

Research Article

Social Cultural Barriers to Prevention of HIV and AIDS among HIV-Sero Positive Adults in Kenya

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Abstract: The purpose of this study was to investigate socio-cultural barriers to prevention of HIV and AIDS in the context of gender based violence among people living with HIV and AIDS in Thika Sub-County, Kenya. The Health Belief Model and General systems Theory guided the study. A survey of 239 randomly selected respondents from randomly selected support groups for people living with HIV and AIDS (PLWHA) was conducted. Data were collected by use of interview schedules, focus group discussions and key informant interviews. The data were analyzed using both quantitative and qualitative methods. Results showed that HIV prevention was impeded by interplay of factors which seemed to emanate from gender power imbalances. The barriers which were paramount comprised condom refusal (40.3%), alcohol abuse (38.2%), stigma and discrimination (35.7%), financial constraints (28.1%), condom fatigue (23.5%), lack of female condoms (17.6%) ignorance and non-acceptance of one's HIV sero-positive status (15.1%). Other minor barriers included people's curiosity (5.0%), peer influence (2.9%), desire to have more children (2.5%), having multiple partners (2.1%) and lack of protective materials (1.7%). The study also established that there were gender based violence meted against men and women which included: sexual violence in form of forced sex, denial of sexual intimacy, abandonment by sexual partner, physical violence, psychological violence, economic violence, stigma, discrimination and community social isolation among PLWHA. It was recommended that there was need for community based intervention programs targeting PLWHA to address socio-cultural barriers that impede self-efficacy in the prevention of HIV and AIDS and thereby reduce gender-based violence among People Living with HIV and AIDS.

Keywords: Socio-Cultural Barriers, Gender based violence, HIV and AIDS Prevention, Sexual behaviour, Reproductive behavior, PLWHA, Kenya.

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1.0 INTRODUCTION

1.1. Background of the study

Research has demonstrated that key to the household's response when struck by HIV is not the women's, but their spouse's reaction to the new crisis in the family (Kieru, 2013). A study by CHGA reveals that the struggles for equality begin in the family which is also the primary site for stigmatization, discrimination, violence and abuse against women (Commission on HIV/ AIDS and Governance in Africa [CHGA], 2004). This is shown in a study done by WHO (2006) which found that most women living with HIV/AIDS suffer from stigmatization and discrimination like being considered vectors of HIV transmission to their children; this is worsened by their inability to control their sexual and reproductive health which is hampered by the cultural norms that subject them to harmful sexual and reproductive practices. Evidence show that women who are HIV positive fear

seeking information on sex and buying or negotiating for condom use because they will be labeled sexually active (GA Report, 2008) reducing their ability to successfully take a healthy sexual and reproduction action. Similarly a study done in Uganda by Nakawiya (2006) found out that many women who have tested HIV positive continue to breastfeed their infants for fear of being ostracized and isolated.

On the contrary, men are socially and culturally accepted to have more sexual partners in their lifetime as opposed to women (Oyore, 2009). Bearing in mind that it has been found out that generally there is perceived unwillingness of men to have protected sex putting women are at risk of HIV infection or re-infection. This is worsened by the lack of female-controlled methods for preventing HIV transmission during sexual intercourse. The female condom which has been seen as a possible tool for HIV prevention that

women themselves can have control of and use, is still too expensive and in too short supply to be widely available. Still it requires a similar kind of negotiation as using the male condom, and may therefore not be the solution to gender power relations issues (CHGA, 2004).

Likewise, engaging in sex under the influence of alcohol can impair judgment, compromise power relations, and increase risky sexual behaviour (KDHS, 2008/09). Marriage and other sexual relations do not protect women against HIV or re-infection. Hence if the man has multiple partners and does not use a condom, his female partner is vulnerable, even if she is faithful (CHGA, 2004).

1.2 Problem Statement

Women do bear a higher burden of HIV prevalence than men (KDHS 2008/09). This is shown by gender analysis in a study by KAIS (2007) which indicated that women were twice as much infected with HIV (8.4%) compared to men (5.4%). Numerous studies show that PLWHA engage in risky sexual and reproductive health practices. For instance, a study by Oyebola (2009) carried out in Nigeria revealed that risky sexual behaviour remains a common practice among PLWHA. Along with this Oyore (2009) and Otieno (2008) in their studies carried out in Nairobi reported that PLWHA have multiple concurrent sexual partnerships with a casual or commercial sex worker. PLWHA after receiving a positive HIV diagnosis, continue to be sexually active and indulge in risky sexual behaviour.

Thus there are gaps in terms of barriers to safe sexual and reproductive behaviours which are associated with gender based violence; subsequently promoting HIV infection or re-infection. Therefore it is more prudent to focus attention on the prevention of new HIV infections on the minority (PLWHA) than the majority (HIV negative people). Given the foregoing scenario, there was need to examine barriers to prevention of HIV and AIDS in the context of GBV among PLWHA in order to develop intervention strategies focusing on PLWHA: the case of 'prevention with positives'.

1.3 Purpose of the study

The purpose of this study was to assess socio-cultural barriers to prevention of HIV and AIDS in the context of gender based violence among people living with HIV and AIDS in Thika Sub-County, Kenya.

1.4 OBJECTIVES

The objectives of the study were:

1. To describe socio-demographic characteristics of PLWHA.
2. To identify socio-cultural barriers to safe sexual and reproductive practices of PLWHA.

3. To determine the forms of gender-based violence experienced by PLWHA.

1.5 Theoretical framework

The study was based on the Health Belief Model (Rosenstock & Stretcher, 1997) and General Systems Theory (Bertalanffy, 1968 and Littlejohn, 1999). The Health Belief Model was used because it explains how behaviour change process is believed to occur. From this model, it can be conceptualized that PLWHA are highly susceptible to gender-based violence due to their HIV status. Besides there could be perceived socio-cultural barriers that could impede them from living positively. The General System theory was used to explain how objects or elements interact in their environment over time. The main components of the systems theory include the input, throughput, output and feedback mechanisms.

In this study the inputs were defined as demographic factors such as sex, age, residence, marital status, education, occupation, income levels, and religious beliefs of PLWHA. Other inputs included number of children, duration since testing HIV positive and being accompanied during HIV testing. These factors may influence directly or indirectly gender-based violence among PLWHA. The Throughput component or transformation factors were the barriers to safe sexual and reproductive practices and associated gender based violence that may be the end result in this interaction. The output component was the likelihood of PLWHA to take a conscious and healthy HIV preventive action.

2.0. METHODOLOGY

The study employed a survey research design. The sample consisted of 239 randomly selected respondents who belonged to support groups for PLWHA in three divisions of Thika Sub-County namely Ruiru, Thika Municipality and Kamwangi. Participation in the study was purely on voluntary basis, and respondents were fully informed of the research objectives and methods to be used prior to the commencement of the research. Informed consent was sought from the respondents before any information was gathered. Confidentiality of the participants' identities were assured and kept by use of identification codes throughout the study and in all subsequent reports. Respondents who were willing and able to participate in the study were scheduled for a face-to-face interview in their homes conducted by trained researchers. Three methods of data collection were used namely In-Depth Interviews, Focus Group Discussions and Key Informant Interviews. An interview guide was developed with three sections: the first section elicited information on socio-demographic characteristics of the informants. The second part contained information on barriers to prevention of HIV and AIDS due to unsafe sexual and reproductive

practices. The third section contained data on their likelihood of taking a conscious and healthy HIV preventive action. Data were collected in home interviews scheduled by appointment that lasted about one hour to one and half hours. All interviews were conducted in a language the respondents were most conversant with which were either Kiswahili or Kikuyu and later translated into English language.

The Focus Group Discussion method was used to collect qualitative data from among selected support groups for PLWHA that did not participate in the in-depth interviews, but had similar characteristics. Four FGDs were conducted comprising 8 respondents each

randomly selected and categorized according to the criteria of age and sex. The categories comprised younger male respondents (40 years or younger), older male respondents (41 years and older), younger female respondents (35 years and younger) and older female respondents (36 years and older). The FGD data were analyzed using a thematic approach and the coded verbatim statements that best explained the subject under discussion were cited as voices. The key informant interviews were conducted with health care providers working at the Comprehensive Care Centres (CCC) in the local district hospital where PLWHA received health care services on regular bases.

3.0. RESULTS

3.1. Distribution of respondents by sample characteristics

Table 1: Gender differences according to social-demographic characteristics (residence, age and marital status)

Demographic Characteristics	Female	Male	Both sexes
Residence	N=149	N=90	N=239
Peri-urban	39.6%	23.3%	33.5%
Urban	17.4%	38.9%	25.5%
Rural	43.0%	37.8%	41.0%
Age	N=149	N=90	N=239
30 years and younger	19.5%	7.8%	15.1%
31-40 years	43.0%	41.1%	42.3%
41-50 years	37.6%	30.0%	34.7%
51 years or older	0.0%	21.1%	7.9%
Marital Status	N=149	N=90	N=239
Married	36.2%	61.1%	45.6%
Single	17.4%	3.3%	12.1%
Widow/widower	24.8%	13.3%	20.5%
Divorced/separated	21.5%	22.2%	21.8%

The results as shown in Table 1 revealed that nearly two thirds of the respondents (62.3%) interviewed were females and the rest (37.7%) were males. Majority of the respondents lived in the rural areas (41.0%) where the females (43.0%) were more than the male respondents (37.8%). A third of the respondents lived in the peri-urban area where the females formed the majority (39.6%) while a quarter of the respondents lived in the urban areas (25.5%) with the males forming the majority (38.9%) compared to females (17.4%). This finding showed a statistically significant gender difference by residence ($\chi^2=0.14.905$, $df=2$, $p=0.001$). With regard to age, a larger proportion (42.3%) fell at the age category of 31-40 years where the female respondents formed the majority (43.0%) as opposed to their male counterparts (41.1%). This was followed by those in age category of 41-50 years

(34.7%) with females being the majority (37.6%) as compared to males (30.0%). Age category of 30 years and below accounted for (15.1%) [Females 19.5%; males 7.8%] while 7.9% were in the age category of 51 years or older where the male respondents were only included in this age category (21.1%). This result revealed significant gender difference by age ($\chi^2=0.37.516$, $df=3$, $p=0.000$). In terms of marital status 45.6% of respondents were married, with nearly two thirds (61.1%) being married male respondents and slightly more than a third being married females (36.2%). This was followed by 20.5% of the respondents who were widowed (Females 24.8%; males 13.3%), 21.8% divorced/separated (Females 21.5%; males 2.2%) and 12.1% single (Females 17.4%; males 3.3%). This finding showed a significant difference in marital status by gender ($\chi^2=0.20.457$, $df=3$, $p=0.000$).

Table 2. Gender differences according to social-demographic characteristics (income, education, occupation and religion)

Demographic Characteristics	Female	Male	Both sexes
Income (Kshs.)	N=137	N=89	N=226
Below 1,000	13.9%	5.6%	10.6%
1,001-5,000	50.4%	29.2%	42.0%
5,001-10,000	27.0%	32.6%	18.1%
Over 10,001	8.8%	32.6%	18.1%
Level of Education	N=149	N=90	N=239
No formal education			
Primary	6.0%	3.3%	5.0%
Secondary	59.7%	61.1%	60.3%
College	33.6%	25.6%	30.5%
	0.7%	10.0%	4.2%
Occupation	N=149	N=90	N=239
Permanently employed			
Casual workers	2.7%	18.9%	8.8%
Business/self employed	49.0%	48.9%	49.0%
Unemployed	40.3%	31.1%	36.8%
	8.1%	1.1%	5.4%
Religion	N=149	N=90	N=239
Catholics			
Protestants	40.9%	43.3%	41.8%
Muslims	48.3%	37.8%	44.4%
No religion	2.0%	2.2%	2.1%
	8.7%	16.7%	11.7%

As shown in Table 2, 60.3% had primary level of education with more males (61.1%) than females (59.7%). This was followed by 30.1% having secondary education and only 4.2% had reached college level while 5.4% had no formal education at all. This findings showed a significant difference in education levels by gender ($\chi^2=13.683$, $df=3$, $p=0.003$). The occupations of the respondents in ranked order were unskilled or casual laborers (49.0%) which had no much gender differentiation (Females 49.0%; Males 48.9%), business people in micro and small enterprises (36.8%), permanently employed (8.8%) and 5.4% of the respondents were unemployed. Further analysis showed there was a significant gender difference by occupation ($\chi^2=23.018$, $df=3$, $p=0.000$). In terms of average income, 42.0% of the respondents earned an income of

between Kshs.1,001-5,000 followed by Kshs.5,001-10,000 (29.2%), over Kshs.10,000 (18.1%) and below Kshs.1000 (10.6%). The findings also showed that almost two thirds of the female respondents (64.3%) earned below Kshs.5,000 while the nearly the same proportion (65.2%) of the male respondents earned above Kshs.5,001. This results showed a statistically significant difference in income by gender ($\chi^2=26.656$, $df=3$, $p=0.000$). The religious affiliations showed that 44.4% of the respondents were Protestants where the females accounted for 48.3% and the males 37.8%; 41.8% were Catholics with no much gender differentiation (Females 40.9%; Males 43.3%); Muslims (2.1%) while 11.7% did not state their religion. There was no significant gender difference by religion ($\chi^2=4.516$, $df=3$, $p=0.211$).

Table 3. Number of children and duration after testing HIV positive by gender

Factors	Female	Male	Both sexes
Number of children ever born	N=149	N=90	N=239
None			
1-3 children	6.0%	5.6%	5.9%
4 children or more	53.0%	51.1%	52.3%
	40.9%	43.3%	41.8%
Duration after testing HIV positive	N=148	N=89	N=237
1 month -1 year			
2-3 years	18.2%	23.6%	20.3%
4-5 years	24.3%	25.8%	24.9%
6 years and over	26.4%	23.6%	25.3%
	31.1%	27.0%	29.5%
Being accompanied during HIV testing	N=149	N=90	N=239
Accompanied			
Not accompanied	40.9%	42.2%	41.4%
	59.1%	57.8%	58.6%

The study as shown in Table 3 revealed that 52.3% had between 1-3 children, followed by those who had 4 children or more (41.8%) and those who had no child (5.9%) in that order.

There were no statistically significant gender difference by number of children ever born ($\chi^2=0.138$, $df=2$, $p=0.933$). Results for duration after testing HIV positive showed that 29.5% of the respondents had tested HIV positive 6 years or earlier prior to the time

of study, followed by 4 to 5 years (25.3%), 2 to 3 years (24.9%), and one or less year (20.3%). This factor showed no significant gender difference in duration after testing HIV positive ($\chi^2=1.323$, $df=3$, $p=0.724$). The study also revealed that 58.6% were accompanied during HIV testing while 41.4% were not accompanied. This finding showed no significant gender difference by whether the person was accompanied for HIV testing or not ($\chi^2=0.013$, $df=1$, $p=0.845$).

3.2. Socio-Cultural Barriers to Prevention of HIV and AIDS

Table 4. Socio-Cultural Barriers to Prevention of HIV and AIDS in Rank Order

Socio-Cultural Barriers	Frequency (N=238)	Percentage
Partners' refusal to use condoms	96	40.3
Alcohol abuse	91	38.2
Stigma, isolation and discrimination	85	35.7
Lack of money	67	28.1
Condom fatigue	56	23.5
Lack of female condoms	42	17.6
Ignorance and non-acceptance of HIV sero-positive status	36	15.1
People's criticisms	12	5.0
Peer influence	7	2.9
Desire to have more children	6	2.5
Multiple sexual partners	5	2.1
Lack of protective material e.g. gloves	4	1.7

*Multiple responses were allowed

The findings revealed that 94.5% of the respondents were experiencing socio-cultural barriers to prevention of HIV and AIDS due to various reasons indicated on Table 4. Among those who were experiencing barriers to prevention of HIV and AIDS, more female respondents (62.9%) indicated facing challenges as opposed to their male counterparts (37.1%). The findings further revealed that 40.3% of the female respondents indicated that their male partners' refusal to use a condom was a paramount barrier in their quest to preventing HIV and AIDS. This may have led to re-infections or new HIV infections. This was more critical among the regular sexual partners where the husband/male sexual partner felt that as long as the couple were concordant they could have sex without a condom. This was attested by the following sentiments which were very common during FGDs:

"If both of us are infected by HIV, why do we need to use a condom?" (Reports from Male FGDs).

"Sometimes themen refuse to use condoms since both sexual partners are HIV positive" (Reports from Female FGDs)

3.3 Forms of Gender Based Violence in the Context of HIV and AIDS

Reports from the qualitative data showed that there were four common forms of gender based violence among people living with HIV and AIDS.

These included physical violence, sexual violence, economic violence and psychological violence.

3.4 The Condom fatigue, physical and sexual violence

Cases were common where physical and sexual violence was meted against females by their male sexual partners for refusing to have sex without a condom as one respondent in Ruiru gave an account:

"My husband sometimes refuses to use a condom.. He says it's boring, tiring and inconveniencing. making sex un-enjoyable. .If I refuse to have sex without a condom sometimes I get a slap and I give in, I feel so bad because he might re-infect me with a new HIV strain that does not respond to the ARVs I am taking." (Female Participant X1E).

This meant that some women gave in to forced sex without a condom and that could have affected the female respondents psychologically and emotionally as they had sex knowing very well they might be re-infected with HIV strains which might be resistant to ARVs they were taking. Other women reported that their husbands or stable sexual partners sometimes refused to have sex with them if they continued insisting that a condom has to be used. Some of the women reported that they were abandoned sexually as the husbands/sexual partners turned to seeking sex elsewhere outside their regular sexual partners. Forced sex for some women and denial of sexual intimacy for

others was a form of gender based violence against the female partners, who were seeking to take a conscious and safe HIV preventive action by insisting on condom use. These findings were consistent with a study done by UNAIDS (2006) worldwide which found out that PLWHA did not use condoms since their partners were HIV infected. The findings were also supported by CHGA (2004) which indicated that generally men prefer to have unprotected sex thereby putting women at risk of HIV infection or re-infection.

Consistent use of a condom was considered tiresome and reduced sexual satisfaction as reported by 23.5% of the respondents. Some respondents did not use condoms through mutual understanding with their sexual partners especially where both were HIV sero positive. Others who consistently used condoms with their regular partners reported having sexual relations with occasional sexual partner where a condom was not used. This was supported by qualitative data from one male respondent from Ruiru:

"I sometimes go out there (engaging in extra-marital sex) to have sex without a condom at least to remind myself how it used to feel before I became HIV positive." (Male Participant Y2D).

This was a deliberate case of sexual violence where a male respondent goes in search of sexual satisfaction through unprotected sex without caring about protecting the occasional sexual partner. These results were supported by Wamoyi, Fenwick, Urassa, Zaba & Stones, (2011) who reported that the challenges for most of PLWHA were using condoms consistently and finding a suitable sexual partner (preferably someone who is HIV positive) who could agree to have a sexual relationship with them. Likewise a study by UNAIDS (2006) indicated that negative attitude towards condom use among PLWHA remained due to 'condom fatigue' of consistency and this could hinder efforts for prevention of HIV. For those men who had multiple sexual partners and did not use condoms, their female partners were vulnerable, even if they remained faithful to one male partner. Hence the females living with HIV and AIDS underwent psychological stress and sexual harassment where they were made to have unprotected sex by their male sexual partners without their consent. This constituted sexual violence against women by their sexual partners.

A proportion of 17.6% of the female respondents indicated having experienced the challenge of lacking female condoms. They reported that femidoms (female condoms) were expensive and were not commonly available in the local pharmacies. This made them to compromise on safe sexual practices when their sexual partners refused to use male condoms. They emphasized that if femidoms were easily available and accessible like the male condoms,

they could be in a better position to negotiate for safe sex as remarked by one female respondent from Thika municipality:

"The problem comes in because our (female) condoms are not available and they are very expensive .so I cannot do anything when my partner refuses to use a male condom" (Female Participant X1C)

Similar findings were reported by CHGA (2004) which indicated that generally there is perceived unwillingness of men to have protected sex. This is made worse by female condoms being still too expensive and in too short supply to be widely available. Still it requires a similar kind of negotiation as using the male condom, and may therefore not be the solution to gender power relations issues (CHGA, 2004). The females living with the virus seemed to experience emotional stress especially where the male sexual partner refused to use a condom and she did not have a female condom to protect herself.

Another barrier to HIV prevention with PLWHA was ignorance and non-acceptance of HIV positive status, where sexual partners did not believe that one was HIV infected (15.1%) as the respondents appeared normal and looked healthy due to ARV therapy. This was supported by Stall (2007) who reported that attempts by PLWHA to use condoms to protect their sexual partners were often met with anger or disbelief that they were infected.

3.5 Alcohol abuse and sexual violence

Alcohol abuse was indicated by 38.2% of the respondents as a major barrier to prevention of HIV and AIDS. The results showed slightly more than half of the male respondents (51.1%) took alcohol as compared to a quarter of the female respondents (25.9%). It was established that those sexual partners who took alcohol reported getting into risky sexual behaviour and even forgot to take ARVs which with time lowered their body's immunity and weakened them as sometimes they did not eat well. This was evidenced by some respondents' sentiments as follows:

"Drunkenness leads to having sex with strangers without using a condom" (Reports from Male FGD).

This was a case of unprotected sex with multiple sexual partners under the influence of alcohol.

A male respondent reported that he often skipped his medication after taking alcohol:

"Sometimes when I am drunk, I forget to take medicine (ARVs) and my health continues to deteriorate.." (Male Participant Y1D)

These findings are supported by KDHS (2008/2009) report that indicated that engaging in sex under the influence of alcohol can impair judgment, compromise gender power relations, and increase risky

sexual behaviour. In addition Stall (2007) indicated in a study on substance abuse and risky sexual behaviour that the use of alcohol or drugs was related to sexual behaviour that was high risk for HIV infection. However other respondents indicated that alcohol helped them to forget their daily stresses and also gave them the zeal to have sex.

3.6 Financial constraints and sexual violence

Lack of money was reported by 28.1% of female respondents as a barrier to prevention of HIV and AIDS. They reported that most of their finances were used on medication and buying quality food in order to manage and control the virus. They reported that they compromised on having unsafe sex in exchange for money (transactional sex) which put them into multiple risks of unplanned pregnancies, sexually transmitted infections and HIV re-infection. This was evidenced by a female respondent who reported that:

"We (commercial sex workers) receive more money when we offer sex without a condom. For example, with a condom you earn Kshs. 100-200 (equivalent to one to two (\$1 to 2) USD and without a condom you earn Kshs. 1000 (\$10) or more if operating in Nairobi city." (Female Participant X1A)

In this case, an HIV positive female commercial sex worker chooses to have unprotected sex to obtain more money. Lack of self-disclosure of HIV status to a sexual partner constitutes sexual violence against a sexual partner regardless of the motive to earn more money from the transaction. Similar to previous cases cited in this study, this female respondent deliberately engaged in transactional unprotected sex in exchange for money without caring about protecting the male clients.

3.7 Stigma, discrimination and psychological violence

Stigma was also cited as a barrier to prevention of HIV and AIDS by 35.7% of the respondents. They asserted that one was not able to disclose their HIV status due to stigma associated with the virus. One female respondent from Thika municipality (who reported that she was a commercial sex worker) reported that:

"I usually tell my sexual partners to use condoms but they refuse, so we just have unprotected sex. I don't disclose my HIV positive status because I might lose the client." (Female Participant X2A).

Another young female respondent (21 years) who was also a commercial sex worker operating in Nairobi but attending a support group in Ruiru reported that:

"I don't tell my clients (sexual partners) my condition, that I am HIV positive: if they want to use a condom or not, it is up to them" (Female Participant X1A).

In both of these cases, HIV positive female commercial sex workers refused to disclose their HIV positive status to their sexual partners in order to obtain money from their clients. In addition they attempted to protect themselves from being stigmatized due to their HIV positive status. Lack of self-disclosure of HIV status to a sexual partner is a form of sexual violence against a sexual partner. In these cases, female respondents deliberately engaged in transactional unprotected sex in exchange for money without caring about protecting their male clients.

These findings concurred with those of a study by Stall (2007) who reported that in cases where HIV-positive partners had not disclosed their status to their HIV negative or untested regular partners, unprotected sex was more likely to take place. This lack of disclosure was to avoid stigmatization and discrimination especially by women who were considered as being vectors of HIV transmission to their sexual partners and to their children. This was worsened by their inability to control their sexual and reproductive health which was hampered by the cultural norms that subject women to harmful sexual and reproductive practices (WHO, 2006).

3.8 Community social isolation and psychological violence

In the context of this study, psychological violence constitutes mistreatment and undermining of one's self-esteem. It includes isolation from family, friends and community, or criticisms, threats and belittling comments against another person. The study found cases of psychological violence against PLWHA in terms of people's criticisms about respondent's life issues such why a mother was not breastfeeding if she had an infant, or why she had only one child. People's criticisms were observed to be also a socio-cultural barrier that hindered safe sexual and reproductive practices (5.0%). Some respondents compromised in situations that jeopardized their children, sexual partners or themselves of HIV infection or re-infection for fear of being associated with PLWHA and isolated by family and friends. This was evidenced by these common sentiments made by the respondents:

"Sometimes I become irritated by people who are curious and ask me why I am not breastfeeding my baby" (Report from Female FGDs).

"Others ask: "Why do you have only one child? This makes me to desire to have another child despite my HIV positive status." (Report from Female FGDs).

This finding was consistent with an observation made by a study done in Uganda by Nakawiya (2006) who found out that many women who had tested HIV positive continued to breastfeed their infants for fear of being ostracized and isolated in their communities. This put the children in danger of contracting HIV through MTCT.

4.0. DISCUSSION

4.1 Gender based violence in the context of HIV and AIDS

Results showed that socio-cultural barriers to prevention of HIV and AIDS were associated with gender based violence (GBV) among PLWHA. GBV in the context of PLWHA included behaviours carried out with the primary intent of causing physical, sexual, psychological and economic harm to a man or woman by a spouse, cohabiting partner, regular or casual sexual partner among the study respondents.

4.2 Physical and Sexual Violence

The results showed cases were common where physical violence was meted against females by their male sexual partners for refusing to have sex without a condom. Forced sex for some women and denial of sexual intimacy for others was a form of gender based violence against the female partners, who were seeking to take a conscious and safe HIV preventive action by insisting on condom use consistently. These findings revealed that more female respondents (62.9%) faced challenges in their pursuit of HIV prevention as opposed to their male counterparts (37.1%). The results also showed that on matters of sexuality the gender power relations still remained tilted in favour of males at the expense of females. This could be associated with social and cultural norms which deterred women from making decisions about their sexual and reproductive behaviours. It was evident that most males refused and disapproved of condom use which hindered the female sexual partners from being able to negotiate for safe sex. This was worsened by the fact that female condoms were in short supply and they were not easily available. In addition they were expensive and were still subject to acceptance by the male partners. These findings were consistent with Stuart, (2009a) who reported that power imbalances in some sexual relationships may prevent women from insisting on condom use even though they remained the only “dual function” contraceptive method to prevent both pregnancy and HIV infection. Women who were HIV positive feared seeking information on sex, and buying or negotiating for condom use because they were labeled sexually active (CHGA Report, 2008). Nonetheless the continued perception of the dominance of men with regard to condom acquisition and use could have negative implications on relationships. Likewise the findings were also supported by CHGA (2007) which reported that whereas both partners should be able to negotiate on condoms use, in reality it is males that make these decisions. Similarly

CHGA (2004) reported that generally there was perceived unwillingness of males to have protected sex, putting females at risk of HIV infection or re-infection. Hence females lacked control of their own bodies and sexuality.

4.3 Alcohol abuse and Sexual violence

There were twice as many males (51.1%) as females (25.9%) abusing alcohol. Under the influence of alcohol, some males refused to use a condom even with multiple sexual partners. This put their spouses, stable or regular sexual partners at risk of HIV infection or re-infection. It was therefore evident that alcohol intake was a barrier to prevention of HIV and AIDS and contributed to sexual violence against females. These findings are supported by KDHS (2008/2009) report that suggested that engaging in sex under the influence of alcohol can impair judgment, compromise power relations, and increase risky sexual behaviour. In addition, Stall (2007) indicated in their study on substance use and risky sexual behaviour for exposure to HIV, that the use of alcohol or drugs was related to sexual behaviour that was high risk for HIV infection.

4.4 Psychological Violence, Stigma and discrimination

Stigma and discrimination was cited as a barrier to prevention of HIV and AIDS. It was asserted that this factor hindered HIV self-disclosure hence in cases where HIV positive status was not disclosed, likelihood of risky sexual behaviour was high. These findings concurred with those of a study in Boston Conference Report (2010) which reported that in cases where HIV-positive partners had not disclosed their status to their HIV negative or untested regular partners, unprotected sex was more likely to occur. This lack of disclosure was to avoid stigmatization and discrimination especially by women who were considered as being vectors of HIV transmission to their sexual partners and to children as well. This was worsened by their inability to control their sexual and reproductive health which was hampered by the cultural norms that subject women to harmful sexual and reproductive practices (WHO, 2006).

4.5 Economic violence against women

Economic violence against women referred to denying women access to material support, withholding money or denial of access to money by a spouse or sexual partner. There were cases where transactional sex led to both physical and economic violence against women by male clients. Some male sexual partners refused to pay for sexual services provided by commercial sex workers and also meted physical violence on those female sexual partners. This could be explained by the fact that some women got compromised by having unsafe sex in exchange for money (transactional sex). This placed them at risk of acquiring sexually transmitted infections including HIV

as well as the risks of unplanned pregnancies and physical abuse. Financial constraints was therefore cited as a barrier to prevention of HIV and AIDS and also led to sexual and economic forms of gender based violence.

5.0. CONCLUSION

More female respondents (62.9%) faced socio-cultural barriers in their pursuit of HIV prevention compared to their male counterparts (37.1%) which were associated with gender-based violence. Socio-cultural barriers to prevention of HIV and AIDS were significantly associated with self-efficacy in HIV prevention. Therefore HIV prevention was hampered by interplay of factors which seemed to emanate from gender power imbalances. The dominant barriers included condom refusal and fatigue, lack of HIV self-disclosure, alcohol abuse, financial constraints, stigma, discrimination and community social isolation. Other minor barriers comprised of lack of female condom, peer influence, multiple sexual partners, desire to have more children, lack of protective materials (gloves) and people's criticisms of PLWHA. These barriers seemed to lower the likelihood of taking a conscious and healthy HIV preventive action.

The study also established that there were gender based violence meted against men and women which included: sexual violence in form of forced sex, denial of sexual intimacy, abandonment by sexual partner, physical violence, psychological violence, economic violence, stigma, discrimination and community social isolation of PLWHA. It was recommended that there was need for community based intervention programs targeting PLWHA to address socio-cultural barriers that impede self-efficacy in the prevention of HIV and AIDS and thereby reduce gender-based violence among People Living with HIV and AIDS.

REFERENCES

1. Bertalanffy, V. (1968). *General Systems Theory*, New York: Braziller.
2. Boston Conference Report (2010). The pregnancy intentions of HIV positive women.
3. Commission on HIV/AIDS and Governance in Africa [CHGA] (2004). Impact of HIV and AIDS on gender, orphans and vulnerable children. Discussion outcomes of CHGA interactive, Cameroon. Economic Commission for Africa. <http://www.uneca.org/CHGA>. Retrieved on 9th June, 2011.
4. Forwarding the Research Agenda, 17-19 March 2010. Harvard School of Public Health, Boston, MA.
5. General Assembly Report of the UN Secretary General (2008). "Declaration of Commitment on HIV/AIDS and Political Declaration on HIV/AIDS: Midway of the Millennium Development Goals"- April 1, 2008.
6. Kenya (2003). Kenya Demographic and Health Survey [KDHS]. Central Bureau of Statistics-Nairobi, Kenya.
7. Kenya AIDS Indicator Survey [KAIS] (2007). Final Report September 2009 Republic Of Kenya. Nairobi.
8. Kieru, J. N. (2013). Predictors of self-efficacy in HIV prevention among people living with HIV and AIDS in Thika District, Kenya. Unpublished Ph.D. thesis, Kenyatta University.
9. Littlejohn, S. W. (1999). *Theories of Human Communication*, Belmont, CA: Wadsworth/Thomson Learning.
10. Nakawiya, S. (2006). *Desire for Children and Pregnancy Risk Behavior among HIV-Infected men and women in Uganda*, AIDS and Behavior – May 2006. Cited in CSIS 2006.
11. Otieno, B.A. (2008). Effects of Antiretroviral Therapy on sexual behavior among people living with HIV and AIDS in Kibera slums in Nairobi, Kenya. Unpublished MPH thesis: Kenyatta University.
12. Oyebola, B. (2009). Fertility desire and sexual behaviour of People Living with HIV/AIDS in South Western Nigeria. Hope Worldwide Nigeria.
13. Oyore, J.P. (2009). Determinants of adherence to antiretroviral therapy and high risk behavior among HIV infected patients on treatment in Nairobi province, Kenya. Unpublished Ph.D. thesis, Kenyatta University.
14. Rosenstock, I. M. & Stretcher, V. (1997). The Health Belief Model. In Glauz, K., Lewis, F. M. & Rimer, B. K. (1997) *Health Behaviour & Health Education: Theory Research and Practice*. Sanfransisco: Jossey-Bass (Eds.)
15. Stall, R. (2007). Prevention with positives: A critical literature review. Department of behavioral and community health sciences. University of Pittsburg
16. Stuart, G. S., 2009a. Fourteen million women with limited options: HIV/AIDS and highly effective reversible contraception in sub-Saharan Africa. *Contraception*, 80 (5), 412
17. UNAIDS (2006). *Advancing Sexual and Reproductive Health for People Living with HIV/AIDS worldwide through research, policy analysis and public education*. New York. United Nations Publications.
18. Wamoyi, J., Fenwick A. Urassa M. Zaba B., & Stones W. (2011). Changes in sexual desires and behaviours of people living with HIV. *BioMed Central Ltd. PublicHealth 11*. 1471-2458/11/10.
19. WHO (2006). *Sexual and Reproductive Health of Women Living with HIV and AIDS*. Guidelines on care, treatment and support for women living with HIV/AIDS and their children in resource-constrained settings. France: WHO.