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Responses to and Resources for Intimate Partner Violence: Qualitative Findings from Women, Men, and Service Providers in Rural Kenya

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Abstract

Intimate partner violence (IPV) is reported by one in five women globally, but the prevalence is much higher in East Africa. Though some formal and informal resources do exist for women experiencing IPV, data suggest that disclosure, help seeking, and subsequent utilization of these resources are often hindered by socio-cultural, economic, and institutional factors. This paper explores actions taken by victims, available support services, and barriers to utilization of available IPV resources by pregnant women in rural Nyanza, Kenya. Qualitative data were collected through 9 focus group discussions and 20 in-depth interviews with pregnant women, partners or male relatives of pregnant women, and service providers. Data were managed in NVivo 8 using a descriptive analytical approach that harnessed thematic content coding and in-depth grounded analysis. We found that while formal resources for IPV were scarce, women utilized many informal resources (family, pastors, local leaders) as well as the health facility. In rare occasions, women escalated their response to formal services (police, judiciary). The community was sometimes responsive to women experiencing IPV, but often viewed it as a "normal" part of local culture. Further barriers to women accessing services included logistical challenges and providers who were under-trained or uncommitted to responding to IPV appropriately. Moreover, the very sanctions meant to address violence (such as fines or jail) were often inhibiting for women who depended on their partners for financial resources. The results suggest that future IPV interventions should address community views around IPV and build upon locally available resources – including the health clinic - to address violence among women of child-bearing age.

Keywords

disclosure of domestic violence; domestic violence in cultural contexts; support seeking; Kenya

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Background

Intimate partner violence (IPV) is a major public health problem and a global human rights challenge (UNAIDS, UNFPA, & UNIFEM, 2004). It is defined as the physical, psychological, economical or sexual abuse of one person by another due to advantaged position based on sex or gender, and is rooted in the unequal power relations between men and women (Dunkle, et al., 2004b). Both men and women may experience IPV, however women are disproportionately victims (Glass, Campbell, Nije-Carr, & Thompson, 2011). Worldwide, the one-year prevalence of IPV among married women ranges between 15% – 17 %, (Garcia-Moreno, Heise, Jansen, Ellsberg, & Watts, 2005; Lawoko, 2006; L. E. Okenwa, Lawoko, & Jansson, 2009) with variations depending on factors such as culture, norm, laws and other local conditions that favor/disfavor gender inequity (L. Okenwa, Lawoko, & Jansson, 2011). An estimated 3% – 25% of women experience IPV in pregnancy (Gazmararian, et al., 2000; Horn, 2010).

The negative consequences of IPV for women of child bearing age are far-reaching, including health, social, economic and psychological effects (Koss, Bachar, & Hopkins, 2003; C. Maternowska, J. Keesbury, & N. Kilonzo, 2009; Romito, Molzan Turan, & De Marchi, 2005). Research has shown that women who experience violence have increased risks of suffering adverse health outcomes (Dunkle, et al., 2004a), adopting high–risk behaviors (R. K. Jewkes, K. Dunkle, M. Nduna, & N. Shai, 2010), and are more likely to attempt suicide than unabused counterparts (Devries, et al., 2011). A South African study showed that women who were beaten by their male partners were 48% more likely to become infected by human immunodeficiency virus (HIV) than their counterparts in non-violent relationships (R. Jewkes, K. Dunkle, M. Nduna, & N. Shai, 2010).

In Kenya, 47% of ever-married women aged 15–49 years have experienced IPV (Central Bureau of Statistics (CBS) [Kenya], 2010), and 28% of women seeking antenatal care report IPV in pregnancy (Kiarie, et al., 2006a; Makayoto, Omolo, Kamweya, Harder, & Mutai, 2012). Another study among women attending sexually-transmitted infection (STI) clinics in Nairobi, found that HIV-positive women were twice as likely to have experienced lifetime IPV as women who were HIV-negative (Fonck, Leye, Kidula, Ndinya-Achola, & Temmerman, 2005).

Current understanding of responses to IPV and utilization of existing resources is limited; there is need for a better understanding of these to ensure access to and delivery of services to IPV victims (C Maternowska, J Keesbury, & N Kilonzo, 2009). Women often respond to violence using ineffective coping strategies or suffering in silence (Puri, Tamang, & Shah, 2011). This is compounded by the fact that violence against women is considered normal in many communities (Kenya, 2011). Access to services may also be made more difficult due to governmental policies and societal norms (Horn, 2010), and extremely limited formal IPV services in many rural settings.

In order to understand the context of IPV in rural Kenya, we conducted in-depth qualitative research with pregnant women, male family members, and community members. We explored responses to violence, available resources, and barriers to accessing these resources. Understanding responses to violence, indentifying available resources, and barriers to utilization of these resources has important implications for prevention of further IPV towards pregnant women in this and other rural settings.

Methods

Study setting

The study was conducted in Migori and Rongo Districts, which are located in the southwestern part of Nyanza Province, Kenya, bordering Tanzania. Peasant farming and petty trade are the main sources of livelihood, and educational levels are generally low for both women and men. Non-governmental organizations (NGOs) have a heavy presence; working in health, education and socio-economic development. HIV prevalence in the region more than doubles that of other parts of Kenya, with 15.3% of Nyanza Province living with HIV (NASCOP, 2009). The estimated HIV prevalence among pregnant women attending sentinel surveillance ANC clinics in Nyanza is 15.5 % (NASCOP, 2009). Although 93.6% of women in Nyanza have at least one antenatal care (ANC) visit during pregnancy, most births take place at home with the assistance of traditional birth attendants (Kenya National Bureau of Statistics, 2010). Both maternal and infant mortality rates are high (Emenike, Lawoko, & Dalal, 2008; Kenya National Bureau of Statistics (KNBS), 2010). The communities are patriarchal, and men tend to dominate and assert their authority, in some cases using violence (FIDA-Kenya, 2008). In Nyanza Province, more than half (59.6%) of women have ever experienced IPV and 37% reported IPV in pregnancy (Kenya National Bureau of Statistics (KNBS), 2010; Makayoto, et al., 2012).

Participants

A total of 90 men and women participated in 9 focus group discussions (FGDs) and 20 In-depth interviews (IDIs). Four FGDs were conducted with pregnant women, 4 FGDs with men, and 1 FGD with service providers. Twenty in-depth interviews (IDIs) were conducted with service providers. The FGDs with pregnant women and men included 2 groups with younger participants (18–30 years of age) and 2 groups with older participants (31 years of age or older), with 6–8 participants in each group. The socio-demographic characteristics of the participants in the 8 focus groups with community women and men are summarized in Table 1.

Recruitment was conducted using convenience and purposive sampling methodology, in an effort to achieve data saturation. To recruit pregnant women (n=29), a general announcement about participating in the study was made in the waiting area of antenatal care clinics (ANC) at four health facilities in the study districts. Pregnant and postpartum women that took part in the research represented a convenience sampling of participants. Researchers explained that this was unlike their regular medical care and that women were invited, but not obliged, to participate in the study at the health facility later that day.

Male partners and relatives of pregnant or postpartum women (n=32) were recruited in two separate communities (near, but not overlapping the antenatal clinics) through lay health workers familiar with the surrounding areas. Since male partners came from a different catchment area, this recruitment method minimized the chance that a pregnant woman's partners would learn of her participation in the research, potentially placing her at further risk of violence. Those men who were interested in participating were invited to participate at a convenient time and location in the community.

Representatives of organizations that deal with issues related to IPV were purposively recruited to take part in one FGD (10 participants). In addition, 20 service providers were recruited to participate in an IDI. These providers included healthcare workers, police officers, representatives of women's rights groups, members of groups working on IPV in Kenya, magistrates, village leaders, and other local opinion leaders (Table 2). They were informed of the study by email, phone, or in person by one of the study investigators. Those

interested were taken through the informed consent process, after which an appointment for interview was made at a convenient time and place.

Procedures

Focus Group Discussions were facilitated by two trained moderators (same sex as the group members, and two moderators within the service provider mixed gender group) using guidelines developed by the research team. The IDIs with service providers were conducted by a trained qualitative researcher, after obtaining signed informed consent, using an in-depth interview guide. Both FGDs and IDIs were recorded on digital voice recorders, after obtaining the consent of the participants. Data collection was conducted between January and April, 2010.

The focus group guides were translated into English, Kiswahili, and Dholuo and the discussions were conducted in either Dholuo (pregnant/postpartum women and male partner/family members), Kiswahili (service providers). All IDIs were conducted in English, a national language of Kenya, spoken by all service providers. Interview guides and focus group guides were similar across groups, and were developed in a series of meetings with the research team. We asked women, men, and service providers what types of IPV occurred in the community. The interviews explored the types of responses taken by IPV survivors and the reaction from their peers and families when disclosing violence. We asked about the existing resources for IPV survivors, and whether there were barriers to accessing existing resources. Lastly, we explored the particular triggers of violence experienced by pregnant women and how local setting framed IPV towards pregnant women, a topic discussed in a separate manuscript (Hatcher, et al., 2013).

Several steps were taken to recruit participants in ways that ensured confidentiality. Study staff were trained to describe research as the “social barriers” to use of health services in the community. This was important to protect the privacy of participants and created a willingness to participate. Interviews and focus groups did not include any questions asking participants about their personal experiences with IPV. All participants were offered an information sheet containing contact information for local resources (counseling, legal advice, and health care). In cases of severe violence, researchers were trained to accompany the participant to the office of the most appropriate local resource for preventing or mitigating the impacts of IPV.

Data management and analysis

Recordings from the digital voice recorders were uploaded to a computer and password-protected. A professional transcriptionist transcribed each recording and translated into English. The research team reviewed a sample of the translation, and errors were queried over email. Transcripts were managed with QSR Nvivo version 8, using a descriptive approach to qualitative data analysis. The research team created an initial list of broad thematic codes based on the research questions, and refined it through detailed team discussions (Miles & Huberman, 1994). The transcripts were then broad-coded according to thematic content independently by two researchers. Coding reports were printed and a series of meetings were held among three authors to build a more complex coding framework of fine codes. Using Nvivo, fine codes were developed independently by two researchers, using a grounded theory approach (Hutchison, Johnston, & Breckon, 2010), which allowed the voices of participant to define sub-themes in the data. Thus, the analytical approach incorporated both “top-down” thematic coding and “grounded” emergent fine codes. Full coding reports were written to include representative quotations that illustrated the final sub-themes.

Ethical considerations

Ethical clearance was granted by the National Ethical Review Committee (ERC) of the Kenya Medical Research Institute (KEMRI), the Committee on Human Research (CHR) of the University of California, San Francisco (UCSF), and the Institutional Review Board of the University of Alabama at Birmingham (UAB).

Results

Analysis of the FGD and IDI data revealed several major themes. Here, we present three themes related to responses to resources and barriers to access of IPV services. First, women's responses to IPV suggested a hierarchy of responses, ranging from silence to visiting a clinic and pressing charges against the perpetrator. Second, we explore the barriers to delivering IPV services, and the challenges for women utilizing existing support services.

Women's Responses to IPV

We identified nine types of actions that women often take in response to IPV (See Figure 1).

There seemed to be a common pathway of actions that women take in responding to IPV, starting with their families, moving along to community structures, continuing to hospitals, and sometimes moving to police or non-governmental organizations, or legal structures:

> [Women] would start from the home set up, then they would tell the parents in-law. And then the closest people they can talk to are the village elders and the chief; then the health workers where they have gone for healthcare; then the police and other organizations if they are available there. (IDI, Health Service Provider 9)

Many participants said that most women preferred doing nothing when abused by partner. Staying silent about violence seemed more likely for women living in this setting, where very few services exist:

> Some of them opt to share with their friends but most of them opt to suffer in silence, a few can opt to run back to their parents. (IDI, Health Service Provider 8)

Other women take some action, but tend to reach out to informal support systems such as relatives and elders. Many pregnant women talked about starting with returning home to their maternal family after violence occurs, waiting out the period of conflict to subside. Other pregnant women described talking to their partner's family about the violence:

> There are some little ones that we can finish on our own but if you are not able to handle them then you go to his parents…Anything beyond the parents would be taken to the extended family. (FGD Young Women 1)

In particular, fathers of the male partner were consulted in cases of marital disputes:

> Among the Luos if there is a problem if your father is still alive then you go to him and tell him that my wife has done this to me then she is called to a meeting. (Male Partners and Family Members FGD 1)

Local administrators, such as the chiefs and community elders, act as judges and arbitrators for victims of violence. The chiefs have the authority to arrest and bring the perpetrator of IPV to justice. Chiefs customarily convene a small community meeting made up of villages elders to arbitrate between offended parties. However, this process has challenges since often chiefs side with the perpetrator:

> Mostly they run to their administrators like the chiefs. And usually they [the administrators] would be the people from the same community and sometimes the relatives of the husband so they do little to assist because they very much advocate

> for settling these matters at home that bringing them to the law. –(Other Service Provider 7)

Religious leaders also provide spiritual support to victims of violence. Pastors offer couple counseling to members of their congregation who experience family problems, such as violence.

Some women experiencing violence choose to go to the hospital. Community members sometimes support a victim of violence by escorting them to the local clinic. Male partners and family members described health facilities as places that offer guidance for the community:

R2: I think if we invite those who offer guidance and counseling in the community.

I: Where can we get this one?

R2: Health facilities. Okay if we go to places like the hospital where there are AIDS programs. (Male Partners and Family Members FGD 1)

However, this seems to happen when there are obvious physical injuries:

> I think they come to seek medical advice if they have been actually beaten in such a way that they need treatment, maybe they are bleeding or such cases. (IDI, Health Service Provider 1)

Some women would report an incident of IPV to police, after failing to get recourse from the informal structures. In Kenya, an official form (P3 form) is used to document reports of violence as well as in the court system to press charges. They arrest perpetrators, especially those that have committed serious offences such as rape or murder. However, they rarely get involved in disputes such as wife beating; as they consider those types of acts “domestic problems” that a husband and wife can settle on their own:

> We always just counsel them, like the sexual abuse, and then tell them to go back and think and not to push and constitute a case. Because sometimes they prefer to manage it at the community level, so we just give them appropriate advice and let them decide. We don’t want to give them direction… You know issues to do with the family are very complex because culture also comes in, so we also don’t want to go against the culture, we inquire from them if they have a local system. (IDI, Health Service Provider 1)

The courts of law are usually perceived by women as the last resort, and it appears that women only seek legal assistance through the court when they feel they can no longer live with the husband and their life is in danger.

> We may not even know. We are actually at the end. They’ll go through the village elders then go to the police station. They go to the hospitals. When they come to us we are as the last resort. They come to us for penal justice against the offender. (IDI, Judiciary Service Provider 4)

Some women who experience IPV are able to get support from non-governmental organizations, particularly for legal assistance.

> Some who are maybe enlightened may go to different organizations that support women for legal support. (IDI, Health Service Provider 9)

Some women talked of taking other kinds of extreme action in response to violence. For example, one study participant discussed the desire to kill oneself after experiencing IPV.

> I just want to say something, that if women don't do the things we have said then the only thing they see in their minds is death…You feel that you need to take poison or get a rope and go hang yourself. Those are the things that cross your mind. (FGD Young Women 1)

Despite a lack of IPV services, when compared to larger cities such as Nairobi, some formal and informal resources do exist in these communities. Resources included the family, local administrators, religious leaders and the police. Most of the respondents agreed that health care clinics were a common "first step" for victims of violence. However, they explained that women tend to seek medical attention for the injuries sustained from violence, but not the violence itself. Once they are treated and feel better, they go back home and life continues. It is important to note that individual women may not always navigate the hierarchy of actions in the same way. Yet, the notable finding from our research was that there was a general trend among women as a whole towards a hierarchy of responses that moved from the informal, via health care, through to formal and extreme action.

Barriers to accessing IPV services

While some IPV resources do exist in the study districts, many of these resources have important gaps. In many cases, women are not aware of these services and that violence of any kind is a violation of ones human rights. Even if they are aware, women still face significant challenges accessing these resources. The existing IPV services are often disjointed, weak, and tended to blame or judge women for reporting violence.

Logistical challenges and lack of linkages—Women reporting IPV are often referred for additional services and asked to travel to new locations, such as hospitals and police stations in neighboring towns:

> On interview that is when you can be able to identify psychological trauma, especially in these cases of sexual assault. Unfortunately we don't have a psychiatrist in the hospital but we refer –we can refer them to neighboring hospitals. (IDI, Health Service Provider 2)

However, at times, there is no linkage system in place to refer women for additional support. Even when referral is possible, it can be difficult for women travel to another town for services:

> Legal services are still a weakness because we don't have these organizations like FIDA [Federation of Women Lawyers] and linking to FIDA from Rongo is not exactly easy. (IDI, Health Service Provider 2)

Obtaining IPV services and pressing charges is costly. In Kenya, a victim of violence needs to access a P3 form from the police, which must be completed by a medical officer, after which it must be returned to the police who will then press charges before a court of law. Most of these women are poor and cannot afford to pay for the P3 form, medical examination and transportation.

Occasionally, a service provider will assist women who do not have the resources to access services.

> You see sometimes, widows are beaten and they don't even have cash to pay for P3 form in the hospital which they charge Ksh. 300/= and some ladies can't raise that. (IDI, health Service Provider 7)

Other times, service providers will insist on being paid for services like filling out the P3 form (which is supposed to be offered free of charge) as a way to avoid the hassles related to testifying in court:

> Police is mixed, because police put money forward, so for the services they provide, they want some money, but that one I am also not ruling it out with health service provider., Like to fill the P3 form, they will ask for money. (IDI, Health Service Provider 1)

The legal system in particular requires women to jump through many bureaucratic hoops, leading many women to give up on the process:

> When it comes to the issue of taking up legal action like the P3 and the process is so long and cumbersome that some people just give up. (NGO, Legal Service Provider 14)

Lack of service provider knowledge, skills, and commitment—Health services often focus only on the physical treatment of women experiencing violence and fail to offer counseling or other needed treatment:

> We just give an overview on how to handle such issues depending on how it presents, if there are cuts, bruises… but we are not so much into gender-based activities. (IDI Health Service Provider 8)

In Nyanza Province, service providers are sometimes trained on post-rape care, but not on how to deal with other types of IPV. One interview illustrated the lack of training on IPV issues outside of rape:

> There were some trainings initially, when we were doing post-rape a few people were trained when they were developing those manuals, but it was mainly focused on rape and defilement…But broader perspective of violence as a whole there is really deficiency in training. (IDI, Health Services Provider 2)

Even where services do exist, they are often lacking the urgency and efficiency needed to punish the perpetrators of violence.

> To some extent I felt that justice was not done, because the way this guy had beaten the woman, some action would have been taken so that is like a lesson to other men. The local negotiations just encourage others. (IDI, Health Service Provider 8)

Participants related how service providers sometimes destroy evidence so as to stop court proceedings. In some cases the perpetrators of violence would influence the service provider to drop the case by giving a bribe. One service provider describes feeling ‘helpless’ because often legal cases are lost based on a small mistake in collecting evidence:

> You became helpless because maybe the evidence … is not properly collected or the investigation has not been properly done. And in our justice system, of course if somebody has to be convicted, they will be convicted on proof that they are actually guilty. If you don’t have evidence to be able to prove… that person committed the crime, you are feeling helpless. (IDI, Legal Service Provider 12)

Tendency to normalize violence and reject those who intervene—Participants said that some members of the community are not concerned about cases of gender-based violence, especially physical partner violence, viewing it as “normal”:

> People in the community don’t take it seriously, because if a woman has been violated you get a family member supporting the violence. There are cases where the community is involved like sexual assault, but wife beating; the community does not get involved. (FGD, Health Service Provider 1)

Study participants spoke of many ways in which the broader community justifies IPV. Intimate partner violence is perceived as an expression of love by the partner or disciplining a wife, both of which are considered, ways of strengthening family relationships:

> A man slapping the wife, they say is normal, it is in a way to make them know who is the owner, so like disagreement in the house which don't cause more harm they take it to be normal…slaps, using cane to beat your wife, that one they take it to be normal in the house. (IDI, Health Service Provider 5)

This community sentiment around violence influences the way that service providers, such as health workers, are able to respond to cases of IPV. Several service providers explained that those who intervene in violence cases sometimes feel threatened by the community:

> They don't talk good about interveners, they talk ill, they must find a name to call you, if not a prostitute then what, they must find a way of intimidating you. (IDI, Other Service Providers 18)

Much of our data depicted a broader social environment that condones- and even encourages- violence. Sometimes service providers blame the woman for the violence that she experiences:

> Yeah! The complainant, the Police, send them away saying, you are the one who has become difficult go back and sort out…, you woman are the one who wants to break her house.' (IDI, Legal Service Provider 12)

If a woman talks to people about being beaten by her husband, she may be looked down upon or perceived to be responsible for the violence. In one focus group, female participants spoke of other women and neighbors laughing at her:

R: Others will look at you scornfully, and some laugh.

R: Others would tell you: "If you are a woman and you have gone to report to the village elder, they will say" No, he has never done anything wrong. It is you who was wrong." And they [village elders] will not listen to your problem. (FGD, Older Women 3)

Inadequacy of penalties to deter violence—Some cases of GBV are brought to the clan elders. The elders may choose to arrest the perpetrator with the help of a community vigilante group, such as the *sungusungu*. The elders would then call a community meeting. Sometimes the result of this community meeting is that the wife chooses to forgive the husband:

> The man apologized, then I forgave him after that we went out with the children for nyamachoma (roasted meat). Now we have talked as a family and have decided I forgive him. (FGD Older Women 3)

If a woman decides to press formal charges, a full investigation is conducted. However, as expressed by one of health care service providers, the man may find a way (such as bribery) to get around the legal system:

> I advised her to go to the chief, then to the police so that the case can be followed by the government. So later she went to the chief and was given P3 form. I filled the P3 and the chief promised to arrest the person. But later the case went [was dismissed] because the woman came and told me, "Daktari [doctor], that man has gone to the chief to give something small [a bribe] so that the case just left that way." (IDI, Health Service Provider 5)

If the husband is found guilty at this community court, he is given a penalty, such as a fine or strokes of the cane, and is subsequently discharged:

> If you are badly injured you go to the community. If he is on the wrong the livestock that should have helped in the family are used to pay for the fine imposed by the sungusungu [vigilante]. (FGD Young Men 1)

Ironically, in this case, the woman who took steps to charge her husband in the community court was subsequently put in a position of *increased* risk, as her partner was forced to pay a fine from important family resources. This situation represents the double burden of women, who must suffer from violence and concomitantly deal with the consequences if they choose to press charges.

Discussion

We found that IPV among women of childbearing age is a common occurrence in rural Kenya. Although some formal and informal resources exist for addressing IPV, there are many barriers to accessing these resources. Here, we compare our findings to the global IPV literature, in an effort to understand the extent to which Kenya is unique in its responses to and resources for violence.

Our results suggest that in rural Kenyan settings, many women chose to remain silent about IPV experiences. This mirrors global findings, in which more than half of battered women have never told anyone about the violence before the survey (Ellsberg, Heise, Pena, Agurto, & Winkvist, 2001; Fox, et al., 2007; Puri, et al., 2011; Yount & Li, 2009).

Informal support systems are another important source of support for IPV victims. Women in our study sought informal support through extended family, rather than seeking support through formal institutions. This is similar to findings from both industrialized (Fanslow & Robinson, 2010; Istat, 2008; Walby & Allen, 2004) and developing country settings (Clark, Silverman, Shahrouri, Everson-Rose, & Groce, 2010; Puri, et al., 2011; Schuler, Bates, & Islam, 2008). Women of all cultures may avoid formal support structures if they feel alone in the experience or shame about the violence (Edin, Dahlgren, Lalos, & Hogberg, 2010; Ellsberg, Pena, Herrera, Liljestrand, & Winkvist, 2000; Fanslow & Robinson, 2010; Gage & Hutchinson, 2006; Puri, et al., 2011). Our study participants suggested that legal and criminal responses to IPV may not be appropriate for all women in this setting, since poverty or family pressures may preclude a woman leaving or prosecuting a husband.

Identification and prevention of violence against women can play an important part in improving the health of the mother and child. Our study shows that, while the extended family is normally the first point of recourse for women seeking support for violence, the health facility is generally the first *formal* place visited by women. Battered women visit the health facilities by themselves or are escorted there by neighbors to get treatment for injuries sustained from violence. This provides an opportunity for screening for violence, provision of care, and referral to other services by the health workers. However, in many settings, healthcare providers' training does not include IPV as a health concern (Colombini, Mayhew, & Watts, 2008). Thus, healthcare workers often lack the skills to deal with a pervasive problem like IPV, and ultimately, women's health and wellbeing is worsened because of this training gap.

Access to resources also seemed to be strongly influenced by logistic and provider barriers. The participants described how difficult it is to file a legal suit against a spouse: the process involves the acquisition of a P3 form, which is obtained at a cost and requires an identification card (ID). Most of the women do not have IDs and therefore must use their husband's; this makes it almost impossible to take legal action against the perpetrator if it is the husband. This aligns with global IPV literature, which suggests that a woman's response to violence is shaped largely by the circumstances of the abuse and her assessment of

available options (Ellsberg, et al., 2001). According to studies conducted in the US, women who remain with their abusers have suffered less severe abuse (Jacobson, Gottman, Gortner, Berns, & Shortt, 1996), and are more likely to be financially dependent on their partners (Strube, 1988). We found that, many women in rural Kenya choose to "remain silent" when suffering from IPV, in order to protect the family and preserve their dignity in the community.

Few formal support avenues, save for the police and health centers, exist for abused women in this rural setting. Further to this, the few that exist do not have the potential to detect violence especially among pregnant women. This is consistent with a study conducted in Nicaragua, in which not a single rural woman reported having sought help through formal channels despite suffering severe violence (Ellsberg, et al., 2001). Thus, staying silent may reflect both rural women's limited access to services, as well as reluctance to seek help or conformity to the social cultural demands. In rural, underserved communities globally, a lack of health and social resources inhibits women from seeking IPV care (Krishnan, Hilbert, & VanLeeuwen, 2001; Liang, Goodman, Tummala-Narra, & Weintraub, 2005).

Further it is interesting to note that structural aspects of formal support services that do exist (such as the *sungusungu* vigilante approach) may re-enforce traditional gender imbalances (Laisser, Nyström, Lindmark, Lugina, & Emmelin, 2011). Laws and regulations maintain gender dynamics that give men power over women, creating further difficulty for women to separate from violent situations (Laisser, et al., 2011). In this gendered context, community structures that are meant to offer support – such as chiefs and village elders – often blame women themselves for provoking the violence. Moreover, when women do achieve "justice" and their violent partners receive penalties, this punishment often inflicts greater challenges for the economic security of women and their children.

Some studies have suggested that IPV interventions work with families (L. Okenwa, et al., 2011), since it is the first and preferred choice of support for women. However, consistent with other studies in Kenya (Lawoko, 2008), we found that family members often support norms and practices that justify violence. Participants in this study describe how traditionally, family members encourage wife beating as form of discipline by the husband out of love for his wife. Similar to studies elsewhere (Clark, et al., 2010), we found that family beliefs make it difficult for these women to identify violence, and thereby respond appropriately. Disclosure of abuse to some institutions such as law enforcement agencies is viewed as disrespect for the family (Ahrens, Rios-Mandel, Isas, & del Carmen Lopez, 2010; L. Okenwa, et al., 2011). We would, therefore, encourage community norms around IPV rather than intervening at solely a family level. A community-level strategy is consistent with new evidence that community characteristics – not simply family or individual attributes – predict violence (Li, et al., 2010; Pallitto & O'Campo, 2005).

Even if women reach IPV support resources, service providers' attitudes towards IPV may discourage the woman from seeking further formal support. In many settings, authorities such as the police have been reported to advise women to go and settle with their husbands, deny women the opportunity to press charges, and ultimately reduce their interest in seeking justice (Ezechi, et al., 2004; Ilika, 2005). In this study some participants related how certain service providers, would be so determined to destroy evidence so as to stop court proceedings. In some cases the perpetrators of violence would influence the service provider to drop the case by giving bribe. This is consistent with studies on disclosure of sexual assault that show how victims were silenced by corruption and indifference of the service providers (Ahrens, Campbell, Ternier, ÄêThames, Wasco, & Sefl, 2007).

Limitations

The findings of this study must be seen in the light of the following limitations. For the FGDs with women, we recruited only pregnant women attending ANC clinics, thus, running the risk of introducing selection bias if the reactions to and perceptions regarding IPV and resource utilization of these women differ from non-users of ANC services. However, over 90% of pregnant women attend ANC clinics in Nyanza Province (Kenya National Bureau of Statistics, 2010), so we anticipate that the sample is somewhat representative of this setting. Regardless, the findings are specific to rural Nyanza Province, and may not be generalizable to other East African settings. In-depth qualitative data can offer insights into the experience of women, male partners, and community members, but cannot determine the weight or importance of various responses. In addition, the transcripts were translated one way only, from Luo or Kiswahili to English, due to lack of resources for back-translation. However, the first author and two other researchers reread the local language and English transcripts to check and correct any translation errors before data analysis began.

Conclusions and recommendations

These findings offer insights for appropriate policies and interventions to prevent and mitigate effects of IPV in rural settings in Africa. First, it is clear that the broader community plays a key role in supporting victims of IPV and encouraging a useful resolution of conflict. Thus interventions and policies on IPV prevention should be aimed at creating awareness of IPV and its consequences at the community level. An example of this type of programming can be found in nearby Uganda, where a cluster-randomized trial is currently evaluating the effect of community-level interventions on social norms around IPV (Abramsky, et al., 2012). Second, removing logistical barriers, such as requirements for filling the P3 form in Kenya, may promote the use of formal IPV services. Policies that bring the P3 forms closer to the people and remove the charges for both the P3 and medical examination of victims should be put in place in order to increase access of the legal services.

Lastly, our data supports the fact that health facilities located in rural areas may be appropriate places to provide services for prevention and mitigation of IPV. Training on IPV for health care workers should emphasize all types of IPV as an important health concern; and systems should be set up to create linkages with other types of social and legal services required by persons at risk of or experiencing violence.

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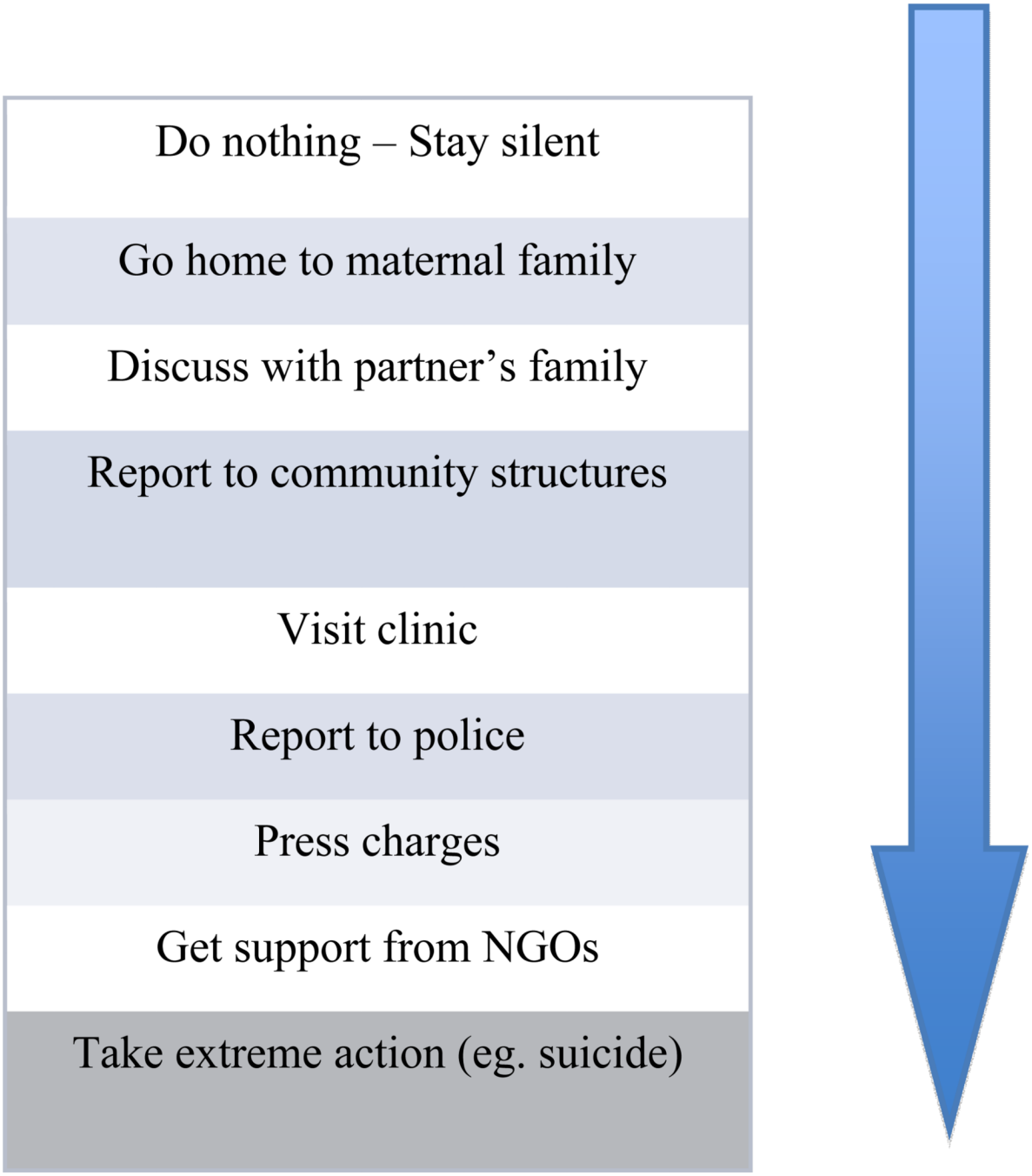

Figure 1.
Women's Responses to Gender-Based Violence*
*= The arrow indicates a hierarchy of response, ranging from passive to active response

Table 1

Characteristics of Pregnant Women and Male Partners in Focus Group Discussions

	Pregnant women (n=29)		Male partner (n=31)		Total (n=60)	
Variables	**n**	**%**	**n**	**%**	**n**	**%**
Age in years						
18 – 30	14	48	15	48	29	48
31 – 49	15	52	16	52	31	52
Marital status						
Married	27	93	27	87	54	90
Single	2	7	2	7	4	7
Not stated	0	0	2	7	2	3
Occupation						
Bodaboda	0	0	3	10	3	5
Fish monger	2	7	0	0	2	3
Housewife	5	17	0	0	5	8
Peasant farmer	7	24	22	71	29	48
Petty business	12	41	4	13	16	27
Teacher	2	7	2	7	4	7
Unemployed	1	3	0	0	1	1
Number of living children						
None	4	13	2	7	6	10
1 – 4	21	72	23	74	44	73
5 or more	3	10	6	19	9	15
Not stated	1	3	0	0	1	1
Educational level						
Primary	27	93	26	84	53	88
Secondary	2	7	5	16	7	12

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Table 2

Characteristics of service provider participants in in-depth interviews and focus group discussion

	IDI		FGD	
Variables	**N=20**	**%**	**N=10**	**%**
Age in years				
<36	8	40	3	30
36 – 45	5	25	4	40
46 – 55	5	25	3	30
>55	2	10	-	-
Gender				
Female	8	40	4	40
Male	12	60	6	60
Marital status				
Married	16	80	9	90
Single	3	15	1	10
Widow	1	5	-	-
Type of Organization				
Faith-based organization	1	5	-	-
Judiciary/Legal/Police	2	10	-	-
NGO/CBO	5	25	2	20
Provincial Administration	3	15	5	50
Public Health	9	45	3	30
Main area of responsibility				
Administration of Justice	3	15	-	-
Health care and treatment	9	45	3	30
GBV services	4	20	2	20
Maintaining law and order	3	15	5	50
Spiritual services	1	5	-	-

IDI, in-depth interview; NGO, non-governmental organization; CBO, community-based organization; GBV, gender-based violence