

**FACTORS INFLUENCING SPREAD OF HIV/AIDS AMONG BORANA WOMEN IN
SOLOLO DIVISION, MOYALE DISTRICT, KENYA**

BY

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**A RESEARCH PROJECT REPORT SUBMITTED IN PARTIAL FULFILMENT FOR
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DECLARATION

This research project report is my original work and has not been presented for a degree in any other university.

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DEDICATION

This work is dedicated to my family especially my mother Kule Bule, my sisters Loko, Daki who made sure that my study is a success even though they never went to school. Also my humble dedication and appreciations goes to my little kids Libe and Daki for their encouragement and support. Despite our nomadic culture they provided all that I needed to ensure that my entire studies are successful and I thank everyone who made my study a success.

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
CBO	Community Based Organizations
FBO	Faith Based Organizations
FGM	Female Genital Mutilation
GBV	Gender Based Violence
GOK	Government Of Kenya
HIV	Human Immuno Virus
ICRC	International committee of the Red Cross
IEC	Information, Education/ Communication
KDSH	Kenya Demographic Health Surveys
KIT	Royal Tropical Institute
MSM	Men Who Have Sex With Men
MTCT	Mother to Child Transmission
NACC	National Aids Control Council
NASCOP	Kenya National Aids and Sexually Transmitted Disease Control
NGO	Non Governmental Organizations
OLF	Oromo Liberation Front
SPSS	Statistical Package for Social Sciences

STD	Sexually Transmitted Diseases
TPB	Theory of Planned Behaviour
TRA	Theory of Reasoned Action
UNAIDS	United Nation on HIV/AIDS
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children Fund
WHO	World Health Organization

ABSTRACT

This study was set out to explore the socio aspects which leads to the spread of HIV and AIDS among Borana women aged between 15-45, the issues are cultural practices like FGM, wife inheritance, domestic violence and the management of HIV/AIDS. Female genital mutilation and wife inheritance is also very rampant, among Borana community, which leads to the spread of HIV/AIDS. The community practices FGM in order to reduce women sexual argues, to uphold traditions and as a sign of maturity, this is done using crude weapons which are shared among the victims and this can lead to spread of HIV/AIDS. Early marriage is also rampant because the community doesn't value girl child education, therefore access to information, which raises the level of awareness of the respondents in relation to spread and prevention of HIV/AIDS is denied. The study therefore sought to establish social factors which lead to the spread of the disease and recommends remedies like women empowerment through education. Disregard for harmful cultural practices like female genital mutilation and wife inheritance. For this to be achieved the society, Government, churches, NGOs and other stakeholders will work in unity to reduce the rapid spread of HIV/AIDS. The researcher used a total of 196 respondents from Sololo Division, Moyale District. Questionnaires were used in order to get information from the field. Also questionnaires were administered to NGO workers, health workers who assist in the management of HIV/AIDS. The data was analyzed using Statistical Package for Social Science as it will be presented inform of frequency tables, percentages and cross tabulations which was clearly to show the relationship between the variables. This study established that there was a positive correlation between female genital mutilation, early marriages, wife inheritance, domestic violence and Spread of HIV/AIDS among borana women with wife inheritance influencing the spread of HIV/AIDSs most, followed by female genital mutilation, early marriages and domestic violence. This study recommend that the government of Kenya, NGOs and community based organization leaders should come together and create more awareness on VCT and its importance in Moyale District, condemn FGM, early marriages and domestic violence.

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Globally women make up 46% of all people living with HIV, and the proportion of women infected with HIV/AIDS is increasing in Asia, Eastern Europe and Africa. In sub-Saharan Africa, the region most affected by HIV/AIDS, 61% of all adults and three out of four young people living with the virus are female. Gender has a significant impact on (1) the transmission of HIV/AIDS in both heterosexual and homosexual relationships and on (2) the “differential” experiences of infected and affected women and men. As the world addresses the HIV/AIDS pandemic, the inequitable sexual interaction between men and women will continue to have grave consequences, highlighting the importance of addressing gender-related expectations and attitudes (Bradley and Mishra, 2008). Despite this reality, policies and programmes have been slow to incorporate a gender perspective into the HIV/AIDS agenda. This is despite the fifth goal in the Millennium Development Goals for improving maternal health.

While several decades have passed since HIV/AIDS was first identified in the 1980's, the pandemic's complexities persist in challenging communities, countries and response efforts. The challenges associated with HIV/AIDS have proven to be especially difficult because they differ from culture to culture. The ways in which the pandemic is regarded as well as the ways in which responses are conceived and implemented are intimately linked to factors such as traditional practices, gender issues and beliefs. Sub-Saharan Africa remains the hardest hit region, accounting for 72% of all new HIV infections in 2008. During the same year there were 22.4 million adults and children living with HIV compared to 19.7 million in 2001 (UNAIDS/WHO, 2009).

The available evidence suggests that HIV/AIDS prevalence in Sub-Saharan Africa has stabilized and in some settings may be declining; however data from the 2007 Kenya AIDS Indicator Survey (KAIS) indicates that HIV/AIDS prevalence in the county has been on the rise. It has increased from 6.7% to 7.4% since 2003 hence reversing the decline reported in previous studies.

The magnitude and impact of HIV/AIDS in Kenya is not only a major public health problem and development challenge, but also it is increasingly creating a negative socio-economic impact. The realisation that the country is losing about 700 of its people daily made the Government to declare HIV/AIDS a national disaster. More than one million people have died since 1984, leaving close to one million orphans (NACC Strategic Plan, 2008). The report further indicates that by mid-2000, more than two million Kenyans were living with HIV/AIDS. In one year alone, close to 200,000 new infections occur in the country.

The National AIDS and STIs Control Programme (NASCO) whose vision is to improve accessibility of quality treatment and care for people living with HIV/AIDS have conducted several programmes based on a medical point of view which has led to a reduction in the rate of new infections. These include the prevention of mother-to-child transmission of HIV (PMTCT); HIV Testing and Counselling (HTC); basic education and dissemination of information about HIV; communication about behaviour change and mass media campaigns. In addition, NASCO is spearheading efforts to increase access to male circumcision, anti-retroviral therapy and treatment for sexually transmitted infections (NASCO, 2009). Most of these strategies are geared to assisting the government in achieving the goals in the vision, 2030. In the Health sector, special attention will be paid in lowering the incidence of HIV/AIDS, malaria and TB, and lowering infant and mortality ratios. All this will reduce inequalities in access to health care and improve key areas where Kenya is lagging, especially in lowering infant and maternal mortality (Kenya Vision 2030).

Much has been written in this area, but scanty information is available on how socio-culture predisposes women to the spread of HIV/AIDS in Marsabit District, Kenya. One of the striking features of HIV/AIDS is its impact on women and girls in the area. At the beginning of the pandemic, women and girls were at the periphery; today they are at the centre. Globally, the incidence of HIV/AIDS among women has gone up (NACC, 2007).

Women now account for about half of all people living with HIV/AIDS worldwide. This is attributed to poverty; gender based abuse and violence in homes, schools, work places

and other social spheres, lack of information, coercion by older men and men having several concurrent sexual relationships that entice young women in a giant network of infection (NACC, 2007).

Willis (2002), reported that women are seen as disadvantaged in many areas of life. Sadly, this is also reflected in the clinical statistics surrounding HIV and AIDS, particularly in developing countries. In spite of the statistics from researchers pointing out that much has been made of the spread of AIDS by sex-workers in various African countries, a large number of women infected have one and only one sexual partner. Willis continues to say that though no fault of their own, majority of women worldwide who are infected are frequently monogamous, living out their lives as good wives and mothers in a variety of situations.

HIV/AIDS should be understood in the context of cultural beliefs because cultural practices vary. Some are beneficial in HIV/AIDS prevention while others perpetuate its spread. The beneficial ones need to be enhanced and others changed or modified. Culture is so integrated into everyday life and beliefs that it is sometimes difficult to separate the beneficial practices from harmful ones.

Some practices like faithfulness in marriage and instruction on sexuality to the youth during initiation are practices that should be encouraged since they contribute to family preservation. However, some practices, for example wife inheritance and circumcision, may facilitate transmission of the HIV virus (Kalipeni, 2000).

There are cultural norms among the Kenyan people which promote male dominance and treat women as subordinate to men. These norms influence the continuing spread of HIV/AIDS. Many of these are ingrained within the cultural values and beliefs. Until these cultural norms are dealt with, the problems surrounding women and HIV/AIDS cannot be addressed and combated. Despite the availability of information on the AIDS pandemic, people are still not changing their behaviour (Aksornkoo, 2008). This study deals with the question of the role of culture in the spread of HIV/AIDS among women.

1.1.1 Spread of HIV/AIDS among Women

Women and girls continue to be affected disproportionately by HIV/AIDS in sub-Saharan Africa, the number of women infected and affected by HIV/AIDS has continued to increase over the years (UNAIDS/WHO, 2009). For example, the 2003 Kenya Demographic Health Survey shows that HIV/AIDS prevalence in women aged 15- 49 years was 9% while for men was under 5 %. It also revealed that HIV/AIDS prevalence rate among young girls aged between 15- 24 was 5.8% compared to 1.2 % for young men in the same age range (KDHS, 2003).

According to the latest (2008) WHO and UNAIDS global estimates, women comprise 50% of people living with HIV/AIDS. The spread of HIV/AIDS in sub-Saharan Africa remains a global public health challenge with an estimated 30 million Africans now living with the disease. Women bear a disproportionate burden of the infected as they constitute 61% of the disease cluster in the region. Adolescent girls are 3 – 4 times more likely to be infected compared to their male counterparts (Tabi and Frimpong, 2003). The patriarchal nature of African societies continues to shape women's sexual behaviour in the region. This in turn accounts for the high prevalence of HIV/AIDS among women in sub-Saharan Africa.

The spread of HIV/AIDS among women is greatly enhanced by the cultural and economic powerlessness of this group. It is now clear that women have borne the brunt of the epidemic, especially young girls in their teens (15 to 19 years), who are six times as many as their male counterparts. Older men turn to younger girls for sex under the misconception that they are AIDS-free (NACC, 2000). Even the ones who are not infected are affected in that when parents succumb to the disease they are forced to look after them, often without sufficient information, medication or support.

Throughout the developing world the impact of HIV/AIDS on women has been significant and rising. Women are more vulnerable than men, both epidemiologically and biologically. Women are frequently less educated than men. This disparity is critical because literacy rates for women are strong predictors of infant mortality rates and fertility decisions. Discrimination against the female gender begins during the pregnancy

of the mother, as manifested in the high incidence of abortion of female foetuses. Female infanticide has been on the rise in many countries. Cultural preference for sons results in preferential allocation of family resources (food, schooling, health care) to them. Girls are allotted disproportionate burden of housework, which is a detriment to their self-esteem

The life cycle of women is also impacted by sexual and domestic violence. In different parts of the world, between 16% and 52% of women suffer physical violence from their male partners, and at least 1 in 5 women suffer rape or attempted rape in their lifetimes, often by known men. Rape survivors live in shame, restrained by fear of social stigma and unable to bring legal action.

1.1.2 Borana Women

The study will focus on the Borana whose origin has been traced to Ethiopia. The Borana economy is based on pastoralism, although those who occupy areas such as Moyale and Mt. Marsabit and the higher altitudes grow a few food crops. Livestock is, therefore, an important resource for the Borana. It plays an essential role in ritual and religious sacrifices. For instance, it is used to pay fines in the traditional courts of law and in paying bride price. For example, a male child is presented with a heifer at his naming ceremony which takes place when he is around a year old. The heifer is known as handura (navel). The animal forms the nucleus of his own independent herd (Baxter, 1996: 125). Most important, livestock is a major food source.

The Borana consider it important, therefore, that a man should establish his own herd as soon as possible. Women are not allowed to own cattle in the community. Since cattle are the basic form of subsistence, women have minimal control over this resource. The Borana marriage laws are very elaborate. The Borana community is divided into two clans, the *Sabbo* and the *Gona*. Marriage between these two groups is based on the rule of exogamy. The total population of Moyale is 103,799 comprising of 54,291 males and 49,508 females.

Girls must learn how to become good wives and good mothers by the time they are considered ready for marriage, usually as soon as they attain menarche. Chronologically

this age is below eighteen years. Data on enrollment rates indicate that in upper primary school, girls' ages range between 12-16 years and it is from this age group that brides are chosen. In this age group prospective brides are taught role expectations, values, and wifely skills, according to Borana tradition. This is reflected in the higher school dropout rates for girls at upper primary levels.

Since wifely knowledge and skills are imparted at home, girls must stay away from school in order to benefit from their mothers' and other relatives' counsel. As a result, formal education for female children, who after marriage will move out to their husband's home, is not emphasized.

While types I and II of FGM are the predominant types throughout the country, the Somali, Borana, Rendille, and Samburu practise the more severe form of type III, including infibulation. The Boran believe that uncut girls and women have an overactive and uncontrollable sex drive that increases their likelihood of having sex before and outside of marriage. It is also believed that narrowing the vaginal opening enhances male sexual pleasure, thus reducing divorce or unfaithfulness. These communities believe also that a woman's natural external genitalia are ugly and unhygienic, and that they will continue to grow if they are not cut away. Removing the external genitalia is believed to enhance hygiene and make a female spiritually clean (Jaldesa, Askew, Njue and Wanjiru. 2004).

According to NASCOP (2003), the prevalence of HIV/AIDS among girls is 2.7 in Moyale. While prevalence in pastoral districts is in the range of 2-18 %, well within the national average, the growth rate is significantly higher, partly as a result of the weakness of outreach and awareness programs to these areas. This is despite the acknowledgement of the threat posed by HIV/AIDS to development' in the Economic Recovery Strategy plan (2003-2007).

Cultural practices among the pastoralist have been cited as they lead to acceleration of HIV/AIDS infection in pastoralist areas. In particular, the wife sharing, wife inheritance, ritual cleansing, use of unsterilized instruments in childbirth female genital mutilation (FGM), male circumcision and surgery by traditional medics body tattooing and piercing

have been singled out as putting participants at elevated exposure and infection levels. However, there have been no studies to determine the extent of these practices and therefore their contribution to the spread of HIV/AIDS.

Vulnerability to HIV/AIDS is fuelled by a lack of respect for the rights of women and children. For women living in pastoralist areas, rights to security, freedom from inhuman or degrading treatment, to information, education, expression, association, privacy and confidentiality are hard to come by. Where these rights are compromised, individuals at risk of HIV/AIDS infection are denied and/or discouraged from obtaining information, goods and services necessary for self-protection. The low status of women in pastoralist communities and their lack of decision making power makes them unable to act as agents of behaviour change within their communities it also exposes them to infection through culturally imposed obligations; Women are expected to accede to sexual advances of their spouses, even when they have cause to suspect this may result in infection. They have no say on their accordance to practices such as FGM, and wife inheritance, which place them directly in the line of infection.

Social structures disadvantage women, within the community and the household. Social and economic changes often result in additional burdens on women without offering them more benefit or voice. Development seldom offers women opportunity to use their knowledge or skills even in such pertinent areas as food security, health and livestock husbandry. This status quo has often posed dilemmas in development projects, especially when they find that success is dependent on challenging gender roles in resolutely patriarchal pastoralist societies.

As Pastoralists the Borana people move from place to place seasonally in search of pasture and water. Because of geographic inaccessibility, political marginalization and lack of representation in the mainstream politics, the Borana people remains to be one of the most disadvantaged communities in the country.

1.2 Statement of the Problem

The issue of HIV/AIDS constitutes both social and economic problem, especially in sub-Saharan Africa. Davison and Neale (1998) hold that the core of the problem is risky

sexual practice and not sexual orientation. Sexual contact usually increase the risk on women owing their physiological conditions such as greater, Exposed surface area in female genital tract. Aleman et al (1995) argued that AIDS was first recognized as a threat to women in the third world countries particularly in Africa and the Caribbean basin, where heterosexual transmission was identified and is responsible for hundreds and thousands of deaths. Since most victims of the diseases are women especially those in the productive age this suggest that, mother to child (MTC) transmission is another cause of HIV/AIDS.

Preventive measures including the use of condoms, which are believed to be important in the control of HIV/AIDS and sexually transmitted diseases (STD'S) are not widely used because of lack of knowledge, awareness, and also cultural background that discourage the use of condoms as well as cultural practices like female genital mutilation as well as wife inheritance which facilitates rapid spread of the diseases.

The rapid spread of AIDS worldwide and the patterns that have been generated by this spread have transformed HIV/AIDS into a woman's disease (Lindsey, 1997). HIV/AIDS has affected women from sub-Saharan Africa in disproportionate numbers more than anywhere else in the world. The number of women being infected with HIV through heterosexual transmission is rapidly rising. Since men are in power, it is men's issues that get addressed as state concerns. This creates more problems for women whose concerns are seen as secondary, and thus not important to the state (National AIDS Control Council [NACC], 2007). HIV/AIDS is a women's issue because the risks and consequences are different for women (Campbell, 2004) and therefore should be studied using a different, feminized perspective. In 2008/09 HIV prevalence among women was twice as high as that for men at 8 percent and 4.3 percent respectively. This disparity is even greater in young women aged 15-24 who are four times more likely to become infected with HIV than men of the same age (UNGASS, 2010). In view of the above, study therefore seeks to investigate the socio issues that lead to spread of HIV/AIDS among married women age between 15-45 years old. The study was carried out in Obbu Division Moyale District of Eastern Province.

1.3 Purpose of the Study

The purpose of this study is to determine the factors influencing spread of HIV/AIDS among Borana women in Sololo Division, Moyale District.

1.4 Objectives of the Study

The specific objectives of the study were:

1. To find whether female genital mutilation contributes to the spread HIV/AIDS among Borana women in Sololo Division
2. To establish whether early marriages contribute to the spread of HIV/AIDS among Borana women in Sololo Division
3. To determine whether wife inheritance leads to the spread of HIV/AIDS among Borana women in Sololo Division
4. To find whether domestic violence contributes to the spread of HIV/AIDS among Borana women in Sololo Division

1.5 Research Questions

This research study sought to answer the following questions;

1. Does female genital mutilation contributes to the spread HIV/AIDS among Borana women in Sololo Division?
2. How does early marriage contribute to the spread of HIV/AIDS among Borana women in Sololo Division?
3. Does wife inheritance lead to the spread of HIV/AIDS among Borana women in Sololo Division?
4. How does domestic violence contribute to the spread of HIV/AIDS among Borana women in Sololo Division?

1.6 Significance of the Study

A lot has been written on the subject of women's vulnerability, cultural norms making it difficult to fight HIV/AIDS and on gender issues which helps to clarify the gender roles and the need to be aware of gender injustices and inequality. There is, however, very little

written on the elements of African culture that helps to spread the infection. The state, public and private sector have worked together in different levels to stop the spread of HIV/AIDS. In response to all these claims, people have come up with theories on how to heal, protect and prevent themselves from contracting HIV/AIDS. Unfortunately those who are powerless in our societies bear the brunt of these wrong beliefs about HIV/AIDS. Women and youth are abused and raped. Young girls are raped with some believing that sleeping with a virgin is a cure for HIV/AIDS.

This study offers an incomparable window on the internal dynamic of social cultural factors that affects women's lives. The research was expected to help to find ways to encourage men to talk about their sexuality and safety and their responsibility to their wives, partners and children.

This study established whether there is an association between various cultural practices and the risk of transmission of HIV/AIDS in Kenyan girls and women. An association between the cultural practices and increased risk of HIV infection, if established, might prove a valuable weapon in the campaign against practices such as FGM. Information obtained from this study may also be used in strategy-formulation to combat the spread of HIV/AIDS among Kenyans, as well as other communities that continue to practice rituals such as FGM. Therefore, this study proved to be significant in those aspects.

The study provided researchers and academicians with a base upon which secondary material on the influence of culture on the spread of HIV/AIDS among women will be drawn. This study was also set a base upon which more studies on influence of culture on the spread of HIV/AIDS among women in Kenya can be done.

1.7 Limitations of the Study

There were expected challenges during data collection because some of the target respondents may fail to give the required information due to the nature of the data and also the subject matter. The researcher however worked at winning the confidence of those involved in this research by giving them the reasons for the research and assuring them of confidentiality.

Communication might also be a problem due to language barrier and education level of the respondents. The researcher however used local interpreters from within the locations indicated in the study. Local school leavers were also engaged at a fee in order to help in the collection of data.

1.8 Delimitations of the Study

The study focused on factors influencing the spread and management of HIV/AIDS in women. The study was carried among Borana women in Sololo Division in Moyale District, community based organizations, religious organizations and NGOs in the area.

1.9 Basic Assumptions of the Study

The researcher made the assumption that the respondents were cooperative enough in order to give the required information in the study. It was assumed that all information collected from respondents is correct and gives a clear and true picture.

The researcher also assumed that external factors like tribal conflicts will not arise as this would affect the process of data collection and hence the completion of the project. The researcher assumed that the cited respondents have some knowledge on HIV/AIDs. The researcher also assumed that the results of this study provided a guide to the Government and other development partners dealing with the issue of the HIV/AIDs control.

1.10 Definition of Significant Terms

Attitude A persons positive or negative feelings toward performing the defined behaviour

Behavioural Beliefs Behavioural beliefs are a combination of a person's beliefs regarding the outcomes of a defined behaviour and the person's evaluation of potential outcomes.

Domestic violence It refers to physical, sexual, verbal and physiological abuse mainly through insults, beatings, rape or even torture

Early Marriage The term “early marriage” is used to refer to both formal marriages and informal unions in which a girl lives with a partner as if married before age of 18.

Female Genital mutilation It refers to partial or complete removal of female external genitalia for cultural or other reasons

Gender The differences between women and men within the same household and within and between cultures, which are socially and culturally constructed and change over time.

Gender Dimensions The gender dimensions of HIV and AIDS are the gender-based economic, social, legal, cultural and physiological factors that influence all aspects of the epidemic and are intimately linked to gender inequality.

Gender Mainstreaming Mainstreaming a gender perspective is the process of assessing the implications for women and men of any planned action including legislation, policies or programmes in all areas and at all levels.

Intention The intent to perform a behaviour is the best predictor that a desired behaviour will actually occur.

Normative Beliefs Normative beliefs are a combination of a person's beliefs regarding other people's views of a behaviour and the person's willingness to conform to those views.

Transmission The method by which a disease is passed from one patient or host to another.

Wife Inheritance A situation where in case of husband death the widow is remarried to close relative for ritual cleansing or cultural practice

1.11 Organization of the Study

The study is organized into three chapters, each of which contains specific information. Chapter one contains the introduction to the study. It gives background of the study, statement of the problem, objectives of the study both general objectives of the study, specific Objectives of the study, research questions, significance of the Study, limitations of the Study, delimitations of the study, basic assumptions of the Study and the definition of significant terms. On the other hand, chapter two reviews the literature based on the

objectives of the study. It further looked at the conceptual framework and the theoretical review. Chapter three covers the research methodology of the study. The chapter describes the research design, target population, sampling procedure, tools and techniques of data collection, pre-testing, operational definition of variables, data analysis and ethical considerations.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents a review of the related literature on the subject under study presented by various researchers, scholars, analysts and authors. The specific areas covered here are the State of HIV/AIDS, HIV/AIDS control, theoretical review, empirical review, the conceptual framework and the research gap.

2.1.1 The Global State of HIV/AIDS

HIV/AIDS scenario especially in the 21st Century has become a frightening phenomenon. According to Giddens (1993) the World Health Organization (WHO) estimated that, by the year 2000 more than thirty million adults and ten million children will have become infected by the virus. Tarantula et al (1994/5) assets that the spread of HIV has not been stopped in any community or country in the United States at least 40,000 to 80,000 new HIV infections were anticipated during 1992. In 1997 more than 75,000 new HIV infections occurred in Europe. In just five years the accumulative number of HIV infected Africans has tripled from 2.5 million to over 7.5 million today. According to World Bank (1997) in many developing countries the HIV and AIDS is spreading rapidly in major cities of Argentina, Brazil, Cambodia, India and Thailand more than 2% of pregnant women now carry HIV (Global Report, 2008).

United Nations Children's fund UNICEF (2000) reported that each day 8,500 children and young people around the world are affected with HIV and 2,500 women die from AIDS. In 1998 alone the number of women killed by HIV/AIDS was 900,000. Kasurai and Bases (2000) reported that 36.1 million people would die from AIDS and of these 80% were in Africa. A study by International Committee of the Red Cross ICRC (1999) assets that 33.4 million people worldwide are living with HIV virus. Of these more than 90 percent live in developing world that 50% new HIV/AIDS infections occur in young people between 15-44 years.

The Joint United Nations Programmes on HIV/AIDS (UNAIDS and WHO), estimated the number of people living with HIV/AIDS at the end of 2006 to be 39.5 million people worldwide. While approximately 10% of the world's population lives in sub-Saharan Africa, an enormous 64% of all people living with HIV live in this region including 77% of all women living with HIV (Strategic Plan for South Africa, 2007-2011).

Since the first cases of Acquired Immuno Deficiency Syndrome (AIDS) were reported in 1981, infection with Human Immunodeficiency Virus (HIV) has grown to pandemic proportions, resulting in an estimated 65 million infections and 25 million deaths. During 2005 alone, an estimated 2.8 million people died from AIDS, 4.1 million were newly infected with HIV, and 38.6 million were living with HIV. A report, published on the eve of the sixteenth International AIDS Conference (August 13-18, 2006, in Toronto, Canada), summarizes selected regional trends in the HIV/AIDS pandemic, based largely on data from the *2006 Report on the Global AIDS Epidemic* by the Joint United Nations Programmes on HIV/AIDS.

2.1.2 HIV/AIDS in Sub-Saharan Africa

Sub-Saharan Africa is home to approximately 64% of the world population living with HIV. It is more heavily affected by HIV/AIDS than any other region of the world. An estimated 22 million people were living with HIV at the end of 2007 and approximately 1.9 million additional people were infected with HIV during that year. In just the past year, the HIV/AIDS epidemic in Africa has claimed the lives of an estimated 1.5 million people in this region. More than eleven million children have been orphaned by AIDS.

2.1.3 HIV/AIDS in Kenya

The Kenya National AIDS and sexually Transmitted Disease Control Programme NASCOP (1999) estimated that in 1998 there were 1.9 million people who were infected with HIV/AIDS including 100,000 children. These figures are under estimated since the deaths among youths and adults have often increased rapidly. The organization further noted that 2.2 million people have died of HIV/AIDS in the country. The manifestation of the infection indicates that there is increase in hospitalization and lack of care for HIV/AIDS patients. Moreover affected victims discharged from hospitals for terminal

care and home nursing often die unattended due to lack of knowledge and negative attitude among service providers.

According to Kenya National HIV and AIDS Strategic plan (2000) the death toll by June 2000 was estimated at 1.5 million people since the epidemic started early 1980's. The cumulative number of deaths due to HIV/AIDS in Kenya may rise to 2.5 million by the end of 2005, if no interventions are introduced. Shimoli (2001) affirms that 2.2 million Kenyans are living with HIV/AIDS and 250,000 have HIV/AIDS. It is further estimated that 700 Kenyans die every day from the diseases and that a total number of 1.5 million have died of HIV/AIDS leaving one million orphans. NASCOP (1999) reported that the most immediate and visible impacts of HIV/AIDS on the education system could already be seen and felt. Most children infected at birth through MTCT have not lived to enroll in school. Some of those enrolled have dropped out of school in order to earn money for their families and ill relatives. Teachers have equally fallen ill and died of HIV/AIDS. The drastic spread of HIV/AIDS infection threatens human survival and therefore has negative impacts on social and economic fabrics of society's worldwide.

Kenya is experiencing a mixed and geographically heterogeneous HIV/AIDS epidemic. Its characteristics are those of both a 'generalized' epidemic among the mainstream population, and a 'concentrated' epidemic among specific most-at-risk populations. The pattern emerging is of highly variable epidemiological dynamics, geographically with respect to modes of transmission, and with substantial age and sex differentials.

Nationally most new infections (44%) occur in couples who engage in heterosexual activity within a union or regular partnership. Men and women who engage in casual sex contributed 20% of new infections, while sex workers and their clients contributed 14%. Men who have sex with men (MSM) and prison populations contributed 15% of new infections, and injecting drug use accounts for 3.8% while health facility-related infections contributed 2.5 % of new cases(Turmen,2003).

2.1.4 HIV/AIDS in Moyale

Vulnerability to HIV/AIDS is fuelled by a lack of respect for the rights of women and children. For women living in pastoralist areas, rights to security, freedom from inhuman

or degrading treatment, to information, education, expression, association, privacy and confidentiality are hard to come by. Where these rights are compromised, individuals at risk of HIV infection are denied and/or discouraged from obtaining information, goods and services necessary for self-protection (Kemboi 2002). The low status of women in pastoralist communities and their lack of decision making power make them unable to act as agents of behaviour change within their communities it also exposes them to infection through culturally imposed obligations; Women are expected to accede to sexual advances of their spouses, even when they have cause to suspect this may result in infection. They have no say on their accordance to practices such as FGM, and wife inheritance, which place them directly in the line of infection.

Reports of HIV/AIDS, malaria and respiratory track infection are rampant in all centers of Moyale District and Sololo Division. There is an old man who is a herbalist, he gives people mixture of Herbal Medics, and cure them from Malaria, typhoid and many diseases. One day a woman went to him and told him that she is suffering from HIV/AIDS and she has lost her husband two years ago after a long battle with Aids, He gave her a type of medicine, but first he told her to have the test before he starts giving her the medicine, she traveled 600 or more miles where she was tested by an Italian Doctor and it was confirmed to be HIV I and HIV2 positive he gave her the Medicine and after 21 days she went back to the same hospital and was informed to be HIV1 positive and HIV2 could not be detected, as she was coming from 1250 miles in Nairobi the old man gave her some more of the Medicine and told her to use it for not less than 90 days and not more than 150 days, She did as per the description and on completion she was informed to have the HIV test after 7 days from the last day of Medication, she went to test and was informed that she was Negative and went on with her interview with UNHCR and now she has been resettled in the USA (GoK,1997)

2.1.5 HIV/AIDS in Sololo Division

The estimated number of HIV/AIDS related orphans in the town of Sololo alone is 200. In the urban area of Sololo, HIV/AIDS-Positive underage orphans are one of the most urgent and serious problems. The children live in poor conditions, without resources due

to the disintegration of the family caused by HIV/AIDS related deaths of one or both parents. Unfortunately, in Sololo Division, extreme poverty exists and traditional system of aid for the orphans will not be able to handle the exponentially increasing number that will predictably continue to rise over the next few years due to rapid spread of the HIV/AIDS pandemic. Furthermore, in recent decades, the traditional family model has also undergone changes caused by the impact of the modern western and Islamic lifestyle. Apart from the social and economic changes, the stability of values and traditional models are also under discussion. The traditional extended and polygamist family is being replaced by the concept of a monogamous and single-parent family unit, something that was in the past completely extraneous to the local culture. The bonds inside the clans are becoming weaker and this cultural conflict between past and present has a negative effects of Losing both parents to HIV/AIDS has lead to millions of orphans and other children live with sick or dying family members. Particularly importance is place on the issue of HIV/AIDS prevention and sexual abuse by various stakeholders in the area (NACC, 2002).

The culture of the pastoral tribes in terms of traditions and beliefs in away has led to spread of diseases especially the communicable ones. Age old traditions such as limited construction of pit latrines, female genital mutilation and indiscriminate disposal of domestic waste are some of the traditions that are not health supportive. In addition, biased gender practices and beliefs have led to discrimination against women and limited access and ownership of resources. Polygamy and keeping of multiple partners had exacerbated spread of STI and HIV among pastoralists groups. Needs assessment survey conducted by pastoralists foundation for life revealed the following cultural practices is 100% practiced in the target communities. Female genital mutilation is associated with the following negative out comes on the health of an individual and family unit(source: Daily Nation Newspaper, 1st April 2010)

2.2 HIV/AIDS Control

There are both conventional and nonconventional methods of HIV/AIDS control/management. (UNAIDS/WHO, 2009). Although there is no cure for HIV/AIDS, researchers have developed treatments in the last 10 years that have slowed the

progression of the disease. It is important to get treatment soon after detection, such as receiving therapies that bolster the immune system, lower stress and bolster a good nutritional regimen. Although alternative therapies will not cure or stop HIV/AIDS, when used in conjunction with conventional medicine, they can extend and improve the quality of life of someone with HIV/AIDS. Consideration of alternative therapies in conjunction with conventional medicine may offer additional opportunities for persons living with HIV/AIDS to be proactively involved in their treatment.

The national AIDS control policy principally aims at the following strategy for prevention and control of the disease: Prevention of further spread of the disease by making the people aware of its implications and provide them with the necessary tools for protecting themselves, controlling STDs among vulnerable sections together with promotion of condom use as a preventive measure, ensuring availability of safe blood and blood products; and reinforcing the traditional moral values among youth and other impressionable groups of population; To create an enabling socio-economic environment so that all sections of population can protect themselves from the infection and families and communities can provide care and support to people living with HIV/AIDS and improving services for the care of people living with AIDS in times of sickness both in hospitals and at homes through community healthcare (UNGASS, 2008).

It is increasingly being recognized worldwide that the conventional Information, Education and Communication (IEC) campaigns have utterly failed in bringing in-depth and long-term changes in risky behaviour for halting the spread of HIV/AIDS pandemic. The mass media information has also been predominantly general and non-targeted information on HIV/AIDS prevention and care, the form and content of the messages are mostly not tailored to be understood and integrated by diverse population groups (Henrion, 2003). This major shortcoming has been unambiguously acknowledged by the UNESCO and the UNAIDS, which have admitted in their country assessment reports that the national policies to-date have not brought significant changes in behaviour among the population in respect of HIV/AIDS prevention, care and support.

The failure of the IEC, including mass media campaigns, has been essentially because of the fact that HIV/AIDS prevention strategies and policies; have been considered purely a

bio-medical problem or a cognitive issue; rather than as a complex societal and cultural phenomenon. The focus has been dysfunctionally or ineffectually on the individual behaviour and attitude; rather than understanding the same as an integral part of the collective societal and cultural norms, practices and settings (UNAIDS, 2009).

Besides the insufficient consideration and integration of people's societal and cultural references and resources (which include, people's life style, their ways of thinking, and their motivational responses); the HIV/AIDS control and prevention strategies also have other serious deficiencies like standardized communication messages, pre-cooked preventive education, partial and fractured involvement of the community as well as inadequate and passive involvement of the stakeholders and civil society (NACC, 2009).

The existing HIV/AIDS control strategies followed by the governmental agencies are perceived by people at large as a superimposed external intervention. Community has the most important role in stimulating debate, defining activities, creating motivation and generating interest in HIV/AIDS prevention and control strategies; as the community, as a group of people; is normally bounded by a set of beliefs, practices, life styles and religious convictions; and depending upon its participation and integration will be motivated or dis-motivated to act as a group in relation to HIV/AIDS prevention, care and support (Mazrui, 2006)

The culture approach to HIV/AIDS prevention and care facilitates the reinforcement of the positive elements in the local culture of a given population to foster positive behaviour and attitude as well as seeks acceptable and relevant changes in the not-so-positive elements in the same cultural process to motivate the given group or persons to avoid risk-taking behaviour and vulnerable situations. Cultural references and resources of any given population; which are considered as obstacles for HIV/AIDS prevention and control strategies include; sexual violence against women and girls; polygamy; religious dogmas, taboos, exclusivity, and superstitions; lack/inadequacy of primary health facilities in remote rural areas, leading to people's dependence on unskilled and unsafe health services; and people's blind faith in superstitious physco-therapeutic treatment by the traditional healers (UNAIDS, 2009). A process of simultaneous co-existence and conflict of positive and negative values, influencing and shaping behaviour pattern and attitude,

prevail in any given society or culture or group. The need is to optimize, harmonize and popularize the positive factors in the culture of a given population as well as minimize and eliminate the negative elements or obstructive aspects therein to ensure safe and responsible behaviour to reverse the process of expansion of HIV/AIDS epidemic. No attempt should be made to change the culture of a community or a given population group as the same will be counterproductive and will be deprivation of human rights as culture is the greatest asset and sense of autonomy of a given population. The cultural approach is indispensable if behaviour patterns are to be changed on a long-term basis, a vital condition for slowing down or for stopping the expansion of the epidemic.

2.3 Theoretical Review

Theories are set of ideas that describe a social situation, and theories give a directives on what needs to be done to deal with a particular problem. In regard to issues on awareness of Hiv/Aids the researcher will use a combination of feminist theories

Feminist Theory

The research is guided by feminist theory, which affords powerful insight into the contexts in which women are put at risk for HIV and partner violence. According to the principles of liberal feminist theory, women are vulnerable to HIV infection due to lack of equal opportunity and education exacerbated by traditional practices which keep women misinformed, disempowered, and dependent on men (Turshen, 2003).

Liberal feminist theory suggests that women can reduce their vulnerability to HIV infection if they have access to education and equal opportunity; however liberal feminism is deficient because it does not believe in upsetting the status quo. Liberal feminist theory suggests that traditional practices that impede women's progress should be deconstructed to benefit women (Lindsey, 1997).

Socialist/Marxist feminist theory attributes women's vulnerability to HIV to the capitalist system and patriarchy endemic in the society. Socialist/Marxist feminist theory argues that capitalism and patriarchy inhibit women from acquiring complete independence over their lives which enhance HIV vulnerability. The remedy is to overthrow the capitalist

system and patriarchy which would give women spaces in which they can have some say and control over their lives.

The radical feminist theory is more beneficial in fighting HIV/AIDS because it states that women are extremely vulnerable to HIV infection due to patriarchal processes in the culture and environment that affect their health, and therefore women should strive to overthrow patriarchy. Radical feminist theory suggests that the only way to fight women's vulnerability is to expose what is considered private and make it public. According to research on African women, many women are getting infected by their husbands or partners (Fleischman, 2003). With the aid of liberal, socialist/Marxist and radical feminist theories, an HIV vulnerability model was constructed for this study that consists of powerlessness, lack of AIDS-related knowledge, cultural practices, sexual behaviour, and perception of HIV/AIDS risk. Feminist theories guided this study by demonstrating that women are most vulnerable to HIV infection when they have the least control over their sexual lives because of lack of economic power, cultural constraints, and disparities created by patriarchy (Lindsey, 1997). Patriarchy is a strong force in Kenya (Mikell, 1997; Turmen, 2003) and feminist theories are needed to expose what is in the society that creates conditions of vulnerability to HIV infection among women. Thus, this study will use feminist theory in this study to provide alternative methods in examining Sololo women's vulnerability to HIV/AIDS by looking at cultural conditions and disparities that affect women in the Borana society.

2.4 Empirical Review

Cultural practices that contribute to HIV/AIDS vulnerability among women are significant topics affecting women but have generally been understudied. According to Wodi (2002), cultural differences can be useful, in explaining different HIV/AIDS vulnerabilities.

2.4.1 Female Genital Mutilation

The world Health Organization defines Female Genital Mutilation as 'all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs, whether for cultural or other non- therapeutic (non- medical)

reasons (Willcox, 2005). It further observes that about 132 million women have been subject to FGM and that approximately 2 million women and girls are added to this number each year. Female genital mutilation, commonly called female circumcision, involves the partial or complete removal of the external female genitalia. This practice, carried out in many African and Middle Eastern countries for cultural reasons, leaves behind abnormal scarring which increases the chances of contracting HIV/AIDS.

Female circumcision is a deeply ingrained custom that is still widely practiced in Kenya. Research has shown that some Kenyan women continue to practice female circumcision even after it was outlawed and banned in 1982 (Toubia, 2009). For some societies that practice female circumcision, a family or clan's honor depends on a girl's virginity or sexual restraint. Face and honor are two virtues that are highly prized in Kenya; however, a double standard exists because men do not have to live their lives under the same microscope. In some societies, the rituals is a time of joyous celebration and elaborate festivities, while in others it is shrouded in concealment and secrecy. Female circumcision is an important topic in AIDS discourses because circumcision performed on women, not men, makes women more vulnerable to HIV/AIDS infection because the possibility of HIV/AIDS entry is high due to the sharing of instruments that are tainted with blood (NACC, 2002; Turshen, 2000). In addition, because FGM raises the social status of the parents, the dowry demands can be high and therefore the young girls can be married off to older men who are already infected (Brady, 2009).

Provision of reproductive health services is hampered by harmful practices including female genital mutilation (FGM) or female circumcision. Thirty eight percent of women age 15-49 have undergone the practice in Kenya. Although the practice is declining nationally it is still deep rooted among the Kisii, Kalenjin Maasai, and the Meru. According to the 1998 KDHS, 97 percent of Kisii women, 62 percent of Kalenjin, 89 percent Maasai and 54 percent Meru women are circumcised. Traditional circumcision is still practiced in a few parts of the country though not at a large extent (GTZ, 2007). The instruments, which are used, are just shared without proper sterilization, which may facilitate high HIV/AIDS transmission. Female genital mutilation is totally discouraged by the government.

Willcox (2005) observes that in Kenya by the age of 19, 30% of women have been circumcised and 50% of women over the age of 35 have been circumcised. Among the Kalenjin community which the Keiyos form part of, the practice is still rampant with a percentage of 62% closely after the Maasais with an 89% practice rate.

Female Genital Mutilation predisposes women to HIV/AIDS infection in many ways (example, increased need for blood transfusion due to hemorrhage either when the procedure is performed, at child birth, or a result of vaginal tearing during defibulation and intercourse). Women who have undergone FGM have a small opening, just large enough for the passage of urine and blood. Penetration or intercourse is difficult, often resulting in tissue damage, lesions and post coital bleeding (Little, 2003).

The 2003 Kenyan Demographic Health Survey (KDHS) reported that 32% of all Kenyan women aged between 15 and 49 years are circumcised. This is noted to be a decline from the 1998 KDHS when it was recorded at 38%. Some ethnic groups circumcise their females as early as infancy, Female infants are also mutilated (among the *Taita* for instance), while *Borana* conduct the practice on girls on girls under the age of 10 years. In all districts reports point to the practice being inflicted on even younger girls (GTZ, 2007)

Women are exposed to the risk of HIV/AIDS by particular rites and customs. The most shocking is the practice of female genital mutilation. Enforced as a check on women's promiscuity, and often justified as part of African tradition, these horrific operations are often carried out by local 'physicians' using unsterilized instruments. Such operations carry considerable danger to the young girls' health in themselves. The implications for the spread of AIDS need not be spelt out.

FGC/FGM places girls and women at increased risk of HIV/AIDS infection through several routes. Firstly, the use of unsterilized instruments, such as razors or knives, to carry out the procedure among a number of girls risks passing the virus from one girl to the next. Secondly, FGM renders the female genitals more likely to tear during intercourse. In cases of sewing up of the vaginal entrance, penetration is bound to lead to

bleeding, which in turn makes sexual transmission of the virus from an HIV/AIDS positive partner much more likely (Willcox, 2005).

Thirdly, difficulties with intercourse may make a woman less likely to welcome the partner's advances and betrothal and the marriage of a child shall have no legal effect, and all necessary action, including legislation, should be taken to specify a minimum age for marriage and to make the registration of marriages in an official registry compulsory. In their general recommendations of 1994, the Convention considers that the minimum age for marriage should be 18 years.

Although little evidence exists, it has also been argued that female circumcision has a protective effect against transmission. Few studies have shown that FGM is associated with a decreased risk of HIV/AIDS (Stallings et al, 2005). Yount and Abraham (2007) in their article propose that women who participate in the practice of FGM are more likely to follow the approved set of gender guidelines for the community and are thereby less likely to engage in sex before marriage and extramarital affairs.

The nature of the procedure also has likelihood to increase discomfort for females during sexual intercourse, (Campbell, 2004) therefore severely cut women may be less sexually active due to pain associated with the act. Because FGM has the potential to decrease the frequency of sexual intercourse, it can thereby be postulated that it could lead to a decreased risk of HIV/AIDS transmission because "coital frequency is positively associated with HIV/AIDS infection" (Yount and Abraham 2007).

Brady (2009) identified female circumcision as a contributing factor to the spread of HIV/AIDS. However, in a study of 638 women ages 15-44 in Tanzania, Klouman (2006) failed to find an association between female mutilation and HIV/AIDS infection (or other STDs or infertility). More studies are needed to clarify whether female genital mutilation increases the risk for HIV/AIDS infection.

2.4.2 Early Marriages

HIV/AIDS risk among young girls is steadily rising in Africa for several reasons. For economic and social reasons, women are forced to engage in relationships with older men

in order to gain access to their money and material goods. Cross generational sex (Fleischman, 2003), age-mixing (Sargent and Johnson, 2006), and the concept of sugar daddies all refer to older men who entice younger women and have sexual relationships with them, believing that they will be cured if they sleep with a virgin (GoK, 2002; Shell and Zeitlin, 2000). Studies have shown that young girls are infected with HIV/AIDS infection at younger ages because of their association with older men who may be infected. In countries such as Botswana, Malawi, South Africa, Zimbabwe, and Kenya, it is well documented that older men seek younger girls in the hope that the girls are not sexually active and are therefore free of HIV/AIDS (Common Secretariat, 2001; Kalipeni, 2000). From the Democratic Republic of Congo, to Uganda, to Malawi, research has shown that young girls are vulnerable to the enticement of older men who promise money and material benefit in exchange for sex.

In addition, younger women are biologically more prone to HIV/AIDS infection than older women because of the vulnerability of the female anatomy (Doyal, 2005). Women are more vulnerable to HIV/AIDS given that they are the receptors while the men are the depositors of semen, which when contaminated with HIV is a danger to women. Thus, younger women may be more vulnerable to HIV infection than older women.

Young girls in relationships are more likely to be socially and sexually vulnerable because of their dependence on men economically and submissiveness of women in a society where women are often expected to be socially and culturally subservient to men (Fleischman, 2003). In addition, young women get married to older men in Kenya increasing HIV/AIDS vulnerability because of the power imbalance that exists in terms of experience, authority, and control over sexual activity and resources. Studies done in the Caribbean, South Africa, Namibia, and Uganda have shown similar results that age plays a vital role in HIV vulnerability with younger women being more vulnerable (NACC, 2002).

In Kenya, women are getting infected at a very young age with AIDS cases on the rise in the 20-45 age bracket and peaking at ages 25-29 (Akwara et al., 2003). Kalipeni (2000) further stated that age plays a significant role in increasing HIV vulnerability among younger women as middle aged men are known to seek younger girls 10-15 years of age

in the belief that they are sexually inexperienced and free of HIV/AIDS infection. This suggests that women usually succumb to older men for resources at an earlier age because of limited access to economic and educational opportunities (NACC, 2007).

Today, the majority of sexually active girls aged 15-19 in developing countries are married. Ironically perhaps, these girls have significantly higher rates of infection than their sexually active, unmarried peers. At this relatively early stage in their physical development, girls are particularly susceptible to HIV/AIDS infection. When they marry older men, who are likely to have had previous sexual partners and who are also less predisposed than younger males to use condoms, the risk of infection is multiplied. In Kisumu, 30% of male partners of married adolescent girls were infected with HIV/AIDS. Unmarried but sexually active girls are more likely to have relationships with younger men, who are more inclined to favour condom use.

2.4.3 Wife Inheritance

In many sub-Saharan African countries, a man's property, including his wife, passes to his adult sons or brothers after his death (Kalipeni, 2000). The fate of African widows ranges from disinheritance and forceful deprivation of property to the mandatory observance of harmful rituals. One of these traditional rituals is widow inheritance, a practice whereby the widow agrees to marry her husband's younger brother to continue as a member of the family. In case of refusal, she is expelled and left to care for her children alone.

Widow inheritance found among some ethnic groups in Kenya is another practice that exposes women to HIV/AIDS infection. This is a cultural practice that involves the inheritance of a widow by the brother or male cousin of the deceased husband. According to Kenyan customary law, when a husband dies, the widow is absorbed into the husband's family as a way to ensure that the widow and her children are provided for and the family name is kept.

Wife inheritance is one of the traditional practices of some countries that promote the spread of HIV/AIDS. In several African countries like Kenya, Swaziland and Zimbabwe,

when a man dies, his wife almost automatically becomes the possession of his brothers, along with his cattle, house and land. Elaborate ceremonies involve the woman putting a bowl of water in front of her late husband's brothers as she 'chooses' one to be her next master while he still lives with his other wife or wives. Each time this happens, several people become exposed to HIV/AIDS (Andersen, 2003). Each time wife inheritance happens several people are exposed to the risk of HIV/AIDS infection. Younger widows are at particular risk because they are more likely to seek and be sought by other sex partners. Nevertheless, wife inheritance is seldom if ever mentioned as a confounding factor in studies of HIV/AIDS transmission.

In a study of 92 widows whose husbands died of a chronic illness between November 1991 and October 1992 in Kenya, Okeyo and Allen (2008) found that 47 women (51%) had already been inherited, 34 (37%) had plans to be inherited, and 11 (12%) refused to be inherited for fear of spreading HIV/AIDS. Comparing the sexual behaviours of inherited and uninherited widows, they found that inherited widows were more likely to be sexually active, to have sex with casual partners and to engage in ritual sex but the difference between the 2 groups with regard to HIV/AIDS seroprevalence was not significant. If a man died of AIDS and had infected his wives, the younger brother(s) will in turn become infected. However, a younger brother may be HIV-infected and, upon marrying his deceased brother's wife or wives, he will infect her or them (Turmen, 2003).

Another interesting observation on how culture may perpetuate the spread of HIV/AIDS comes from Caldwell (2009) who notes that in the culture of the Luo of Uganda a woman who is not inherited is cursed. She is not allowed to fetch water or enter people's houses for fear that her bad luck will be passed on. Adherence to culture becomes an obvious death trap especially in cases where the partner died of AIDS.

Widow inheritance has become dangerous with the advent of HIV/AIDS. This practice increases the risk of contracting the AIDS virus particularly when the new bride is infected or if the inheritor is infected, putting both at risk. In summary, in terms of cultural practices, the vulnerable position of women has to be recognized (Lindsey, 1997)

particularly because there are some cultural rituals that pose a danger to women because of the vulnerability of the female anatomy.

2.4.4 Domestic Violence

Domestic violence, when women are perpetrated by their partners, is the most common form of gender-based violence. Also known as spousal abuse, or intimate partner abuse, it occurs when a family member or partner physically or psychologically dominates another. Domestic violence occurs in all cultures; people of all races, ethnicities, religions, sexes and classes can be perpetrators of domestic violence (Kalipeni, 2000). Domestic violence has many forms including physical violence, sexual abuse, emotional abuse, intimidation, economic deprivation and threats of violence.

Domestic abuse can both result in, or is a consequence of HIV/AIDS infection. The threat of violence can influence a woman's expectations in a relationship, influence her ability to negotiate when and how sex takes place and whether or not to use a condom, which in turn increases the risk for HIV transmission. Gender violence can also be a punitive reaction to a positive HIV diagnosis within a relationship. As most diagnoses are made during pregnancies, women often find out their status before their partner and thereby risk facing discrimination, abuse at the hands of their partners, or even abandonment. Many women are therefore faced with the choice of staying in an abusive relationship or homelessness, or remaining silent about their HIV/AIDS status. Sexual abuse and rape also occur worldwide. Sex trafficking and harmful cultural practices are other examples of gender-based violence that can substantially increase the risk for HIV/AIDS infection.

While women are considered equal and have gained many rights in Africa, there is still discrimination, not only in the law, but in daily interactions among women and men. Many men believe they are the custodians of African culture and regard women as inferior, and believe that women should obey men. They feel a woman's place is in the home where her main duty is to bear and raise children. While women have gained substantial rights and opportunities in recent decades, inequality among the genders is still very prevalent. African culture continues to promote patriarchy in many ways and this perpetuates the subordination of women. Abuse against women is still extremely

common and encourages the tradition of male dominance. This has a substantial impact on the continuing spread of HIV/AIDS. The culture continues to endorse the subordination of women through many of its cultural practices. Many of these ideas which encourage male dominance also increase the acceptance and justification of violence against women. Throughout history, men have been given the right to control women and have exercised whatever means they felt necessary to achieve this domination. Women were viewed as the property of their fathers and then of their husbands; a woman was required to obey a man's command and the husband was permitted, even encouraged, to punish her for misbehaviour in the form of a beating and torture. The use of power and control in the form of sexual, emotional, or physical violence is central to the perpetuation of female abuse. Asserting power over women allows men to establish "male control and dominance", not only in relationships, but also in the beliefs and structures of society (Wallace, 2005).

NACC (2009) observed that not all young people have sex because they want to. In a nationwide study of women 12 to 24 years old, 25% said they had lost their virginity because they had been forced. Unwilling sex with an infected person carries a higher risk of infection, especially for girls. Since force is used, abrasions and cuts are more likely and the virus can easily find its way into the bloodstream. More to this, condom use is unlikely in such situations.

According to Smyke (2001), African culture continues to promote patriarchy in many ways and this perpetuates the subordination of women. One major issue surrounding women in Africa is the problem of violence. Abuse against women and children is still extremely common and feeds into the culture and tradition of male dominance. Because women are still refused rights and are seen as inferior to men, they are more likely to be mistreated at the work-place, in the community and at a personal level. Women are viewed as the property of men, first of their fathers and then, when they get married, of their husbands. This is encouraging male dominance and also increases and encourages violence against women. In order to stop the spread of the HIV/AIDS pandemic, women need to be given power and control over themselves and their sexual lives. If women are given the authority that they deserve, men will not be able to make decisions for women

regarding sexual practices. These issues regarding women's rights and equality have an important and substantial impact on the continuing spread of HIV/AIDS. The experience of violence affects the risk of HIV/AIDS and other sexually transmitted infections (STIs) directly when it interferes with women's ability to negotiate condom use.

In many cultures women are not recognized, let alone treated, as the equals of men. Sexual abuse including rape is just one part of a wider problem of gender based violence (GBV). In every country, upwards from 20% of women have been abused by the men they live with. Where women fear violence from men including emotional and psychological violence and social and economic deprivation, as well as physical violence they are least likely to be able to negotiate for safe sex or condom use, or to prevent their husbands or partners from having other sexual relationships (Jackson, 1999)

Spradley and McCurdy (2003) observed that women with or at risk of HIV/AIDS came from populations that are also at risk of violence. However, for a small proportion of women, violence may occur around disclosure or in response to condom negotiation. Were (2004) added his voice to the role of gender based violence in spreading HIV/AIDS by noting that domestic violence and human immunodeficiency virus (HIV) infection are problems of great public health worldwide, especially sub-Saharan Africa and much of the developing countries. Gender power imbalance is the driving force behind the "epidemics". HIV/AIDS infection is mainly acquired through heterosexual relations, which themselves are greatly influenced by socio-cultural factors, underlying which are gender power imbalances. Women with violent or controlling male partners are at increased risk of HIV/AIDS infection. Abusive men are more likely to have HIV/AIDS and impose risky sexual practices on partners. Research on connections between social constructions of masculinity, intimate partner violence, male dominance in relationships, and HIV/AIDS risk behaviours in men, as well as effective interventions, are therefore urgently needed.

The inevitable results of "dry sex" include increased friction, vaginal lacerations, suppression of the vagina's natural bacteria, and torn condoms (when these are used). All these consequences increase a woman's risk of STD and HIV/AIDS infections.

Fortunately, the tradition of “dry sex” is waning among the educated urban young, but any change in this traditional mating behaviour is also resisted because of rejection of Western gender roles (Willis, 2002).

Discussions of sexuality are considered indecent for girls and women. Throughout their lives, women are expected to bear suffering and humiliation in silence. Right from the cradle, this is the life to which girls are groomed and indoctrinated. Thus, from fear of castigation, rejection, and shaming, most women suffer any venereal diseases, including HIV/AIDS, without a word. Fertile ground indeed for the spread of AIDS (Were, 2004).

African women’s low status in marriage also makes them vulnerable to violence from their husbands. When men beat up their wives, there are no reprisals. Marital rape must be suffered in silence. Fear of beating and rape keeps many women from questioning their husbands’ sexual escapades. And submission frequently reaps a death sentence: many women contract HIV/AIDS as a result of coerced sex (Smyke, 2001). For unmarried girls, the situation is even worse. If a rape is reported, it is the girl who suffers the shame, and all chance of future marriage. Under such circumstances, women’s ability to protect themselves is minimal. AIDS has added a further, nasty dimension to this situation. While rape continues to thrive, checking the spread of HIV/AIDS becomes an uphill task.

Sexual violence and coercion of women in sub-Saharan Africa and the implication for HIV/AIDS transmission have been reported in earlier studies. More recently, similar observations have been documented (Kenda 2005). Even more current studies continue to associate intimate partner violence and high levels of male control in a woman’s current relationship with HIV/AIDS seropositivity. The authors warn that women with violent or controlling male partners remain at increased risk of HIV/AIDS infection. They argue for social discourse and effective intervention strategies on the relationship between masculinity, intimate partner violence, male dominance in relationships, and their implications for high HIV/AIDS prevalence among women in sub-Saharan Africa.

Cravero (2005) submits that poverty, ignorance and violence increase the vulnerability of women and girls to HIV/AIDS. One cannot tell a woman to abstain from sex when he has

no choice on whether or not to have sex. One cannot tell her to be faithful when she already is and her spouse is not. One cannot inform her about the condom option when she is not in a position to negotiate for safer sex.

HIV/AIDS infection as relevant to Gender Based Violence (GBV) is primarily acquired through sexual relations, which themselves are greatly influenced by socio-cultural factors, underlying which are gender power imbalances. Gender based violence, or the fear of it, may interfere with the ability to negotiate safer sex or refuse unwanted sex. Furthermore, violence against a woman can interfere with her ability to access treatment and care, maintain adherence to ARV treatment, or carry out her infant feeding choices. Evidence also exists that living with HIV/AIDS can constitute a risk factor for GBV, with many people reporting experiences of violence following disclosure of HIV/AIDS status, or even following admission that HIV testing has been sought. Thus a vicious cycle of increasing vulnerabilities to both GBV and HIV can be established.

Women are obliged to have intercourse anytime and under risky conditions: e.g., male spouses having sexual relations with other women, becoming infected with STDs, and demanding sex under the influence of alcohol. Trauma caused by forced sex increases the likelihood of HIV/AIDS transmission. Some countries have taken the legal decisions against this type of behaviour, e.g. in Zimbabwe, the sexual offences act considers non-consensual sex within marriage as a rape.

Violence increases vulnerability to HIV/AIDS infection in several ways. Sexual violence can result in 'direct transmission' of HIV/AIDS which can be the result of forced or coercive sexual intercourse with an HIV/AIDS infected partner. The biological risk of transmission in a violent sexual encounter is determined by the type of sexual exposure (vaginal, anal or oral). Transmission of HIV/AIDS is higher for anal, followed by vaginal, and then oral sex.. Risk of direct transmission in forced and coerced sexual encounters is also dependent upon the degree of trauma, such as vaginal or anal lacerations and abrasions, which occurs when force is used. For example, where sexual violence occurs in girls and young women, risk of transmission is likely to be higher because girls' vaginal tracts are immature and tear easily during sexual intercourse.

Sexual violence can also result in 'indirect transmission' of HIV/AIDS infection among women or men: violence or the threat of violence affects the individual's power and ability to negotiate the conditions of sexual intercourse, especially condom use.

Violence has many facets. Within the household this can include battering by an intimate partner, marital rape, dowry-related violence, and sexual abuse. Violence outside the home can include rape, sexual abuse, sexual harassment and assault.

2.4.7 Research Gaps

Differences in the prevalence rates of HIV/AIDS between men and women in Kenya may be attributed to deep entrenchment in cultural practices which may have serious implications on the spread of HIV/AIDS as well as other communicable diseases (Tiessen 2004). The study focuses on social aspects that contribute to spread of HIV/AIDS which researchers have done extensive research on the same. However there exists a gap which needs further investigation on what leads to spread of HIV/AIDS. According to UNAIDS study (2006) in cases of sexual violence women and girls are vulnerable to tears and bruising which provides site for entry of HIV into their system. Further study by UNAIDS (2006) confirms that even when consensual young women and girls are at increased risk of HIV/AIDS infection because of their undeveloped vaginal tracks which are susceptible to tears during sexual intercourse. Female genital mutilation may increase individual risk of acquiring blood-borne pathogens such as HIV/AIDS or the hepatitis B virus. However, there is yet no evidence that it is a major contributor to the spread of HIV or Hepatitis B or other blood borne diseases. However a recent study in Kenya reported that group operations using the same unclean cutting instruments with consequent risk of transmission are still common (Maendeleo ya wanawake organization 1991). The reviewed literature has shown that there are social aspects that contributes to spread of HIV/AIDS, however there exists a gap in Moyale District which needs further investigations. Generally in Kenya the evidence of HIV/AIDS is prevalent thus calls for further research to build on the existing knowledge.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter is a blueprint of the methodology that was used by the researcher to find answers to the research question. In this chapter the research methodology is presented in the following order: research design, target population, sampling procedure, tools and techniques of data collection, pre-testing, data analysis, ethical considerations and finally the operational definition of variables.

3.2 Research Design

This study used the descriptive research design as it looks at social aspects that leads to spread of HIV/AIDS among Borana women in Sololo Division in Moyale District of North Eastern province. The method was chosen since it is more precise and accurate since it involves description of events in a carefully planned way. Also the descriptive design was used as the respondents were interviewed in their natural settings as well narrating of their experiences in describing a social situation. Descriptive design was used because although the women tend to have the same basic attributes, the specifics of their perception of various issues would also be driven by external forces such as economic status and family/clan background.

3.3 Target Population

The target population refers to population to which the researcher makes inferences to. This population should theoretically be countable, observable and exist within a specific time frame. The target population of the study was 2303 women in their child bearing age (15-49) years, and employees of 31 community based organization, four faith based organization and three health workers in non-governmental organizations who are involved in the control of HIV/AIDS in Moyale district (Appendix 5).

The target population was chosen from Sololo Division of Moyale District due to cultural background as women are marginalized and suffer numerous problems in the hands of

their husband's parents and the community at large. The health and NGO workers were also targeted as they have first hand information on HIV/AIDS management.

3.4 Sampling Procedure and Sample Size

Sampling is the process of choosing the research units of the target population which are to be included in the study. Sampling is done because a complete coverage of the population is not possible. It also requires small portion of the target population, sampling also offer more detail information and high degree of accuracy as it deals with smaller units and it also representative of a larger population.

The data was collected using adjusted sample size of 196 and simple random sampling was used to select 196 Borana Women of child bearing age of 15-49 years as recommended by Mugenda and Mugenda (2003). The researcher also used purposive sampling to select four health workers, three NGOs employees, sixteen CBO employees and four Faith based organization employees.

The sample size was obtained by using the following equation given by Yamane (1967):

$$n = \frac{N}{1 + N(e)^2}$$

Where:

n= sample size

N = Population proportion

e = level of significance (7%)

$$n = 2303/1 + 2303 (0.07)^2$$

$$=188$$

3.5 Tools and Techniques of Data Collection

These are methods of data collection where various techniques were used which included administering of the questionnaires, observation, interviews for collecting primary data and relevant reading materials like text books, journals, magazines, newspapers and websites will be utilized to get secondary data.

3.5.1 Questionnaires

The data in this research was collected using both primary and secondary tools. The primary data collection method include questionnaire with both closed and open ended questions relating to the study was utilized. The open-ended questions are used in order to help the respondents air their views and options on the issues that lead to the spread of HIV/AIDS among women of Sololo Division. Closed-ended questions were used to enable the respondents to choose between available alternatives and also the target populations are illiterate and therefore it's easy for the respondent to choose on the available alternatives. A closed-ended question also makes it easier for the researcher to code the information given for data analysis. The researcher personally delivered the questionnaires to the respondents and requested them to fill in the questionnaires. The drop and pick later method was used in the study.

3.5.2 Observation

The researcher also used observation. This is where a researcher while administering questionnaires looks and observes carefully at the respondents behaviour on how they do things while in the field. Observation was used as it is only through observation that the researcher gets directly involved with the respondents and recording the respondents unintended actions and behaviours; while the study focused on socio aspects that leads to spread of HIV/AIDS as it touched on sensitive issues like female genital mutilation and sex which are culturally considered sacred, thus observations is important as it helps the researcher to capture some social and cultural aspects, which may have been unnoticed or even misinterpreted by respondents. The observations were noted down in the course of the interviews or later in the situations where writing was discouraged if it would be seen to interrupt the interview process.

3.5.3 Interviews

Face to face interviews were also appropriate in generating information pertaining to the study. The researcher asked the respondents questions on issues that leads to spread of HIV/AIDS like female genital mutilation, domestic violence, early marriage which the respondent provide more information and opinions and this helped the researcher to get deeper understanding of socio aspects that leads to spread of HIV/AIDS and analysis of the findings. This was administered using face to face interviews.

3.5.4 Secondary Data

Secondary data collection was also utilized. These are called secondary because there are not primarily obtained from for the study. Relevant reading materials were obtained from textbooks, journals, magazines, newspapers and in the websites. The research secondary data was also obtained from Nairobi University library, main campus and UNAIDS Reports (2009). Secondary data collection method helped the researcher to have a comprehensive understanding of the study and universal knowledge of HIV/AIDS and its spread.

3.6 Pre-testing of Instruments

Before the research tools were administered to the participants, pre-testing was carried out in the neighbouring divisions in order to ensure that the questions were relevant, clearly understood and made sense.

3.6.1 Validity of Instruments

Validity is the degree to which results obtained from the analysis of the data actually represents the phenomenon under study. Validity was ensured by having objective questions included in the questionnaire and by pre-testing the instrument to be used to identify and change any ambiguous, awkward, or offensive questions and technique as emphasized by Cooper and Schindler (2003). Expert opinion was requested to comment on the representativeness and suitability of questions and give suggestions of corrections to be made to the structure of the research tools. This helped to improve the content validity of the data that was collected.

3.6.2 Reliability of Instruments

Reliability on the other hand refers to a measure of the degree to which research instruments yield consistent results (Mugenda and Mugenda, 2003). Pre-testing of the questionnaire was done in order to determine the reliability of the research tools including the wording, structure and sequence of the questions. The pre-testing involved 10 respondents from the target population from the neighbouring division. The respondents were purposively selected since statistical analysis is not necessary in the pilot study. The purpose of the pre-testing was to refine the research tools so that respondents in the major study would have no problem in answering the questions.

3.7 Data Analysis

Data analysis is engaged in after all data has been collected and is a process used to make sense of the data. The type of data analysis tool that was be used is dependent on the type of data, that is; is the data qualitative or quantitative. To analyze quantitative data frequency tables and statistical software packages can be used. The quantitative data in this research was analyzed by descriptive statistics using statistical package for social sciences (SPSS).

The qualitative data was taken an exploratory/conceptual content analysis process, this is more ideal as the information gathered from the open ended questions which was large and could be time consuming if not well planned. The data was then presented using frequency tables and figures. In addition the study was used Karl Pearson's product moment correlation analysis to assess the relationship between the variables. This is because correlation analysis illustrates both the direction and strength of the relationship between two variables.

3.8 Ethical Considerations

Ethical considerations in research can be defined as ensuring that the researcher conforms to the standards of conduct of the authorities in the area of research. Examples of ethical issues that may arise are voluntary participation of respondents, deception to participants, anonymity and confidentiality of information given, analysis and reporting, harm or

danger to participants and any other professional code of ethics expected. To ensure that the research was done in an ethical manner according to the expectations of all authorities, a letter from the university was obtained.

The researcher informed the respondents that the instruments being administered were for research purpose only and the responses from the respondents would be kept secret and confidential. The researcher obtained an introductory letter from the University to collect data from the organization. The researcher also pursued a permit from the National Council of Science and Technology and a letter of approval from NACC offices in Moyale, permitting the research. Also, due to sensitivity of some information collected, the researcher holds a moral obligation to treat the information with utmost propriety. Further, since the respondents might be reluctant to disclose some information, the researcher needs to reassure the respondents of use and confidentiality of the information given.

3.9 Operationalization of Variables

The operationalization of variables is shown in Table 3.1

Table 3.1: Operationalization of variables

Objective	Independent variable	Indicators	Level of scale	Tools of analysis	Type of analysis
To find out whether female genital mutilation spread HIV/AIDS among Borana women	Female Genital Mutilation	Unsterilized instruments sharing Tear of female genitals Difficulties with intercourse	Ordinal Ratio	Mean Percentage Correlation	Descriptive Inferential
To establish whether early marriages contribute to the spread of HIV/AIDS among Borana women	Early Marriages	Marriage for economic and social reasons Sexual vulnerability of young girls in relationship. Percentage of early marriages	Ordinal Ratio	Mean Percentage Correlation	Descriptive Inferential
To determine whether wife inheritance lead to the spread of HIV/AIDS among Borana women	Wife Inheritance	Forceful deprivation Mandatory observance of harmful rituals Having casual sex with related partners Extent of inheritance	Ordinal Ratio	Mean Percentage	Descriptive

To find whether domestic violence leads to spread of HIV/AIDS among Borana women	Domestic Violence	Emotional abuse Psychological violence Physical violence/ Sexual abuse Social and economic deprivation of women	Ordinal Ratio	Mean Percentage	Descriptive
Incidence of HIV/AIDS spread in Sololo Division	Dependent Variable	Number of women infected with HIV/AIDS Awareness of protective devices used HIV status after visiting VCT	Ratio Ordinal	Mean Percentage	Descriptive

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION AND INTERPRETATION

4.1 Introduction

This chapter covers data analysis, presentation and interpretation of the findings. The main objective of this study was to determine the factors influencing spread of HIV/AIDS among Borana women in Sololo Division, Moyale District. The study also sought to establish whether female genital mutilation, early marriages, wife inheritance and domestic violence contribute to the spread of HIV/AIDS among Borana women.

The Response Rate

The researcher targeted a sample of 227 respondents out of which 196 were Borana Women of child bearing age and 31 were employees of community based organization, four faith based organization and three health workers in non-governmental organizations who are involved in the control of HIV/AIDS in the District. In this study 174 questionnaires were collected. This represented a 76.7% response rate.

4.2 Borana Women Findings

4.2.1 General information

As part of the general information, the study sought to find out the participants age bracket and marital status.

Table 4. 1: Age bracket of respondents

	Frequency	Percent
Under 25	26	18.8
26-35	44	31.9
36-45	35	25.3
46-55	18	13.0
56 and above	15	11
Total	138	100

As shown by Table 4.1 above, 31.9% of respondents indicated that they were 26 to 35 years old and the minority of the respondents were 56 years and above.

Marital status

	Frequency	Percent
Married	103	74.6
Single	13	11.0
Divorced	17	12.3
Widow	3	2.1
Total	138	100

In regard to marital status, 74.6% of the respondents indicated that they were married, 12.3% of the respondent indicated that they were divorced and only 2.1% of the respondents indicated that they were widowed. From the findings, it can be concluded that the majority of respondents were married and were aged below 45 years. The number of widowed women was low due to the fact that those whose husbands died were inherited.

The findings of the nature of marriage are given in Table 4.2.

Table 4. 2: Nature of marriage

	Frequency	Percent
Single	81	78.6
Two wives	18	17.5
Three wives	4	3.9
Total	103	100

In an effort to investigate the nature of marriage, the researcher requested the respondents to indicate the nature of their marriage. From the findings, 78.6% of the respondent indicated that they were married as the only wife, 17.5 % indicated that they were married as two wives whereas 3.9% of the respondents indicated that they were married as three wives. It can be concluded that the majority of women were married as one wife. The

respondents married as two wives or three wives were due to the economic and social status of their husbands.

Information on whether the women had married before is presented in Table 4.3.

Table 4. 3: Married before

	Frequency	Percent
Yes	79	57.2
No	59	42.8
Total	138	100

On whether they had been married before, 57.2% of the respondents indicated that they had been married before and 42.8% indicated that they had not been married before. From these findings we can deduce that the majority of respondents had married before and were thus in their second marriage either due to death of their husbands or divorce.

The findings on school attendance are given in Table 4. 4.

Table 4. 4: Attending school at the time of marriage

	Frequency	Percent
Yes	102	83
No	21	17
Total	123	100

On whether they were attending school when they got married, 83% of the respondents indicated that they were in school when they got married while the rest (17%) were not attending school when they got married. From these findings we can deduce that majority of the women who were married or have ever been married were attending school before they got married.

Results on the level of education are shown in Table 4.5.

Table 4. 5: Level of Education

	Frequency	Percent
Primary	5	5
Secondary	96	94.1
No response	1	0.9
Total	102	100

In relation to their level of education, 94.1% of the respondents indicated that they had secondary school education, 5% had primary school education and 0.9 % of the responded withheld information concerning her level of education. From these findings we can deduce that most of the respondents had secondary school education.

Results on the source of income are given in Table 4. 6.

Table 4. 6: Source of Income

	Frequency	Percent
Employment	4	2.9
Business	7	5.1
Herding	122	88.4
others	5	3.6
Total	138	100

In relation to their source of income, 88.4% of the respondents indicated that their source of income was through herding, 5.1% indicated that their sources of income were businesses, 3.6% of the respondents were getting income from other sources and 2.9% were getting their income from employment. This is a proof that the majority of women getting their income from herding activities.

4.2.2 Knowledge on HIV/AIDS

The findings on the knowledge on HIV/AIDS is given in Table 4. 7.

Table 4. 7: Awareness on HIV/AIDS

		Frequency	Percent
Awareness on HIV/AIDS	Yes	97	70.3
	No	41	29.7
Is there cure	Yes	8	5.8
	No	130	94.2

On whether they were aware of HIV/AIDS, 70.3% of the respondents indicated that they were aware while 29.7% indicated that they were not aware. Concerning cure only 5.8 % of the respondents indicated that there is cure for HIV/AIDS while 94.2% indicated that there was no cure. This clearly shows that majority of the respondents had knowledge on of HIV/AIDS and they knew that there was no cure.

In relation to the main causes of spreading HIV/AIDS among woman, the respondents indicated extra marital affairs, many sexual partners, rape, sharing of equipments, blood transfusion were the main causes of HIV/AIDSs.

Table 4.8 below shows the awareness on prevention and VCT

Table 4. 8: Awareness on Prevention and VCT

		Frequency	Percent
Awareness on prevention method	Yes	79	57.2
	No	59	42.8
Access to condom	Yes	19	13.8
	No	119	86.2
Knowledge about VCT	Yes	10	7.2
	No	128	92.8
VCT visit	Yes	7	5.1
	No	121	96.9

On whether they were aware of prevention methods for HIV/AIDs, 57.2% of the respondents indicated that they were aware, while 42.8% indicated that they were not aware. In addition the respondents indicated that the most preferable method of prevention was the use of condoms. On whether they had access to condoms, 86.2% of the respondents indicated that they did not have access while 13.8% indicated that they had access. In relation to knowledge of VCT, 92.8% of the respondents indicated that they did not know of VCT while 7.2% indicated that they knew of VCT. On whether they had visited a VCT center 96.9% indicated that they had not while 5.1% indicated that they had visited a VCT center.

4.2.3 Awareness of Spread of HIV/AIDS

Results on the whether there are wife inheritance practices are shown in Table 4.9.

Table 4. 9: Wife inheritance practice

	Frequency	Percent
Yes	136	98.6
No	2	1.4
Total	138	100

On whether wife inheritance was a practice in their area, 98.6% of the respondents agreed that it was whereas 1.4% disagreed that wife inheritance was not practiced in their area. In relation to who was inheriting the wife most of the respondents indicated a brother to the deceased. The respondents also indicated that death of a husband and bareness were the main causes of wife inheritance.

Table 4. 10: Period of remarrying after husband death

	Frequency	Percent
One to three month	50	63.3
Three to six months	25	31.6
Other	4	5.1

As indicated in the Table 4.10, 63.3% of the respondent indicated that they remarried after between 1 and 3 months after the death of their husbands, 31.6% indicated that they

remarried after between 3 and 6 months after the death of their husbands and 1% indicated other periods that they remarried after the death of their husbands.

In an effort to investigate on the prevalence of domestic violence in the area, the researcher requested the respondents to indicate whether domestic violence occurred in their area.

Table 4. 11: Domestic violence occurrence

	Frequency	Percent
Yes	131	95
No	7	5
Total	138	100

From the findings shown in Table 4.11, 95% of the respondents agreed that domestic violence was prevalent in the area whereas only 5% disagreed on the prevalence of domestic violence in the area. In addition, the respondents indicated that wife beating was the most prevalent form of domestic violence.

Results on the practice of FGM in Moyale, Sololo Division are shown in Table 4.12.

Table 4. 12: Practice of FGM in Sololo Division, Moyale District

	Frequency	Percent
Yes	129	93.5
No	5	3.6
No response	4	2.9
Total	138	100

From the findings, 93.5% of the respondents agreed that female genital mutilation was practiced in Moyale, 3.6% disagreed that female genital mutilation was practiced in Moyale and 2.9% of the respondents did not respond due to the fear and they considered this information as confidential to them.

Table 4. 13 shows the age at which genital mutilation is done

Table 4. 13: Age at which genital mutilation is done

	Frequency	Percent
Below 8 years	6	4.7
8 – 12 years	99	76.7
13- 17 years	18	13.9
Others	6	4.7
Total	129	100

The study also sought to find out the age at which female genital mutilation was done. From the findings, 76.7% of the respondents indicated that it was done at an age of between 8 to 12 years, 13.9% indicated at an age of between 13 and 17 years, 4.7% indicated at another age not indicated and 4.7 % indicated that it was done below 8 years of age. It can thus be concluded that female genital mutilation is done at an age of 8 to 12 years.

Table 4.14 shows findings on schooling of circumcision of females

Table 4. 14: In school or not during circumcision

	Frequency	Percent
Yes	126	97.7
No	3	2.3
Total	129	100

On whether they were in school during circumcision, 97.7% of the respondents agreed that they were schooling when circumcision was done to them but only 2.3% of the respondents were not in school when circumcision was done.

Table 4.15 shows findings on whether education was continued after circumcision.

Table 4. 15: Education was continued after circumcision

	Frequency	Percent
Yes	120	95.2
No	6	4.8
Total	126	100

On whether education was discontinued after education, majority of the respondents did not continue with education after circumcision as indicated by 95.2% of respondents and only 4.8% of the respondents continued with education after circumcision. In relation to who was conducting the circumcision, the respondents indicated that elderly women and traditional birth attendant conducted the circumcision.

Table 4.16 below shows findings on opinion towards female genital mutilation

Table 4. 16: Opinion towards female genital mutilation

		Frequency	Percent
Is FGM acceptable in women	Yes	2	1.4
	No	136	98.6
	Total	138	100
Should FGM continue	Yes	1	0.7
	No	137	99.3
	Total	138	100

On whether female genital mutilation was acceptable in women, 98.6% of the respondents indicated that it was not acceptable while 1.4% indicated that it was acceptable. Further, on whether they thought that female genital mutilation should continue 99.3% indicated that it should not continue while 0.7% indicated that it should continue.

4.3 Leaders/Health Workers findings

4.3.1 General information

In the general information section, the respondents were requested to indicate their gender, age bracket and level of education. The results are shown in Table 4.17.

Table 4. 17: General information

		Frequency	Percent
Gender	Female	29	93.55
	male	2	6.45
	Total	31	100.00
Age bracket	20-25 years	1	3.23
	25-30 years	3	9.68
	Above 30 years	27	87.10
	Total	31	100.00
Level of education	College	3	9.68
	University degree	26	83.87
	Postgraduate	2	6.45
	total	31	100.00

From the findings as shown by Table 4.17 above, 93.55% of the respondents in this section were female and 6.45% were male. This clearly shows that majority of the employees in community based organization, faith based organization and health workers in non-governmental organizations that are involved in the control of HIV/AIDS were female. In relation to their age bracket, 87.10% of the respondents indicated that they were above 30 years in age, 9.68% were between 25 and 30 years in age and 3.23% were between 20 and 25 years in age. In relation to their level of education, 83.87% of the respondents indicated that they had university degree as their highest level of education, 9.68% had college education and 6.45% had postgraduate degrees.

4.3.2 Female Genital Mutilation

The study sought to find out whether female genital mutilation contributes to the spread HIV/AIDS among Borana women. The results are shown in 4.18.

Table 4. 18: Female genital mutilation and the spread of HIV/AIDS

	Frequency	Percent
To a very great extent	17	54.84
To a great extent	11	35.48
To a moderate extent	2	6.45
To a little extent	1	3.23

According to the findings, 54.84% of the respondents indicated that female genital mutilation contributes to the spread HIV/AIDS among Borana women to a very great extent, 35.48% indicated to a great extent, 6.45% indicated to a moderate extent and 3.235 indicated to a little extent. From these findings can deduce that that female genital mutilation contributes to the spread HIV/AIDS among Borana women to a very great extent.

Table 4.9 shows the extent to which the stated aspects of female genital mutilation affect the spread of HIV/AIDS among borana women in the district. A five point likert scale will be used to interpret the data.

Table 4. 19: Aspects of female genital mutilation

	Mean	Std deviation
Unsterilized instruments sharing	4.12	0.981
Tear during intercourse	3.89	0.786
Difficulties with intercourse	3.09	0.982

According to the scale, those aspects which were disagreed 1 while those which were strongly agreed were awarded 5. Within the continuum are 2 for disagree, 3 for moderate

agree and 4 for agree. Mean (weighted average) and standard deviation were used to analyze the data. According to the researcher those aspects with a mean close to 4.0 were rated as to a very great extent while those with a mean close to 3.0 were rated to a low extent or even not considered at all. On the same note the higher the standard deviation the higher the level of dispersion among the respondents.

According to the findings, the respondents agreed with a mean of 4.12 that unsterilized instruments sharing contributes to a great extent to the spread of HIV/AIDS among borana women in the district. In addition, the respondents agreed with a mean of 3.89 that tear during intercourse contribute to a great extent to the spread of HIV/AIDS among borana women in the district. Further, the respondents agreed with a mean of 3.09 that difficulties with intercourse contribute to a moderate extent to the spread of HIV/AIDS among borana women in the district.

4.3.3 Early Marriages

The study also sought to establish whether early marriages contribute to the spread of HIV/AIDS among Borana women.

Table 4. 20: Early marriages and the spread of HIV/AIDS

Extent	Frequency	Percent
To a very great extent	3	9.68
To a great extent	10	32.26
To a moderate extent	17	54.84
To a little extent	1	3.23
Total	31	100

Table 4.20, shows the extent to which early marriages affect the spread of HIV/AIDS among borana women in the district. According to the findings, 54.84% of the respondents reported that early marriages affect the spread of HIV/AIDS among borana women in the district to a moderate extent, 32.26% reported to a great extent, 9.68% reported to a very great extent and 3.23% reported to little extent. From these findings

we can deduce that early marriages affect the spread of HIV/AIDS among borana women in the district to a moderate extent.

Table 4.21 shows the extent to which the stated aspects of early marriages affect the spread of HIV/AIDS among borana women in the district.

Table 4. 21: Aspects of early marriages and the spread of HIV/AIDS

	Mean	Std deviation
Marriage for economic and social reasons	4.07	0.817
Vulnerability of the female anatomy	2.98	0.982
Sexual vulnerability of young girls in relationships	3.99	1.021

From the findings, the respondents agreed with a mean of 4.07 that marriage for economic and social reasons affects the spread of HIV/AIDS among borana women in the district. The respondents also agreed with a mean of 3.99 that sexual vulnerability of young girls in relationships affects the spread of HIV/AIDS among borana women in the district. Further, the respondents agreed with a mean of 2.98 that vulnerability of the female anatomy affects the spread of HIV/AIDS among borana women in the district.

4.3.4 Wife Inheritance

The study also sought to determine whether wife inheritance leads to the spread of HIV/AIDS among Borana women. Table 4.22 shows the extent to which wife inheritance affects the spread of HIV/AIDS among borana women in the district.

Table 4. 22: Wife inheritance and the spread of HIV/AIDS

Extent	Frequency	Percent
To a very great extent	16	51.61
To a great extent	9	29.03
To a moderate extent	5	16.13
To a little extent	1	3.23
Total	31	100

According to the findings, 51.61% of the respondents agreed that wife inheritance affects the spread of HIV/AIDS among borana women in the district to a very great extent, 29.03% indicated to a great extent, 16.13% indicated to a moderate extent and 3.23% indicated to a little extent. From these findings we can deduce that wife inheritance affects the spread of HIV/AIDS among borana women in the district to a very great extent.

Table 4. 23: Aspects of wife inheritance and the spread of HIV/AIDS

	Mean	Std deviation
Forceful deprivation	3.89	0.827
Mandatory observance of harmful rituals	3.01	0.721
Having sex with casual related partners	4.12	0.871

As indicated in Table 4.23 the respondents agreed with a mean of 4.12 that having sex with casual related partners affects the spread of HIV/AIDS among borana women in the district. In addition, the respondents agreed with a mean of 3.89 that forceful deprivation affects the spread of HIV/AIDS among borana women in the district. Further, the respondents agreed with a mean of 3.01 that mandatory observance of harmful rituals affects the spread of HIV/AIDS among borana women in the district.

4.3.5 Domestic Violence

The study also sought find out whether domestic violence contributes to the spread of HIV/AIDS among Borana women.

Table 4. 24: Domestic violence and the spread of HIV/AIDS

Extent	Frequency	Percent
To a very great extent	15	48.39
To a great extent	10	32.26
To a moderate extent	4	12.90
To a little extent	2	6.45
Total	31	100

As shown by Table 4.24 48.39% of the respondents reported that domestic violence affects the spread of HIV/AIDS among borana women in the district to a very great extent, 32.26% reported to a great extent, 12.90% reported to a moderate extent and 6.45% reported to a little extent. From these findings we can deduce that domestic violence affects the spread of HIV/AIDS among borana women in the district to a very great extent.

Table 4.25 shows the extent to which the stated aspects of domestic violence affect the spread of HIV/AIDS among borana women in the district.

Table 4. 25: Aspects of domestic violence and the spread of HIV/AIDS

	Mean	Std deviation
Emotional abuse	2.23	0.762
Psychological violence	2.34	1.092
Physical violence	4.03	0.827
Social and economic deprivation	3.11	0.789
Sexual abuse	4.12	0.928

According to the findings the respondents agreed with a mean of 4.12 that sexual abuse affect the spread of HIV/AIDS among borana women in the district to a great extent. The respondents also agreed with a mean of 4.03 that physical violence affects the spread of HIV/AIDS among borana women in the district to a great extent. In addition, the respondents agreed with a mean of 3.11 that social and economic deprivation affects the spread of HIV/AIDS among borana women in the district to a moderate extent. Further, the respondents agreed with a mean of 2.34 that physical violence affects the spread of HIV/AIDS among borana women in the district to a little extent. Lastly, the respondents agreed with a mean of 2.23 that emotional abuse affects the spread of HIV/AIDS among borana women in the district to a little extent.

4.3.6 Correlation Analysis

A Correlation is a measure of the relationship between two or more variables. The measurement scales used should be at least interval scales. Correlation coefficients can range from -1.00 to +1.00. The value of -1.00 represents a perfect negative correlation while a value of +1.00 represents a perfect positive correlation. A value of 0.00 represents a lack of correlation.

The findings on correlation analysis are given in Table 4. 26

Table 4. 26: Correlation coefficients

		Spread of HIV/AIDS among borana women	Female genital mutilation	Early marriages	Wife inheritance	Domestic violence
Spread of HIV/AIDS among borana women	Pearson Correlation	1				
Female genital mutilation	Pearson Correlation	.92	1			
	Sig. (2-tailed)	0.021				
Early marriages	Pearson Correlation	.54	.113(**)	1		
	Sig. (2-tailed)	0.019	0.021			
Wife inheritance	Pearson Correlation	1.01	.212(**)	.277(**)	1	
	Sig. (2-tailed)	0.025	0.020	0.00		
Domestic violence	Pearson Correlation	1.21	.121(**)	.431(**)	.431(**)	1
	Sig. (2-tailed)	0.012	0.029	0.012	0.00	

The analysis of correlation results between the Spread of HIV/AIDS among borana women and Female genital mutilation shows a positive coefficient 0.92. It indicates that

the result is significant at $\alpha = 5\%$ and that if the Female genital mutilation increases it will have a positive impact on the Spread of HIV/AIDS among borana women. The correlation results between Early marriages and spread of HIV/AIDS among borana women also indicates the same type of result where the correlation coefficient is 0.54 which significant at $\alpha = 5\%$. The results also show that there is a positive association between wife inheritance and Spread of HIV/AIDS among borana women where the correlation coefficient is 1.01. Further, the result shows that there is a positive association between domestic violence and Spread of HIV/AIDS among borana women where the correlation coefficient is 1.21.

4.4 Interview Guide Findings

In relation to the main causes of spreading HIV/AIDS among women, the respondents indicated that wife inheritance, rape, blood transfusion and female genital mutilation were the main causes.

Wife inheritance

The respondents indicated that wife inheritance was a practice in Moyale District. In addition, they indicated that wife inheritance affect the spread of HIV/ AIDS because the deceased wife accepts to be remarried to a close relative of the husband in order to access to her husband property and also kids, she is also subjected to forceful eviction if she refused. This leads to spread of HIV/AIDS because the close relative might suffer HIV/AIDS. Wife inheritance leads to spread of HIV/AIDS in that the widow accepts to marry her husband close relative in order to have access to her late husband's property and kids the inheritor might be sick with HIV/AIDS.

Domestic violence

The respondents also agreed that domestic violence was common in the area. Further, they indicated that domestic violence contributes to spread of HIV/ AIDS in case of rape the women suffers tears and bruises which makes spreading of HIV/AIDS.

Female genital mutilation

The respondents reported that female genital mutilation is very prevalent in Moyale District and it is usually conducted by traditional birth attendant and elderly women.

However, the respondents indicated that female genital mutilation was acceptable to women. The respondents also indicated that FGM affects to great extent because of sharing of cutting equipment which are not sterilized, tear during intercourse also leads to spread of HIV/ AIDS.

Early marriages

The respondents also agreed that early marriages were very prevalent in Sololo Division of Moyale District. This leads to spread of HIV/AIDS because young girls get married to older men for economic gains. The older men had previously many wives who might have HIV/ AIDS and the young girls are infected because the young girls sexual organs are not well developed when married to older men the girls suffer bruised and tears which leads to HIV/ AIDS.

CHAPTER FIVE

SUMMARY OF FINDINGS, DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter contains summary of findings, discussion, conclusions and recommendations for practice and recommendations for further research on the problem.

5.2 Summary of Main Findings

The summary of the main findings are shown in Table 5.1.

Objectives	Main findings
To find whether female genital mutilation contributes to the spread HIV/AIDS among Borana women in Sololo Division	<p>Female genital mutilation contributes to the spread HIV/AIDS among Borana women to a very great extent</p> <p>Unsterilized instruments sharing contributes to a great extent to the spread of HIV/AIDS among borana women in the district</p> <p>Tear during intercourse contribute to a great extent to the spread of HIV/AIDS among borana women in the district</p> <p>Difficulties with intercourse contribute to a moderate extent to the spread of HIV/AIDS among borana women in the district</p>
To establish whether early marriages contribute to the spread of HIV/AIDS among Borana women in Sololo Division	<p>Early marriages affect the spread of HIV/AIDS among borana women in the district to a moderate extent</p> <p>Marriage for economic and social reasons affects the spread of HIV/AIDS among borana women in the district</p> <p>Sexual vulnerability of young girls in relationships affects the</p>

	<p>spread of HIV/AIDS among borana women in the district.</p> <p>Vulnerability of the female anatomy affects the spread of HIV/AIDS among borana women in the district</p>
<p>To determine whether wife inheritance leads to the spread of HIV/AIDS among Borana women in Sololo Division</p>	<p>Wife inheritance affects the spread of HIV/AIDS among borana women in the district to a very great extent</p> <p>Having sex with casual related partners affects the spread of HIV/AIDS among borana women in the district</p> <p>Forceful deprivation affects the spread of HIV/AIDS among borana women in the district</p> <p>Mandatory observance of harmful rituals affects the spread of HIV/AIDS among borana women in the district</p>
<p>To find whether domestic violence contributes to the spread of HIV/AIDS among Borana women in Sololo Division</p>	<p>Domestic violence affects the spread of HIV/AIDS among borana women in the district to a very great extent</p> <p>Sexual abuse affect the spread of HIV/AIDS among borana women in the district to a great extent</p> <p>Social and economic deprivation affects the spread of HIV/AIDS among borana women in the district to a moderate extent</p>

5.3 Discussion of the Findings

Majority of the health workers and leaders were females (93.55%) who were above 30 years in age and had university degree as their highest level of education. Majority of the Borana women were aged between 26 to 35 years old (31.9%). In regard to their marital status majority of them they were married (74.6%). The number of widowed women was low due to the fact that those whose husbands died were inherited. In relation to their highest level of education most of the respondents had secondary school education (94.1%).

Majority of the Borana women had knowledge on of HIV/AIDs and they knew that there was no cure. In relation to the main causes of spreading HIV/AIDS among women, the study found that wife inheritance, rape, blood transfusion and female genital mutilation were the main causes.

5.3.1 Female Genital Mutilation

The study established from the health workers and leaders that female genital mutilation contributes to the spread HIV/AIDS among Borana women to a very great extent (54.84%). The majority of the borana women (93.5%) indicated that female genital mutilation was practiced in Sololo Division, Moyale District. Toubia, (2009) had earlier argued that female circumcision is a deeply ingrained custom that is still widely practiced in Kenya. Research has shown that some Kenyan women continue to practice female circumcision even after it was outlawed and banned in 1982. Female genital mutilation is done at an age of 8 to 12 years (76.7%) the results agree with a report by GTZ, (2007) that thirty eight percent of women age 15-49 have undergone the practice in Kenya.

Unsterilized instruments sharing contributes to a great extent to the spread of HIV/AIDS among borana women in the district (Mean=4.12). Turshen, (2000) had earlier indicated that female circumcision is an important topic in AIDs discourses because circumcision performed on women, not men, makes women more vulnerable to HIV/AIDS infection because the possibility of HIV entry is high due to the sharing of instruments that are tainted with blood. In addition, the study found that tear during intercourse contribute to a great extent to the spread of HIV/AIDS among borana women in the district (Mean =3.89). Further, the study found that difficulties with intercourse contribute to a moderate extent to the spread of HIV/AIDS among borana women in the district (Mean=3.09). These findings also agree with Little (2003) argument that Female Genital Mutilation predisposes women to HIV/AIDS infection in many ways (example, increased need for blood transfusion due to hemorrhage either when the procedure is performed, at child birth, or a result of vaginal tearing during defibulation and intercourse). Women who have undergone FGM have a small opening, just large enough for the passage of urine and blood. Penetration or intercourse is difficult, often resulting in tissue damage, lesions and post coital bleeding (Little, 2003).

Female genital mutilation is very prevalent in Moyale District and it is usually conducted by traditional birth attendant and elderly women. However, the study found that female genital mutilation was acceptable to women. The study also found that FGM affects women to great extent because of sharing of cutting equipment which are not sterilized and tear during intercourse also leads to spread of HIV/ AIDS. Willcox, (2005) had earlier observed that FGM places girls and women at increased risk of HIV/AIDS infection through several routes. Firstly, the use of unsterilized instruments, such as razors or knives, to carry out the procedure among a number of girls risks passing the virus from one girl to the next. Secondly, FGM renders the female genitals more likely to tear during intercourse. In cases of sewing up of the vaginal entrance, penetration is bound to lead to bleeding, which in turn makes sexual transmission of the virus from an HIV positive partner much more likely.

5.3.2 Early Marriages

The study revealed from the health workers and leaders that early marriages affect the spread of HIV/AIDS among borana women in the District to a moderate extent (54.84%). majority of women were married as one wife (78.6%). Women married as two wives or three wives were due to the economic and social status of their husbands. In addition, majority of women (57.2%) had married before and were thus in their second marriage either due to death of their husbands or divorce.

It was also revealed in this study that marriage for economic and social reasons affects the spread of HIV/AIDS among borana women in the district (Mean =4.07). The findings agree with Sargent and Johnson, (2006) observation that for economic and social reasons, women are forced to engage in relationships with older men in order to gain access to their money and material goods. The study also found that sexual vulnerability of young girls in relationships affects the spread of HIV/AIDS among borana women in the district (Mean=3.99). Further, the study found that vulnerability of the female anatomy affects the spread of HIV/AIDS among borana women in the district (Mean =2.98). Doyal, (2005) had earlier indicated that younger women are biologically more prone to HIV/AIDS infection than older women because of the vulnerability of the female

anatomy. Women are more vulnerable to HIV/AIDS given that they are the receptors while the men are the depositors of semen, which when contaminated with HIV/AIDS is a danger to women.

5.3.3 Wife Inheritance

The study also found from the health workers and leaders that wife inheritance affects the spread of HIV/AIDS among borana women in the district to a very great extent (51.61%). Andersen, (2003) had earlier argued that wife inheritance is one of the traditional practices of some countries that promote the spread of HIV/AIDS. Kalipeni, (2000) had also indicated that in many sub-Saharan African countries, a man's property, including his wife, passes to his adult sons or brothers after his death. The study also found that having sex with casual related partners affects the spread of HIV/AIDS among borana women in the district (Mean =4.12). In addition, the study found that forceful deprivation affects the spread of HIV/AIDS among borana women in the district (Mean=3.89). Kalipeni, (2000) had earlier argued that the fate of African widows ranges from disinheritance and forceful deprivation of property to the mandatory observance of harmful rituals. Further, the study also revealed that mandatory observance of harmful rituals affects the spread of HIV/AIDS among borana women in the district (Mean =3.01). According to Kalipeni, (2000) widow inheritance is traditional rituals, a practice whereby the widow agrees to marry her husband's younger brother to continue as a member of the family

The study also established that wife inheritance affect the spread of HIV/ AIDS because the deceased wife accepts to be remarried to a close relative of the husband in order to have access to her husband property and also kids, she is also subjected to forceful eviction if she refused. This leads to spread of HIV/AIDS because the close relative might suffer HIV/ AIDS. Wife inheritance leads to spread of HIV/ AIDS in that the widow accepts to marry her husband close relative in order to have access to her late husband's property and kids the inheritor might be sick with HIV/ AIDS.

5.3.4 Domestic Violence

The study also established from health workers and leaders that domestic violence affects the spread of HIV/AIDS among borana women in the district to a very great extent

(48.39%). These findings agree with Wallace, (2005) argument that domestic abuse can both result in, or is a consequence of HIV/AIDS infection. The threat of violence can influence a woman's expectations in a relationship, influence her ability to negotiate when and how sex takes place and whether or not to use a condom, which in turn increases the risk for HIV transmission. It was also revealed that sexual abuse affect the spread of HIV/AIDS among borana women in the district to a great extent (Mean =4.12). Wallace (2005) also argue that sexual abuse and rape occur worldwide and that sex trafficking and harmful cultural practices are other examples of gender-based violence that can substantially increase the risk for HIV/AIDS infection. The study also found that physical violence affects the spread of HIV/AIDS among borana women in the district to a great extent (Mean=4.03). In addition, the study found that social and economic deprivation affects the spread of HIV/AIDS among borana women in the district to a moderate extent (Mean =3.11). Further, the study found that physical violence affects the spread of HIV/AIDS among borana women in the district to a little extent (Mean =2.34). Lastly, the study established that emotional abuse affects the spread of HIV/AIDS among borana women in the district to a little extent (Mean =2.23). Wallace, (2005) had earlier indicated that abuse against women is still extremely common and encourages the tradition of male dominance. This has a substantial impact on the continuing spread of HIV/AIDS. The culture continues to endorse the subordination of women through many of its cultural practices. Many of these ideas which encourage male dominance also increase the acceptance and justification of violence against women. The study established that domestic violence contributes to spread of HIV/ AIDS in case of rape the women suffers tears and bruises which makes spreading of AIDS/ AIDs.

5.4 Conclusions

The following conclusions were made from the results. From the correlation results the study concludes that there is a relationship between the Spread of HIV/AIDS among borana women and female genital mutilation since there is a positive coefficient 0.92. Female genital mutilation was practiced in Moyale at an age of 8 to 12 years. Unsterilized instruments sharing, tear during intercourse and difficulties with intercourse contribute to a moderate extent to the spread of HIV/AIDS among borana women in the district.

The correlation results between early marriages and spread of HIV/AIDS among borana indicates that the two have a positive correlation where the correlation coefficient is 0.54. It was also established that marriage for economic and social reasons, sexual vulnerability of young girls in relationships and vulnerability of the female anatomy affects the spread of HIV/AIDS among borana women in the district.

The results also show that there is a positive association between wife inheritance and Spread of HIV/AIDS among borana women where the correlation coefficient is 1.01. The study also found that having sex with casual related partners, forceful deprivation and mandatory observance of harmful rituals affects the spread of HIV/AIDS among borana women in the district.

The result shows that there is a positive association between domestic violence and Spread of HIV/AIDS among borana women where the correlation coefficient is 1.21. It was also revealed that sexual abuse, physical violence, social and economic deprivation affects the spread of HIV/AIDS among borana women in the district to a moderate extent. The study established that domestic violence contributes to spread of HIV/ AIDS in case of rape the women suffers tears and bruises which makes spreading of HIV/ AIDs.

5.5 Recommendations

The following recommendations were made from the study. This research study established that most of the Borana women (92.8%) had no knowledge on VCT. This study recommends that the government of Kenya, NGOs and community based organization leaders should come together and create more awareness on VCT and its importance in Moyale District. These organizations should also establish more VCT centers in the area.

It was also established in this study that wife inheritance was practiced in Moyale district to a great extent (98.6%). The study also found that wife inheritance positively influences that spread of HIV/AIDs. This study recommends that the administration, community based organizations and NGOs should collectively condemn this practice.

This study also found that female genital mutilation was practiced in Moyale to a great extent (93.5%) at an age of 8 to 12 years. Despite the fact that this practice was found to contribute to the spread of HIV/AIDs, it was also found to increase school dropout rate. This study therefore recommends that this practice should be stopped. The study also recommends that policymakers should make more policies to stop the act completely.

This study also found that early marriages contributes to the spread of HIV/AIDs to a great extent. The study recommends that early marriages should be stopped in Moyale district since they also cause school dropout.

5.6 Recommendations for Further Studies

From the study, the researcher recommends further research should be done in the area of the effects of female genital mutilation and early marriages on the education of women in Moyale District. A similar study should be done in other divisions in Moyale District to allow for generalization of the factors influencing spread of HIV/AIDs among borana women. Further, a similar study should be done in another area with different cultural practices to allow for comparison. A study should also be done on the effect of availability of health facilities including VCT services on the spread of HIV/AIDs among borana women.

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APPENDICES

Appendix 1: Introduction Letter

Bule Tumme Teresa

P.O. Box 381

Meru.

March, 21st, 2012

Dear Sir/Madam,

RE: REQUEST FOR PARTICIPATION IN A RESEARCH STUDY

I am a final MA degree student at the University of Nairobi. My area of specialization is project planning and management. I am currently undertaking a research on “**Factors Influencing Spread of Hiv/Aids among Borana Women of Sololo Division, Moyale District, Kenya**”.

I would be grateful if you could spare some time from your busy schedule and complete the enclosed questionnaire. All the information provided will be used purely for academic purposes only and will be treated with utmost confidentiality.

Thank you for your cooperation.

Yours faithfully,



Bule Tumme Teresa

L50/66254/2010

Knowledge ON HIV and AIDS

9) Are you aware of HIV and AIDs

Yes [] No []

10) In your opinion does HIV/AIDs have a cure?

Yes [] No []

11) What do you think are the main causes of spreading HIV and AIDs among woman?

.....
.....
.....

12) Give two main causes of spreading of HIV and AIDs among woman

.....
.....
.....

13) Are you aware of any methods of preventing of the disease?

Yes [] No []

14) Which is the most preferred method?

15) If yes give three methods

(a)
(b)
(c)

16) Do you have access to condoms?

Yes [] No []

17) Do you know what is voluntary counseling and testing?

Yes [] No []

18) Have you visited VCT?

Yes [] No []

Awareness of Spread of Hiv/Aids

19) Is wife inheritance a practice in your area?

Yes [] No []

20) If yes, who inherits you?

The brother [] Cousin []

Another clan member []

21) What in your opinion what do you think causes wife inheritance? Death of a husband?

.....
.....

22) After your husband died after how long did you get remarried?

One to three month []

Three to six months []

Others specify.....

23) Does domestic violence occur in this area?

Yes No.

If yes what type?

Beating []

Verbal abuse []

Other specify

24) Is female genital mutilation practiced in Moyale?

Yes [] No []

25) If yes at what age?

Below 8 years [] 8 – 12 years []

13- 17 years [] Others specify

a. Were you in school when you were circumcised?

Yes [] No []

26) If YES did you drop from school?

Yes [] No []

27) Who conducts female circumcision?

28) Is female genital mutilation acceptable in woman?

Yes []

No []

29) Do you think female genital mutilation should continue?

Yes []

No []

If no why?

.....

.....

.....

Appendix 3: Questionnaire for Leaders/Health Workers

Instruction

Please tick in the appropriate bracket or provided spaces

Section A: Background Information

1) Gender

Male []

Female []

2) Age bracket

Below 15 years []

15-20 years []

20-25 years []

25-30 years []

Above 30 years []

3) Education background

Primary []

Secondary []

College []

University degree []

Postgraduate []

Section B: Awareness of Spread of Hiv/Aids among Borana Women

Female Genital Mutilation

4) To what extent does female genital mutilation affect the spread of HIV/AIDS among borana women in your district?

To a very great extent []

To a great extent []

To a moderate extent []

To a little extent []

To no extent []

5) What is the extent to which the following aspects of female genital mutilation affect the spread of HIV/AIDS among borana women in your district?

	Mean	Std deviation
Unsterilized instruments sharing		
Tear during intercourse		
Difficulties with intercourse		

Appendix 4: Interview Guide

1. Marital status
2. What is your age
3. Are you aware of HIV and AIDs
4. What do you think are the main causes of spreading HIV and AIDs among woman?
5. Is wife inheritance a practice in your area? How does it affect the spread of HIV AIDs?
6. Does domestic violence occur in this area?
7. How does domestic violence affect the spread of HIV/AIDS among women in your district?
8. Is female genital mutilation practiced in Moyale? How prevalent is it?
9. Who conducts female circumcision?
10. Is female genital mutilation acceptable in woman?
11. How does female genital mutilation affect the spread of HIV/AIDS among borana women in your district?
12. How prevalent is early marriages among borana women?
13. In which way does early marriage affect the spread of HIV/AIDS among borana women in your district?
14. How does wife inheritance affect the spread of HIV/AIDS among women in your district?



Appendix 5: Letter of Transmittal

UNIVERSITY OF NAIROBI
COLLEGE OF EDUCATION AND EXTERNAL STUDIES
SCHOOL OF CONTINUING AND DISTANCE EDUCATION
DEPARTMENT OF EXTRA-MURAL STUDIES

TO WHOM IT MAY CONCERN

1TH May, 2012

REF: Uon/Cees/Memc/3/2

REF: BULE TUMME TERESA- L50/66254/2010

This is to confirm that the above named person is a Masters student at the University of Nairobi, School of Continuing and Distance Education, Department of Extra-Mural Studies.

She has been pursuing a M.A in *Project Planning and Management* at the Meru Extra-Mural Centre since *September 2010*. She has completed her course work units, did the exams and awaiting results;

She is currently working on her Research Project and would request your assistance to gather research information from your organization.

Your assistance accorded to her will be highly appreciated.



ANDREW RUGENDO
ASSISTANT LECTURER
MERU EXTRA-MURAL CENTRE AND ITS ENVIRONS

Appendix 6: Moyale District Map

