INTIMATE PARTNER VIOLENCE IN PREGNANCY AMONG ANTENATAL ATTENDEES AT HEALTH FACILITIES IN WEST POKOT COUNTY, KENYA

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DECLARATION

This thesis is my original work and has not been presented for a degree in any other University or award.

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DEDICATION
This thesis is dedicated to my beloved wife Loreen Vivian Otieno.
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I would like to express my gratitude to the following people without whom this thesis would not have been a success.

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DEFINITION OF TERMS

Overall Intimate partner violence
According to the United Nation Assembly 1993, on declaration of elimination of violence against women, Intimate partner violence (IPV) against women has been defined as ‘any act of gender-based violence that result in or is likely to result in physical, sexual or psychological harm or suffering to a woman by men, including threat of such acts, coercion or arbitrary depriving of liberty, whether occurring in public or private life (WHO, 2000).

Physical Abuse
Refers to pattern of physical assaults and threats used to control another person. It includes punching, hitting, choking, biting, and throwing objects at a person, kicking and pushing and using a weapon such as a gun or a knife. Physical abuse usually escalates over time and may end in the woman's death (UNFPA, 2001).

Sexual Abuse
Refers to mistreatment or the control of a partner sexually. This can include demands for sex using coercion or the performance of certain sexual acts, forcing her to have sex with other people, treating her in a sexually derogatory manner and/or insisting on unsafe sex (UNFPA, 2001).

Emotional and Verbal Abuse
Refers to the mistreatment and undermining of a partner's self-worth. It can include criticism, threats, insults, belittling comments and manipulation on the part of the batterer (UNFPA, 2001).

Psychological Abuse
This is the use of various tactics to isolate and undermine a partner's self-esteem causing her to be more dependent on and frightened of the batterer (UNFPA, 2001)
Pregnancy
According to the Free Medical dictionary pregnancy is defined as the period from conceptions to birth.

Intimate Partner Violence in Pregnancy
Refers to IPV that takes place from the time a woman becomes pregnant until delivery.

Antenatal Care
Antenatal care refers to the regular medical and nursing care recommended for women during pregnancy (Medicine Net, 2011).

Intimate Partner
According to the US National Centre for Injury Prevention and Control an intimate partner might be a current or former sex or dating partner whether or not the couples lived together.
ABBREVIATIONS AND ACRONYMS

ANC...............................................................Antenatal Care

FGDs............................................................Focused Group Discussion

IPV...............................................................Intimate Partner Violence

KNBS............................................................Kenya National Bureau of Statistic

MCH.............................................................Maternal and Child Health

MDGs............................................................Millennium Development Goals

UNFPA.........................................................United Nations Funds For Population and Development.

WHO............................................................World Health Organization
ABSTRACT

Violence against women perpetuated by intimate partners is worldwide and an important public health concern as well as human rights issue. Intimate partner violence in pregnancy has drawn attention due to its prevalence, detrimental health consequences and intervention potential. In Kenya, the 2014 Kenya Demographic and Health Survey report estimates that 38% of ever-married women age 15-49 have ever experienced Intimate Partner Violence. There is scanty information on the prevalence and associated risk factors of intimate partner violence in pregnancy in West Pokot County. The objective of this study was to investigate factors contributing to intimate partner violence in pregnancy among antenatal attendees at the health facilities in West Pokot Sub-County. The study was done in 11 health facilities in West Pokot Sub-County. Using cross sectional study design, a total of 238 antenatal attendees who were proportionately and systematically selected from a sample frame of 622 were interviewed for experience of various forms of intimate partner violence in their current pregnancy. This was followed by qualitative research comprising of 4 Focused Group Discussions with 48 community health workers and key informant interviews with 20 health workers. The qualitative study explored community level risk factors on intimate partner violence in pregnancy and the quality of care offered to antenatal attendee experiencing intimate partner violence in pregnancy. Quantitative data was managed using the statistical package for social scientist (SPSS) while Qualitative data was consolidated into various themes. Bivariate and logistic regression analysis was done to determine factors associated with experience of IPV in the index of pregnancy with P ≤ 0.05 being considered significant. Informed consent was sought from the participants. Confidentiality and privacy was maintained throughout the study. Ethical clearance was obtained from Kenyatta University Ethics Review Committee, and a research permit from National Council for Science, Technology and Innovation. The study found prevalence of overall, physical, psychological and sexual IPV in pregnancy to be 66.9%, 29.9%, 55.8% and 39.2% respectively. After adjusting for confounders, Overall IPV in pregnancy was significantly associated with Alcohol intake by partner (OR 2.116, 95% CI 1.950-2.260, P 0.000) and partner’s level of education (OR 1.265, 95% CI 1.079-1.487, P 0.031), while psychological and sexual IPV was significantly associated with age of partner (OR 2.292, 95% CI 2.123-2.722, P 0.007) and age of pregnant women (OR 1.174, 95% CI 1.001-1.397 P 0.049) respectively. The care offered to antenatal attendees experiencing IPV is not in line with WHO guidelines and standard on handling gender based violence cases. The study findings indicates that IPV in pregnancy among antenatal attendees in West Pokot is very high. This unveils the weaknesses and gaps on gender based violence interventions both in health facilities and community level. Based on this study there is need for the national government, County government of West Pokot to integrate screening of IPV with maternal and child health services.
CHAPTER ONE: INTRODUCTION

1.1 Background of the study

Violence against women perpetuated by intimate partners is a worldwide and an important public health concern as well as human rights issue. More than 1.3 million people worldwide die each year as a result of violence in all its forms, accounting for 2.5% of global mortality (WHO, 2014). Despite the magnitude of deaths resulting from violence and the massive scale on which the non-fatal consequences of violence affect women there are important gaps in data that undermine violence prevention efforts (WHO, 2014). Women of reproductive age group experience the most gender based violence as they are more likely to be in sexual partnership (Heise & Ellsberg, 1999). This kind of violence by intimate partner in pregnancy is manifested by physical, sexual, emotional abusive act and controlling behavior. Studies conducted worldwide have estimated that between 10% and 71% of women suffer from IPV in their life (Heise, 2002). In Africa it affects millions of women and the prevalence in Sub-Saharan Africa is ranked high even in comparison with levels in other developing regions (WHO, 2002). Violence of all types is strongly associated with social determinants such as weak governance; poor rule of law; cultural and social and gender norms; unemployment; income and gender inequality; rapid social change; and limited education opportunities (WHO, 2014). Together these factors create a social climate conducive to violence, and in the absence of efforts to address them, sustained violence prevention gains are difficult to achieve. Intimate Partner Violence has been associated with various reproductive health outcomes although various studies indicate that the finding may not be consistent across all cultures. Violence during pregnancy is in most cases a continuation of proceeding violence but pregnancy can also initiate violence as 50% reported to have been beaten for the first time during a pregnancy (WHO, 2005). A study from Johns Hopkins University School of Public
Health revealed that abused women are at higher risk of miscarriages, stillbirths, and are more likely to give birth to low birth weight children, a risk factor for neonatal and infant deaths (Heise & Ellsberg, 1999) point to the need to research violence against pregnant women so as to help contribute to safe motherhood and health babies, (Shamu & Zarowsky, 2013). Violence also increases the burden of health sector as it increases costs of serving the victims of violence. Rape and domestic violence accounts for 5-10% of healthy years lost by women (WHO, 2002).

1.2 Problem statement
Globally, between 15% and 71% of women experience IPV during their lifetime, (Gracia-Moreno, 2006). The prevalence of IPV during pregnancy in sub-Saharan Africa is among the highest reported globally (Shamu, 2011). In Kenya, it is estimated that 38% of women suffer from IPV in their lifetime (KNBS, 2015) while gender based violence towards pregnant women in Kenya is estimated to be 13.5%, (Drivers & Johnson, 2010) a higher prevalence than that of many conditions normally screened for during pregnancy, (Gazmararian & Spitz, 2000). Pregnant women exposed to violence are more likely to experience stress, depression, miscarriage, pre-term delivery, induced abortion, and stillbirth, (Okenwa & Jonsson, 2011). Their infants are in turn, more likely to experience low birth weight, illness, under-nutrition and mortality (Rico & Abramsky, 2011) and hence could be one of the contributors to the current estimated high maternal mortality rate of 565 deaths per 100,000 births which is above the national figure of 488 deaths per 100,000 births in Kenya.

1.3 Justification of the study
Intimate Partner violence in pregnancy is a very sensitive issue at the community level. Moreover, negative maternal and child health outcomes associated with violence against pregnant women are directly linked to Millennium Development
Goals (MDGs) number 4 and 5; to reduce child mortality and improve maternal health as well as MDG 3 to promote gender equality and empowerment of women. Therefore findings from this study will be valuable in informing the government, programmers and policy makers on how to develop intimate partner violence interventions and health service provision protocols which are responsive to needs of West Pokot Sub-County.

1.4 Research questions
a) What is the prevalence of intimate partner violence in the current pregnancy among antenatal attendees in West Pokot Sub-County?
b) What are risk factors of IPV in pregnancy among antenatal attendees in West Pokot Sub-County?
c) What is the quality of care offered to antenatal attendees experiencing intimate partner violence in West Pokot Sub-County?

1.5 Hypothesis
The study will be guided by the following null hypothesis

H₀. There is no relationship between intimate partner violence in pregnancy and economic, cultural, socio demographic, health care factors among antenatal attendees in the health facilities in West Pokot Sub-County.

1.6 Objectives of the study
1.6.1 Broad Objective
To investigate factors contributing to intimate partner violence in pregnancy among antenatal attendees at the health facilities in West Pokot Sub-County.

1.6.2 Specific objectives
a) To determine the prevalence of intimate partner violence in the current pregnancy among antenatal attendees at the health facilities in West Pokot Sub-County.
b) To determine risk factors of IPV in pregnancy among antenatal attendees at the health facilities in West Pokot sub-county.

c) To assess quality of care offered to pregnant women experiencing intimate partner violence in the health facilities in West Pokot Sub-County.

1.7 Significance and anticipated output of the study
This study will represent an important step toward redressing the dearth of evidence on the prevalence intimate partner violence in pregnancy in the nomadic and pastoralist community of West Pokot District.

In-depth information on the prevalence, risk factors for IPV in pregnancy and documented available health care services for victims is likely to inform policy direction on addressing IPV in pregnancy. Moreover, the outcome of the study will provide evidence for advocacy, strategic planning, partnership and networking by government and all stakeholder in health provision on intimate partner violence prevention hence a significant intervention for lowering current levels of maternal mortality in settings such as West Pokot.

1.9 The Ecological Approach to IPV
The determinants of intimate partner violence are manifested and often are as a result of complex inter-play between factors at the individual, relationship, community and societal level as depicted in the ecological model (Heise, 1998).
Within the ecological model, "personal" factors are the individual characteristics or behaviors that impact a person's health such as age. "Relationship" factors are the dynamic partnership issues that frame health outcomes such as partner's characteristics. "Community" refers to the broader social or structural factors that impact on health such as community and health care systems (WHO, 2010). The approach helps to understand IPV in a broader spectrum and may also help to develop comprehensive interventions to prevent IPV. For example, the ecological framework helps to examine the influence of the health system as a social ecology on IPV in pregnancy (Shamu & Marleen, 2013).

1.10 Conceptual framework

Figure 1.2 lays the conceptual framework for this study. Various variables are used to examine factors contributing to IPV in pregnancy. The first groups are independent variables; socio demographic characteristic of pregnant women (individual level), characteristics of the partner (relationship level), norms and culture (community level) and quality of care (societal level) that determines occurrence of intimate partner violence (Krug & Mercy, 2002). For this particular study, intimate partner violence is considered as dependent variable.
Figure 1.2: Conceptual framework for intimate partner violence in pregnancy

Adopted and modified from: (Ellsberg, 2005)
CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction
In this section literature related to Intimate Partner Violence in pregnancy is reviewed not only to determine the gaps in knowledge on the subject in Kenya, but also to provide a direction for generating suitable data collection instrument and a sound theoretical basis and perspective for discussing and presenting the study findings.

2.2 Global Prevalence of Intimate Partner Violence
Estimates of the prevalence of pregnancy related violence vary due to differences in research designs, measures used and population sampled. Global estimates of intimate partner violence perpetrated by men against women indicate that 30% of ever partnered women worldwide have experienced physical and/or sexual violence by an intimate partner at some point in their lives (WHO, 2014). It is also estimated that 15% and 71% of women experience IPV during their lifetime (Gracia-Moreno, 2006). The WHO multi-country study on women’s health and domestic violence against women which consists of population-based surveys conducted in various countries using the same methods and definitions, found the prevalence of physical intimate partner violence in pregnancy to range between 1% in Japan city to 28% in Peru Province, with the majority of sites ranging between 4% and 12%. This finding are supported by an analysis of Demographic and Health Surveys and the International Violence against Women Survey, which found prevalence rates for intimate partner violence during pregnancy between 2% in Australia, Denmark, Cambodia and Philippines to be 13.5% in Uganda, with the majority ranging between 4% and 9% (Drivers & Johnson, 2010). Clinical studies around the world which are less resource intensive to conduct as compared to population based, tend to yield higher prevalence rates but often are the only sources of information available, found the highest prevalence in Egypt with 32%, followed by India (28%), Saudi Arabia (21%) and
Mexico (11%) (Campbell, 2004). The result of a study conducted at Delhi hospital to determine the prevalence of domestic violence in women attending antenatal clinic showed that 26.9% of women reported physical abuse, 29 and 6.2% reported emotional and sexual abuse respectively (Sigh & Soren, 2008).

Regionally, Eastern Mediterranean and South East Asia regions, approximately 37% of ever-partnered women report experiencing physical and/or sexual violence by an intimate partner in their lives followed by the region of the Americas, with approximately 30% of women reporting lifetime exposure (WHO, 2014).

2.3 Prevalence of intimate partner violence in Africa
A study on systematic review of African studies on intimate partner violence against pregnant women found the prevalence of IPV during pregnancy ranging 2% to 57%; 23–40% for physical, 3–27% for sexual and 25–49% for emotional intimate partner violence during pregnancy with meta-analysis yielding an overall prevalence of 15.23% (95% CI: 14.38 to 16.08%) (Shamu S, 2011). However, the global status report on violence prevention indicates that in Africa 37% of ever-partnered women report experiencing physical and/or sexual violence by an intimate partner in their lives (WHO, 2014).

A cross sectional study on domestic violence among antenatal attendees in the University of Port Harcourt Teaching Hospital indicated the prevalence of domestic violence during pregnancy to be 7.8% with verbal abuse as the commonest form of violence at 43% and 1.2% suffering from physical injuries (Jeremiah & Oriji, 2011). However, similar study conducted in Nigeria to determine prevalence of IPV to pregnant women within 12 months prior to and during the current pregnancy indicated higher prevalence at 14.2%. In this study verbal abuse was the most common (66.2%) (Fawole & Fawole, 2008). Population based studies in Africa
estimates rates of IPV in the region are among the highest in the world (Garcia-Moreno & Ellsberg, 2006).

2.4 Prevalence of intimate partner violence in Kenya
In Kenya, the 2014 demographic health survey report estimates that 38% suffer from IPV in their lifetime (KNBS, 2015). Gender based violence towards pregnant women in Kenya is estimated to be 13.5% (Drivers & Johnson, 2010). In urban Kenya, 28% of urban pregnant women reported lifetime IPV (Kiarie & Richardson, 2006). A cross-sectional study conducted in Kisumu District hospital to determine the prevalence of IPV among pregnant women seeking antenatal care reported lifetime overall, physical, psychological and sexual IPV to be 53, 26, 42 and 15%, respectively. The prevalence of overall, physical, psychological, and sexual IPV during pregnancy was 37, 10, 29 and 12%, respectively. However, the study showed that IPV within the past 12 months before pregnancy was 52, 25, 40 and 15% respectively (Makayoto, 2013).

2.5 Prevalence of intimate partner violence in West Pokot
Systematic reviews suggest that no studies to date have measured prevalence of IPV during pregnancy among Kenyan rural women (Drivers & Johnson, 2010). However, in the neighbouring Uganda that borders West Pokot in the North between 13.5% to 27.7% of pregnant women report IPV during pregnancy (Kaye, 2006).

2.6 Risk factors of intimate partner violence in pregnancy
A combination of a number of associated risk factors add to the level of strain that is associated with pregnancy and motherhood and might thus increase the risk of IPV in pregnancy. Risk factors of IPV are present at every level of the socio-ecological model including the individual level, relationship level, the community level and the larger society (Heise, 1998).
2.6.1 Individual and relationship risk factors and IPV

Women identified as being at greater risk of experiencing IPV in pregnancy compared to other women include: those with lower level of social support (Jasinki, 2004); younger unmarried women (Jasinki, 2004); women with low socio-economic status such low education level and income (Castro, 2003).

A study on Prevalence of violence against pregnant women in Abeokuta, Nigeria indicated that polygamous unions, low level of education in both women and partner and consumption of alcohol by partner were significant (p<0.05) risk factor of violence prior to pregnancy (Fawole & Fawole, 2008).

Findings of a study conducted in Rwanda among pregnant women showed that alcohol use by partner was positively associated with life time IPV (OR=2.52; 95% CI (1.35, 4.71) for occasional drinkers and OR=3.85; 95% CI (1.81, 8.21) for heavy drinkers. In the same study, women with elementary education were less likely to report life time IPV as compared to women with no formal education. (OR=0.30; 95% CI (0.11, 0.78) (Campbell, 2004).

In a study on Domestic Abuse in Kenya conducted jointly by Population communication Africa, Ford Foundation, National council of women, Canadian International Development Agency and Gender Equality Support Program, 24.3% of the respondents acknowledged poverty as a major cause of domestic violence and another 53.4% related domestic violence with substance abuse, which was correlated with frustration of poverty (Jonstone, 2002). In several research studies, the data suggest that women with high educational attainment are at a greater risk of being victimized by their partners than women with low educational attainment (Klomegah, 2008).

The study conducted at Kisumu District hospital indicated that being in a polygamous partnership resulted to an over two fold increased odds of IPV compared to being in
monogamous partnership, and those who had partner who drank alcohol had more than twice the odds of experiencing IPV during their pregnancy than women whose partners did not drink alcohol (Makayoto, 2013).

2.6.2 Society and community level risk factors and IPV
Research studies across cultures have revealed a number of societal and cultural factors that might give rise to higher levels of violence. For example (Levinson, 1998) examined the cultural patterns of wife beating – exploring the factors that consistently distinguish societies where wife beating is common from those where the practice is rare or absent.

One of the most common theories to explain the perpetration and experiencing of intimate partner violence and sexual violence is the maintenance of patriarchy or male dominance within a society (Taft, 2009). Patriarchal and male dominance norms reflect gender inequality and inequities at a societal level, and legitimize intimate partner violence and sexual violence perpetrated by men (Russo, 2006). While they are located at the societal level, these gender norms play out at the level of community, relationship and individual behaviors. Societal norms related to gender are believed to contribute to violence against women and gender inequality and other inequities by creating power hierarchies where men are viewed by society as economically and religiously superior, and of higher social status compared to women (Ali, 2008). A qualitative study conducted in Kenya indicated that men are socialized to believe that they are superior to women, should dominate their partners and endorse traditional gender roles and Women’s subordination and submission is then considered to be normal, expected, accepted (Hatcher & Odero, 2013). Women isolation and lack of social support from community leaders and elders (Mann, 2009), pejorative community attitude that devalue women and legitimize domestic
abuse (Jewkes, 2010) and the community poverty levels, (Eaton, 2012). Other society level include pervasive and antiquated gender norms, predominantly patriarchal societies (Archer, 2002), inadequate or ineffective laws and policies regarding IPV, and limited education and awareness of IPV issues from low enforcement officials, health workers, lawyers and the government, (Guruge, 2012).

2.7 Association between Intimate Partner Violence and pregnancy

Pregnancy, although not a disease, is a delicate period when women are expected to be protected from various violence by all members of the community, especially their partners. The exact correlation between pregnancy and IPV is not clear but studies indicate that violence is associated to changes, strain and disagreement within a relationship, (Jasinki, 2004). However it is still not clear whether or not pregnancy increases the risk of violence. Some studies have indicated that violence is likely to escalate during pregnancy or pregnancy triggers violence (Edin, 2006).

It has been shown that expecting a first child as well as having an unexpected pregnancy is a significant risk factor for IPV (Jasinki, 2004). A study conducted in China indicated prevalence of IPV 12 months before pregnancy, approximate 9 months of pregnancy and after the pregnancy to be 9.1, 4.3 and 8.3% respectively, (Guo, 2004). Some of studies have also indicated that the months immediately after delivery as a more risky time, compared to both before and during pregnancy (Hiden, 2000). An analysis of Kenya Demographic and Health Survey (KDHS 2003) showed that women with terminated pregnancy are more likely to experience physical, emotional and sexual violence (p=0.0001) (Emenike, 2006). Another study conducted in Kenya at Kisumu District hospital showed that a third of women who were exposed to violence 12 months before pregnancy were not exposed to violence during the pregnancy (Makayoto, 2013).
2.8 Consequences of IPV in Pregnancy
Women experiencing violence during pregnancy are subject to a number of detrimental social, mental, physical, psychological, behavioral and reproductive health outcomes which jeopardize both the mother and the unborn baby. A report on Trauma during Pregnancy indicated that Intentional injury from physical abuse during pregnancy has become more prevalent and is a frequent cause of blunt abdominal trauma and maternal and fetal morbidity (Brown, 2012). It has been estimated that 10% of hospitalizations due to injury in pregnancy are the result of intentional injuries inflicted upon the pregnant woman, (Chembliss, 2008). Women who are abused are 2.3 times more likely to experience preterm labor (Shumway, 1999). In addition, an increased risk of preterm labor is associated with more serious violence.

2.9 Assessing the quality of health care based Domestic Violence interventions
The quality of a health care-based domestic violence program, like the quality of other health services, can be examined using a paradigm first described by Donabedian, (Donabedian, 1966). This approach measures the quality of health care by examining the structure, process, and outcomes associated with that care. Health care-based domestic violence programs typically incorporate numerous components, designed to promote systematic improvement in victim services. Many of these components are structure- and process-oriented.

These measures fall within various domains of Domestic violence program activities, including: hospital physical environment, hospital cultural environment, training of providers, screening and safety, documentation, intervention services and collaboration (Jeffrey 2002) These criteria do not guarantee successful domestic violence outcomes, but they are felt to increase the quality of care and reduce risk of experiencing violence (Jeffrey 2002).
2.9.1 The Health Sector and Intimate partner violence
Due to the magnitude of IPV problem and its effects on the mother and the unborn child, gynecological and pediatric professional organizations have recommended interventions with pregnant women in antenatal care settings (Roelens, 2006). However, literature reviews on screening pregnant women for IPV reports that health care staff are not fully equipped with the knowledge and capacity and do not have the willingness to implement IPV interventions such as routine screening for IPV (Erickson & Sigel, 2001). Results from studies conducted in Belgium, Canada and Tanzania show that pregnant women do not disclose IPV to health care staff unless they are prompted to (Stewart, 1993), (Antelman, 2001), (Roelens, 2006). Challenges such as nurses negative attitude and scolding of patients in reproductive and sexual health sessions have been documented in South Africa (Jewkes 1998). Qualitative studies with midwives who screened clients for domestic violence found time constrains, lack of training, lack of privacy, unsupportive management, lack of support resources, fear of offending the patients, not changing and lack of feedback after referral to be the obstacles to responding to IPV (Loraine & Gill Mezey, 2006), (Mezey, 2003), (McCosker-Haward, 2005), (Feder, 2006).

2.9.2 Antenatal care services and Intimate partner violence
Antenatal care provides a window of opportunity for identifying women who experience intimate partner violence (WHO, 2000). Not only is it often the only point of contact for women within a health-care setting, but also provision of health services and support through the duration of a pregnancy, and the possibility for follow-up, make antenatal care a suitable setting for addressing issues of abuse (WHO, 2000).

2.9.3 Role of health care providers
The medical community can play a vital role in identifying women who are experiencing IPV and halting the cycle of abuse through screening, offering ongoing
support, and reviewing available prevention and referral options. Screening of IPV during pregnancy should occur at the first prenatal visit, at least once per trimester, and at the postpartum checkups (American Collage of Obstetricians and Gynecologist, 2012).

2.10 Summary of Literature Review
In summary, Intimate partner violence in pregnancy cannot be overlooked considering the documented prevalence and consequence on maternal and child health. Individual, relationship, community and societal level factors have been shown in the literature review to be strongly related prevalence of IPV and the quality of care offered to such victims. Though antenatal care has been shown to provide a window of opportunity for identifying women who experience intimate partner violence and also often the only point of contact for women within a health-care setting, there is very limited literature especially on the quality of care for antenatal attendees who experience IPV. The study therefore determined the prevalence of IPV in the current pregnancy, risk factors and quality of care offered to antenatal attendees experiencing IPV in West Pokot Sub-county.
CHAPTER THREE: MATERIALS AND METHODS

3.1 Introduction
This chapter presents a detailed overview of methodology that was employed by the researcher to conduct the study.

3.2 Research Design
This was a descriptive cross-sectional study to determine the prevalence of intimate partner violence during the pregnancy among antenatal attendees in 11 sampled health facilities. This methodology was chosen as it would show the prevalence of IPV in pregnancy at a point in time, risk factors and also the current status on the quality of care offered to pregnant women experiencing IPV. Both quantitative and qualitative approaches were used in the study.

3.3 Research Variables
The choice of variables for risk factors analysis was based on the ecological model basis for risk factors (Heise, 1998). The dependent variable for this study was experience of intimate partner violence during pregnancy; physical, sexual and emotional violence. This was measured using six physical violence questions, three sexual violence questions, and four questions for emotional/psychological violence. Answering positive to one question in each of the specific types of violence was coded as that type of violence. Independent variable for the study were socio-demographic characteristics of both pregnant women and their current partner’s, for quantitative data and community factors and health service response to IPV for qualitative data.
3.4 Study area

3.4.1 Location of West Pokot Sub-County
The study was conducted in health facilities in West Pokot Sub-County in West Pokot County, Kenya. It lies within Longitude 34° 47' and 35°35' east and latitude 1 and 2 North (Appendix vii). West Pokot Sub-County has a population of 194,222. Women of reproductive age (WRA) are 41,564 which comprise of 21.4% of the population. Five percent of the women of reproductive age (2078) are projected to be pregnant and female to male ratio of 51:49 respectively (HMIS-West Pokot, 2011). There are 20 health facilities in West Pokot Sub-county which include one Level IV Hospital, four level three, and fifteen level two health facilities.

3.4.2 Justification of study area
The Sub-County was purposively selected due to high poverty rate of 69.4 which is above the national figure of 46% (County integrated development plan) which is linked to the analysis of 2008/2009 KDH survey based on the wealth quintiles which shows that those classified as the poorest and the poor were more accepting of GBV based on the woman’s behavior (Amuyanzi-Nyamongo, 2012).

3.5 Study Population
The study population was all antenatal attendees at the maternal and child health clinics in the sampled health facilities, community health workers for FGDs and health workers in various facilities for KII.

3.5.1 Inclusion criteria
All antenatal attendees irrespective of their parity and trimester in the clinics at health facilities in the Sub-County and who gave consent to participate voluntarily were included in the study. All health facilities that are offering antenatal care services were legible for sampling.
3.5.2 Exclusion criteria
Antenatal attendees who were very sick and declined to participate were excluded from this study. Facilities located at the insecure places were excluded from the study.

3.6 Sample Size determination
The minimum sample size for health facilities was determined by $n = \frac{N}{1 + N(e)^2}$ (Israel, 1992). Where $n =$ number of facilities to be sampled, $N =$ Total number of facilities in the area $e =$ level of precision; margin of error 20%. $n = 20 / (1 + 20(0.2^2)) = 11.11$. The minimum sample size for the respondents was determined by using the statistical formula of Fisher et.al 1991 for calculating sample size; $N = \frac{Z^2pq}{d^2}$. Where; $N =$ Minimum sample size for a statistically significant survey, $Z =$ Normal deviant at the portion of 95% confidence interval = 1.96, $P =$ 37% (Overall prevalence of IPV in pregnancy among pregnant women attending Kisumu District hospital, Kenya (Makayoto, 2012). $q = 1 - p$, $d =$ Margin of error acceptable = 0.05. $1.96^2 (0.37)(0.63)/0.05^2 = 358$, since the target population is less than 10,000. The, the following formulae was used. Where $n_f = \frac{n}{1 + \frac{n}{N}}$. Where $n_f =$ the desired sample size (when the population is less than 10,000, Therefore $n_f = 358 / ((1 + (358/ 622))$. Minimum sample size ($N) = 227.22 * 5%$ adjustment to cater for recording errors$^\prime = 238.5 \approx 238$ respondents.

3.7 Sampling procedure
Stratified two stage random sampling was used in this study. The health facilities in the Sub-County were first stratified according to MOH service delivery levels (Republic of Kenya/MOH/Health Secretariate, 2005). This resulted into three strata; Level II, III and IV from which 11 health facilities were proportionately and randomly sampled from a total of 20 health facilities in the Sub-County. The respondents were distributed proportionately to each health facility depending on the average number
antenatal attendees in health facilities in the year 2012 as per District health information system (Table 3.1.) This was followed by systematic random sampling at interval of three mothers at each health facility to identify the respondents where the interval was the overage monthly antennal attendance divided by required sample size (622/238=2.613≈3). The starting point was randomly generated number at each facility included in the study (Mugenda, 2005). This was done using the established clinic queues to systematically sample antenatal attendees for interview until the sample size was achieved for each health facility. Data was collected within one month from 1st to 26th September 2014 to avoid any bias that might have resulted from antenatal revisits in the following month.

**Table 3.1: Distribution of respondents according to Health Facilities**

<table>
<thead>
<tr>
<th>Health facility</th>
<th>HF Level (Strata)</th>
<th>Total antenatal attendees in year 2012</th>
<th>Average antenatal attendees in each Month</th>
<th>Proportionate sample/Health facility</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kapenguria district hospital</td>
<td>IV</td>
<td>4069</td>
<td>399</td>
<td>153</td>
<td>141</td>
</tr>
<tr>
<td>Serewo</td>
<td>III</td>
<td>492</td>
<td>41</td>
<td>16</td>
<td>14</td>
</tr>
<tr>
<td>BCFC</td>
<td>II</td>
<td>168</td>
<td>14</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Bwena</td>
<td>II</td>
<td>259</td>
<td>21</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Chepnyal</td>
<td>II</td>
<td>236</td>
<td>19</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Embogh</td>
<td>II</td>
<td>436</td>
<td>36</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>Kadokony</td>
<td>II</td>
<td>177</td>
<td>14</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Kaibos</td>
<td>II</td>
<td>158</td>
<td>13</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Miskwony</td>
<td>II</td>
<td>283</td>
<td>23</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Ptoyo</td>
<td>II</td>
<td>385</td>
<td>32</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Tuina</td>
<td>II</td>
<td>130</td>
<td>10</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td></td>
<td><strong>622</strong></td>
<td><strong>238</strong></td>
<td><strong>224</strong></td>
<td></td>
</tr>
</tbody>
</table>
3.8 Construction of Research Instruments
An Interviewer administered structured questionnaire was used in the study adopted most questions from WHO standardized questionnaire for research on gender based violence for quantitative data collection (Appendix 3), focused group discussions, key informant interview schedules and observation checklist were used to collect qualitative data (Appendix 5 and 6). The instruments were constructed based on the research questions and objectives of this study and translated to Kiswahili language which is familiar to almost everyone in the study area.

3.9 Pre-testing
Data collection tools were pre-tested at Jamii medical clinic to fine-tune the data collection tools. Health workers with past experience in data collection were recruited and trained as research assistance to collect data for this study.

3.9.1 Validity
The researcher established validity of the data collection instruments during the pre-test to check the instrument's ability to collect the required information on the various study variables. The raw data was edited to detect errors and omissions to ensure accuracy, consistency and uniformity during data analysis.

3.9.2 Reliability
The researcher pretested the tools at Jamii medical clinic located at Kapenguria in Makutano. Here, antenatal mothers attending the clinic were randomly sampled to participate in the pre-test. The outcome of analysis by SPSS was used to re-view the data collection tools to ensure reliability. The study achieved a reliability coefficient (alpha) of 70.

3.10 Data Collection Techniques
Pregnant women attending the ANC clinic were interviewed in private room at the maternal child health clinic after taking their informed consent. During the interview
the researcher assistants explained the objectives of the study to the respondents. The Key Informant interviews were held with twenty health workers selected from key maternal health service delivery points in level III and IV health facilities. Four Focused Group discussions were conducted with twelve community health worker from each of four community health units in the Sub-County. This was done on their usual monthly meeting days and the 1st twelve to arrive were included to participate in the study. The participant who were identified to be victims of any form of IPV were referred to the maternal child health counselor at Kapenguria District Hospital for further support.

3.11 Data Analysis
Data was entered; cleaned, analyzed and stored using SPSS. Descriptive analysis of variables and graphical presentation was done using proportions and frequency to describe the social demographic characteristics of women and intimate partner's. Prevalence of women reporting the various forms of IPV in the current pregnancy was sought. Odd ratio was used to show the strength of associations. Bivariate analysis was done to compare independent factors of women who experience violence in the index of pregnancy with women who did not. Multiple logistic regression analysis predicting overall, physical, psychological and sexual IPV was used to explore the adjusted association of covariates that had a $p < 0.1$ in the bivariate analyses with a $P \leq 0.05$ being considered significant. Responses from the FGDs and KII's were analyzed by content analysis, summarized under various themes, inferences made from each theme and conclusions drawn was then triangulated with the data from the questionnaire.
3.12 Ethical consideration
Anonymity and confidentiality was ensured. The participant were provided with adequate information on the research before the interview, and because of the level of literacy, consent obtained was mainly verbal. The confidentiality of the information gathered was assured. Their right of refusal to participate in the study was respected. Ethical approval was obtained from Kenyatta University Ethics Review Committee (Appendix 10) while research permit was obtained from committee of the National council for Science and Technology (Appendix 10 and 11).

3.13 Logistical Consideration
The choice of study methodology was partially informed by the harsh climate, raged terrain and scattered type of settlement in the Sub-County of study.

3.14 Study Limitation
The cross sectional approach, though systematically well perfumed, limits conclusions that can be drawn with regards to casualty. The study was also health facility based focusing on antenatal attendees and findings cannot be generalized to all pregnant women because pregnant women who seek antenatal care may differ in exposure to IPV from women who do not attend antenatal care. This limitation was addressed by proportionate distribution of target sample and random sampling of health facilities across the sub-county.
CHAPTER FOUR: RESULTS

4.1 Sociodemographic characteristics of the study population

The study approached 238 antenatal attendees. Two were sick and further 12 incomplete questioner were removed from the analysis, giving response rate of 224 (94.1%). The sociodemographic characteristics of the study population is summarized in Table 4.1. below. Among the 224 women respondents, 44 (19.6%) were aged between 35 and 39), 20 (8.9%) were aged between 45 -49 while 56 (25%) of their male partners were between 30-34 and minority 24 (10.7%) to be aged between 45-49. More respondents reported to have had more than one pregnancy 117 (52.2%) while 311 (13.6%), 90 (40.2%) and 103(45%) were in their first, second and third trimesters respectively. Most respondents reported to be married 184 (82.1%) with 116 (51.8%) having been in marriage for four year and less and only 65 (29%) had been married for ten years and above. Most of women had formal education 182 (81.3%) with the highest level of complete primary school 114 (50.9%). Only 4 (1.8%) of the respondents had university degree education which is lower than their partners as they reported that 207 (92.4%) had formal education with the highest level of complete secondary school 62 (27.6%). Only 16 (7.1%) of the partners had university degree education. The majority of the respondents 168 (75%) were unemployed while half of their partners 113 (50.4%) were unemployed and only 49 (21.8%) were on salaried employment. Few respondents were in polygamy marriage 35 (15.6%) and 25 (11.2%) reported to be taking alcohol, however, a high of 87 (38.8%) of their partner were reported to be taking alcohol.
Table 4.1: Socio-demographic characteristic of study population

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>N=224</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age respondent (years)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-19</td>
<td>23</td>
<td>10.3</td>
</tr>
<tr>
<td>20-24</td>
<td>40</td>
<td>17.9</td>
</tr>
<tr>
<td>25-29</td>
<td>30</td>
<td>13.4</td>
</tr>
<tr>
<td>30-34</td>
<td>38</td>
<td>17.0</td>
</tr>
<tr>
<td>35-39</td>
<td>44</td>
<td>19.6</td>
</tr>
<tr>
<td>40-44</td>
<td>29</td>
<td>12.9</td>
</tr>
<tr>
<td>45-49</td>
<td>20</td>
<td>8.9</td>
</tr>
<tr>
<td><strong>Parity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>multipara</td>
<td>117</td>
<td>52.2</td>
</tr>
<tr>
<td>primi</td>
<td>107</td>
<td>47.8</td>
</tr>
<tr>
<td><strong>Trimester</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>trimester one</td>
<td>31</td>
<td>13.8</td>
</tr>
<tr>
<td>trimester two</td>
<td>90</td>
<td>40.2</td>
</tr>
<tr>
<td>trimester three</td>
<td>103</td>
<td>45.0</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>never married</td>
<td>34</td>
<td>15.2</td>
</tr>
<tr>
<td>married</td>
<td>184</td>
<td>82.1</td>
</tr>
<tr>
<td>others</td>
<td>6</td>
<td>2.7</td>
</tr>
<tr>
<td><strong>Polygamy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>yes</td>
<td>35</td>
<td>15.6</td>
</tr>
<tr>
<td>no</td>
<td>189</td>
<td>84.4</td>
</tr>
<tr>
<td><strong>Respondent's Alcohol intake</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>yes</td>
<td>25</td>
<td>11.2</td>
</tr>
<tr>
<td>no</td>
<td>199</td>
<td>88.8</td>
</tr>
<tr>
<td><strong>Age of partner(years)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25-29</td>
<td>36</td>
<td>16.1</td>
</tr>
<tr>
<td>30-34</td>
<td>56</td>
<td>25.0</td>
</tr>
<tr>
<td>35-39</td>
<td>53</td>
<td>23.7</td>
</tr>
<tr>
<td>40-44</td>
<td>55</td>
<td>24.6</td>
</tr>
<tr>
<td>45-49</td>
<td>24</td>
<td>10.7</td>
</tr>
<tr>
<td><strong>Partner's level of education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No education</td>
<td>17</td>
<td>7.6</td>
</tr>
<tr>
<td>primary</td>
<td>94</td>
<td>42.0</td>
</tr>
<tr>
<td>secondary</td>
<td>62</td>
<td>27.7</td>
</tr>
<tr>
<td>college</td>
<td>35</td>
<td>15.6</td>
</tr>
<tr>
<td>university</td>
<td>16</td>
<td>7.1</td>
</tr>
<tr>
<td><strong>Occupation of partner</strong></td>
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<td></td>
</tr>
<tr>
<td>unemployed</td>
<td>113</td>
<td>50.4</td>
</tr>
<tr>
<td>casual work/temporary</td>
<td>53</td>
<td>23.6</td>
</tr>
<tr>
<td>salaried/employed</td>
<td>49</td>
<td>21.8</td>
</tr>
<tr>
<td>others</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td><strong>Partner's alcohol intake</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>yes</td>
<td>87</td>
<td>38.8</td>
</tr>
<tr>
<td>no</td>
<td>137</td>
<td>61.1</td>
</tr>
</tbody>
</table>
4.2 Prevalence of intimate partner violence in the current pregnancy.
This study determined the prevalence of overall IPV in pregnancy among antenatal attendees in West Pokot Sub-county to be 150 (66.9%).

4.2.1 Prevalence of physical Intimate Partner Violence
Physical IPV reported by the study respondents was 67 (29.9%); slapped 56 (25%), pushed, shaken, something thrown on them 41 (18.3%), punch or hurt and twist arm or pull hair were both 8 (3.6%), kick, drag or beat 7 (3.1%) while choke or burn and threaten to attack were the least type of physical violence reported by antenatal attendees in West Pokot sub-county 2 (0.9), (Figure 4.1).

![Graph showing prevalence of physical intimate partner violence in pregnancy]

Figure 4.1: Prevalence of physical intimate partner violence in pregnancy

4.2.2 Prevalence of Psychological/Emotional Intimate Partner Violence
The study showed psychological/emotional IPV of 125 (55.8%). Being insulted or made to feel bad about oneself was mostly reported 117 (52.2%) as depicted in figure 4.2. Compared to other types of psychological violence belittled or humiliated was reported to be 99 (44.2%) while scare or intimidate and threatened to hurt someone you care about were reported to be 25 (11.2%) and 20 (8.9%) respectively, (Figure 4.2).
Figure 4.2: Prevalence of psychological intimate partner violence in pregnancy

4.2.3 Prevalence of Sexual Intimate Partner Violence
For sexual IPV, 88 (39.2%) of the respondents reported to have experienced various types of sexual violence in their current pregnancy. The highest being sexual intercourse with the partner due to fear 79 (35.3%) followed by forced sexual intercourse 19 (8.5%) and lowest being forced to do something sexual that is degrading or humiliating 10 (4.5%), (Figure 4.3).

Figure 4.3: Prevalence of sexual intimate partner violence
To determine the overlapping between the forms IPV, a three-way contingency table analysis was performed. Outcome of the procedure is presented using intersecting circles (Figure 4.4).

**Psychological and Physical (24%)**

**Sexual and Physical (18%)**

**Physical IPV**

\[ n = 68 (30\%) \]

**Psych. IPV**

\[ n = 126 (56\%) \]

**Sexual IPV**

\[ n = 92 (41\%) \]

**Sexual and Psychological (34%)**

**Sexual and Psychological and Physical (16%)**

**Figure 4.4: Intersection between forms of IPV in pregnancy**

These results were also supported by the outcome of the FGDs. Across all the FGDs participants mentioned psychological, physical, sexual, and economical violence. Psychological was ranked first, Economical second; where the man controls the expenditure of the woman, sexual third and physical fourth.

### 4.3 Predisposing risk factors of IPV in pregnancy

The bivariate analysis showed association between various factors and overall IPV among the pregnant women, however only alcohol intake by partner was significantly associated with overall IPV \( (p=0.000) \), (Table 4.2).
Table 4.2: Bivariate Analysis comparing characteristics of women who experience overall IPV with those who did not.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Abused</th>
<th>Not Abused</th>
<th>Crude OR (95% CI)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (in years)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-19</td>
<td>13 (5.8)</td>
<td>10 (4.5)</td>
<td>.349-1.166</td>
<td>.144</td>
</tr>
<tr>
<td>20-24</td>
<td>27 (12.1)</td>
<td>13 (5.8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25-29</td>
<td>26 (11.6)</td>
<td>4 (1.8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30-34</td>
<td>26 (11.6)</td>
<td>12 (5.4)</td>
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</tr>
<tr>
<td>35-39</td>
<td>28 (12.5)</td>
<td>16 (7.1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40-44</td>
<td>16 (7.1)</td>
<td>13 (5.8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>45-49</td>
<td>15 (6.7)</td>
<td>5 (2.2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Parity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multipara</td>
<td>79 (35.3)</td>
<td>38 (17)</td>
<td>.582-1.857</td>
<td>.896</td>
</tr>
<tr>
<td>Primipara</td>
<td>72 (32.1)</td>
<td>35 (15.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Trimester</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trimester 1</td>
<td>26 (11.6)</td>
<td>5 (2.2)</td>
<td>.516-1.186</td>
<td>.247</td>
</tr>
<tr>
<td>Trimester 2</td>
<td>55 (24.6)</td>
<td>35 (15.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trimester 3</td>
<td>70 (31.2)</td>
<td>33 (14.7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never married</td>
<td>20 (8.9)</td>
<td>14 (6.3)</td>
<td>.666-2.087</td>
<td>.572</td>
</tr>
<tr>
<td>Married</td>
<td>127 (56.7)</td>
<td>57 (25.4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>4 (1.8)</td>
<td>2 (0.9)</td>
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<td></td>
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</tr>
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<td>University</td>
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</tr>
<tr>
<td>Casual/temporary worker</td>
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<td>Salaried/permanent worker</td>
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</tr>
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<td>73 (32.6)</td>
<td>64 (28.6)</td>
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</tr>
<tr>
<td>Partner drink alcohol</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
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<td>29 (12.9)</td>
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<td>1.66-1.102</td>
<td>0.15</td>
</tr>
<tr>
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<td>67 (29.9)</td>
<td>1.66-1.102</td>
<td>0.15</td>
</tr>
<tr>
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</tr>
<tr>
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<td>71 (31.7)</td>
<td>45 (20.1)</td>
<td>0.912-1.805</td>
<td>0.15</td>
</tr>
<tr>
<td>5-9</td>
<td>71 (31.7)</td>
<td>45 (20.1)</td>
<td>0.912-1.805</td>
<td>0.15</td>
</tr>
<tr>
<td>≥10</td>
<td>71 (31.7)</td>
<td>45 (20.1)</td>
<td>0.912-1.805</td>
<td>0.15</td>
</tr>
</tbody>
</table>

Table 4.3 shows multiple logistic regression analysis to determine factors that were independently associated with overall IPV. This was done while controlling for variables with $p \leq 0.1$. Two factors remained significant risk factors of IPV in pregnant women. More violence was reported by pregnant women whose partner were taking alcohol, ($p = 0.000$). Women whose partner had no education were also more likely to experience overall IPV, ($p = 0.031$).
Table 4.3: Multiple Logistic Regression Analysis of Risk factors for overall IPV.

<table>
<thead>
<tr>
<th>Independent Variables</th>
<th>B</th>
<th>S.E.</th>
<th>p-value</th>
<th>OR</th>
<th>95% C.I. for OR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
<td>Lower</td>
</tr>
<tr>
<td>Age of respondent</td>
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<td>.375</td>
<td>.441</td>
<td>.749</td>
<td>.359</td>
</tr>
<tr>
<td>Age of partner</td>
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<td>.462</td>
<td>.266</td>
<td>.598</td>
<td>.242</td>
</tr>
<tr>
<td>Length of relationship</td>
<td>.095</td>
<td>.207</td>
<td>.646</td>
<td>1.100</td>
<td>.733</td>
</tr>
<tr>
<td>Partner’s level of education</td>
<td>-1.329</td>
<td>.617</td>
<td>.031*</td>
<td>1.265</td>
<td>1.079</td>
</tr>
<tr>
<td>Partner drinking alcohol</td>
<td>-2.156</td>
<td>.413</td>
<td>.000*</td>
<td>2.116</td>
<td>1.950</td>
</tr>
</tbody>
</table>

At the community level, various risk factors for overall IPV in pregnancy were identified. During the FGDs, five main themes emerged. These are presented below, not in order of strength of perceived risks.

**Pregnancy itself:**
One young man explained: "Most unmarried girls go through a lot in the community when they get pregnant. This pregnancy is considered unwanted. The man refuse to take responsibility leading to psychological stress, most of the time these girls are taken away to stay with relative to avoid shame to the family or even punishment from the parents more so fathers.

"Most women are always quarrelsome, moody easily irritated and do not want to be close to their husband, this things attract beating and therefore, the pregnancy itself triggers violence 'one old man said.

**Alcohol intake:** Alcohol intake or drug abuse was cited by almost all the participant in the FGDs to be the main source of all forms of violence through the life cycle of a relationship.

"Some men are alcoholic and do not provide for the family but they want their pregnant wives to provide failure to do so women are beaten 'a young lady noted.

**Sex preference:** "If the woman has been giving birth to girls only and she is expecting another child, she is threatened to be chased away if she give birth to
another girl hence the women live in fear and stress in the whole pregnancy period’ ‘a middle aged man said

**Culture:** Many participants described IPV as a consistent and unchangeable aspect of local culture.

One of the woman said:

“In our culture, sex in marriage is dictated by men. Sometimes a woman may be in need of sex but the culture does not allow them to ask for it but men must be given sex when they want even if the woman is not ready so we suffer silently’ one woman expressed.

Another respondent said:

“In some instance when a man realize that you are pregnant he desists and does not sleep in your house until you give birth and the child starts walking, this is very stressful and the only thing one can do is to use his cloth as a pillow to sniff his odor’’

**4.3.1 Risk factors associated with physical violence**

Table 4.4 shows the factors associated physical IPV among pregnant women. Level of education of pregnant women, polygamy marriage and alcohol intake by both partner and pregnant women were significantly associated with physical IPV (p≤0.05).
### Table 4.4: Bivariate Analysis comparing characteristics of women who experience physical IPV with those who did not.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Abused n (%)</th>
<th>Not Abused n (%)</th>
<th>Crude OR (95% CI)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (in years)</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>20 (8.9)</td>
<td>.616-2.118</td>
<td>.674</td>
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<tr>
<td>20-24</td>
<td>15 (6.7)</td>
<td>25 (11.2)</td>
<td></td>
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</tr>
<tr>
<td>25-29</td>
<td>10 (4.5)</td>
<td>20 (8.9)</td>
<td></td>
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</tr>
<tr>
<td>30-34</td>
<td>13 (5.8)</td>
<td>25 (11.2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35-39</td>
<td>12 (5.4)</td>
<td>32 (14.3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40-44</td>
<td>6 (2.7)</td>
<td>23 (10.3)</td>
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</tr>
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<td>45-49</td>
<td>9 (4.0)</td>
<td>11 (4.9)</td>
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<td><strong>Parity</strong></td>
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<td>83 (37.1)</td>
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<td>Trimester 1</td>
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<td>20 (8.9)</td>
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</tr>
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<td>Trimester 3</td>
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<tr>
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<td>Others</td>
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<td>2 (0.8)</td>
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</tr>
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<td>12 (5.4)</td>
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Table 4.4: Continued

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<th>p value</th>
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<td>40-44</td>
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</tr>
<tr>
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</tr>
<tr>
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</tr>
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<td>18 (8)</td>
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<td>0-4</td>
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<td>≥10</td>
<td>25 (11.2)</td>
<td>40 (17.9)</td>
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</tbody>
</table>

Table 4.5 show multiple logistic regression analysis of factors that were associated with physical violence. Only alcohol intake by partner remained significantly associated with physical IPV, (p=0.000). Pregnant women with partner who drinks alcohol were three times more likely to experience physical violence than pregnant women whose partner does not drink alcohol.

Table 4.5: Multiple Logistic Regression Analysis of Risk factors for physical IPV.

<table>
<thead>
<tr>
<th>Independent Variables</th>
<th>B</th>
<th>S.E.</th>
<th>p-value</th>
<th>OR</th>
<th>95% C.I. for OR</th>
</tr>
</thead>
<tbody>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Lower</td>
</tr>
<tr>
<td>School attendance (respondent)</td>
<td>1.354</td>
<td>.934</td>
<td>.147</td>
<td>.873</td>
<td>.621</td>
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<td>Respondent level of education</td>
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<td>.197</td>
<td>.736</td>
<td>.463</td>
</tr>
<tr>
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<td>.432</td>
<td>.426</td>
<td>.709</td>
<td>.304</td>
</tr>
<tr>
<td>Respondent taking alcohol</td>
<td>-.153</td>
<td>.486</td>
<td>.754</td>
<td>.858</td>
<td>.331</td>
</tr>
<tr>
<td>Partner taking alcohol</td>
<td>-1.600</td>
<td>.343</td>
<td>.000*</td>
<td>3.202</td>
<td>3.103</td>
</tr>
<tr>
<td>Constant</td>
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<td>1.353</td>
<td>.240</td>
<td>.902</td>
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</tr>
</tbody>
</table>
4.3.2 Risk factors associated with psychological violence

Table 4.6 shows the factors associated psychological IPV among respondents in the current pregnancy. Age of partner, Length of relationship and Partner’s alcohol intake were significantly associated with psychological IPV, (P<0.05). Age of respondent was not significantly associated, (p=0.052).

Table 4.6: Bivariate Analysis comparing characteristics of women who experience psychological /Emotional IPV with those who did not.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Abused</th>
<th>Not Abused</th>
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Multiple logistic regression analysis indicated two factors to be associated with psychological IPV. Pregnant women with partner less than 25 years of age were two time more likely to experience psychological IPV than women whose partner were more than 25 years of age (p=0.007) while pregnant women with partner who takes alcohol were slightly more likely to experience psychological IPV than those whose partner don’t take alcohol (p=0.000), (Table 4.7).

Table 4.6: Continued

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Table 4.7: Multiple Logistic Regression Analysis of Risk factors for psychological /Emotional IPV.

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4.3.3 Risk factors associated with sexual violence

Table 4.8 showed that Partner’s level of education and Partner alcohol intake were significantly associated with sexual IPV (P<0.05) while Age of respondent was not significantly associated with sexual IPV (P=0.065).

Table 4.8: Bivariate Analysis comparing characteristics of women who experience sexual IPV with those who did not.

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Table 4.8: Continued

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<td>45-49</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupation (partner)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td>46 (20.5)</td>
<td>67 (29.9)</td>
<td>21 (9.4)</td>
<td>32 (14.3)</td>
<td>.513-.700</td>
<td>.343</td>
</tr>
<tr>
<td>Casual/temporary worker</td>
<td>24 (10.7)</td>
<td>25 (11.2)</td>
<td>1 (0.4)</td>
<td>8 (3.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaried/permanent worker</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partner drink alcohol</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>44 (19.6)</td>
<td>43 (19.2)</td>
<td>48 (21.4)</td>
<td>89 (39.7)</td>
<td>3.286-3.874</td>
<td>.015*</td>
</tr>
<tr>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polygamy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>15 (6.7)</td>
<td>20 (8.9)</td>
<td>77 (34.4)</td>
<td>112 (50)</td>
<td>.019-.276</td>
<td>.753</td>
</tr>
<tr>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Length of current relationship</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-4</td>
<td>48 (21.4)</td>
<td>68 (30.4)</td>
<td>19 (8.5)</td>
<td>24 (10.7)</td>
<td>.086-.389</td>
<td>.701</td>
</tr>
<tr>
<td>5-9</td>
<td>25 (11.2)</td>
<td>40 (17.9)</td>
<td>25 (11.2)</td>
<td>40 (17.9)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4.9 shows that alcohol intake by partner was significantly associated with sexual IPV, (P<0.05). Pregnant women with partner’s who take alcohol were 2.486 more likely to experience sexual IPV than pregnant women whose partner were not
taking alcohol. Age of the pregnant women was also found to be significantly associated with sexual IPV. The odds of pregnant women aged less than 25 years experiencing sexual IPV was found to be 1.174 than pregnant women aged more than 25 years, (p=0.049).

Table 4.9: Multiple Logistic Regression Analysis of Risk factors for sexual IPV.

<table>
<thead>
<tr>
<th></th>
<th>B</th>
<th>S.E.</th>
<th>p-value</th>
<th>OR</th>
<th>95% C.I. for OR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Lower</td>
</tr>
<tr>
<td>Age of respondent</td>
<td>-0.555</td>
<td>0.281</td>
<td>0.049*</td>
<td>1.174</td>
<td>1.001</td>
</tr>
<tr>
<td>Partner school attendance</td>
<td>-1.106</td>
<td>0.607</td>
<td>0.069</td>
<td>0.331</td>
<td>0.701</td>
</tr>
<tr>
<td>Partner taking alcohol</td>
<td>-0.722</td>
<td>0.287</td>
<td>0.012*</td>
<td>2.486</td>
<td>2.277</td>
</tr>
<tr>
<td>Constant</td>
<td>2.816</td>
<td>0.987</td>
<td>0.004</td>
<td>16.708</td>
<td></td>
</tr>
</tbody>
</table>

4.4 Quality of care offered to antenatal attendees experiencing intimate partner violence.
Twenty health workers participated in the KII. Among the participants were clinical officers, medical officers, counselor and nurses. This study identified various performance measures to assess the quality of care for domestic violence in a health facility based system.

4.4.1 Skills and Training of care Providers
The health care workers were asked to state whether they had received any training on care and management of domestic violence cases especially IPV in pregnancy. The result shows that minority of them (40%) had received general training on care and management of domestic violence case. They were further asked to state any content of the training that they remember at the time of the interview. The areas mentioned were: gender based violence, sexual violence, and counselling. They were also asked if in their opinion they thought the training was sufficient and all (100%) of the participants indicated that these trainings were not adequate to enhance their capacity to comprehensively handle IPV cases among antenatal attendee and other clients.
4.4.2 Physical Environment
This information was obtained from direct observations throughout the health facilities to establish public display of domestic violence-related posters or brochures in various location with the facilities that are accessible by the antenatal attendees and other clients. Most of the participants reported that these posters used be available in strategic position at Kapenguria District hospital but they are no longer available in all the health facilities in the sub-county.

4.4.3 Policies and Procedures
The participants were asked if they have or are aware of the existing guidelines for management of domestic violence cases. Most of the health care workers admitted to be aware there are some guideline but they are neither within daily reach nor being used. The document that could be traced at the time of the interview in some facilities were National guideline on medical management of rape and sexual violence (MOH, 2004) and a simplified version of the sexual offence Act (MOH 2006).

4.4.4 Screening for Intimate partner violence
All the key informants indicated that routine screening of IPV and other domestic violence issues are not conducted in all the health care service points including maternal child health clinics. They noted that screening for violence has never been part of the history taking in the maternal and child health clinics and even in all other service delivery points. “One can only be interested if a client voluntarily discloses” one of key informant emphasized.

4.4.5 Intervention Services
When asked about the availability of medical intervention for IPV cases, most of the health workers admitted that the services provided are general and might not cover all the component domestic violence care as required. All health facilities did not have a standard intervention checklist to assist when handling case of violence especially
IPV in pregnancy. There is no specialized care and the victims are handled just like other general medical conditions; no counselling arrangement, transportation, referral, follow-up and even safety plans when the client is released home.

Across all the FGDs, churches, village elders and family members are the intervener for intimate partner violence. According to the participants in the FGDs, community has its own way of classifying what is termed as violence in the context of the culture and this what will necessitate an intervention or not. Older men agreed with the sentiments that violence is a normal, accepted part of culture.

4.4.6 Documentation
This was done by reviewing the actual documentation tools, if one existed. None of the ministry of health tools captured data related to gender based violence, intimate partner violence or domestic violence except for the voluntary counselling and testing section that uses MOH 363 to report sexual violence cases. The health care workers reported that most case are recorded as diagnostic for complication like in the theater a case of still birth in Kapenguria District hospital was related to an abdominal kick by a woman’s husband during pregnancy and recorded in the patient file.

Generally, the key informants identified four main challenges to quality care for IPV victims in health facility setting: Excessive workload at the MCH due to staff shortage hence no time to investigate for other problems, inadequate knowledge and skills to manage IPV cases, lack of guidelines and procedures to manage IPV cases, the culture of silence on IPV in the community hence few cases are reported.
CHAPTER FIVE: DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1 Discussion

5.1.1 Prevalence of IPV in Pregnancy
This study found overall IPV in the current pregnancy to be 66.9% among the antenatal attendees, which is the highest in African countries but close to 63.1% reported in Zimbabwe (Shamu & Zarowsky, 2013). A review of 19 studies conducted in Africa showed overall IPV prevalence during pregnancy to be ranging from 2.3% in Nigeria to 57.1 in Uganda and a meta-analysis yielded an overall prevalence of 15% (95% CI=14-16%) (Shamu, 2011). This prevalence is also much higher than gender based violence toward pregnant women in Kenya which is estimated to be 13.5%, (Drivers & Johnson, 2010) and overall IPV in the index of pregnancy as reported to be 37% in the Kisumu study (Makayoto, 2013). However it is within the global range of lifetime IPV in the general women population of 15% to 71%, (Garcia-Moreno & Ellsberg, 2006). The wide ranging estimates could be attributed to social and cultural diversity in Africa (Uthman & Moradi, 2013). Furthermore only three of the nineteen African reviewed studies determined psychological IPV in pregnancy hence lower overall IPV as compared to this study which included all the three forms of IPV.

This study found the prevalence of physical IPV in the current pregnancy to be 29.9% this is within the range of three various studies conducted in Africa which found physical IPV during pregnancy to be ranging from 22.5% to 40% (Shamu, 2011) but higher than a facility based study conducted in Kisumu, Kenya that found prevalence of physical IPV during pregnancy to be 10%, (Makayoto, 2013). The variation estimates are likely to be as a result of different social and cultural context.
The study showed emotional/psychological IPV prevalence of 55.8% which is lower than the prevalence of 66.2% reported by a study conducted in Abeokuta, Nigeria among antenatal attendees in three health facilities, (Fawole & Fawole, 2008). However, this result is higher than a study conducted at Kisumu District Hospital where the prevalence of emotional/psychological IPV during pregnancy was found to be 29%, (Makayoto, 2013) and also above the range of three African studies that reported IPV during pregnancy to be between 24.8% and 49%, (Shamu, 2011).

Furthermore this study revealed sexual IPV in the current pregnancy to be 39.2% which is higher than other studies conducted in Africa that reported sexual IPV prevalence during pregnancy to be 2.7% in Uganda, 12% in Kenya, 26.5% in Nigeria and 19% in South Africa and 38.9 in Zimbabwe, (Kaye, 2006), (Makayoto, 2013), (Hoque, 2009), (Umeora & Ejikeme, 2008). This high prevalence of sexual IPV in the study setting may be due to cultural reasons that, the initiator for sex is usually the male partner as women are shaped to satisfy their partners. To some extent, sex has remained a silent subject of discussion in most pastoralist communities even between intimate partners where women are not expected to express their desire. This prevailing societal norms put men as the determinant of sexual affairs in any relationship and women must just comply.

Generally, variation in the violence prevalence estimates may be due to true differences in the prevalence of violent acts within different study populations, as well as methodological differences between studies (Jesinki, 2001). The prevalence rates could also be because this study was clinic based but more notably questions referred to the current pregnancy at any of the gestation ages which potentially reduced recall bias. Most other studies collected data in the 1st, 2nd or 3rd trimesters of the most
recent or previous pregnancy unlike this study that asked questions specific to current pregnancy.

These results on prevalence were also supported by the outcome of the FGDs where Psychological IPV was ranked first, Economical second; where the man controls the expenditure of the woman, sexual third and physical forth.

5.1.2 **Predisposing risk factors of IPV in Pregnancy**
Parity, marital status, gestation age, level of education of pregnant women and occupation of both pregnant women and partners were not associated with overall, physical, psychological and sexual IPV in pregnancy before and after controlling for confounding and interaction between independent factors which differ from other studies. A study in Abeokuta Nigeria revealed low level of education to be significantly associated with experiencing violence during pregnancy (Fawole & Fawole, 2008). Inconsistently, a study among antenatal attendees at the University of Port Harcourt teaching hospital found experience IPV to be of more in women of low parity, (Jeremiah & Oriji, 2011). Unlike this study, other studies have found that women are more likely to experience violence during pregnancy if they are unmarried, (Cokkinides, Sanderson, & Addy, 1999), (Saltman, 2003). Length of current relationship, level of education and polygamous marriage were associated with various IPV but were not significant after controlling for confounding and interaction between independent factors, (p>0.005).

This result is inconsistent with a study conducted in Kisumu District Hospital which reported polygamy to be significantly associated with overall IPV in pregnancy, (Makayoto, 2013) but in agreement with the same study that there is no significant association between IPV and level of education. Project involving more than 1000 pregnant women in the US revealed that income and education levels were the most
significant predictors of pregnancy violence, (Bohn & Campbell, 2004). However, a systematic review of African studies identified three studies that reported strong positive association between pregnant women’s low level of education and experiencing IPV and \( p<0.005 \) and six other studies where the relationship did not reach statistical significance \( p \geq 0.005 \), (Shamu, 2011).

Alcohol intake by partner was found to be significantly associated with overall, physical, psychological and sexual IPV in pregnancy. This findings is consistent with findings from other five studies conducted in Africa, (Shamu, 2011). The relationship between IPV and alcohol use is complex because it can be bidirectional with alcohol drinking leading to IPV or IPV leading alcohol drinking or it may involve both partner, (Bacchus & Bewley, 2006). Alcohol use can also result in household neglect facilitating marital or relationship tension that may result to violence, (Weiser & Heisler, 2006).

This study also found that women whose partner had not attended school were more likely to experience overall IPV. Other research findings have revealed that men who perpetrate violence during pregnancy tend to have lower socioeconomic status. This includes lower levels of education, (Nasir, 2003). Most studies have only reported significant relationship of level of education and IPV in pregnancy but not school attendance only as reported in this study.

Age of pregnant women and Age of the partner were also found to be risk factors to psychological and sexual IPV in pregnancy respectively. Pregnant women aged 25 years and below were more likely to experience sexual IPV, while pregnant women with partner aged 25 years and below were more likely to experience psychological IPV. This findings is consistent with a number of studies. Other studies have also documented younger age among pregnant women be associated with increased IPV,
Two studies estimated that women younger than 20 years old were three to four times more likely than women aged 30 or older to experience violence during pregnancy, (Cokkinides, Sanderson, & Addy, 1999), (Saltman, 2003). Additional risk factors identified during the FGDs were pregnancy itself and cultural norms. The study identified that unwanted or unintended pregnancy could be a source of intimate partner violence. This in agreement with study by (Jesinki, 2001), which indicated that expecting a first child as well as unplanned or unwanted pregnancy is a significant risk factor for IPV. One participant highlighted that most women are always quarrelsome, moody easily irritated resulting into IPV, this is explained by some studies have indicated that violence is likely to escalate during pregnancy or pregnancy triggers violence (Kerstine, 2002). The physical and emotional changes in women during pregnancy brings with them some demands for more or different economic, social and sexual requirement in a partnership which normally place pressure on men hence trigger violence, (Edin, 2006).

Many participants described IPV as a consistent and unchangeable aspect of local culture. This concurs with a study conducted in Kenya which indicated that men are socialized to believe that they are superior to women, should dominate their partners and endorse traditional gender roles and Women’s subordination and submission is then considered to be normal, expected, accepted, (Hatcher & Odero, 2013). Moreover a study in Ethiopia also found several community members believed IPV against women was acceptable under particular conditions including failure to give birth, suspicion of infidelity, constantly arguing with the husband or neighbour/community member, disobeying her husband and circumstances in which a woman attempts to go against the culture and vocalize her thoughts or opinion, (Joyner, 2012).
5.1.3 Quality of care for IPV victims in Pregnancy

The study revealed health system shortcomings on the quality of care in responding to IPV in antenatal care setting in West Pokot sub-county. This is contrary to the WHO clinical and policy guideline on responding to intimate partner violence and sexual violence against women (WHO, 2013). This may be a risk factor to sustained perpetuation of intimate partner violence in pregnancy.

Skills and Training of care Providers:

The results indicated that less than half of the health workers (40%) had been trained on issues related to domestic violence. Moreover even the few who reported to be trained indicated that these training were not adequate to enhance their capacity to comprehensively manage any violence cases. This results is comparable with a United States study which showed that most health care providers reported to have inadequate training on the subject of IPV and lack knowledge about community resources, (Frank & Linda, 2006). While in Africa, all midwives in a study in Zimbabwe stated that they had no specific training, skills or competence to recognize abused women during antenatal and postnatal care, (Shamu & Marleen, 2013).

Policies and Procedures:

This study identified some guideline but they are neither within daily reach nor being used. Generally, all the facilities in the sub-county are inadequately provided with guidelines and job aid to manage IPV in pregnancy and other domestic violence issues. None of the facilities in the sub-county has a committee or task force to champion gender based violence interventions. This is consistence with a study conducted in Finland which revealed that more than one third of health care workers still did not know whether any of the guidelines on domestic violence existed or not even after adoption and orientation on the materials, (Tuija & Eija, 2014).
Screening for Intimate partner violence:

According to this study, routine screening of IPV and other domestic violence issues are not conducted in all the health care service points including maternal child health clinics. This result is consistent with other recent international research results, (Sundborg & Wandel, 2012), (Tuija & Eija, 2014) and a study in Zimbabwe where all midwives stated that facilities were not conducting any form of screening for IPV, (Shamu & Marleen, 2013). This study cites time constrain, staff shortage and inadequate working space as the barriers to IPV screening in the antenatal care setting. A review of various studies have reported a number of both real and perceived clinical barriers to IPV screening in health care settings. Lack of knowledge, education or training on the issue was cited in 68% of the studies, while inadequate follow-up, resources and support staff and time constrain was cited was cited in 63% and 82% of the reviewed studies respectively (Sprague, et al., 2012). A study by (Velzeboer & Clavel 2003) indicated that reluctance of healthcare providers to probe abused may due to fear of offending the women, fear of opening a ‘Pandora’s box of cases that they may not be well equipped to manage.

Intervention Services, Physical Environment and Documentation:

This study revealed that health facilities did not have a standard intervention checklist to assist when handling case of violence especially IPV in pregnancy. There is no specialized care and the victims are handled just like other general medical conditions; no counselling arrangement, transportation, referral, follow-up and even safety plans when the client is released home.

For the health facilities physical environment, findings revealed that all health facilities had no IEC material or any posters and brochures displaying information related to domestic violence at strategic point accessible to clients. There was also no
hot line number on display that could be used by clients in need of care as a result of abuse.

This study also indicated that domestic violence cases are recorded as diagnostic for complication like any other medical conditions. These results are in line with a study conducted in a low income setting of Harare Zimbabwe which indicated that responding to IPV in antenatal setting is difficult for both health sector related reasons and health workers own embeddedness in a patriarchal culture which normalize IPV, (Shamu & Marleen, 2013).

During the FGDs the participants identified Churches leaders, village elders and family members to be the main intervener for intimate partner violence. This is in line with, (Hatcher & Odero, 2013) who identified extended family as an important resource for women experiencing IPV by providing guidance to the couple. However it also noted in their study that extended families also encourage women to keep silent about IPV as a way to protect family image hence a predictor for IPV on the other hand. Similar to other studies that few interventions for IPV during pregnancy exist in East Africa, (Stock & Kilonzo, 2010) this study also found that the community is not aware of any legal or formal structures that could help to address occurrence of violence in pregnancy.

5.2 Conclusions
This study was guided by null hypothesis; $H_0$. There is no relationship between intimate partner violence in pregnancy and economic, cultural, socio demographic, health care factors among antenatal attendees in the health facilities in West Pokot Sub-County and aimed to determine the prevalence of intimate partner violence in the current pregnancy among antenatal attendees at the health facilities in West Pokot Sub-County, risk factors of IPV in pregnancy among antenatal attendees at the health
facilities in West Pokot sub-county and to assess quality of care offered to pregnant women experiencing intimate partner violence in the health facilities in West Pokot Sub-County.

5.2.1 Prevalence of IPV in pregnancy
The overall, physical, psychological and sexual IPV of 67%, 30%, 56% and 40% respectively during pregnancy among antenatal attendees in this study are among the highest ever reported in a health facility based study.

5.2.2 Risk factors of IPV in pregnancy
The major risk factors for IPV were alcohol intake, Age of both women and partner's and lack of formal education by partner. All the three forms of IPV were associated with partner's alcohol intake, while sexual, psychological and overall IPV were associated with age of antenatal attendees, age of partners and level of education of partners respectively.

5.2.3 Quality of care offered to antenatal attendees experiencing IPV
The quality of health care services offered to antenatal attendees experiencing violence was not in line with WHO guidelines and recommendations on advocacy, social mobilization, screening, documentation, referral system and case management procedures. The results demonstrated inadequate skills and knowledge among the health workers on handling IPV victims, lack of screening of for IPV, no referral network, inadequate documentation of IPV cases and unconducive environment for communication of IPV issues.

5.4 Recommendations
In light with the study findings, the study suggest specific recommendations based on conclusions and directed to implementing agencies.
5.4.1 Recommendations for Policy
Efforts by the Ministry of health both at the National and County level to address maternal and newborn health need to include issues of violence against women since the study shows that partner violence is common during pregnancy in West Pokot Sub-County and is likely to be associated with adverse health outcomes for the mother, the pregnancy and the newborn. Sexual and reproductive health, adolescent health, and HIV/ AIDS prevention policies and programmes should address issues of violence, sexuality, and power dynamics in gender relations systematically as key elements. Information on violence against women, its health consequences and an appropriate response needs to be integrated into the curriculum and training of health-care providers working in family planning, prenatal and postnatal care and delivery. At a minimum, health-care providers should be informed and aware of the possibility of violence as an underlying factor in women’s ill-health during pregnancy and postpartum, especially in resource-poor settings of West Pokot Sub-County where these are the most common points of contact with the health service for women. Development of interventions by the government and non-governmental agencies to prevent violence against women from happening should include those that promote gender equality, safe and responsible relationships.

5.4.2 Recommendation for Practice
The Ministry of health and other partners should promote integration of IPV screening services in Maternal and child health clinic with aim identifying those experiencing violence and also identifying those at risk due to their own and partners’ sociodemographic characteristics to initiate timely preventive measures. The health workers skills and knowledge can be improved through continuous sensitization of health workers through training in gender based violence to enable them recognize and respond to high IPV risk cases. At the community level, the Ministry of health
should implement primary prevention interventions in form of community educational campaigns to sensitize the community on maternal and child health consequences of IPV in pregnancy and together with the community leaders address inequitable norms, beliefs and practices, secondary prevention mechanisms by health workers in antenatal and post-natal care settings should address IPV during pregnancy because these are unique opportunities to consistently contact women at risk. Finally, wide dissemination to increase national and public awareness on the high prevalence of IPV in pregnancy and screening for IPV among pregnant women visiting antenatal health care facilities in West Pokot may enable implementation of appropriate interventions among abused pregnant women.

5.5 Suggestion for further Research
This study suggest further research on:

- Intervention research on the feasibility and effectiveness of integrating an intimate partner violence intervention into antenatal care in resource-poor settings.
- Male involvement in addressing intimate partner violence in pregnancy.
- Community attitude and beliefs that contributes to IPV in pregnancy.
- Longitudinal study to measure IPV before, during and after pregnancy.
6.0: References


Appendix 1: Informed Consent Form, English version

This Informed Consent Form is for antenatal attendees in West Pokot Sub-County, Kenya and who I am inviting to participate in this study. The title of my research is "Intimate partner violence in pregnancy among antenatal attendees in West Pokot County, Kenya." The principal investigator is Owaka Isaac, MPH student at Kenyatta University.

Instructions:

This Informed Consent Form has two parts:

• Information Sheet (to share information about the research with you)
• Certificate of Consent (for signatures if you agree to take part)

You will be given a copy of the full Informed Consent Form

PART I: Information Sheet

Introduction

My name is __________________________ and we are conducting a study that asks antenatal attendees on intimate partner violence. I am going to give you information and invite you to be part of this research. Before you decide, you can talk to anyone you feel comfortable with about the research. There may be some words that you do not understand. Please ask me to stop as we go through the information and I will take time to explain. If you have questions later, you can ask them to the study principal investigator. We would very much appreciate your participation in this study.

Purpose of the research

The study will be examining factors contributing to intimate partner violence in pregnancy among antenatal attendees at the health facilities in West Pokot Sub-County. The outcome of the study will be useful in informing policy direction and
programming of intervention to reduce the maternal consequences of intimate partner violence in pregnancy especially in West Pokot County.

Type of Research Intervention
This research will involve questions which I will read to you and then you say out loud may inform me to skip them and move on to the next question.

Participant selection
You are being invited to take part in this study because you attend this facility for antenatal services.

Voluntary Participation
Your participation in this research is entirely voluntary. It is your choice whether to participate or not. Whether you choose to participate or not, all the services you receive at this facility will continue and nothing will change. If you choose not to participate in this study, you will be offered the treatment that is routinely offered in this health facility and we will tell you more about it later. You may change your mind later and stop participating even if you agreed earlier.

Duration
The study session will take between 30 to 45 minutes to complete

Risks and Side Effects
We are asking you to share with us some very personal and confidential information, and you may feel uncomfortable talking about some of the topics. You do not have to answer any question or take part in the discussion/interview/survey if you don't wish to do so, and that is also fine. You do not have to give us any reason for not responding to any question, or for refusing to take part in the interview.

Benefits
There will be no direct benefit to you, but your participation is likely to help us find out more about intimate partner violence in pregnancy in this Sub-County.

Reimbursements
You will not be provided any incentive to take part in the study

Confidentiality and Sharing the Results
The information that we collect from this study will be kept confidential. Any information about you will have a number on it instead of your name. Only the researchers will know what your number is and we will lock that information up with a lock and key. It will not be shared with or given to anyone.

Right to Refuse or Withdraw
You do not have to take part in this research if you do not wish to do so and refusing to participate will not affect your services at this facility in any way. You will still have all the benefits that you would otherwise have at this facility. You may stop participating in the research at any time that you wish without losing any of your rights as a client here. Your services at this facility will not be affected at all.

Who to Contact
If you have any questions you may ask them now or later, even after the study has started. If you wish to ask questions later, you may contact Owaka Isaac (Principle investigator) on Cell phone: 025870089, Email: owakaros@yahoo.com

This study has been reviewed and approved by Kenyatta University Ethics Review Committee (KU-ERC), which is a committee whose task it is to make sure that research participants are protected from harm. If you wish to find about more about the KU-ERC, contact Chairman: kuerc.chairman@ku.ac.ke or kuerc.secretary@ku.ac.ke or ercku2008@gmail.com Permission has also been granted by the National Council for Science and Technology (NCST).
You can ask me any more questions about any part of the research study, if you wish to. Do you have any questions?

PART II: Certificate of Consent

If the participant is illiterate but gives oral consent, a witness must sign. A researcher or the person going over the informed consent must sign each the consent.

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions that I have asked have been answered to my satisfaction. I consent voluntarily to participate as a participant in this research.

Print Name of Participant ____________________________

Signature of Participant ____________________________

If illiterate

A literate witness must sign (if possible, this person should be selected by the participant and should have no connection to the research team). Participants who are illiterate should include their thumb-print as well.

I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Print name of witness ____________________________ AND Thumb print of participant

Signature of witness ____________________________

Date ____________________________

Day/month/year

Statement by the researcher/person taking consent
I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands that the following will be done:

1.

2.

3.

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

_A copy of this ICF has been provided to the participant._

**Print Name of Researcher/person taking the consent**

______________________________

**Signature of Researcher/person taking the consent**

______________________________

**Date**

______________________________

  Day/month/year
Fomu hii ya Kibali cha Ufahamu ni ya wahudhuriaji kliniki wajawazito katika Kaunti Ndogo ya Pokot Magharibi, Kenya na wale ninaoaalika kushiriki katika utafiti huu.

Kichwa cha utafiti wangu ni "Dhuluma za mpenzi wa karibu katika ujauzito miongoni mwa wahudhuriaji kliniki wajawazito katika Kaunti ya Pokot Magharibi, Kenya." Mchunguzaji mkuu ni Owaka Isaac, mwanafunzi wa MPH kwenye Chuo Kikuu cha Kenyatta.

Maagizo:

Fomu hii ya Kibali cha Ufahamu ina sehemu mbili:
- Karatasi ya Maelezo (kushiriki maelezo kuhusu utafiti na wewe)
- Cheti cha Kibali (kwa sahihi kama unakubali kushiriki)

Utapewa nakala ya Fomu kamili ya Kibali cha Ufahamutu

SEHEMU YA I: Karatasi ya Maelezo

Utambulisho


Lengo la utafiti

Utafiti huu utakuwa ukichunguzwa sababu zinazochangia dhuluma za mpenzi wa karibu katika ujauzito miongoni mwa wahudhuriaji kliniki wajawazito kwenye vituo vya afya katika Kaunti Ndogo ya Pokot Magharibi. Matokeo ya utafiti yatakuwa
muhimu kupata mwelekeo wa sera na kupangana njia za kupunguza madhara ya wajawazito ya dhuluma za mpenzi wa karibu katika ujauzito haswa katika Kaunti ya Pokot Magharibi.

Aina za Njia za Utafiti

Utafiti huu utahusisha maswali ambayo nitakusomea na kisha unaweza kuniambia niyaruke na kuende kwenye swali linalofuata.

Uchaguzi wa mshiriki

Unaalikwa kushiriki utafiti huu kwa sababu unahudhuria kituo hiki kwa huduma za ujauzito.

Ushiriki wa Kujitolea


Muda

Kipindi cha utafiti kitachukua kati ya dakika 30 hadi 45 kukamilika.

Hatari na Madhara ya Kando

Tunakuomba kushiriki nasi baadhi ya maelezo yako ya binafsi na ya siri, na unaweza kuonelea kutozungumza nasi kuhusu mambo mengine. Si lazima uzibu swali lolote au kushiriki katika majadili/mahoji/utafiti kama hutaki kufanya hivyo, na hivyo ni vyema pia. Si lazima utupe sababu yoyote ya kutojibu swali lolote, au kukataa kushiriki katika mahoji.

Faida
Hakutakuwa na faida za moja kwa moja kwako, lakini ushiriki wako huenda
ukatusaidia kujua zaid kuhusu dhuluma za mpenzi wa karibu katika ujauzito katika
Kaunti hii Ndogo.

Malipo
Hutapewa malipo yoyote ili kushiriki katika utafiti huu.

Siri na Kishiriki Matokeo
Maelezo tutakayokusanya katika utafiti huu yatawekwa siri. Maelezo yoyote
kukuwusu yatakuwa na nambari badala ya jina. Ni watafiti tu watakojua nambari yako
na tutafunaga maelezo hayo kwa kufuli na funguo. Hayatashirikiwa wala kupewa
mtu yeyote.

Haki ya Kukataa au Kujiondoa
Si lazima ushiriki katika utafiti huu kama hutaki kufanya hivyo na kukataa kushiriki
hakutaathiri huduma zako kwenye kituo hiki kwa njia yoyote. Unaweza kuacha
kushiriki katika utafiti huu wakati wowote unaotaka bila kuvutega haki zako zozote
kama mteja wa hapa. Huduma zako kwenye kituo hiki hazitaathiriwa kwa vyovyote.

Wa kuwasiliana naye
Kama una maswali yoyote unaweza kuyauliza sasa au baadaye, hata baada ya utafiti
huu kuanza. Ukitaka kuwakuliza maswali baadaye, wasiliana na Owaka Isaac (Mchunguzi
Mkuu) kwa Runumu: 0725870089, Email:owakaros@yahoo.com

Utafiti huu umekaguliwa na kuidhinishwa na Kamati ya Ukaguzi wa Maadili ya Chuo
Kikuu cha Kenyatta (KU-ERC), kamati ambayo kazi yake ni kuhakikisha kuwa
washiriki wa utafiti wamelindwa dhidi ya madhara yoyote. Kama ungependa kujua
zaidi kuhusu KU-ERC, wasiliana na Mwenyekiti KU-ERC:kuerc.chairman@ku.ac.ke
or kuerc.secretary@ku.ac.ke au ercku2008@gmail.com

Idhini imetolewa pia na Baraza la Taifa la Sayansi na Teknolojia (NCST).
Unaweza kuniuliza maswali mengine yoyote kuhusu sehemu yoyote ya zoezi la utafiti, ukitaka. Una maswali yoyote?

SEHEMU YA II: Cheti cha Kibali

Ikiwa mshiriki hajui kusoma wala kuandika lakini anatoa kibali cha mdomo, lazima shahidi atie sahihi. Mtafiti au mtu anayepitia fomu ya kibali cha ufahamu lazima atie sahihi kila kibali.

Nimesoma maelezo yaliyotajwa, au nimesomewa. Nimepata fursa ya kuuliza maswali kuyahusu na maswali yoyote ambayo nimeuliza yamejibiwa na nikaridhika.

Ninakubali kwa hiari kushiriki kama mshiriki katika utafiti huu.

Chapisha Jina la Mshiriki _______________________

Sahihi ya Mshiriki _______________________

Ikiwa hajui kuosma wala kuandika

Lazima shahidi anayejua kusoma na kuandika atie sahihi (ikiwezekana, mtu huyu anastahili kuchaguliwa na mshiriki na asiyie na uhusiano na timu ya utafiti). Washiriki ambao hawajui kusoma wala kuandika wanastahili kujumuisha alama zao za vidole pia.

Nimeshuhudia usomewaji sahihi wa fomu ya kibali kwa mshiriki, na amekuwa na fursa ya kuuliza maswali. Ninathibitisha kuwa mtu huyu amekubali kwa hiari.

Chapisha jina la shahidi ______________________ na Alama ya kidole ya shahidi

Sahihi ya shahidi ______________________

Tarehe ______________________

Siku/mwezi/mwaka

Taarifa ya mtafiti/mtu anayechukua kibali

Nimemsomea kwa usahihi karatasi ya maelezo anayeweza kuwa mshiriki, na kwa uwezo wangu kuhakikisha kuwa mshiriki anakakisha kuwa mshiriki yafuatayo yatafanywa:
1. Ninathibitisha kuwa mshiriki alipewa fursa ya kuuliza maswali kuhusu utafiti, na maswali yote yaliyoulizwa ya mshiriki yamejibiwa kwa usahihi na kwa uwezo wangu.

2. Ninathibitisha kuwa mtu hajashurutishwa kutoa kibali, na kibali kimetolewa kwa hiari na kujitolea.


Chapisha Jina la Mtatifu/mtu anayechukua kibali

Sahihi ya Mtatifu/mtu anayechukua sahihi

Tarehe

Siku/mwezi/mwaka
Appendix 3: Interview Schedule, English version

Interview schedule for study on Intimate partner violence in pregnancy among antenatal attendees at health facilities in west pokot county, kenya.

<table>
<thead>
<tr>
<th>Name of interviewer</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Interview Number</td>
<td></td>
</tr>
<tr>
<td>Name of Health Facility</td>
<td></td>
</tr>
<tr>
<td>Date of interview</td>
<td></td>
</tr>
</tbody>
</table>

Socio-economic and socio-demographic characteristics of respondent

Tick appropriately according to the choices.

1. How old were you at your last birthday? (Years)
   15-19 [ ] 20-24 [ ] 24-29 [ ] 30-34[ ] 35-39 [ ] 40-44 [ ] 45-49 [ ] 49 and above [ ]

2. Parity, how many pregnancies have you carried including this one?
   Multipara [ ] Primipara [ ]

3. What is the trimester of this pregnancy, (how many months since you become pregnant?)
   Trimester one [ ] Trimester two [ ] Trimester three [ ]

4. What is your marital status?
   Never married [ ] Married [ ] Divorced [ ] Widowed [ ] Living with a man (cohabiting) [ ]

5. How old is your partner?
   15-19 [ ] 20-24 [ ] 24-29 [ ] 30-34[ ] 35-39 [ ] 40-44 [ ] 45-49 [ ] 49 and above [ ]

6. What is the length of the current relationship? (Years)
   0-4 [ ] 5-9[ ] ≥10 [ ]

7. Have you ever attended school? Yes [ ] No [ ]

8. What is the highest level of school you attended: primary, vocational, secondary, or higher?
   Primary [ ] Secondary [ ] College [ ] University [ ]

9. Has your partner ever attended school? Yes [ ] No [ ]
10. What is the highest level of school he attended: primary, vocational, secondary, or higher?

Primary [ ] Secondary [ ] College [ ] University [ ]

11. What is your occupation, that is, what kind of work do you mainly do?

Housewife/unemployed [ ] Casual work/temporally [ ] Salaried worker/employed [ ]

Others (specify)..................................

12. What is the occupation of your partner, that is, what kind of work does he mainly do?

Unemployed [ ] Casual work/temporally [ ] Salaried worker/employed [ ]

Others (specify).........................4

13 Polygamy; is your partner married to other wives?

Yes [ ] No [ ]

14. Do you currently drink alcohol?

Yes [ ] No [ ]

15. Does your partner currently take alcohol?

Yes [ ] No [ ]

Prevalence of intimate partner violence in pregnancy.

The next questions are about things that happen to many women, and that your current partner, or any other partner may have done to you.

Physical violence during pregnancy

In your current pregnancy does/did) your (last) husband/partner ever does any of the following things to you?

16. Push you, shake you, or throw something at you? Yes [ ] No [ ]

17. Slap you? Yes [ ] No [ ]

18. Twist your arm or pull your hair? Yes [ ] No [ ]

19. Punch you with his fist or with something that could hurt you? Yes [ ] No [ ]

20. Kick you, drag you or beat you up? Yes [ ] No [ ]

21. Try to choke you or burn you on purpose? Yes [ ] No [ ]
22. Threaten or attack you with a knife, gun, or any other weapon?  Yes [ ]  No [ ]

**Emotional violence/Psychological violence during pregnancy**

*Now if you will permit me, I need to ask some more questions about your relationship with your (husband/partner. If we should come to any question that you do not want to answer, just let me know and we will go on to the next question.*

In your current pregnancy does/did) your husband/partner ever does any of the following things to you?

23. Insulted you or made you feel bad about yourself?  Yes [ ]  No [ ]

24. Belittled or humiliated you in front of other people? Yes [ ] No [ ]

25. Done things to scare or intimidate you on purpose (e.g. by the way he looked at you, by yelling and smashing things)? Yes [ ] No [ ]

26. Threatened to hurt you or someone you care about? Yes [ ] No [ ]

**Sexual violence during pregnancy**

*Now I need to ask you some questions about sexual activity in order to gain a better understanding of some important life issues.*

In your current pregnancy does/did) your husband/partner ever does any of the following things to you?

27. Ever physically force you to have sexual intercourse when you did not want to? Yes [ ] No [ ]

28. Ever force you to do something sexual that you found degrading or humiliating? Yes [ ] No [ ]

29. Ever have sexual intercourse you did not want to because you were afraid of what your partner or any other partner might do? Yes [ ] No [ ]

30. During pregnancy, people are always tested for AIDs virus, how was your result, positive or negative? Positive [ ] Negative [ ]
Appendix 4: Interview Schedule, Swahili version

Ratiba ya mahojiano kwa utafiti kuhusu Dhuluma za mpenzi wa karibu katika ujauzito miongoni mwa wahudhuriaji kliniki wajawazito kwenye vituo vya afya katika Kaunti ya Pokoto Magharibi, Kenya.

<table>
<thead>
<tr>
<th>Jina la Mhoji</th>
<th>Nambari ya Mahojiano</th>
<th>Jina la Kituo cha Afya</th>
<th>Tarehe ya Mahojiano</th>
</tr>
</thead>
</table>

Tabia za uchumi na na demografia na na jamii ya mhojiwa

Weka alama vizuri kulingana na machaguio.

1. Ulikuwa na umri gani ulipoadhimisha siku yako ya kuzaliwa? (Miaka)
   25 na zaidi [ ] Chini ya 25 [ ]

2. Idadi ya mimba: Umekuwa mjamzito mara ngapi ikiwa ni pamoja na huu ulio nao?
   Mara mbili na zaidi [ ] Moja/Hakuna [ ]

3. Ujauzito huu ni wa miezi mingapi?
   Miezi mitatu ya kwanza [ ] Miezi mitatu ya pili [ ] Miezi mitatu ya mwisho [ ]

4. Hali yako ya ndoa ni gani?
   Sijawahi kuolewa [ ] Nimeolewa [ ] Nimetalikiwa [ ] Mjane [ ] Ninaishi na mwanamume ambaye hajanioa [ ]

5. Mpenzi wako ana miaka mingapi? 25 na zaidi [ ] Chini ya 25 [ ]

6. Uhusiano wa sasa ni wa muda gani? (Miaka) 0-4 [ ] 5-9[ ] Zaidi ya10 [ ]

7. Umewahi kuenda shuleni? Ndiyo [ ] La [ ]

8. Kiwango chako cha juu zaidi cha shule ni gani: msingi, ufundi, upili, au juu zaidi?
   Msingi [ ] Upili [ ] Chuo kidogo [ ] Chuo Kikuu [ ]

9. Mpenzi wako amewahi kuenda shuleni? Ndiyo [ ] La [ ]

10. Kiwango chako cha juu zaidi cha shule ni gani: shule ya msingi, ufundi, upili, au juu zaidi?
Shule ya Msingi [] Upili [] Chuo kidogo [] Chuo Kikuu []

11. Unafanya kazi gani?
Mke nyumbani/sina kazi [] Kibarua/kazi ya muda [] Mfanyakazi ninayepokea mshahara/nimeajiriwa []
Nyingine (bainisha)............................

12. Mwenzako wa ndoa anafanya kazi gani?
Hajaajiriwa [] Kibarua/kazi ya muda [] Mfanyakazi anayepokea mshahara/ameajiriwa []
Nyingine (bainisha)............................4

13. Ndoa ya wake wengi; Je, mpenzi wako ana wake wengine?
Ndiyo [] La []

14. Unakunywa pombe kwa sasa?
Ndiyo [] La []

15. Mpenzi wako anakunywa pombe kwa sasa?
Ndiyo [] La []

Ueneaji wa dhuluma za mpenzi wa karibu katika ujauzito.

Maswali yanayofuata yanahusu vitu vinavyotendeka kwa wanawake wengi, na yale ambayo mpenzi wako wa sasa, au mpenzi mwengine yeyote huenda amekutendea.

Dhuluma za kupigwa wakati wa ujauzito
Katika ujauzito wako wa sasa, je, mume/mpenzi wa mwisho anafanya/amewahi kufanya lolote kati ya mambo yafulatayo?

   La []

17. Kukuzaba kofi? Ndiyo [] La []

18. Kuukunja mkono wako au kuzivuta nywele zako? Ndiyo []
   La []

   La []
20. Kukupiga teke, kukukokota chini/kuvuta au kukupiga? Ndiyo [ ]
La [ ]

21. Kukukaba kooni au kukuchoma kwa makusudi? Ndiyo [ ]
La [ ]

22. Kukutisha au kukushambulia kwa kisu, bunduki, au silaya yoyote? Ndiyo [ ]
La [ ]

**Dhuluma za hisia/Dhuluma za kisaikolojia wakati wa ujuzito**

*Sasa ukiniruhusu, ninahitaji kuuliza maswali zaidi kuhusu uhusiano wako na (mume/mpenzi). Endapo nitauliza swali lolote ambalo hutaki kulijibu, tafadhali nifahamishe na tutaenda kwenye swali linalofuata.*

Katika ujuzito wako wa sasa, je, mume/mpenzi wa mwisho anafanya/amewahi kufanya lolote kati ya mambo yafuatayo?

23. Kukutusi au kukufanya kujiona hufai? Ndiyo [ ] La [ ]

24. Kukudhalilisha au kukuaiibisha mbele ya watu wengine? Ndiyo [ ] La [ ]

25. Kufanya vitu kukoogopeshia au kukutisha kwa makusudi (mfano namna alivyokuangalia, kwa kupiga kelele na kugonga vitu? Ndiyo [ ] La [ ]

26. Kutishia kukuumiza wewe au mtu mwengine unayemjali? Ndiyo [ ] La [ ]

**Dhuluma za kimapenzi wakati wa ujuzito**

*Sasa ninahitaji kukuuliza maswali mengine kuhusu shughli za kimapenzi ili kupata uelewa bora wa baadhi ya masuala muhimu maishani.*

Katika ujuzito wako wa sasa, je, mume/mpenzi wa mwisho anafanya/amewahi kufanya lolote kati ya mambo yafuatayo?

27. Kukulazimisha kwa nguvu kufanya mapenzi ukiwa hutaki? Ndiyo [ ] La [ ]

28. Kukulazimisha kufanya kitu cha mapenzi ulichokiona ni cha kudhalilisha au kuaibisha? Ndiyo [ ] La [ ]

29. Kufanya mapenzi bila kutaka kwa sababu uliogopa kile ambacho mpenzi wako au mpenzi mwengine yeyote anachoweza kukifanya? Ndiyo [ ] La [ ]

30. Wakati wa ujuzito, kwa kawaida watu hupimwa virusi vya UKIMWI, matokeo yako yalikuwaje, una UKIMWI au huna UKIMWI? Nina UKIMWI [ ]
Sina UKIMWI [ ]
Appendix 5: Key informant interview guide

Key informant interview guide for study on intimate partner violence in pregnancy among antenatal attendees at health facilities in West Pokot County, Kenya.

<table>
<thead>
<tr>
<th>Name of interviewer</th>
<th>Interview Number</th>
<th>Name of Health Facility</th>
<th>Date of interview</th>
<th>Start time</th>
<th>End time</th>
</tr>
</thead>
</table>

(As the interviewer, introduce yourself, explain the objectives of the study, and request the respondent’s consent to be interviewed.

Note the respondent’s name, position, and job title; describe his or her duties; and enter the institution’s name and location and the date of the interview).

**TASKS AND TRAINING**

1. What is your profession?
2. Have you received any training on this job
   - Yes ( )
   - No ( )
3. If yes, what specific training have you received for this job in relation to intimate partner violence or gender-based violence

<table>
<thead>
<tr>
<th>Type of training</th>
<th>Organization/Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. Do you think this training has been sufficient? Details
   - Yes ( )
   - No ( )

**MANAGEMENT AND PROCEDURE**

5. Do you or your colleagues conduct routine screening of intimate partner violence in pregnancy among antenatal attendees?
6. How many antenatal attendees experiencing IPV does the clinic serve per month?

7. Do you have a way of keeping records on cases? Is there a form and procedure for recording them?
   Yes ( )  No ( )  Can you explain it to me? (Request a copy of the record form, referral slips, and any other documents that may exist.)

8. What treatment/management guidelines for gender based violence cases (sexual, psychological, physical) do you use in this facility?
   National guideline ( )  others (Specify) ( ) (can I see a copy)

9. Are treatment prescribed always available?
   Yes ( )  No ( )
   If no give reasons of how often
   Rarely ( )  No ( )

10. What is the reasons for lack of treatment/Management?
    No supplies ( )  Inadequate skilled staff ( )  Others Specify

11. Do you (or your colleagues) provide follow-up care to pregnant women who have been victims of intimate partner violence (sexual, psychological, and physical)?
    Yes ( )  No ( )  How?

12. Are there mechanisms for referring them to other institutions or organizations?
    Yes ( )  No ( )  Where and How

13. What is your relationship with them? Is there coordination with other institutions to address the needs of abused women?

14. Do you think the services offered in this facility to antenatal attendees IPV victims are adequate?
    No ( )  Yes ( )  Elaborate

**CHALLENGES AND RECOMMENDATION**

15. What kinds of problems do you face, if any while performing your role in responding to IPV in pregnancy? (probe-- examining, evidence collection,
16. How could these best be rectified?

17. Is there anything you would like to see done differently to enable the facility handle IPV in pregnancy cases well?
Yes ( ) No ( )
If yes, What......................... (Legislation, policy, staffing... etc...)

Thank you very much for your participation
Appendix 6: FGD guide, English version

FGD for study on Intimate partner violence in pregnancy among antenatal attendees at health facilities in west pokot county, Kenya.

- Participant per FGD (7-12)
- Adults (= or > 18 years, men and women.
- One moderator, one note taker (and use of tape recorder)
- Neutral venue outside the facility
- One FGD per Division.

**Short introductory remarks**

Introduction of researcher and participants

Thank Participant for agreeing to participate, all share a common feature-they are all community health workers, are here to share their thoughts about intimate partner violence in pregnancy ; we want to learn from all the participants

Explain the purpose of the study, purpose of this discussion, reassurance about confidentiality, agree on rules.

**TOPICS FOR DISCUSSION**

1. What problems have women and girls experienced in health and security in your community? (PROBE on violence, not on health.)
2. What type of intimate partner violence is experienced by pregnant women attending antenatal care in this facility? (Sexual, physical, psychological)
3. Which is the most common one in pregnancy? Can put them in order from the highest to the lowest.
4. Who is the main perpetrator of this kind of violence? (PROBE: outside/inside of community, people you know/don’t know.) What happens to the perpetrators?
5. In your opinion, what factors contributes to intimate partner violence in pregnancy?
6. Does our culture encourage intimate partner violence? (sexual, physical and
7. What are community responses when sexual violence occurs? What is done to prevent violence? What is done to help survivors? How could these efforts be improved? Do women’s support networks exist to help survivors?

8. What social and legal services exist to help address these problems? (PROBE: health, police, legal counseling, social counseling.) Who provides these services? How could these efforts be improved?

Ending the discussion

Is there anything that you think we have not discussed and that you would like to add? If so please feel free to do so....

Thank you very much for your participation. Your input has been very valuable. The study results will later be disseminated to different stakeholders, including at the community level.

Thank You. (Serenyowuo)
Appendix 7: FGD guide, Swahili version

Majadiliano Yanayolenga Kikundi (FGD) kwa utafiti kuhusu dhuluma za mpenzi wa karibu katika ujauzito miongoni mwa wahudhurijaji kliniki wajawazito kwenye vitu vya afya katika Kaunti ya Pokot Magharibi, Kenya.

- Mshiriki kwa Majadiliano Yanayolenga Kikundi (FGD) (7-12)
- Watu wazima (wario na au zaidi ya miaka 18, wanaume na wanawake).
- Msimamizi mmoja, anayeandika mmoja (na utumiaji tepurekoda)
- Eneo la pande zote nje ya kituo
- Majadiliano Yanayolenga Kikundi (FGD) kwa kila Tarafa.

Hotuba fupi ya utangulizi

Utambulisho wa mtafiti na washiriki

Mshukuru Mshiriki kwa kukubali kushiriki, wote ni wafanyakazi wa afya kwa jamii, wapo hapa ili kushiriki mawazo yao kuhusu dhuluma za mpenzi wa karibu katika ujauzito: tunataka kujifunza kutoka kwa washiriki wote.

Elezea lengo la utafiti, lengo la majadiliano haya, uhakikisho kuhusu siri, kubaliana kuhusu kanuni.

MADA ZA MAJADILIANO

9. Ni matatizo gani ambayo wanawake na wasichana wanakumbana nayo katika afya na usalama katika jamii yako? (CHUNGUZA dhuluma, siyo afya.)

10. Ni aina gani ya dhuluma za mpenzi wa karibu wajo hujawazito wanaohudhuria huduma ya ujauzito katika kituo hiki? (Kimapenzi, kimwili, kisaikolojia)


12. Ni nani ndie mhusika mkuu wa aina hii ya dhuluma? (CHUNGUZA: nje/ndani ya jamii, watu unaowajua/usiwajua.) Ni nini kinachowatendekea wahusika?

13. Kwa maoni yako, ni sababu zipi zinazochangia dhuluma za mpenzi wa karibu katika ujauzito?

14. Mila zetu zinahimiza dhuluma za mpenzi wa karibu? (kimapenzi, kimwili na

16. Ni huduma zipi za sheria na jamii zilizopo ili kusaidia kuangazia matatizo haya? (CHUNGUZA: afya, polisi, ushauri wa sheria, ushauri wa jamii.) Ni nani anayetoa huduma hizi? Ni vipi juhudi hizi zinavyoweza kuboreshwa?

17. Kukamilisha majadiliano

Kuna chochote unachofikiria kuwa hatujajadili na kwamba ungependa kuongezea? Ikiwa ndivyo tafadhali kuwa huru kuongezea...

Asante sana kwa ushiriki wako. Mchango wako umekuwa wa thamani sana. Matokeo ya utafiti yatasambazwa kwa washikadu tofauti, ikiwa ni pamoja na kwenye kiwango cha jamii.

Asante. (Serenyowuo)
Appendix 8: Map of West Pokot Sub-County
Appendix 9: Ethical certificate

KENYATTA UNIVERSITY
ETHICS REVIEW COMMITTEE

Email: chairmen.kuere@kau.ac.ke
secretary.kuere@kau.ac.ke

Our Ref: KU/E/COM11/51/335
Date: 6th June, 2014

Isaac Owaka
Dept. of Environmental Health,
Kenyatta University,
P.O Box 43844, Nairobi

RE APPLICATION NUMBER KU2/205/182 — "INTIMATE PARTNER VIOLENCE IN PREGNANCY AMONG ANTENATAL ATTENDEES AT HEALTH FACILITIES IN WEST POKOT COUNTY, KENYA" - VERSION 2

1. IDENTIFICATION OF PROTOCOL
The application before the committee is with a research topic "Intimate Partner Violence in Pregnancy among Antenatal Attendees at Health Facilities in West Pokot County, Kenya" — Version 2 dated 26th May, 2014.

2. APPLICANT
Isaac Owaka, Dept. of Environmental Health

3. STUDY SITE
West Pokot County, Kenya

4. DECISION
The committee has considered the research protocol in accordance with the Kenyatta University Research Policy (section 7.2.1.3) and the Kenyatta University Ethics Review Committee Guidelines AND APPROVED that the research may proceed for a period of ONE year from 6th June, 2014.

5. ADVISE/CONDITIONS
   i. Progress reports are submitted to the KU-ERC every six months and a full report is submitted at the end of the study.
   ii. Serious and unexpected adverse events related to the conduct of the study are reported to this board immediately they occur.
   iii. Notify the Kenyatta University Ethics Committee of any amendments to the protocol.
   iv. Submit an electronic copy of the protocol to KU-ERC.

When replying, kindly quote the application number above.
If you accept the decision reached and advice and conditions stated please return the space provided below and return to KU-ERC a copy of the letter.

PROF. NICHOLAS K. GIKONYO
CHAIRMAN ETHICS REVIEW COMMITTEE

I. Accept the advice given and will fulfill the conditions therein.

Signature: Dated this day of

cc. Vice-Chancellor
   Director: Institute for Research Science and Technology
Appendix 10: Research Authorization

NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

Telephone: +254 20 2214471
2241401 310571 2298420
Fax: +254 20 318245 318249
Email: secretariat@nacosti.co.ke
Website: www.nacosti.co.ke
When replying please quote

Ref No

NACOSTI/P/14/5988/2736

Isaac Ogweno Owaka
Kenyatta University
P.O. Box 13444,00100
NAIROBI

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on "Intimate partner violence in pregnancy among antenatal attendees in West Pokot County, Kenya," I am pleased to inform you that you have been authorized to undertake research in West Pokot County for a period ending 31st December, 2014.

You are advised to report to the County Commissioner and the County Director of Education, West Pokot County before embarking on the research project

On completion of the research, you are expected to submit two hard copies and one soft copy in pdf of the research report thesis to our office

DR. S. K. LAMATI, OGW
FOR: SECRETARY CEO

Copy to

The County Commissioner
The County Director of Education
West Pokot County

18th August, 2014
Appendix11: Research Permit

THIS IS TO CERTIFY THAT:
MR. ISAAC OGWENO OWAKA
of KENYATTA UNIVERSITY, 0-200 MUHORONI, has been permitted to
conduct research in West Pokot County

on the topic: INTIMATE PARTNER
VIOLENCE IN PREGNANCY AMONG
ANTENATAL ATTENDEES IN WEST POKOT
COUNTY, KENYA.

for the period ending:
31st December, 2014

CONDITIONS

1. You must report to the County Commissioner and
   the County Education Officer of the area before
   embarking on your research. Failure to do that
   may lead to the cancellation of your permit
2. Government Officers will not be interviewed
   without prior appointment.
3. No questionnaire will be used unless it has been
   approved.
4. Excavation, filming and collection of biological
   specimens are subject to further permission from
   the relevant Government Ministries.
5. You are required to submit at least two(2) hard
   copies and one(1) soft copy of your final report.
6. The Government of Kenya reserves the right to
   modify the conditions of this permit including
   its cancellation without notice

Permit No: NACOSTI/P/14/5988/2736
Date Of Issue: 18th August, 2014
Fee Received: Ksh 1,000

REPUBLIC OF KENYA

National Commission for Science, Technology and Innovation

RESEARCH CLEARANCE