clinic where they spent much of the day waiting for health examinations, lab work, and medications. Interviews were conducted during these waiting periods so as not to inconvenience women in their efforts to return home. After obtaining standard demographic information, the investigator posed broad, open-ended questions about what each woman's life had been like before and after diagnosis with HIV infection. Question topics included health and illness, access to health care, relationships with family and community and, most important to this analysis, relationships with partners and issues around HIV transmission risk. The investigator assumed a listening stance and avoided interruption of unfolding stories (Morse & Richards, 2002). Afterward, she wrote field notes describing the participant's nonverbal behaviors, setting, level of rapport, and her emotional reactions.

Sample Characteristics

All 20 rural women in this study were between the ages of 26 and 54 (mean age = 37 years). They were all mothers with anywhere from 1 to 10 children; half the participants had more than 3 children. At the time of the study, most were raising their children alone; 75% were widowed ($n = 12$), divorced ($n = 1$), or separated from spouses ($n = 2$). A majority of the women lived in abject poverty: 95% ($n = 19$) had incomes of less than $1 per day. Most had only a primary school education; two had never been to school at all. Limited education deterred them from obtaining formal employment. Most women relied on subsistence farming to feed their families, but limited access to land, poor soil fertility, frequent droughts, and periods of disabling HIV-related illness curtailed their harvests. On occasion they earned a meager wage doing piecework on larger farms or from “food for work” programs. Food insecurity was a continual problem.

In all but one case, the women acquired HIV infection from their husbands. At the time of the interviews, the average length of time since they had been diagnosed was 4 years. Eighty percent ($n = 16$) were symptomatic at the time of diagnosis, but only 25% ($n = 5$) were on ARV treatment.

Data Management and Analysis

To retain their complexity and context, interview data were transcribed verbatim in the languages used by the participants. A topical codebook was developed by reading and rereading the transcripts and field notes. Then, using QRS NVivo 7.0, a qualitative data management software program, topic coding of the transcripts was done keeping participants' stories intact. These analytic efforts accomplished with original language transcripts kept the first author engaged with the women's voices and close to the feelings and values expressed in the words and phrases they used. Even apparently familiar terms and expressions that have direct lexical equivalents can carry cultural and emotional meanings in one language that do not necessarily occur in another (Birbili, 2000). Studies have shown that such meanings can be lost in translation (Pitchforth & Teijlingen, 2005).

Translation to English was done after topic coding was complete, which helped to carry over meanings in descriptive conceptual equivalents. Translation progressed topic-by-topic, rather than transcript-by-transcript. In other words, original-language data coded to a particular topic was translated to English, and this procedure was repeated for each topic. The first author did the initial translations to English. An equally proficient translator then compared the English translations to the original language data and, with the first author, made adjustments as necessary to ensure congruency. These processes for gaining comparability of meaning (Temple, 1997) were facilitated by the first author's cultural

knowledge and her proficiency in the languages used by participants, and by the ongoing analytic dialogue that occurred between the first and second authors.

English translations of the topic coded data pertaining to HIV transmission risk and risk reduction were analyzed using a multi-staged narrative analysis process. At each stage, the first and second authors discussed developing analyses and reached consensus before moving on to the next stage. In stage 1, we identified the risk stories that participants had told. Risk story was operationalized as the relating of events and evaluations surrounding an experience of HIV risk, for instance, what happened when a woman asked her husband to use a condom, or what happened when a woman was propositioned for sex. Recognizing that stories have formal properties and specific functions, in stage 2, we utilized Labov's (1972) narrative structural approach, applying it as described by Stevens (1998).

In stage 3, we did within-case analysis. For each participant, we closely examined each risk story in relation to its story elements: abstract, orientation, complicating action, evaluation, and resolution. Then we looked at all of an individual's risk stories, identifying patterns of risk and risk reduction in her life, which we represented in a narrative summary for each woman.

In stage 4, we did across-case analysis, searching for similarities and differences among participants in the risk stories they told. We compared and contrasted the various narrative summaries and constructed qualitative matrices, plotting story elements across study participants and comparing each participant's HIV risk experiences with every other participant's HIV risk experiences. From these activities we were able to identify and describe common narrative themes. In stage 5, we selected exemplar interview excerpts that best illustrated these themes. Excerpts included in this paper were chosen to represent as many of the individuals in the rural sample as possible.

This narrative approach helped us see how Kenyan women living with HIV imposed order on the flow of their HIV risk experiences to make sense of events and actions in their lives (Reissman, 2008). Using criteria set forth by Hall and Stevens (1991), we made every effort to produce findings that were “well grounded, cogent, justifiable, relevant and meaningful” (p. 20). To this end of scientific adequacy, we discussed developing analytic patterns and interpretations with each other at regular intervals, resolving differences through dialogue. For transparency and auditability, ongoing documentation of methodological and analytic decisions was maintained in a research diary (Huberman & Miles, 1994). Frequent reference to field notes and the original tape recordings further supported the rigor of our methods. The first author also traveled back to Kenya to verify the credibility of our findings. In data-based presentations to Kenyan audiences drawn from HIV clinic patients, HIV clinic practitioners, and researchers, she sought feedback about authenticity and verisimilitude, which we incorporated. In addition, combining within-case and across-case approaches to qualitative data, as we did, has the potential to produce more contextually grounded, transferable findings (Ayres, Kavanaugh, & Knafl, 2003).

Results

From our analysis of these HIV-infected women's narratives about HIV transmission risk, two major themes emerged: gender-based obstacles, even in the context of known HIV diagnosis, and struggles with economic pressures amid HIV risks. In the following sections we present these themes in detail and include substantiating interview excerpts.

Gender-Based Obstacles Even in the Context of Known HIV Diagnosis

Women in this study continually grappled with gender-based obstacles related to HIV transmission risks, even long after their HIV diagnoses were known. The men in their lives resisted condom use, would not abide women's efforts to abstain from sexual relations, regularly misused alcohol, and continued sexual activities outside primary partnerships. Longstanding cultural practices also worked to constrain women.

Condom refusal by male partners—Condom refusal by male partners was the principal gender-based obstacle women faced. Before women were diagnosed with HIV, as well as after they knew and disclosed their HIV status, the men in their lives were unwilling to use condoms: “After I was positive, I was told to use condoms. I have both, for women and men. But, he has refused.” Another woman said:

> As for condoms, I had told him we must use. He said, `I don't use those things.' Aah! I told him that is what we are being taught so that we can live longer. He would tell me he doesn't want to, he wants skin-to-skin. He would refuse. What am I supposed to do?

Women were deeply disheartened by men's refusals:

> The greatest problem in my house is that my husband has refused to believe that he and I are infected. He still wants to have sex with me. The greatest problem now I have is that one. Many days I am crying, and sometimes I pray death to come soon. Because you have somebody in the house, you have told him he must use condoms, and he has refused. And at night he wants sex. You tell me what to do with him. I have thought I should take some pills so that he can come and find me dead, because most of my problems are from him.

Sometimes men agreed to use condoms so that women would agree to have sex, only to remove the condoms during sexual activity, “It is all about the man removing the condom. He doesn't want to keep on using it. It makes me feel low. It makes me feel used.”

Participants contended that men did not seem to fear getting HIV, nor did they seem to worry about passing the virus on to others. Instead, men looked to fate, as one woman pointed out: “Men say, `The one to die will die. The one to live will live.'” Another woman narrated:

> My husband was thinking the way I tell him I am positive is not the truth, and he misused the condom. The way it is supposed to be used, he was not comfortable with it. After 3 months I found out I was pregnant. That child is here. Last month she was tested and was found to have the HIV problem.

As this excerpt suggests, potential consequences of men's resistance to barrier methods could be dire for women, including pregnancies they did not desire and mother-to-infant transmission of HIV.

Misuse of alcohol by men only added to the difficulties women experienced in protecting against transmission risks. When male partners misused alcohol, the women reported that the men in their lives frequently utilized sexual force if asked to use condoms. As one woman stated:

> At times he can come in the house drunk, he finds me asleep, he removes my clothes. I mean, he wants us to have sex without a condom. It is just like raping. Him, he would be raping me at times.

Women also linked men's alcohol misuse with pursuit of multiple sex partners:

> My husband was told by the doctor to leave them alone, drinking and sleeping with women. But him, what! He continued. I would tell him not to. But when he leaves the house, he goes where he wants. He continued like that until he became very ill.

Using the words "he moves," participants described how their spouses frequently had unprotected sexual activities outside the primary partnership. They understood this behavior as bringing increased health risks to the sexual relationship as well as endangering others with HIV infection. Men's migration to the cities seeking employment, and the long periods of separation from their wives reinforced this pattern:

> My husband would go to different women because he was living in Nairobi. I can say before God that I got this illness while I was in my own home. Even sometimes I would go to Nairobi and find he has another woman he is keeping in the house. I warn him, "You know that we will both die." I asked him several times. "Do these friends of yours know how you are?" He said, "No. They will just die."

Even in the midst of these risk factors, women expressed their interest in wanting to comply with HIV transmission reduction instructions given by their health care providers. As one woman explained: "I was given a rule by the doctor [health care provider]. He told me when someone has that illness [HIV] she is not supposed to be with other people sexually. You are supposed to stay [abstain] or you use a condom."

Their experiences led the women to conclude that men were not willing to be told what to do by women. Their stories portrayed men who wanted to continue experiencing a sexual life as they always had, with unprotected sexual pleasure a prominent feature, no matter the HIV diagnosis of their female partners.

Longstanding traditional cultural practices—Traditional cultural practices posed further gender-based risks for HIV-infected women. Participants spoke of polygamy, *kũtũania* (Akamba term for widow keeping), and *Ĩweto* (Akamba term for a woman who marries another woman with the intention of this wife giving birth to a male child for inheritance of family property). It was difficult for individual women to say no to longstanding traditions because the cultural fabric of the community was woven through their daily lives. The acceptability of polygamy allowed men to take more than one wife, jeopardizing uninfected women who might be taken as co-wives by HIV-infected men. First wives, too, had reason to worry when their HIV-infected husbands sought co-wives.

Likewise, according to *kũtũania*, when a woman is widowed, she is expected to be taken as a co-wife by a brother of her deceased husband. The dilemma imposed by this tradition is captured in one participant's story. From the time she had been diagnosed with HIV, she was counseled by health care providers to "Be free from tradition so your people do not force you into the things you know are going to harm you." Recognizing that she could pass the virus to her husband's family if her husband's brother was uninfected, and that she could be re-infected if her husband's brother was infected with HIV, she took steps to thwart tradition:

> When my husband died, I was left with his younger brother. That younger brother, I told him my HIV status so that we could have friendship, so that in the society I am not forced into the traditions. You see, among Akamba people we have the practice of *kũtũania*.

Her efforts were successful. With her HIV status well-known among the relatives of her husband, she was then free to accept potential help without worrying about sexual debt.

Being Ĩ*weto* was another way women were placed at risk in rural eastern Kenya. Traditionally, a woman who has been unable to bear sons "marries" another woman, an Ĩ*weto*, who then is expected to have sexual relations with men other than the husband so that she can bear male children to inherit the husband's property on the wife's behalf. One woman in the study was an Ĩ*weto*:

> Me, I was married by that woman. She has no male child, and she had trouble getting pregnant. She felt she is going to be left here with no one to protect her land. Her husband has another wife, and she wanted to make sure that her land is not taken by somebody else [i.e., the co-wife's male children]. Yes, so that my sons would be left farming there. That illness [HIV], I contracted it from those men I had sexual relations with.

Struggles with Economic Pressures Amid HIV Risks

Despite what might seem like insurmountable HIV transmission risks, women in rural eastern Kenya attempted risk reduction with a delicate balance of assertiveness and acquiescence, balancing economic pressures as best they could. Sexual abstinence was not in the realm of personal choice for participants who were married at the time of the study. According to convention and religious belief, refusing to have sex with one's husband was not acceptable. So, as long as they were married, and their husbands were still living, the women felt there was little recourse but to have unprotected sex should that be their husbands' bidding. It was a woman's responsibility to maintain harmony in the marriage, so while participants might have valiantly encouraged their husbands to use condoms, if their husbands refused, women generally acquiesced.

Married women living with HIV had noble reasons for engaging in unprotected sex with their husbands: it is right for a woman to obey her husband, the children need their father, the family cannot survive without the husband's income. One participant rationalized the danger to her health as only transient. Her husband's insistence on unprotected sex during his brief intervals at home was tolerable because he would leave again for the city and the work he found there. She felt she could cope with a few days of re-infection risk because there would be 2 to 3 months between his visits when she could recuperate, "When he goes in me [sexual intercourse], I just think, you are about to leave. You will go in me today, and tomorrow you leave. I just know by the time you come back I have rested." She chose to maintain peace with her husband, knowing that if she were to refuse to have unprotected sex with him, he might rape her, ostracize her from the home, or abandon her altogether and stop providing economic support to the family.

Women attempted to convince husbands to use condoms. But insisting on condom use within primary partnerships took a great deal of courage because it strained relationships and posed risks for violence and abandonment. When a husband abandoned his wife in rural Kenya, he typically also abandoned his children. Women were forced to weigh the multifaceted consequences for their children's education, nutrition, and health before insisting on condom use. As exemplified by the following excerpt, insisting on use of condoms could result in abandonment:

> He told me he cannot use condoms. I told him I can get the condoms for him for free from the clinic. He told me, "Even when I was a young man I never used those things, and I can never use them!" He wanted skin-to-skin, he did not want to "eat a candy with its wrapper." I told him you can look for where you will find skin-to-skin, but not with me. He told me because I refused to have sex with him without a condom he will never support me. And, then he left for the city.

For those in the study who were widowed, divorced, or abandoned, there was the potential to "stay," which was the term women in the study used to mean refraining from sexual relations. The women's desire to stay healthy by avoiding re-infection encouraged them toward abstinence: "I was in the hospital. In that way, I found out that those viruses increase more if you have a sexual partner. I stopped completely. Since then, I have gone for almost 5 months without getting sick." Another woman said:

> When I found out I was positive, I decided as for me I can stay [abstain]. I can live for more years than other people. Aah! So I said I can avoid those things of going here and there in sexual relations. That is what can make someone to die soon. But if you stop that, you can live.

The choice to abstain was not so readily available to others. When women found themselves alone in widowhood, divorce, or abandonment, they faced challenges to survival that could persuade them to engage in sexual encounters they would not otherwise have chosen. The economically impoverished conditions of their daily lives forced them at times to rationalize transactional sex. As one participant said, "The trouble of a mother is her children."

Typically, in rural areas, when a lone woman in the village finds herself with no food for her children or is unable by herself to accomplish a task like planting her field, she calls on neighbors for help. But, according to the women in our study, their need for assistance was often met with expectations of sexual payment. Women who were widowed or abandoned, or whose husbands were away working in the city faced persistent demands for sexual favors by local men:

> Some men come and tell me, "Because your husband died, why don't you let me come and be with you? I will be helping you." I tell them no, because I have grown children. It would be shameful for the children to see someone come in the evening and leave in the morning. I just told them no.

Participants insisted that they wanted to refuse the sexual advances, but it was difficult when they were faced with daily survival needs: "Women need other ways for financial support, because usually men come at night knocking on their doors. You know, if someone knocks on your door and you know you are having nothing, no food, you will open the door."

When sexual favors were not granted, men refused to help the women. This predicament of being pressured for transactional sex to stave off hunger and malnutrition brought with it terrible responsibility for HIV-infected women. The men who came to them were often married men with families of their own. In their desperation, women knew they had to provide for their children, yet they did not want to be part of the cycle of HIV transmission in their communities:

> If you agree for the men to come to your house, you mess up for yourself and your family members because today he would come to you, tomorrow to your sister, and the next day he will go to your daughter, the one you are supposed to protect! You see.

By refusing transactional sex and the meager economic subsistence it could bring, impoverished women raising children alone suffered:

> My children, I would tell them, "Your father left you a long time ago, but I am still pushing for you." I usually say if someone wants to help me, he can help me, but there are no sexual relations. My friendship will not be found there. I tell them if you push me there, my health is going to mess up, and I don't want that. But, what comes to your mind is that there is no food in your house and having sexual relations will help you. So, then you think I cannot stay without having sex.

Discussion

In this study we explored the experiences of rural women in eastern Kenya who were living with HIV, whereas prior HIV research has tended to focus on urban Nairobi or western Kenya. A sense of responsibility motivated participants' risk reduction efforts. These Kenyan women living with HIV stressed their responsibilities to their children. They wanted desperately to protect their own health so they could live to raise their children. They also wanted to protect the health of their partners and the health of others in the community who might be exposed to HIV. They recognized the amplified transmission risk inherent in sexual networks of concurrent partnerships and felt responsible. But, for the most part, they were unable to substantially influence the sexual behaviors of male partners. A sense of responsibility was also emphasized in a Ugandan study of both HIV-infected men and women, and identified as a hopeful motivator of behavior change (King et al., 2009).

Gender based obstacles, even in the context of known HIV diagnosis, and profound economic pressures acted to thwart concerted efforts to reduce HIV transmission risk made by women living with HIV in rural eastern Kenya. Participants faced formidable HIV transmission risks as a consequence of behaviors by men, including men's refusals to use condoms, misuse of alcohol, and concurrent sexual liaisons. If a woman objected to her husband engaging in these behaviors, she might be violated or abandoned. If she resisted men in her village asking for sex, she might be deprived of assistance typically accorded a neighbor. Situated as they were in the contexts of extreme poverty, with children to feed, educate, and keep healthy, women in this study resisted HIV transmission risks when they could, and acquiesced when they had to for survival needs. Other researchers in the African context have also linked economic hardship and food insecurity experienced by HIV-infected women to the occurrence of coerced unprotected sex within marriage and transactional sex outside marriage (Kathewera-Banda et al., 2005).

Abstinence, being faithful, and using condoms, the ABCs of HIV prevention strategy (UNAIDS/WHO, 2004, 2008)), were apparent in the women's accounts; they had the knowledge and desire to change their behaviors. According to the women's accounts, however, the men in their lives seemed little influenced by health teaching, unbending in their domineering gender roles, and unchallenged by authority as they continued in behaviors that exposed others to HIV infection. High rates of condom refusal among men are not unique to eastern Kenya, having been reported in studies across sub-Saharan Africa (Badenhorst, Staden, & Coetsee, 2008). The women reported that their husbands continued to have multiple sex partners even after they became aware of their own and their wives' HIV diagnoses. This finding differed from that of another Kenyan study suggesting that marriage may be protective because of an association with higher sexual exclusivity (Hattori & Dodoo, 2007), but echoed conclusions from other African research that, for men, marital status made little or no difference in the number of extramarital partners (Glynn et al., 2003).

Pressures from prevailing traditional cultural practices of polygamy, *kũtũ**ania*, and *Ĩweto* were also described by the women as posing HIV transmission risk. Elaborating the potential link between *Ĩweto* and HIV transmission adds to knowledge about the more fully studied cultural mores of polygamy and wife inheritance. Historically, among the Akamba people in eastern Kenya, all of these practices functioned to maintain family stability (Cardigan, 1998; Mbiti, 1990). Their contemporary practice in the era of the HIV epidemic, however, placed women in serious jeopardy (Ambasa-Shisanya, 2007).

While the findings of this study are not new, they inform the literature in relation to gender-based struggles and sociocultural structures that women continue to contend with even after

being diagnosed with HIV. Although the narratives of these 20 women were consistent in identifying patterns of HIV transmission risk and risk reduction efforts, they cannot be taken to represent the experiences of all Kenyan women living with HIV. Given their rich, nuanced detail and the specificity with which they illuminated the specific nature of gender relations, however, findings from this qualitative study may be transferable to other women in similar circumstances (Lincoln & Guba, 1985).

Recommendations

Based on the potential transferability of these findings, and to the extent that they may point to underlying structural drivers of the epidemic, we offer three recommendations. First, community-based participatory programs are necessary to help Kenyan women become economically self-sufficient (Weinhardt et al., 2009). Economic empowerment of women is absolutely necessary to give them adequate negotiating rights within intimate relationships and to curtail sex exchanged for survival resources. According to several critics, a lack of understanding about how economic conditions for women are inextricably connected to HIV risk has been a major shortcoming in empirically driven HIV prevention programs in Africa to date (Kalipeni, Oppong, & Zerai, 2007). Our findings support a growing consensus about the urgent need for complex, multi-level interventions to prevent HIV in which structural factors such as poverty, food insecurity, and widespread gender-based social inequities are simultaneously tackled (Gupta, Parkhurst, Ogden, Aggleton, & Mahal, 2008; Weinhardt et al., 2009).

Second, across sectors of society every attempt should be made to include men in HIV risk reduction interventions. While efforts to empower women are essential, our findings suggest that additional interventions aimed at reducing HIV transmission risk for women must take into account actions by men. Arresting the spread of HIV cannot be accomplished without them. By this statement we recognize that in the African context, it is difficult to improve the status of women without involving men, because men and women are socially and culturally interdependent (Connell, 2002).

Kenyan policymakers and civic organizations might be most effective if they worked together to shift gender imbalances. For instance, policies that mandate HIV testing for women (with antenatal care) but afford no parallel process to assure that men are tested for HIV and engage men to discover their perspectives on responsible sexual health would be beneficial (Kalichman et al., 2009), as would studies of boys to the same purpose, because there is evidence that sexual coercion among youth is prevalent (Njue, Voeten, & Remes, 2009). In-depth qualitative studies of Kenyan men may help understand the psychological, social, cultural, and economic factors that hinder and help them to reduce HIV transmission risks. Focus group discussions among men about how the HIV epidemic has affected their lives and what motivates their behaviors may provide further impetus for change (Mkandawire-Valhmu & Stevens, 2010). This might mean further calling attention to gendered inequalities as part of the efforts to lessen the burden of HIV on women. HIV prevention and care might then be designed for couples rather than sex-segregated services, so long as the rights and autonomy of women can be protected.

Third, engaging grassroots efforts within rural communities will be necessary to reveal the potential for HIV transmission in traditional cultural practices such as polygamy, *kũtũania,* and Ĩ*weto.* With the encouragement of health care workers in collaboration with community leaders and other stakeholders, alternatives for sustaining families might be found. Collectively, villages might also explore how prevailing attitudes toward women and girls put the entire community at risk for HIV.

Conclusion

In this era of global ARV scale up, taking HIV treatment might not be enough to save the lives of women given their gendered roles in intimate sexual relationships. Study after study has substantiated that women in sub-Saharan Africa are at disproportionate risk for HIV infection because of social and economic subordination (Kalipeni et al., 2007; MacLachlan et al., 2009; Sa & Larsen, 2008). Yet, 30 years into this devastating pandemic, women still tell us in vivid detail about the stark reality that they do not have the prerogative to determine when, how, and with whom they have sex. Their stories must propel bold and swift action, not only in research and professional practice, but also as citizens of the world advocating for social justice and transformational change to environments that constrain individuals in reducing vulnerabilities to HIV infection.

Acknowledgments

This research was supported in part by the National Institutes of Health under a Ruth L. Kirschstein National Research Service Award #*F31NR 009628* from the National Institute of Nursing Research, and by an award from the Midwest Nursing Research Society. The authors thank Beatrice Mutemi for her help in recruiting rural participants for this study and the women who freely shared their stories.

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Clinical Considerations

Clinicians should

- Encourage economic empowerment strategies for women to provide them with power, choice, and negotiating abilities within their intimate relationships.
- Seek to integrate men into HIV risk reduction activities starting early in adolescence, incorporating HIV risk reduction strategies in every health care encounter with men and adolescent boys.
- Motivate women and men to engage with each other in grassroots efforts within rural communities to advocate for HIV transmission risk reduction.
- Integrate region-specific traditional cultural practices into routine screening for HIV transmission risks, and elicit women's perspectives about reducing HIV transmission risk associated with these traditional practices.