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Intimate Partner Violence, Human Rights Violations, and HIV among Women in Nairobi, Kenya

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Abstract

This study presents qualitative results from a mixed-method investigation conducted between May and August 2012 into the prevalence and consequences of four forms of intimate partner violence among women living with HIV who attended the Comprehensive Care Clinic at the Kenyatta National Hospital in Nairobi. As a part of the research, a quantitative survey found that among 600 sexually active women living with HIV aged 18–69, all reported experiencing emotional abuse; 20%, 17%, and 15% experienced controlling behavior, physical violence, and sexual violence, respectively. Qualitative research using focus group discussions with 19 women from the quantitative survey sought to contextualize these experiences and place them within a larger social structure where institutionalized gender inequality sets the tone for intimate partner violence against women in households. Participants reported that intimate partner violence led to their exposure to the virus and made them leery of disclosing their positive status or seeking support from a male partner for fear of a violent reaction. This fear and the socio-structural conditions in Kenya limit their ability to actively pursue comprehensive care, the stress of which can exacerbate symptoms and make managing the disease more difficult.

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Introduction

"The life I have led has been a life of struggle." This statement, made by a participant in the study described below, captures the daily reality and lived experience of a woman living with HIV in Nairobi, Kenya. The set of conditions that defined her life prior to acquiring the disease has only been compounded by the difficulty of managing life with HIV, including maintaining her antiretroviral treatment and protecting her body from opportunistic infections, all while looking after her children and trying to ensure that their basic needs are met. This struggle, experienced by many in her situation, is multilayered and multifaceted. Poverty, stigma, structural violence, human rights violations, gender inequality, and interpersonal abuse all coalesce to put women at heightened risk of acquiring the virus and also serve to exacerbate symptoms and limit access to adequate health care once infected. This study presents the findings of the qualitative portion of an investigation into the prevalence and consequences of intimate partner violence among HIV-positive women attending the Comprehensive Care Clinic at the Kenyatta National Hospital in Nairobi.

The World Health Organization (WHO) identifies four forms of intimate partner violence, including physical, sexual, and emotional violence, and controlling behavior.[1] While several studies have considered the increased vulnerability to HIV exposure among women who experience intimate partner violence, few studies to date have evaluated all four forms of intimate partner violence among women living with HIV, with controlling behavior being the most often neglected category of intimate partner violence.[2] This mixed-method study considers the link between particular sociodemographic factors and the likelihood of experiencing a specific form or forms of intimate partner violence among women living with HIV in Kenya, home to the third-largest HIV epidemic in the world.[3] The quantitative portion of this study surveyed a cross-sectional sample of 600 sexually active women living with HIV aged 18–69 on sociodemographic characteristics, health care decisions, and experiences of intimate partner violence with a current partner within the previous six months. All participants reported experiencing emotional abuse from their partners. In addition, 20% of the sample reported experiencing controlling behavior, 17% reported physical violence, and 15% reported sexual violence. Women with lower socioeconomic status were more likely to report experiencing controlling behavior. Unemployed women were more likely to suffer physical violence, and non-Christian women experienced higher rates of physical and sexual violence.[4] The qualitative aspect of the study sought to contextualize the statistical analysis by letting women speak about their experiences of violence and abuse, as well as to contextualize these experiences within the larger social structure—one that keeps women financially dependent on men and constrains their personal agency. These factors are both cause and consequence of violence, and they inform the lived experience of HIV for women in these situations. Ultimately, this portion of the study is an effort to call attention to the lived experiences of women and increase our understanding of the specific ways in which women in Nairobi experience intimate partner violence and what meaningful impact this has on their lives and livelihoods. Like the woman in the opening quote, all of the women interviewed in this study struggle to live in a complex web of social, psychological, and physical suffering that accompanies a life of insecurity, oppression, violence, and HIV.

Background

HIV in Kenya

Globally, an estimated 38 million individuals are living with HIV.[5] Seventy percent of these individuals live in sub-Saharan Africa.[6] In 2019, 1.7 million new cases were reported, with young women and adolescent girls accounting for one in four new infections.[7] In fact, young women aged 15–24 are twice as likely to be living with HIV as men in the same age bracket. In Kenya in 2019, 1.5 million people were living with HIV—nearly 5% of people aged 15–49—and there were 42,000 new HIV infections and 21,000 AIDS-related deaths.[8] According to the UNAIDS *2020 Global AIDS Update*, Kenya is one of 25 countries that has reduced its incidence-prev-

alence ratio to under 3%, indicating that Kenya is making progress toward "ending the epidemic."[9] Legal victories, an increase in comprehensive care and supportive services for women living with HIV, and new rights-based and community engagement approaches have been successful in this effort. The report also shows that Kenya achieved the 90-90-90 target for 2020 in two areas—90% of people living with HIV know their status (the first "90"), and 90% of those receiving treatment have suppressed viral loads (the third "90"). However, Kenya has yet to reach the 90% milestone with regard to those who know their status and are receiving treatment. Reasons for this shortcoming are likely to include the barriers posed by gender inequity generally and intimate partner violence specifically, as many women are dependent on male partners for accessing care but are also fearful of the repercussions they face when seeking this type of support, especially if their partners are not receiving treatment themselves.

The HIV and human rights nexus: Intimate partner violence

Human rights have shaped the discourse and response to the HIV epidemic. As early as the late 1980s, WHO began framing HIV and AIDS as issues of ethics and human rights, stressing that structural violence, human rights violations, and other social determinants account for the spread of the disease, thereby contradicting the predominant view at the time that individual behavior is to be blamed.[10] The link between human rights abuses and the spread of HIV is now generally accepted in both practice and literature.[11] As Paul Farmer notes, "violence, poverty, and inequality are the fault lines along which HIV spreads."[12] Structural and interpersonal violence, human rights violations, stigma, and discrimination are interwoven and integral to understanding and combatting HIV, especially among women and other underrepresented groups. Hierarchical power structures such as socioeconomic class systems and cultural ideals of male dominance engender inequalities, and for those occupying the lower rungs of these systems, these structures impede personal agency, limit choice and movement, and hinder the realization of civil, political, economic, social, and cultural rights. Violations of the right to association and equal access to information, for example, can lead to lack of education about the disease, the inability to engage in preventative measures, and less access to medical care and participation in support groups in the event of infection. Stigma attached to presumed or known HIV status can increase isolation and lead to discrimination and disparities in employment, housing, and health care.[13] This is compounded for marginalized groups, including women. Women's ability to access information about and treatment for HIV and their willingness to disclose an infection is significantly influenced by structural violence and discrimination, including the "fear of negative reactions, abandonment, and abuse."[14]

As a form of gender-based violence, violence inflicted by an intimate partner is one of the primary drivers of the HIV epidemic, and women in situations of poverty are at particularly high risk of suffering some form of intimate partner violence and, consequently, for contracting HIV.[15] In delimiting four forms of intimate partner violence, WHO defines physical violence as beating, kicking, biting, and slapping; emotional violence as insulting or belittling comments or actions, constant humiliation, intimidation, threats of harm, or threats to take away children; and sexual violence as forced sexual intercourse and other sex acts.[16] Controlling behavior includes isolating a person from family and friends, monitoring their movements, and restricting their access to financial resources, employment, education, or medical care. The latter is the least studied among the four distinct forms of intimate partner violence.[17]

Evidence indicates that women at highest risk for HIV are those (1) in a heterosexual marriage or long-term union in a society where men commonly engage in sex outside the union and (2) in cultures in which gender-based violence, including intimate partner violence, is widespread and culturally accepted.[18] Victims of intimate partner violence are overwhelmingly women, and women in situations of poverty are at increased risk of experiencing this form of violence.[19] Other social and cultural factors

associated with increased risk of intimate partner violence are institutionalized gender inequality, weak legal and community sanctions against intimate partner violence within marriage, acceptance of violence as a way to resolve conflict, and male dominance within the family.

Several studies have identified a strong correlation between intimate partner violence and HIV infection.[20] In sub-Saharan Africa, for example, women who experience violence are one and a half times more likely to become infected with HIV.[21] Power or the ability to influence behavior within the family was traditionally conferred according to age or kin group status. After colonization, however, gender relations were reconfigured, and power shifted considerably to men.[22] This left women more reliant on men to meet their basic needs; as a result, they have less agency in making decisions about their lives and their health, and they have little recourse to prevent abuse. Without treatment, opportunistic infections and other threats to health are more likely. This interferes with the ability to work, to care for their children, and to meet the basic needs of the household, the responsibilities of which often fall to women. Further, intimate partner violence associated with disclosure of status is communally sanctioned and rarely punished, leading women to be blamed for bringing the disease home.[23]

In Kenya, nearly half of all women have experienced some form of violence in their lives.[24] It is estimated that 33% of Kenyan girls have been raped by the time they are 18 years old.[25] Twenty-two percent of girls aged 15–19 describe their first experience with sexual intercourse as unwanted or forced.[26] For women, marriage is one of the largest risk factors for contracting the disease. Emily Mendenhall and colleagues found that 84% of HIV-positive women in Nairobi reported experiencing interpersonal abuse, primarily in the form of physical and emotional abuse from partners.[27] Traditionally, state-led initiatives and prevention efforts in Kenya warn men of the dangers of having sex with sex workers, which perpetuates the idea that all women who have HIV have high levels of sexual activity and that women are to blame for the epidemic.[28] This exacerbates the stigma related to HIV and AIDS and often causes women to delay disclosing their status and seeking treatment.

Health as a human right in context of HIV and AIDS

The right to health is one of the most fundamental human rights and indispensable for a life with human dignity. It is anchored in a number of human rights documents, including the Universal Declaration of Human Rights (article 25), the International Covenant on Economic, Social and Cultural Rights (article 12), and numerous regional and specialized documents. With regard to women, the Convention on the Elimination of All Forms of Discrimination against Women states in its article 11(1)(f) that women have the right to the protection of their health, including reproductive health. Additionally, article 12 calls on state parties to eliminate discrimination in health care. In the context of HIV and AIDS, the need for a tangible implementation of right to health has led to a number of human rights-based documents, including the *International Guidelines on HIV/AIDS and Human Rights*, special reports, and meetings. In addition, a number of legal battles over access to antiretroviral medicines has significantly advanced the right to health and serves as an example of how economic, social, and cultural rights can be implemented through domestic judicial systems.[29] Recent developments in Kenya have strengthened legal protections for women facing violence and HIV. For example, a 2006 law that criminalized acts that exposed other persons to HIV and required individuals who tested positive for HIV to disclose their status to "any sexual contact" or face jail time for up to seven years was ruled unconstitutional by the Kenyan High Court for reasons of gender-based discrimination, among others.[30] The petitioners moved that the law targeted women because women who become pregnant are often tested for HIV, which often means they are the first in the household to know they have HIV and therefore required by law to inform their partners, which may lead to blame, violence, and other consequences of disclosure. While the law seemed like an effective way of preventing the

spread of HIV, the court recognized that the lack of clarity around what "sexual contact" means (does it apply to children during pregnancy, delivery, and breastfeeding?) and the burden it placed on women was unconstitutional. Nevertheless, women continue to face myriad social, cultural, and institutional barriers in accessing judicial institutions and encounter legal ambiguity in many situations, including relating to HIV.[31]

Additionally, organizations such as WOFAK (Women Fighting AIDS in Kenya) and other human rights-based initiatives in Kenya have focused on implementing WHO's *Consolidated Guideline on the Sexual and Reproductive Health and Rights of Women Living with HIV* through engaging all stakeholders in a comprehensive effort to end the epidemic by reducing the vertical (structural) and horizontal (interpersonal) fault lines along which the disease spreads.[32] These organizations recognize that the protection of human rights and women's rights is essential "to safeguard human dignity in the context of HIV and ensure an effective, rights-based response" and have been instrumental in providing support services and engineering policy changes to this end.[33]

Unfortunately, values, norms, and practices related to gender roles still lead to gendered biases in the public health system, the justice system, and social protection programs. Situated and perpetuated within the larger context of gender inequality and gender-based violence, intimate partner violence acts as both a risk factor and a barrier to care for women. A human rights approach is necessary to dismantle these systems of oppression and combat the spread of HIV in Kenya and beyond. An important aspect of the human rights approach is the recognition of the prevalence of all forms of intimate partner violence and the way these shape the transmission and the lived experience of HIV for women in Kenya.

Methods

The qualitative portion of this study was designed to capture the perspectives of women living with HIV in Nairobi and get a sense of how women talk about and manage the dual epidemics of intimate partner violence and HIV in their everyday lives. Data collection took place from May to August 2012. Two separate focus group interviews were conducted with 19 HIV-positive women between the ages of 18 and 69 who were receiving medical care at the Comprehensive Care Clinic at the Kenyatta National Hospital in Nairobi. All of the women interviewed had been sexually active in the previous six months with a man they considered an intimate partner. The interviews lasted about two hours and were facilitated by a trained moderator and assisted by two note takers. Women who were not HIV positive, who were out of the 18–69 age range, who were not sexually active, who had multiple sexual partners, or who were engaging in commercial sex work were excluded from the study. Recruitment of volunteer participants for the focus groups was done in collaboration with the nongovernmental organization Working Mothers with HIV and AIDS in Kenya. Ethical guidelines for participatory research developed by the International Community of Women Living with HIV and AIDS were followed, as were WHO's recommendations for conducting research on violence against women.[34] Each participant signed an informed consent form and an audiotape release. The two sessions were audio recorded and transcribed for the purpose of analysis. The interviews were designed to assess issues related to experiences of violence at the hands of an intimate partner, including how it affects well-being generally and as it relates to HIV specifically. Participants were asked how they acquired HIV, when and how they were diagnosed, whether they knew their partner's status, and whether they had disclosed their status to their partner. Women were also asked if they had experienced violence or abuse from their partners in the past six months. If they answered affirmatively, they were asked to describe the type and frequency of the violence and how it has affected their adherence to HIV treatment, including taking the prescribed medication and attending support groups at the Comprehensive Care Clinic. Finally, participants were asked about what kinds of support they have received and from whom, as well as what would help them in terms of resources, services, information,

educational programs, or other forms of support in dealing with partner abuse and HIV management. The questions and probes elicited conversations about thoughts and experiences around gender stereotypes, inequalities, and violence, as well as what coping strategies women use and how they manage these problems in their daily lives. The following section reviews the results of the qualitative analysis, focusing on the predominant themes and overarching issues that condition the lives of women living with HIV in Nairobi and compound the difficulty of managing life with the condition.

Findings

Diagnosis and disclosure

> *I started seeing discharge and [foul] smell so I kept on wondering what is all this because I have never experienced such a thing so when I went to be treated [for] the UTI … and that's when they asked me if I would like to do an HIV test so I said yes … You know I was so naïve I didn't expect I could have this HIV because I thought it was for the people who walk around so I never thought it could get me, so when I did the HIV test in August in 1996 it was found positive so when I confronted this man he left me, he refused me and it finished just like that.*

None of the participants were able to say for sure when or how they acquired the virus, only when and under what conditions they were diagnosed. Four women were diagnosed during pregnancy, four were diagnosed after their partners tested positive, and one was diagnosed after her ex-partner fell ill. Six of the women had been tested more than once, meaning that at some point they had tested negative. Five of the women went to the hospital on their own accord specifically to be tested, while six were at the hospital for some other reason and were asked if they wanted to be tested. Three women got tested after they suspected their partners of cheating. Three women said that they spent a significant period of time in denial but agreed to begin treatment once they started falling ill with opportunistic infections. With the exception of one woman who was diagnosed after her partner left her, all of the women interviewed had disclosed their status to their partners. Several women mentioned that their partners reacted in a negative way, and two women reported that their partners reacted with physical violence upon learning of the women's positive status. While all of the women in the focus groups had disclosed their status to their partners, not all of the women knew their partner's status. Among those who did know their partners to be HIV positive, one woman said she discovered this by accident when she found antiretroviral medicine in her partner's coat pocket. Two of the women said that their partners refused to get tested.

Intimate partner violence and management of treatment

> *I remember when we got tested and we went home I asked him how he got this thing, and then I remember after I noticed that this man knew all along even before we got married he knew that he was infected but he never told me and he never went for the testing before. So when I asked him he started beating me. He used to beat me every night and as if that's not enough he used to force himself on me whether I like it or not. When he wants sex he will have it even if it's at midnight he will have it. So it went on like that for two years until he settled but the only thing is that he doesn't like using protection. So whenever you talk about protection he will refuse that time you want it and then when you are sleeping that's when you will hear someone on top of you that he wants sex.*

This quote sums up several overarching themes related to intimate partner violence and abuse among the women interviewed in this study. When asked what comes to mind when they hear the term gender violence, several of the women mentioned forced, unprotected sex. Refusal to use a condom was frequently mentioned as a form of abuse in both focus groups, with one respondent stating, "When he comes to me he wants sex without a condom so I feel abused." One woman explained that when women do ask men to use condoms, they are often beaten or verbally abused because men often interpret that as the woman not wanting to bear his children. Another explained that women always prefer that their men use a condom during sex; however, there are consequences to suggesting

this, and sometimes women find that it is not worth the abuse to make such a demand. The next most common response was emotional or psychological abuse, followed by physical violence and the denial of rights. Two women mentioned verbal abuse, with one woman describing her partner as "using negative words towards me." Emotional abuse was described as the partner being negligent, inattentive, or uninterested, as well as engaging in affairs with other women. One woman said that her partner tells her she is just pretending to be sick. Another woman said that her husband complains that the medication is "making her sexual performance low," and he gives her a hard time for this. Three women mentioned frequent physical abuse, with one woman describing several beatings a day.

Some women reported their partners' refusal to get tested as a form of abuse. Other women said that their partners were in denial about their own status, which made sticking to a treatment regimen more difficult for them. Sometimes women were beaten if they were caught taking their antiretroviral medicine or attending support groups at the clinic. Several women dealt with this by taking their medication secretly. "When my husband is in I can't take them even if the time for taking medicine arrives, I just skip that day because he doesn't want to see the medicine. When he is around I hide them in my neighbor's house," one participant explained. This type of controlling behavior led women to skip medication altogether or take it only when their partners were not around. One woman said that her partner threw her medicine away because the shaking of the pills was annoying him. Several women mentioned that they do not get financial support from their partners, which makes day-to-day living difficult, in turn making it even harder to maintain a treatment regimen.

Stigma

> *My neighbors don't talk when I'm around because they fear me.*

The women interviewed for this study describe how stigmatization leads to social isolation from family members, neighbors, and the larger community. One woman reported enduring abuse from her brother, describing an instance where he broke a teacup in front of her after she drank from it while berating her for putting his children at risk of contracting the disease by being in his home and using his utensils. Another woman described a similar situation: "[The family] discriminated me until when I eat with a plate they didn't clean it because it has the virus [and no one was willing to touch it] and nobody will eat with what utensils I used [even after they had been cleaned]." One woman said that her parents were originally supportive of her and tried to help her manage her condition, but eventually her "father changed and he chased [her] out," and this has been very painful for her. Another woman said that when her brothers get drunk they shout at her that she is dying, which typically leads to a violent confrontation. Another woman described the same kind of verbal abuse from her sister-in-law, who blames her for bringing home the disease, and another woman reported that her siblings refer to her as a "walking corpse." While the Christian church is sometimes identified as a source of refuge and assistance, a few women interviewed for this study reported that the church harbors discrimination against women living with HIV. One woman reported that she was fired from her job as church secretary when the pastor found out about her status. Another woman said she confided in her pastor that she was positive, and he told everyone in the congregation, after which she was forced to leave the church. Women also described being discriminated against in the workplace, where they are relegated to the least desirable jobs or they are fired outright. This is a vertical violence, coming from managers, but a horizontal violence as well, coming from friends and co-workers. One woman described a situation in which she offered a painkiller to a co-worker who was complaining of a headache, but the co-worker would not accept it because there was no way to be sure it was not antiretroviral medication. One of the women explained that people who have a positive diagnosis often try to keep it a secret. However, the problem is that the women see one another at the clinic or at support groups and they reveal one another's

status to others: "So this stigma we bring it to ourselves, if you know somebody is positive out of their own mouth you need to keep it secret, but if you go and tell somebody who is negative they are going to spread it out in a very negative manner." Responding to this, another woman said, "You see this is what is causing infections to spread because of stigma and discrimination."

Blame

> *I feel that when a woman is infected and other family members know that she is infected they do not blame the husband; they always blame the woman … So for me, I have faced all that and I am carrying the burden alone.*

"We are blamed a lot," lamented one woman on the topic of gender violence, suggesting that women are blamed for contracting the disease and spreading it to their partners. Among the women interviewed, there was an initial assumption that only women with high levels of sexual activity contract HIV. This widespread gendered bias, they explain, leads to discrimination in nearly all domains of life, including within the family. Reinforcing this sentiment, one woman stated, "It's easier for the society to stand and say that it's the woman who wandered around. So you face lots of discrimination because it's easier to discriminate against the woman."

Clinical care and support

> *I have noted something—that the woman's immunity is affected more, so the woman gets sick more often than the man.*

The women interviewed in this study were all taking antiretroviral medication, and most of them believe that it is helping them feel better and reducing their risk of contracting opportunistic infections. One woman commented that there are negative side effects; another said the medication was making her fat. Good nutrition is considered an important component of self-management, but the ability to eat healthy is limited by financial constraints. Participants reported that the support groups at the Kenyatta National Hospital are helpful in terms of educating them on how to manage the disease, meeting new friends who are suffering in similar ways, and providing a source of encouragement, strength, and refuge. Attending support groups at the clinic is also something women identify as an important aspect of treatment, but getting to and from the clinic can be difficult for many women. Those whose husbands are supportive are much more likely to maintain a treatment regimen than those who receive little or no support from their partners. For the women participating in this study, financial support from partners is the most desired form of support, and emotional support from partners and friends is also very important. Five women reported that their partners were supportive, reminding them to take their medicine and sometimes offering to take them to the clinic. Most of the women, however, did not receive much support or assistance from their partners. "My husband does not support me in anything, he is just waiting for me to die," one woman lamented. Another said she does not get support from her husband because "the word HIV is hard to him" and he refuses to talk about it. Another woman said she does not tell her partner when she is going to the clinic in order to avoid getting into a scuffle. One partner refuses to pay for the medication because he insists that the woman is faking the disease. Another partner insists that the woman take only herbal medications, so she takes her antiretroviral medicine in secret whenever possible. Several women said their partners refused to get tested or were in denial about their own status, which made accessing and maintaining treatment more difficult for the women.

When asked about what would help women with HIV who are dealing with abuse from partners, responses included making counseling available, providing more employment opportunities, offering AIDS education to raise awareness and reduce stigma in churches and workplaces, and empowering women to communicate more effectively about their needs. One woman suggested that women should be asked about violence and abuse in the household each time they come to the clinic. Another woman suggested that there be a govern-

ment mandate to get tested for HIV.

Limitations and future research

Nineteen is a small sample size and cannot reflect the diversity of experiences of the 1.6 million people living with HIV in Kenya. Certainly, there will be a different set of concerns for women living in more rural areas as opposed to the city of Nairobi or for women who do not have access to medical care at the Kenyatta National Hospital. However, the purpose of the qualitative portion of this study was to contextualize the findings of the larger cross-sectional survey by giving women the opportunity to speak about their experiences and express their concerns regarding intimate partner violence and managing HIV. While Kenya has been actively changing its approach to the HIV epidemic to be more rights oriented, the perspectives of these women reflect that entrenched cultural ideas around gender inequality, stigma, and blame are difficult to change even with these high-level efforts. Future research should focus on if and how women's day-to-day experiences are changing in light of these new initiatives and policy changes. This would provide a comparative framework to better understand whether new approaches are in fact effecting widespread changes in gender relations at the local level (and particularly within the household) and therefore working to combat the spread of the disease.

Additionally, while all of the women participating in this study were receiving treatment at the clinic, future research should focus on those not receiving biomedical care. Considering the prevalence of abuse in a sample of women who are receiving some level of care in the hospital, it is likely that those outside the national health care system are experiencing abuse as well and that it is affecting their ability to seek treatment.

Discussion: Intimate partner violence as a risk factor and barrier to treatment for women living with HIV

The quantitative portion of this study found that all four forms of intimate partner violence are prevalent among women living with HIV in Nairobi. The results and analysis described here offer important perspectives from a subset of this population and suggest that intimate partner violence is persistent and pervasive in all aspects of managing life with HIV. From acquisition to diagnosis to treatment, gender-based violence conditions every aspect of living with HIV for women in Kenya. This violence is built into cultural, social, and political institutions, and it functions at every level of society, permeating down to the household, where women are at greater risk for exposure to HIV and have fewer recourses in the case of infection. The fact that all of the women interviewed had disclosed their status to their partners but not all of them knew whether their partners were positive (or had discovered this by accident) is an indication that women are disadvantaged by the male-dominated system. Participants expressed a reliance on men to provide the financial resources necessary to obtain medical care for HIV, while men are better positioned to hide their status. This also allows men and other members of the community to blame women for "bringing the disease home" simply because they were the first to disclose their status. Additionally, one specific form of abuse that came up in both focus groups is that male partners often refuse to get tested, which allows them to remain in denial about their own condition and makes them less likely to be supportive of their partners with regard to treatment. In addition to blame (a form of emotional violence), several of the women in this study related that physical violence followed the act of disclosing their status to their partners. For many of the women, the abuse has continued and made management of the disease much more difficult. Many participants recounted being beaten or verbally attacked for taking their medicine, which led them to try to do it in secret and at irregular times.

Controlling behavior by male partners poses a significant barrier to adhering to a treatment schedule and attending support groups for women with HIV. While controlling behavior is often neglected as an analytic category in studies of violence against women, this study suggests that it should be

considered as a cause and a barrier to treatment and health management for women living with HIV in Kenya. Participants considered the acts of refusing to wear a condom during sex, withholding financial and logistical support necessary for treatment, restricting access to medication, and controlling other aspects of treatment examples of controlling behavior that they had experienced. Both the survey and the narrative data from this study showed controlling behavior to be a common experience, especially for women of lower socioeconomic status, and something that very much impedes adherence to prescribed treatment and access to other forms of support. Therefore, we recommend that all four forms of intimate partner violence be regarded as both risk factors and barriers to treatment and assessed in communal and clinical settings.

Stigma was another commonly mentioned barrier to treatment, as well as to employment and to positive social interaction with members of the community. This stigma is isolating and serves to preclude the formation of strong support networks for women living with HIV, which participants spoke of as vital to managing life with the disease. We agree with the participants that more educational programs geared toward reducing stigma are needed. With regard to everyday needs, participants mentioned the need for more economic opportunities—not in the form of government handouts or from their male partners but from gainful employment—and more accessible ways for women to report violence without fearing the repercussions. They also mention the need for better access to counseling services.

Conclusion

These findings support calls for both the prevention and the reduction of HIV to be addressed alongside human rights violations against women and for trauma-informed care to be the basis of care delivery. While studies show that the majority of Kenyans know how HIV is transmitted and that they are well-versed in prevention techniques, the gendered structural determinants of HIV make women differentially more vulnerable to violence, human rights abuses, and constraints on the ability to exert agency in acting according to their knowledge of transmission and prevention.[35] To be effective, programs focused on the prevention and reduction of HIV among women need to address the underlying structural issues and human rights abuses, including all four forms of intimate partner violence. Health care providers need to be aware of the potential social, economic, and human rights consequences of an HIV diagnosis. Similarly, interventions and policies focused on women's empowerment must consider the implications of the HIV epidemic for women's health and their status in society. While legal developments over the past decade, including the 2010 Constitution and recent court cases, have improved the situation for women in Kenya, many deep-rooted societal issues still need to be addressed. It is important not just to have these services available to women but to actually empower and enable women to utilize the services. Proactive leadership and increased funding is necessary to ensure that women are free from physical, sexual, and psychological abuse and that their human rights, including the right to health and freedom from violence, are implemented. We support the notion advocated by Paul Farmer and others that approaches to the prevention and treatment of disease must be dynamic, systemic, and critical.[36] Rather than focusing on individual factors that increase "risk," these approaches should focus on the underlying causes of poverty, violence, and gender inequity. This shifts the burden of resolving this crisis from individuals in vulnerable situations to the broader institutional system that perpetuates those vulnerabilities. For example, Kenya is part of the Global Fund's "Breaking Down Barriers" initiative.[37] This is a rights-based and gender-responsive approach to identifying and addressing barriers to HIV services through interventions related to stigma and discrimination reduction, training for health care providers on human rights and medical ethics, sensitization of lawmakers and law enforcement agents, legal literacy and legal services, monitoring and reforming laws, and reducing HIV-related gender discrimination, harmful gender norms, and violence against women and girls.

These policy interventions have the potential to address the context in which women receive care and can serve as a framework to develop a more targeted approach to supporting HIV-positive women who experience intimate partner violence. Importantly, any efforts to address barriers to HIV prevention and reduction using a human rights-based and gender-responsive approach must consider the lived experience of HIV and make space for stakeholders to express their personal perspectives, needs, and concerns in their own words and then explore how these articulate with the structural limitations and deleterious outcomes imposed by a sociopolitical system that undervalues women, engenders women's rights violations, and tolerates abuse in its many forms. In addition to legal and economic constraints and lack of access to public and health services, these efforts seek to identify and address gender violence at all levels of society. Based on our findings, we recommend that these initiatives include an assessment of all four forms of intimate partner violence that women may experience in the home. This may be particularly relevant in the context of COVID-19, as there is already evidence of an increase in domestic violence as a consequence of the social isolation measures implemented to combat the spread of the virus.[38]

Winnie Byanyima, the executive director of UNAIDS, has called on leaders to support a United Nations General Assembly High-Level Meeting on Ending AIDS in 2021 with the purpose of "address[ing] with urgency the outstanding issues that are holding us back from ending the epidemic as a public health threat by 2030."[39] We recommend that studies like ours and initiatives like the one by the Global Fund—those that highlight the needs and concerns of those living with HIV, including factors related to and barriers imposed by intimate partner violence and other human rights abuses—be considered in any discussions of how to move forward with this goal. Amplifying these voices, especially those of women, will help leaders better understand how the suggested structural changes manifest at the local level and whether they have a meaningful impact on the lives of the individuals they seek to help.

Ethical approval

Ethical approval for the study was obtained from the Institutional Review Board of the University of Alabama at Birmingham (approval no. X120314015) and the Kenyatta National Hospital/University of Nairobi Ethics and Research Committee. Written informed consent was obtained from each participant prior to enrollment in the study, and the study was conducted in accordance with the Declaration of Helsinki.

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