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An insight into preventive behaviour among Maragoli women of Western Kenya

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Marital Sexuality in the Context of HIV/AIDS

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Abstract

Government and other HIV/AIDS intervention agencies have made sexual behaviour modification a major component of their preventive strategy as new cases of the epidemic continue to be reported in Kenya. As the impact of the epidemic becomes increasingly evident, there has been a worrying revelation that married couples are affected, yet there has been little attempt to understand marital HIV/AIDS preventive sexual behaviour. Whereas some studies have shown that women are disadvantaged as far as sexual decision-making is concerned, married women's HIV/AIDS preventive behaviour has not received due research attention. Based on data from a field study conducted among the Maragoli community of western Kenya, this article examines how married women perceive the risk of HIV infection, the preventive strategies they have adopted, and husband perception of wife's right to protection. A major finding of this study is that, even with high knowledge of the risk of HIV infection, a majority of married women have either low or no capacity to influence marital sexual behaviour related to HIV/AIDS prevention. The conclusion drawn is that HIV/AIDS prevention, especially among married women can only be realised by a change in norms which control sexual relationships and deny women the right to determine their own sexual lives.

Résumé

Le gouvernement et les agences intervenant dans la lutte contre le SIDA ont fait de la modification des comportements sexuels une composante majeure de

leur stratégie de prévention alors que de nouveaux cas de SIDA ne cesse d'être enregistrés au Kenya. Au fur et à mesure que l'impact de l'épidémie devient de plus en plus évident, il est inquiétant de constater que les couples mariés sont aussi affectés, bien que les tentatives pour comprendre la prévention du SIDA chez ces couples sont rares. Alors que quelques études ont montré que les femmes sont désavantagées pour ce qui est des décisions en matière de sexualité, le comportement des femmes mariés vis-à-vis du SIDA n'a pas reçu l'attention qu'il mérite.

Cet article examine, à partir de données collectées auprès de la communauté des Maragoli de l'ouest du Kenya, comment les femmes mariées perçoivent le risque d'infection par le VIH, quelles sont les stratégies qu'elles ont adoptées, et la perception des époux par rapport au droit de leur femme à se protéger. Une découverte majeure de cette étude est que, même avec une bonne connaissance du risque d'infection au VIH, la majorité des femmes mariées ont peu ou aucun moyen d'influencer le comportement préventif de leur époux par rapport au SIDA. L'étude conclue que la prévention du SIDA, en particulier auprès des femmes mariées, ne peut se faire que par un changement des normes qui contrôle les rapports sexuels et qui dénient le droit des femmes à conduire leur propre vie sexuelle.

Introduction

Between 1984 and 1997, over 80,000 cases of AIDS were reported to the Ministry of Health in Kenya. Some 1.4 million people including 90,000 children are currently estimated to be HIV positive (Okeyo *et al*, 1998). Almost all of these will develop AIDS and die within the next ten years. About 75% of AIDS cases occur among adults aged between 20–45. AIDS thus affects some of the most productive members of the society. It was projected that the national prevalence of HIV will rise to 10% by the year 2000 (Okeyo *et al*., 1998).

In response to the emergence of AIDS in Kenya, the government decided to establish a national infrastructure under which matters and activities pertaining to the disease could be co-ordinated. In laying down the above infrastructure, the behaviour modification component was put into consideration (Ministry of Health, 1989). Whereas modest success has been achieved in awareness creation countrywide, evidence on the ground suggests that this has not translated into sexual behaviour change among a majority of the population in

both rural and urban areas (Ngugi, 1994). Thus the number of new cases of AIDS has continued to rise although the level of awareness has been increasing. The implication of this is that there is a gap between AIDS knowledge and sexual behaviour change that warrants investigation.

One of the major hindrances to sexual behavioural change as recognised and advanced by HIV/AIDS intervention programmes in Kenya is that sexual negotiations are impaired by unequal gender power relations (Nzioka, 1994). Thus, the question of power relations is central in the behaviour modification strategy. Most HIV/AIDS intervention programmes are yet to adequately address among other issues the role of power relations, and the economic, cultural and social factors that influence and shape sexual behaviour. The socio-economic and cultural situations that women find themselves in, both in and outside marriage continue to put them at great risk of HIV infection (Forsythe, 1996). The dominant social construction of sexuality among most Kenyan communities also seems to put women at risk of HIV infection as it constrains their ability to challenge male domination (Nzioka, 1994).

Large proportions of women who visit antenatal clinics in Kenya have been reported to be HIV positive. Some health facilities in the rural areas report this proportion to be over 20%. A large number of these women are married. Marriage has for a long time been seen to portray patterns of sexual fidelity and provides a norm for social organisation in most Kenyan communities. Indeed, in Kenya the government and other change agencies, particularly those associated with religious groups are making fidelity messages a cornerstone of their AIDS preventive strategies. Since marriage has continued to be seen as more likely to exhibit elements of fidelity, there has been a tendency to view married people as less vulnerable to the epidemic. This perception even seems to have permeated research in the area of AIDS and sexual behavioural change. However, the increasing levels of HIV infection among women, and especially those married, has resulted in an increasing shift in the demographics of HIV infection. This shift is forcing a reassessment of the sexual behavioural change strategies with a view to examining the role of socio-economic and cultural factors in increasing women's HIV/AIDS vulnerability.

The data analysed in this article is based on a 1997 field study conducted among members of the Maragoli community of western Kenya[1]. This is an

[1] The Maragoli are a sub-ethnic group of the Luhya, a Bantu speaking community who form the bulk of the population in the Western province of Kenya. The Luhya are made up of 18 sub-ethnic groups with some variations in language and social cultural practices.

area with high rates of HIV infection, with the proportion of pregnant women infected with the virus rising sharply from less than 5% in 1989 to almost 10% in 1993 (NCPD, 1994). Cultural diversity makes it very difficult to conceptualise Kenyan sexuality[2]. However, most studies conducted in Kenya fail to make specific ethnic group affiliation as units of analysis.

The sample was composed of 156 married women, who were interviewed, and at least 100 married couples who participated in focus group discussions. Key informants were also consulted. The data gathered was meant to establish how married women perceive the risk of HIV infection, the strategies they have adopted for protection; and the constraints inherent in their attempt to influence sexual behaviour related to HIV prevention. There was also an investigation on husbands' perception of the right and responsibility of their wives to protection from HIV/AIDS infection.

For an in-depth exploration, this study integrated both qualitative and quantitative approaches to improve on the interpretation of meaning as well as validity of information. In most African communities, sex is a private, individual, sensitive and taboo subject—one that is not easily discussed. On the other hand, AIDS is a topic charged with emotion ranging from suspicion and doubts to fear and anger (Ulin *et al.,* 1993). This means that sexuality and AIDS involve subjective meanings, which cannot be understood easily without in-depth exploration. For this reason, qualitative techniques were given more prominence in the study. The sensitive nature of the subject, depth of data required and the cultural specificity of the setting rendered concerns about representation and generalisations secondary. The study was not so much aimed at matters of fact or on objective representation of reality, but at more elusive topics of perception, cognition and expression of reality. Therefore, the study adopts a social interpretative approach in analysing data (Berger & Luckmann, 1990). Qualitative data has also been analysed by inferences and discovery procedures as described by Spradley & Mcardy (1975). This involved identification of both tacit and explicit cultural concepts and interpretation of issues related to sexuality and AIDS. Quantitative data was analysed using the SPSS computer programme.

[2] Kenya has forty different indigenous ethnic communities with distinct bodies of cultural social norms and practices. Together with the impact of the policies and infrastructure imposed by the development of the country, their distinct cultural systems channel and limit the range of behaviour including sexual behaviour to be found in any particular social setting. It would therefore be difficult to conceptualise Kenyan sexuality.

Age distribution

Data gathered indicated that women in this population marry and have children after the age of 20 (see table 1). This may be attributed to the wide availability of and interest in education in the area (Oyosi, 1995), which leads to postponement of marriage. Over 55% of the married women are below the age of 30 as compared to about 41% of their husbands. Only about 3.2% of the women are also above the age of 45 years as compared to about 10% of their husbands. This is an indication that majority of these women are in the reproductive stages of their lives, where they are bound to be sexually active. This has implications for HIV/AIDS vulnerability. It can also be noted that women are relatively younger than their husbands, meaning that in most cases women in this community marry older men. As Ochola-Ayayo (1991) contends, such a scenario may have implications for sexual decision-making and freedom because the wives are bound to have less experience when compared to their husbands.

Table 1: Age distribution of married women and their husbands

Age cohorts	Wives		Husbands	
	%	Cum %	%	Cum %
Below 15	0.6	0.6	0	0
15–19	7.7	8.3	1.3	1.3
20–24	19.9	28.2	12.2	13.5
25–29	28.2	56.4	27.6	41.1
30–34	22.4	78.8	26.9	68.0
35–39	12.2	91.0	13.4	81.4
40–44	5.8	96.8	8.3	89.7
45–49	1.9	98.7	5.8	95.5
50 and above	1.3	100	4.5	100
Total	100		100	

Levels of education

Education provides not only basic literacy but also higher level training to facilitate utilisation of and advances in every aspect of life. Indeed, education plays a very important role in AIDS control in the sense that a literate

population has a wider exposure to various sources of information about the epidemic and this may influence interpretation of such information and attitude towards the epidemic. In general, a majority of married couples have at least primary school education. However, the men's level of education was found to be slightly higher than that of women. Only 5.1% of women had at least secondary education and above as compared to 28.2% of the husbands.

The majority of husbands with high education levels in most cases move to towns in search of jobs and other opportunities that give them a higher chance of controlling financial resources. Those who move to town are often young and sexually active men who are vulnerable to HIV infection, putting their wives at risk (Ocholla-Ayayo & Muganzi 1990).

Duration of marriage

About 26.3% of married women in the sample had been married for five years or less while about 21% had been married for over 20 years (table 2). Some marriages had lasted 10 years (49.3%) suggesting that marital instability is not very common in this community. Studies have shown that the longer the marital union the more likely it is for married women to take for granted their husband's sexual behaviour, thus exposing themselves to the risk of HIV infection in the process (Ulin *et al.,* 1993).

Table 2: Duration of marriage

Duration in years	%	Cum %
1–5	26.3	26.3
6–10	24.4	50.7
11–15	16.0	66.7
16–20	12.8	79.5
21–25	10.3	89.8
26–30	5.1	94.9
31–35	3.2	98.1
36 plus	1.9	100.0
Total	100	

Religious orientation

An overwhelming majority of the married women interviewed were Christians with about 84.6% of them being protestants, while 12.8% were Catholics. Muslims accounted for only 2.6%. Religion is very important in HIV/AIDS prevention issues including utilisation of condoms and other contraceptives. As indicated, very few women in this area belong to the Catholic Church, which has openly expressed disapproval of contraceptive use by propagating abstinence, monogamy and faithfulness. Muslims, whose doctrines tend to be against contraceptive use also account for a very small percentage of the population.

Type of marriage

A majority of the married women (96.5%) claimed to be in monogamous marriages. This finding is in line with that of Mburugu (1994), who noted that polygamy is on the decline as it has become unattractive for men to invest in women so as to exploit labour of women and their children, where family land is getting smaller and smaller. Monogamy in this area was also attributed to high cost of living and reduced land size. However, it was observed that the decline in polygamy has to an extent resulted in extra-marital sexual relations on the part of the husbands. Indeed Reid (1995), contends that monogamy can give married women an illusion of safety as far as HIV/AIDS transmission is concerned. Some women interviewed in this area revealed that they could not be certain that theirs were monogamous marriages because they sometimes suspected their husbands of keeping other "wives" elsewhere especially in towns.

Occupation

Data shows that a majority of the married women (86.5%), were mainly involved in agricultural activities with few of them considering themselves as housewives. However, the few who considered themselves as housewives did not entirely depend on their husband's income since they got some income from agriculture. Men appeared to be involved in outdoor activities represented by paid employment, various commercial enterprises and *jua kali*[3]. This translated into male control of financial capital. The higher economic

[3] *Jua kali* is a Swahili phrase which literally means hot sun. It was adopted by the informal business sector to mean business undertaken in non-formal settings.

capability of men has always been associated with their dominant social positions (Gital *et al*., 1994).

Only 5.8% of women were in formal employment as compared to 31% of their husbands. In most cases, formal employment is obtainable away from home, mostly in major towns. Due to land pressure, those left in rural areas in the agricultural sector do not produce much. This means that husbands who are more likely to be either in formal employment or involved in other outdoor activities are in a position to control more financial capital than their wives. Such wives are more likely to be dependent on their husbands, a factor that may have implications for sexual decision-making and protection against HIV/AIDS infection (Gupta, 1994). Indeed it has been argued that the concentration of women in occupations like agriculture in Sub-Saharan African countries has reduced their exposure to information thereby negatively influencing their perception of risk of HIV infection.

Table 3: Main occupation of married women

Occupation	Percentage
Formal employment	5.8
Self-employment	3.2
Self-help activities	4.5
Agricultural activities	86.5

Table 4: Husbands' main occupation

Occupation	Percentage
Formal employment	19.9
Business/jua kali	7.7
Odd jobs	10.9
Agricultural activities	61.5

Knowledge of AIDS

Awareness

A large number of respondents reported to be aware of AIDS with 96% of them having heard or known of the existence of the disease. These findings are in line with other studies conducted in the general population in Kenya which indicate high awareness of HIV/AIDS (Ministry of Health, 1996). However, this general awareness about AIDS does not necessarily translate into essential knowledge of the disease. This is because awareness may not necessarily have a significant relation to knowledge (Nzioka, 1994).

Knowledge on causes of AIDS and modes of transmission

Responses on causes of AIDS indicated an overlap between causes of AIDS and modes of transmission. A significant number of women attributed causes of AIDS to behavioural patterns such as prostitution, sex with HIV infected people, contact with AIDS patients and sexual deviation. AIDS was also attributed to other causes such as witchcraft, curses and contaminated air, all of which featured less frequently. This shows that respondents were not clear on the cause of AIDS as most were more concerned about its transmission rather than the virus behind it.

Whereas there was general awareness of the major modes of transmission of HIV/AIDS as shown in table 5, the mention of mosquito bites, curses, handshakes, witchcraft and breathing contaminated air shows that misconceptions about HIV/AIDS transmission still exist. The role of pre-natal transmission seems to be unclear to most married women. Some studies have shown that in communities where child mortality is high, there is a high probability that pre-natal transmission of HIV is not known to most women (Ulin *et al*., 1993). However, in this study, the reason may just be a gap in knowledge of transmission because the area has low child mortality (Oyosi, 1995).

Table 5: Modes of transmission spontaneously mentioned by sample of married women

N = 149 for all responses

Mode of transmission	Frequency	%
Sexual intercourse	143	96
Blood transfusion	89	60
Use of unsterilized needles	131	88.2
Mother to foetus	12	38.4
Kissing	31	21.2
Shaking hands	10	7.2
Contact with AIDS victims	29	19.6
Breathing victims air	12	8
Mosquito bites	27	7.8
Curses/witchcraft	5	3.4
Sharing	5	4.8

Focus group discussions revealed various areas of consensus and contradiction on issues related to the transmission of AIDS. Women seemed to be well aware of the risk posed by sexual contact with an infected person and some offered striking explanations of how unwary partners may be infected. Whereas explanations were given for the transmission of AIDS in a network of sexual relationships, women tended to describe husbands as the link between women on the outside and wives at home. Married women according to the Maragoli normative structure, were not expected to be involved in extra-marital sexual relationships. The implication here is that it is the "other woman" and not the wife who is responsible for the sexual transmission of HIV/AIDS. In effect, men were often portrayed as vectors of the disease, oblivious of the consequences of their sexual adventures. Although it was acknowledged that extra-marital affairs of married women may also lead to sexual transmission of HIV/AIDS, most discussions supported the notion that wives were less likely than their husbands to have liaisons outside the home.

The role of infected blood in HIV transmission was well understood although there seemed to be misconceptions and exaggerations. There was extreme worry about injections that people get in the mushrooming private medical clinics in the area. There was concern that incompetent nurses or doctors might use unsterilised needles. Respondents confessed to having

deliberately refused to go to hospital or to bringing their own injection needles each time they visited a health facility. A 52-year-old woman expressed her fears saying:

> "*When I go to the hospital, there are these young girls who sneer at me. I fear one day these girls will give me AIDS through an injection. Soon I will refuse to be injected*".

Concerns about infected blood also surfaced in other ways ranging from the plausible to the impossible. Considerable thought was given to the risk of transmission through casual relationships that might involve contact with infected blood or other body fluids such as kissing and transfer of saliva although this was seldom associated to the presence of sores, or cuts. These can allow passage of blood from an infected to an uninfected person. The same kind of reasoning applied to the risk of touching an open lesion or washing an open wound in water used by an HIV infected person. Such segments of the discussions as given below are typical of the divergent opinions expressed by women on this issue:

> "*If you swallow saliva from a man with AIDS then you get it*".

> "*No, to get AIDS through kissing you will have to have a cut in the mouth. It is not the saliva but the blood that gives people the disease*".

Spontaneous discussions raised the possibility that AIDS transmission might be a result of malevolent forces. Thus, the issue of supernatural transmission emerged with an assertion that a person with AIDS may curse someone else to get it. However, a majority of the other respondents disagreed with this kind of assertion. Some respondents also insisted that those who practice witchcraft could "transfer" the disease from one person to another. Such issues of natural causation of HIV/AIDS featured more frequently among women of no education or the elderly.

Causation and transmission of HIV/AIDS was also attributed to a violation of what the community considered to be cultural norms governing sexuality such as pre-marital sex and extra-marital sex. A 53-year-old woman put it this way:

> "*AIDS is nothing but a form of punishment from God. People have become adulterous and promiscuous. This disease never used to be there. If you are immoral you just get it, it doesn't matter what you do.*"

In discussions, vertical transmission of HIV from an infected mother to the unborn infant was rarely mentioned. When discussions turned to issues of vulnerability and consequences of AIDS for the family, only then did a few

women volunteer the information that unborn babies could be at risk. However they could not give adequate explanation as to how this comes about.

Whereas misconceptions and confusion exist among married women on modes of transmission of HIV/AIDS, they featured less frequently than the major known modes of transmission. Married women in this area, however, wrestle with logic of many fragments of information, some valid, others partly true or distortions of actual facts, others with no scientific basis. Some respondents expressed confusion or uncertainty in the face of so many conflicting notions:

> "*This disease is hard to understand. Sometimes they say prostitutes give it. Other times they say men, other times blood and mosquitoes. I think nobody really knows what causes AIDS*."

Misconceptions and confusion about the mode of transmission of HIV/AIDS featured more among the less educated women than those with higher education. This supports the argument that education has an influence on both acquisition and interpretation of health information (Mbatia, 1996). On the other hand, younger women were more likely to have sufficient knowledge as compared to older ones. Such findings were also obtained by Ulin *et al* (1993), in a study among Haitian women. He attributed this to high level of mobility of younger women which exposes them to more information. At the same time, he noted that married women who have a long duration of marriage may not be curious enough to obtain information about HIV/AIDS. The misconceptions about modes of transmission of HIV among married women as revealed by this study is partly due to the fact that people are bombarded with a lot of information, from which they cannot make sense (Nzioka, 1994).

Understanding of the consequences of HIV/AIDS

Although the level of awareness and knowledge of HIV/AIDS among married women in this area is relatively high, the response in protection measures will depend on factors such as a clear understanding of the consequences of HIV infection, its preventive measures and personal beliefs about vulnerability. Corrorano (1992) argues that even if people have knowledge of HIV/AIDS they may not necessarily take preventive measures unless they are aware of such measures and consider themselves at risk.

For most women, AIDS was regarded as a disease to be feared. The consequences of AIDS were usually expressed in terms of inevitable death and the suffering the disease would occasion. Many spoke of the economic costs when the breadwinner dies, the break up of the family unit, poverty, destitution, ostracism, abandonment and even the spread of the disease to other family members. The possibility of social rejection as a consequence of AIDS was taken very seriously. To most women, the disease is equated to epilepsy whose victims in this community were usually isolated and stigmatised. Women alluded to the stigma suffered by a person with AIDS, which is also usually extended to the rest of the family members. Some feared AIDS because of the gossip that would ensue upon their death. A segment of discussions as below is typical of women's concerns about this issue;

> "*I would not like to die strangely and have my children go through misery later when people ostracise them by telling them that their mother died of AIDS*."

The stigma attached to AIDS as expressed by these married women has implications for both control, management and care of people with AIDS. It inhibits free discussion on the disease and also prevents people from willingly confessing to their seropositive status (Ngugi, 1994). Undignified burial was also viewed as one of the consequences of AIDS. It was said that people who die of AIDS in this area are not given dignified burials. It is common for the dead in this community to be treated with a lot of respect and complete burial rites performed. For a confirmed HIV victim, people would fear moving near the body. In the words of one woman, "*one is just planted like a cassava*". Further inquiry revealed that apart from the fear that by moving close to the body one may contract the disease, people who die of the disease are viewed by a majority of people as having been immoral. The treatment they get in death may be equated to what is done to those who commit suicide in the community.

The pre-occupation with economic costs/loss and social consequences for abandoned children exceeded most women's concerns, a reminder perhaps of many women's dependency status for survival (Berer, 1993). Women held almost similar views on the risks and consequences of AIDS, regardless of differences in characteristics such as age, education and occupation.

Do married women perceive themselves to be at risk?

A sample of married women was asked whether they thought women like themselves could be infected with AIDS. About 49% of them answered positively. When asked which persons are most likely to get AIDS, a majority of women (69%) said prostitutes, 36% mentioned those with many sexual partners, while 39% mentioned young people. Worth noting was that only 34% mentioned that anybody can get AIDS. Responses are summarised in table 6.

Table 6: Persons less likely to contract AIDS

N = 149 for all responses

Persons	Frequency	%
Faithful people	86	58
Those with one partner	68	46
Young people	5	0.4
Children	53	36
Religious people	26	18
Married people	58	39
Old people	35	24
Those not promiscuous	64	43

The implication of the findings shown in table 6 is that there is still a belief among a large number of married women that those people unlikely to get AIDS are those faithful to their partners (husbands). Such a belief can give them a sense of security against HIV infection.

In focus group discussions, women did not strongly concur that anyone can be infected with AIDS. There were those who felt that there were exceptions to this rule. Some qualified their opinions by statements such as:

"*Why get scared of AIDS when you do not fool around*"

"*If your husband is good you can't get it*"

"*It is immoral people who get it*"

There was, however, cautious optimism among many women about their safety. Although most tried to assert their own responsible behaviour and

faithfulness, there was less convictions about the latter. They always tried to allay doubts about their husbands. Comments from married women showed their painful awareness that one can never be sure of the HIV status of her husband. However, individually it seemed that many women volunteered that their husbands are faithful to them, but the underlying consensus seemed to be that men cannot be trusted. There were cases where women tried to personalise the issue of trust, by persistently stating that they themselves did not engage in extra-marital affairs but they had misgivings about their husbands. Interestingly, the women still considered their faithfulness as making them less vulnerable to the HIV virus. Such findings are consistent with the arguments of Berer (1993), that monogamy gives married women an illusion of safety from AIDS infection. It was common for women who expressed fears of getting AIDS not to mention their husbands as the likely sources. When they spoke of their fears of contracting AIDS, they were more likely to refer to injections, mosquitoes, accidents and blood transfusions, rather than spouses. Married women tended to deny their own vulnerability.

HIV preventive strategies

The curability of AIDS

While 79.5% of the sample of married women believed that there is no cure for AIDS, 10.4% said that it can be cured while at least 10.1% were not sure. Over half (54.5%) of those who believed that the disease is curable attributed such cure to traditional medicine. However, these respondents were not aware of any particular traditional healer who was known to cure AIDS. This did not stop them from giving some examples of people in the neighbouring districts whom they alleged to be known to treat people with AIDS. Furthermore, they seemed unaware of any individual who had been healed by such medicine men.

Almost all the other remaining respondents who felt that AIDS is curable attributed such cure to spiritual healing. That through prayer, one can easily be cured of AIDS and they gave examples of evangelists whom they claimed cure to have cured people with AIDS. Some even attested to have witnessed HIV/AIDS victims confess that they had been cured by such evangelists.

It is evident from the findings of this study that a majority of married women in this area are aware that there is no recognised cure for AIDS. Strong beliefs in spiritual healing, traditional medicine and any other kind of supernatural healing may be retained by people, regardless of accessibility to information

that consistently stresses on the incurability of AIDS (Reid, 1995). This may explain the findings of this study in the sense that almost all those who feel that there is a cure for AIDS attribute it either to traditional healing or traditional medicine. Such strong beliefs in traditional and spiritual healing were expressed by two women as given below:

"*There is nothing God can not do. There is no disease he cannot cure. God can finish all diseases.*"

"*There are many diseases Europeans can't cure. AIDS has defeated them. This is where the medicine for the black man beat them.*"

The women who felt that AIDS is curable were most likely to be either those with little or no education or those over 40 years of age. This may be understood in the sense that those with little or no education may not have access to information. At the same time, elderly people are more likely to be religious and to believe in traditional cures (Ulin *et al*., 1993).

Understanding of HIV/AIDS preventive measures

Just as a majority of women were aware that AIDS has no cure, they were also aware that the disease is preventable. While 14.1% felt that the disease is not preventable, and 2.4% were not sure, about 83.5% felt that there were preventive measures that can be taken against HIV/AIDS infection. Those who felt that the disease cannot be prevented seemed to show an expression of despair about HIV prevention, which could be an indication of both the gap in general knowledge of AIDS, especially the modes of transmission and prevention and women's powerlessness. The statements given below were gathered from interviews and discussions, and were typical of the feelings of some women on HIV/AIDS prevention.

"*The disease is like an accident you can't stop it*"

"*This is a punishment from God, only God can save us*"

"*Nobody has ever understood this disease, so who can stop it?*"

"*People who have this disease do not have identification marks on their foreheads. You never know when you get it.*"

Various methods of prevention were spontaneously mentioned as shown in table 7.

Table 7: Modes of prevention mentioned spontaneously

N = 124 for all responses

	Frequency	%
Monogamy/faithfulness	92	74.5
Condom use	50	41.0
Immunisation	1	1.4
Prayer	24	20.0
Carrying needles to hospitals	28	23.0
Avoiding injections	5	4.8
Avoiding small clinics	12	10.0
Avoiding blood transfusion	14	12.0
Not sharing food with victims of AIDS	17	14.0
Avoiding company of people with AIDS	24	20.0
Going to church/prayer	22	18.0

The data in table 7 shows that a majority of women are aware that monogamy/faithfulness is a means to protect oneself from HIV infection. Over 74% mentioned faithfulness and monogamy as preventive measures. Less than half mentioned condoms as preventive strategies. Most of those who mentioned condoms were those below the age of 25 years and the newly married. However, this does not necessarily mean that these women use condoms.

Strategies that would ensure protection against transmission through contaminated blood featured less prominently. In general, it could be deduced that despite misconceptions, a majority of married women in this area are aware of the major modes of prevention of AIDS which include faithfulness and condom use. Whereas less than half believed that condoms can be used for protection, this may not imply that they lack information to the effect that condoms can be used, but it may be due to their attitudes and experiences about condom use in marriage.

Preventive strategies adopted by married women

Most married Maragoli women believe that AIDS can be prevented. 83% among them reported to have taken preventive measures against infection while 17% said that they had not. However, it should be noted that even those who may not have taken any preventive measures against AIDS may have still said they did, so as to give a positive picture of themselves. Therefore the statistics presented may not be a true reflection of the proportion of those who have taken measures against HIV infection.

Faithfulness was the main preventive strategy to have been taken as it was mentioned by almost all those who initially reported to have taken preventive measures. Other preventive measures mentioned included carrying needles to hospital, avoiding people with AIDS, avoiding quack doctors and prayer. No woman mentioned condoms as being used for HIV/AIDS prevention, perhaps an indication of the unpopularity of condom use in marriage.

Women's role in adopting HIV/AIDS behaviour

This section examines various factors which may have a bearing on married women's ability to adopt HIV preventive behaviour in their marital relationships as well as to influence their husbands. Whereas there are non-sexual modes of transmission of HIV/AIDS, the study was restricted to sexual behaviour with a view to identifying the conflicts and contradictions between old Maragoli norms of marital sexual behaviour and the new prescriptions for change. Among such prescriptions for change include mutual responsibility and the rights of either partner to protect themselves from HIV infection (Reid, 1995).

Husband-wife communication about AIDS

Husband–wife communication is an important tool of sexual negotiation. Through such communication a married woman can express her desires, fears and opinions as regards HIV prevention to her husband (Elyne, 1997). Without proper communication between husband and wife, it becomes very difficult for a woman not only to adopt preventive behaviour herself but also to influence the husband to do the same.

Of the 156 married women interviewed, only 37% responded positively to discussing AIDS-related issues with their husbands. Those who reported discussing such matters were among those with high school and post-high school education as well as those with stable incomes evidenced by formal employment. Younger women with short marital durations were also more likely to discuss such matters than the older women. The discussions were, however, rarely held as only 7% reported that they frequently had discussions. Such discussions were usually initiated by men (62%); 18% were initiated by women and 20% by both men and women. The implication here is that for the few cases where HIV/AIDS matters are discussed, it is always the husbands who initiate the discussions. The women who reported that they do not discuss AIDS matters with their husbands gave various reasons for this as shown in table 8.

Table 8: Reasons for not discussing AIDS matters

N = 93 for all responses

Reason	Frequency	%
A dreadful disease not to be discussed	37	40
Fear of contracting it	20	22
Husband doesn't like to talk about it	37	34
Can create conflict/problems in marriage	43	47
Husband has no time to talk about it	31	34
Husband can be violent	11	12
There is nothing to discuss about it	12	12

From the spontaneous responses elicited it was evident that mistrust/conflict in marriage was the major reason why married women did not talk to husbands about AIDS. A large number of women also fear that discussing AIDS can lead to infection. For others, either the husband had no time or did not like to talk about it. Violence from the husband came last among the reasons given for not discussing AIDS.

The issue of conflict and mistrust as a reason for not discussing AIDS in marriage was explored in detail. A woman who introduces matters of AIDS to a husband, was thought of as portraying herself as one who is very experienced

in sexual matters and there is a negative attitude towards such women. One women succinctly defined this in saying;

> "*Married women should stick to their husbands and stop talking about things they know nothing about. They will be considered the know it all. They will have to say who gives them lessons on AIDS*".

The above statement is significant as it shows that women are often made to believe that it is men who are knowledgeable in sexual matters. It shows that a woman who discusses AIDS to her husband may be considered promiscuous. This may be the reason why even in cases where women reported that they discuss AIDS matters with their husbands, it was always the husband who initiated the discussions. For purposes of maintaining "harmony and understanding" in marriage, women would rather not talk about AIDS.

Some women gave various reasons why they claimed that some men/husbands do not have time to discuss matters related to AIDS. Cases of alcohol abuse in this area are common. Most husbands who are involved in '*jua kali*' activities and other non-formal jobs usually imbibe local brews as a matter of course. Under the influence of alcohol, such men are unlikely to introduce discussions on AIDS unless in accusing their wives of infidelity. Introducing AIDS matters to a drunken husband, some women claimed, can lead to violence.

Some women also felt that to most husbands, AIDS matters are not a priority. Most would say that they have no time to discuss such matters and go ahead to justify this by expressing their concerns about school fees and food. Most women were, however, in agreement that the main reason why most men would not like to discuss AIDS matters is because such discussions may hit too close to discussions of their own extra-marital affairs. For those women whose husbands work away from home, communication about AIDS matters is even more difficult. Such husbands come home only for a short time. Introducing a topic on AIDS to such a husband could lead to problems of mistrust. In the words of a respondent;

> "*If a husband come home from Nairobi and you start talking to him about AIDS he may think you suspect him of having affairs with prostitutes back in Nairobi*".

It is, therefore, clear that married women in this area have certain desires and fears about HIV prevention but rarely express them to their husbands. Most women would rather share such views and experiences with their female peers. Discussing AIDS is seen as a source of conflict in marriage. There is also a

general feeling among women that they are more likely to be blamed for marital conflicts arising from matters of sexuality.

Wife's response to husband's infidelity

Central to the battle against AIDS is the need to empower women (Schoepf, 1993). However, married women may only be empowered when they have a major concern about their husband's other sexual relationships and when husbands are sufficiently apprehensive of that concern to change their behavioural patterns. Whereas both male and female infidelity is not uncommon in the study area, just as in most African communities (Berer, 1993), there was a general consensus among both men and women that husbands are the most likely culprits. Table 9 summarises some of the major actions that would be taken by married women in case of a husband's infidelity.

Table 9: Likely actions to take when husband is unfaithful

N = 140 for all responses

Action	Frequency	%
No action	27	19.5
Don't know/not sure	15	11.0
Complain/confront him directly	44	31.5
Use third party relative to talk to him	74	53
Abandon/divorce him	14	10.5
Separate from him	18	13
Refuse to have sex with him	9	6.5

Women who may suspect their husbands to be unfaithful in this area have minimal options. The most likely option would be to approach a third party in confidence and request them to talk to the husband. Such persons are usually relatives who would be older than the husband. The next most likely option would be to directly complain/confront the husband, a strategy which often has negative consequences for the wife (Nzioka, 1994). Abandonment, divorce, separation or refusal to have sex were less likely options. Some respondents admitted that there was nothing they could do, while others were not sure of what they would do. When the husband's unfaithfulness was

associated with the risk of transmission of AIDS, the responses from married women as regards the action to be taken changed slightly as shown in table 10. Some women reversed their positions concerning what action they would have taken and even went ahead to challenge their husbands' sexual domination.

Table 10: Likely actions to take when husband puts wife at risk of AIDS infection
N = 140 for all responses

Action	Frequency	%
No action	5	3.5
Don't know/not sure	10	7.5
Complain/confront him directly	85	59.5
Use third party/relative to talk to him	68	49
Abandon/divorce him	28	20.5
Separate from him	32	23.5
Refuse to have sex with him	21	15.5
No response	13	9.5

Berer (1993) notes that even in societies where male infidelity has been taken as a fact of life by married women, with the emergence of AIDS, some have started to take steps that challenge male sexual domination. However, there is always a limit to the actions they can take due to the resultant consequences, hence reducing their ability to adopt appropriate HIV preventive behaviour as well as influence their husbands to do the same.

Direct communication and insistence on fidelity

As mentioned earlier, it was found that matters related to AIDS/HIV infection are rarely discussed by married couples. This may present problems of communication about the need to adopt HIV/AIDS preventive behaviour where women are more disadvantaged than men (Elyne, 1997).

Although most women felt the need to express their concerns about their husband's infidelity through such means as direct verbal communication, this study shows that very few actually dare to take such a step. In fact, there was a general consensus among them that a woman would be better off complaining

about a husband's infidelity without introducing her concerns about AIDS to him[4].

About 74% believed that married women in general had a right to verbally communicate to their husbands their concerns about infidelity. Those opposed to this showed their belief in the Maragoli traditional values, which restrains married women from confronting husbands directly in complaining about infidelity. As it was expected traditionally, it is such women who were most likely to advocate for the use of a third party rather than express their concerns directly. Explaining the Maragoli traditional values related to marriage, Wagner (1949), noted that a woman who confronted the husband directly accusing him of infidelity risked condemnation for being disrespectful. This study also established that there are other negative reactions that such a step may elicit. Such reactions may not only come from the husband but also from other members of the society especially the husband's immediate family members. Some of the major possible reactions mentioned are summarised in table 11.

Table 11: Possible reactions to married women's direct expression of concern about husband's infidelity

N = 136 for all responses

Reaction	Frequency	%
Husband's bitter denial	72	53
No change of behaviour	86	63.5
Change of behaviour	10	8
Withdrawn economic assistance	66	49
Condemnation from husband's family	52	38.5
Physical abuse	29	22
Forced separation/divorce	28	21
Worsened behaviour	58	43

One of the most likely reactions from the husband is denial[5]. Women, as we learned, are not expected to know about their husband's sexual behaviour outside the home. Even if a wife had proof of a husband's infidelity, it is

[4] Such findings were also documented by Ulin *et al.,* 1993.

[5] See also the findings of Ulin *et al.,* (1993), Tuju (1996), Nzioka (1994) and Topouzis (1993).

always very difficult for the husband to accept wrongdoing. Statements such as the following were common in the discussion on this issue;

"*Even if you catch him red-handed, he will always find ways of denying it.*"

Whereas verbal communication is meant to make the husband appreciate the wife's concerns about the need to change his behaviour, the feelings amongst most women was that behaviour will not change. A significant number indeed felt that behaviour would worsen, as the husband would either want to silence the wife or prove his superiority. The married women's passivity compared to the men's active role in the control of sexuality is very clear in these findings. While women are expected to be passive, responsive and receptive in sexual dynamics, men are expected to be active and aggressive initiators of the sexual activities.

The inability to communicate to husbands about their infidelity and fear of risk of HIV-infection was also attributed to withdrawal of economic assistance. Whereas most studies show that power restructuring is becoming an important dynamic between husbands and wives due to the market economy (ATRW, 1992), the economic and social status of most women in the study is still low. The market economy in this area has only managed to raise economic power for a few married women who can seek independence by opting out of the subordination by male heads. For example, whereas women are expected to be submissive to their husbands even in matters of sexuality, there are those who are capable of buying their own land, to which they have unlimited access and control. Such women are relatively well educated and they have the confidence and ability to be free from dependence on the prevailing patriarchal structure. For majority of those women who depend on their husbands, the threat of being denied economic assistance makes them complacent. Such women will not dare talk to their husbands about infidelity and the need for behavioural change to avoid HIV/AIDS infection.

Interestingly it was noted that efforts by married women to directly express their concerns about their husbands' infidelity may elicit negative reactions from the husbands' family members. This is because the husband is most likely to confide in his relatives such as his elder sisters or aunts. More often than not, such relatives will not approve of the wife's action and may greatly influence the husband to take drastic measures against the wife. To avoid living in a hostile social environment, married women remain silent about their husbands' extra-marital sexual affairs at the risk of HIV/AIDS infection. Most husbands would always pre-empt any attempts by their wives to report them to the very relatives.

Physical abuse, forced separation and divorce were also mentioned as possible reactions although they elicited very low responses. Cases of physical abuse, divorce and separation were low in this area Oyosi, 1995. Some husbands would beat their wives who confronted them with accusations of infidelity. They might also forcibly send the wife away from the home for some time. However, few men divorce their wives especially when there has been a long marital duration, dowry paid and there are several children from the marriage. Although dowry payment as a practice is not as strong as it was in the past (Wagner, 1949) it still binds a wife to her husband. Furthermore, contrary to practices in the past, divorce of a wife may not necessarily be followed by the return of bride wealth. Due to the importance given to the need for women to be married, women will always try their best to maintain harmony in the marriage and avoid divorce. Condoning a husband's infidelity is one of the ways of maintaining harmony in a marriage and reduces the ability of influencing adoption of HIV/AIDS preventive behaviour.

Even for those women who could confront their husbands about infidelity, introducing the issue of AIDS was not easy. AIDS is a subject charged with emotion ranging from suspicion and doubt to fear and anger (Ulin *et al.*, 1993; Nzioka, 1994). A husband may accuse the wife of being unfaithful herself and at the risk of HIV infection. Some husbands would even resort to violence. Further, probing revealed that for most married women, even if the husband infects them with any other sexually transmitted disease they would never confront them directly. They may seek treatment and remain silent about it or use a third party to warn the husband. The latter option does not always work. This is because the husband may accuse the wife herself to be source of the disease. Therefore, it can be summarised that the major reasons why married women do not directly communicate with their husbands about infidelity and fear of HIV infection are:

- need to maintain their economic base,
- marital harmony and
- established norms that govern husband–wife relationships.

The use of a third party

Most married women agreed that the use of a third party was better in expressing their concerns about their husbands' infidelity though not necessarily an effective one. As a strategy, the use of a third party is a remnant of traditional Maragoli values (Wagner, 1949). In the past, it was unacceptable for a married woman to confront her husband with accusations of infidelity. According to a 71-year old key informant,

> "*A good wife should approach an elderly person who is a relative of the husband and share with her/him her grievances. It is this person's role to talk to the husband and warn him not to bring diseases to the home.*"

The findings of this study showed that this strategy may not necessarily work for most women. It may backfire if the husband accuses the wife of exposing their private lives. Without a better option, most women would rather suffer in silence. At the same time, the use of a third party may not necessarily guarantee sexual behavioural change in the husband. Whereas the normative structure among the Maragoli people prescribes that the third party be used, findings of this study indicate that for the most part, relatives of the husband are more inclined to condone his extra-marital affairs, the older the party, the greater the likelihood that they would side with the husband. Such parties may also not necessarily show their disapproval of the husband's behaviour but only express the wife's concerns. It is also very easy for the husband to convince such a third party that the wife's concerns are not genuine.

Church elders were considered by some women as possible intermediaries between them and their husbands. These findings show the church has a role in changing sexual behaviour. However, as we found out in this study, the problem with this strategy was that most men may claim to belong to certain religious groups but in practice do not go to church. Even if they go to church, they may be very hesitant to involve religious people in their private lives. Thus, whereas women may opt for the church as a mediator, this strategy is also not very effective.

Conflicts in marriage arising from sexual matters in this area are sometimes brought to the attention of the clan or village elders who convene "*barazas*" for resolution. Village elders (*amagutu*) take an active role in the settlement of such matters. Interestingly, it was found that rarely do matters of a husband's infidelity get to such a level for resolution. Asked to comment on this, one village elder (*ligutu*) said;

> "*A husband's life outside the home is his own business provided he does not spoil people's*

young daughters."

Often, it is when the wife is accused of infidelity that such matters are brought to the attention of elders. This shows a bias in favour of male infidelity perpetuated and condoned by a male-dominated society. Therefore married women aggrieved by husband infidelity rarely venture to use *barazas*. Most married women regard their sexual lives as private and would not wish such matters to be brought to the scrutiny of the public. Secondly, taking the initiative to bring such matters to the public may destroy the harmony in the home. Thirdly, and very significant, was the issue of male superiority in the said *barazas*. In such meetings, it is likely that proceedings would be controlled by men who are likely to be biased against the women aggrieved. An AIDS educator in this area expressed her sentiments thus;

"*In this area, women feel that freedom is given to men to do whatever they want. Any problems that emanate from marital sexuality will always be blamed on the wife.*"

This depicts a grim picture of the role of a third party in married women's ability to influence their husbands' marital sexual behaviour in HIV/AIDS prevention.

Insistence on condom use

Condoms are seldom used in marriage (Ulin, 1993; Nzioka, 1994; Tuju, 1996). It is very difficult for a married woman to convince a husband to use a condom if she feels there is need to do so. Indeed a married woman may never have any justifiable reason to request a husband to use a condom, not even for HIV prevention. As Nzioka (1994) argues, the few occasions when condoms are likely to be used by married couples in this area, are for family planning purposes and not disease control. Women in particular, had various concerns about the use of condoms, namely; their acceptability and effectiveness for HIV prevention, a woman's right to ask a husband to use them and the kind of response that women anticipated from their husbands.

Data gathered showed that almost all women were aware that condoms can be used for HIV prevention. However, a significant number were concerned about their effectiveness. Some, fearing transmission through saliva, doubted that condoms would be adequate protection. Others questioned the quality of condoms and the possibility of perforation and tears. Some even alleged that in fact, condoms are in fact laced with the HIV/AIDS virus. However, according to most women an even greater deterrent to condom use was the

immoral connotation and the view that men would never accept to use them. Condoms are always associated with immorality and casual sex. Very few women, for example, agreed that they would go looking for condoms even if they needed them. One woman retorted:

"*You go to a chemist to buy condoms and everybody would think you are a prostitute.*"

The differences of opinion that polarised women's focus group discussions showed the problems associated with condom use as a means to protect themselves from HIV infection. The responses tended to follow a pattern in which women at first agreed that any woman has a right to protect herself from AIDS. But then, they began to raise stringent conditions under which "any" woman could properly propose the use of condoms.

A minority of women stated flatly that there were no women who would ask their husbands to use condoms. However, among most of them, there was a feeling that some women had a right to ask their partners to use condoms. A criterion on which most agreed was that the woman was to be certain of her risk. The woman with this right is she who knows that her partner is "fooling around". Married women were, however, not expected to ask their husbands to use condoms on them. Interestingly some married women said that a married woman who fears that her husband ran the risk of HIV infection should advise him to use condoms on the "other woman" but not on his wife. Other women who are considered to have a right to ask for the use of condoms were prostitutes and schoolgirls, neither of whom, it was pointed out, would wish to be burdened with children. Women considered as those without a right were those in long-term relationships (marriage) and those whose husbands may wish to have more children. Several women observed that Christian women need not bring up the subject of condoms because Christian men do not have sexual affairs with other women. Two common elements that stand out in the criteria above are sexual freedom and fertility—traditional values that are now threatened by the risk of HIV/AIDS.

In considering sexual freedom, it is noted that women who request the use of condoms may in essence be questioning their husbands' fidelity and, thus be seen to challenge the validity of the double standards that govern the marital relationship. For example, an irony in the "rules" that some women suggested that should determine a woman's right to ask for condoms is that women are not supposed to know whether their husbands are frequenting prostitutes or having affairs with other women.

It was established that fertility was a competing value that often overshadowed disease prevention as a priority in decisions about sexuality[6]. First, it was apparent that the link between condoms and contraception was more familiar than the link with disease prevention. Secondly, focus group participants who tended to deny women the right to insist on condom use frequently turned to the rhetoric of family planning to find culturally acceptable metaphors to justify the use of condoms for AIDS prevention. They felt that it was easier to convince a promiscuous husband to accept the use of condoms under the guise of family planning than confront him with the more threatening issue of AIDS prevention.

Married women in this area cannot be said to take lightly the public health prescriptions on condom use as a precaution against AIDS. Some understand and can accept the preventive value of condoms, but there are costs, that for most, outweigh the benefits. Aside from their own misgivings about condoms and their safety, women were very sceptical and even apprehensive about the reaction of husbands to such a proposal. In the group discussions they recommended that women in general should demand the use of condoms if they could not trust their partners. However, when asked how the same men would react, their opinions varied from the firm belief that "men who are not beasts" will agree, to an equally strong view that few, if any men, will even be willing to use condoms, especially with their wives.

Women who took the more negative stance on the issue of partner response to condoms were more numerous and more vocal. For the most part, their concerns centred on issues of denial and trust. They contended that men refuse to admit to having other partners and instead, turn the blame on their wives. They would want to know why they are being asked, whether it is because the woman herself is sick or her own behaviour is putting her at risk. Suggesting to a husband to use condoms, some women said, provokes him to accuse the woman of having other "husbands". If he wishes to take her request for condoms as evidence of infidelity he may respond with physical abuse, withdrawal of economic assistance/support or divorce. Fear of physical abuse was not a major theme, but fear of abandonment or economic neglect and social condemnation was. Women in this area could easily be manipulated by men who had the power to deprive them of resources for basic survival. Men who did not get what they wanted could retaliate by withholding money for food, clothing and childcare. Women who do not work have no right to

[6] see also Ayayo, 1991; Ayayo & Muganzi, 1990.

make demands. Women with jobs have such rights because they have other options for themselves and their children. Reacting to the right of a woman to ask for the husband's use of a condom, one woman said:

> "*If the husband is making money and you are not, he never pays much attention of you, but if both people are working, the woman is worth something. I have experienced this in my own house, and I realise that my husband would not treat me the way he does if I had a job.*"

Comments such as the above take the problem of AIDS prevention to a more basic level, to the direct link between women's fear and frustration in the face of the epidemic plus a sense of powerlessness to control their own lives. For women, money was as much a symbol of freedom as it was a material resource for achieving independence from male domination. Without access to income, they lacked the self-esteem and the financial security to be full partners in critical decisions that could enhance their chances of survival in the epidemic. One such decision is the right to demand the use of condoms for HIV/AIDS prevention.

Sex and women's control of access to their bodies

Majority of married women in the study had no control over access to their bodies by their husbands. Despite many comments to the effect that discovering a husband's infidelity would justify refusal to have sex with him due to the threat of AIDS, refusing sex still seemed to be a relatively new and even a frightening idea for most women. It was indeed an unusual occurrence in marriage. It was evident that denying a husband sex may not be a very practical option but it was perceived by some women as a bargaining tactic to force a husband into responsible behaviour. Much as women may give reasons such as illness, menstruation, fatigue or pregnancy as reason for abstinence, the general opinion was that a married woman can never have sufficient reason to deny the husband sex. Furthermore, the mention of fear of risk of HIV infection or husband's infidelity as reasons not to have sex with him could be very counter productive.

Asked if they could refuse to have sex with their husbands if they suspected them of infidelity, 18% of women said they could, 78% said that they could not, while 4% were not sure. Those who said that they could not, gave reasons like forced sexual intercourse, physical abuse, abandonment, or lack of material support. The major reason was, however, that such a step may inversely make a husband worsen his behaviour. It was generally believed that the husband

will try to get sexual gratification elsewhere. Group discussions expressed sentiments as follows:

"*Refusing sex does not help you. You will send him to prostitutes and he will not change*."

When asked if they could refuse to have sex with their husbands if they feared that they could be infected with the HIV/AIDS virus, 30% of the women said that they could while 70% said that they could not. However, discussions showed that some were confused over the issue as they felt that temporary sex refusal may protect them from their husbands. Further statements and comments from the women also showed that in practice, they cannot take this step due to the consequences that may follow. Interestingly, some women felt that it is a woman's duty to ensure her husband's sexual gratification, no matter what her feelings. Failure to do that was synonymous to abdicating one's role as a wife. This and the fear of breaking up the marriage, denial of economic assistance and subjecting the husband to more risk leads to women's lack control over access to their bodies.

Male Perspectives of Women's role in influencing HIV/AIDS Preventive Behaviour

Position of women in household decision-making

The way husbands perceive the role of women in household decision-making processes, may also influence their perspectives on women's role in sexual decision-making and adoption of HIV/AIDS preventive behaviour (Berer, 1993). In general, there tended to be an ambivalence from men as regards household decision-making. With respect to household duties, majority of the men felt that it is wrong for wives to depend completely on husbands' authority for everyday decisions such as cooking and childcare. They argued for example, that once a husband provides money for household expenses, the wife should decide how to spend it, provided "she carried out her responsibilities to his satisfaction". However, the examples men gave to illustrate men's satisfaction belied their support for women's rights to make even ordinary decisions. The following segment from discussions is typical of the expressions of men on issues of household decision-making. It displays that decision-making frequently seemed to mean compliance on the part of the woman rather than actual independence.

"*It is not always good for a husband to decide what the wife should cook. The wife should decide but she should ensure that what she cooks is what the husband would like to eat that day.*"

Statements in support of joint decision-making were similarly couched with terms that suggested that men are supposed to make decisions and women to agree. Decisions, which husbands believed should be made in this fashion, were for example those related to use of family planning methods, whether and where to send children to school and whom their children should associate with. While in general men wanted to be consulted about a service that required payment of fee, opinion favoured granting the wife the authority to act in emergencies with the understanding that she would inform the husband of her actions at a later date or time.

Interestingly some men believed that women should make their own decisions in household matters but they felt that husbands assume the authority because women expect it of them. One man quipped:

"*Sometimes the husband becomes the sole decision-maker because of the wife. Even if you try to decide things together, she always has it in her mind that your decision comes first. Whatever you do is right. Of course some women who are tough don't like that, but they think they are supposed to give you the right to act.*"

Generally, men in this area do not believe in women's authority in decision-making in the household. Such a concept of decision-making authority could be extended to sexual decision-making.

Sexual freedom and women's rights

Majority of men spoke of monogamy as ideal, but they also accepted multiple sexual relationships as a fact of life, at least for men. There was a tendency for them to assume a double standard that grants sexual freedom to men and denies women the right to question their husbands' sexual activities. They frequently prefaced their remarks with "if" clauses, for example. It was common to hear them say;

"*If the wife suspects the husband of having another woman*" … or

"*If she realises that you move dangerously*"

What such statements imply is that it is not normal for women to know about men's sexual affairs but that they sometimes find out. On the other hand, men were emphatic that a wife has no right to have any man apart from her husband. Although some men and women tended to speak from personal

experience on many issues under discussion, men were less likely to believe or admit that their own wives might be unfaithful. When they alluded to the possibility of their wives infidelity; they did so in terms of a man's power to control a woman's behaviour. These findings contrast the remarks of many married women that they (or women like themselves) could not trust their men, knew little or nothing about their partners' extra marital activity and felt powerless to control their behaviour outside the home.

There was a tendency for men to describe women who showed concern about their husband's sexual activities as being disrespectful. A good wife they claimed, should concentrate on taking care of children and looking after the husband. One quipped;

> "*When a wife starts to follow her husband around to find out what he does outside the home, she doesn't know what marriage is all about.*"

Women with knowledge of sexual matters were referred to as "loose or immoral" by some men. According to a 60-year old key informant,

> "*When a wife starts to know things about sex and love, then you know she is heading in the wrong direction. The next thing she will become is a prostitute.*"

In general, the way most men seem to perceive female sexual freedom is what the society expects of them. Women should not be assertive in sexual matters. Men expected "loose women" to have multiple partners, but this norm did not apply to a married woman by custom or law. Men warned that even in marriage, women required surveillance and discipline as argued by one male focus group discussant;

> "*When a man comes home from town, he has to enquire from those around him, including neighbours, to find out whether his wife acted in any immoral manner during his absence*".

In the same way as most women, men also seemed to be aware of the chain of transmission and men's position as the link between HIV-infected women and their wives at home. However, there was a tendency by some men to defend their freedom in this regard. Men's defence of their freedom indicated the influence of traditional values related to marriage and parenthood on their attitudes towards female sexuality. For instance, some argued that when a wife is not able to conceive or give birth to sons there is nothing wrong for a husband to try and get the children elsewhere. However, for some men, in particular those with post-secondary education, this was not a justification for men's extra-marital sexual relations. They seemed to be aware that the ability to bear sons may not necessarily be attributed to the wife alone. However, the

general consensus was that society may condone extra-marital sexual affairs on such grounds.

From the foregoing, irrespective of their educational level and other individual characteristics, men tend to express opinions that indicate that women should not have sexual freedom. They tend not to recognise women's rights and responsibilities in challenging male sexual domination.

Right to withdraw from sexual relations

The extent to which women are able to control access to their bodies is critical in their capacity to protect themselves from contracting AIDS. Men tried to debate circumstances under which married women have the right to refuse to have sex with their husbands and the reaction they might expect from their husbands. Sharp differences of opinion polarised the discussions showing the struggle men have to resolve, that is, a basic contradiction between the right to demand compliance and the right for women to refuse.

One perspective more common among men was that wives who are well treated by their husbands actually have no reason to deny them sexual gratification. Good treatment of wives in this case mostly meant material provision and financial assistance. For the most part, however, some men tended to grant women the right to refuse sex under certain conditions. Such men who expressed a relatively confusing attitude would say "*you have to try and understand the reason why she refuses*". However, the central position was that there are circumstances that justify a woman's refusal. Fatigue, ill health, family planning, hunger, unhappiness and financial neglect were some of the circumstances mentioned but with little enthusiasm. Although men made little direct reference, positive or negative to women's economic dependence, they acknowledged the unhappiness of those who feel neglected or abandoned by men seeking their own pleasure.

Even though participants in group discussions tended to agree that most men would overlook wives' occasional refusal, their comments also offered numerous examples of valid objections by a man to such decisions on the part of the woman. Frequent disclaimers such as "*women have a right to refuse but…*" revealed the difficulty men had as they struggled to resolve competing issues of freedom and responsibility. There was clearly a limit to most husbands' tolerance of rejection.

Refusing to have sex because of a partner's promiscuity provided a different kind of justification from refusal due to temporary indisposition like menstruation or fatigue. Almost without exception men concurred on the danger of sex with many partners and agreed that women have a right to protect themselves from AIDS. The men were aware of women's concerns about the threat posed by the husband's sexual freedom as in this man's comment below:

> "*The wife can refuse to sleep with the husband if she notices that he goes with other women. She might think that if the husband has sex with another woman, he could get infected, and also give it to her. She could take the precaution of avoiding sex with him that day.*"

The above statement is significant because:

- it represents the view of most men, that when a married woman discovers that sexual contact with her husband puts her at risk of HIV/AIDS, she has a right to protect herself. Even those men who had earlier condemned women who refuse to have sex for trivial reasons, reversed their position.
- the issue of refusal now takes on a temporal dimension. The comment above seems to suggest that a woman's decision to refuse sex is relatively recent, linked to the appearance of a new disease and a fear that did not exist in the past.
- the phrase "*she can avoid sex on that day*" raises a question about the understanding of transmission. It shows a lack of understanding on the nature of risk.

Those men who felt that women had a right to refuse sex with husbands who put them at risk of HIV infection also had reservations. They warned that such a strategy could easily backfire, leading the husband to accuse her of infidelity, and provide him impetus to be even more promiscuous. It is noted in the previous sections that women also tended to have such fears. Some men openly expressed their opinions that refusing sex may ultimately threaten the stability of the whole family. Classic examples of such opinions are expressed in segments as given below:

> "*If the wife refuses to have sex, the husband could sleep with anybody who will give him AIDS, which he will bring back home to the wife.*"

> "*The family can be destroyed when the husband leaves the wife because of sex. He may think that she has sex with another man. Yet the woman may be refusing for another reason*".

Most men had a tendency to blame the wife for creating problems that could lead to HIV infection. Men's (il)logical conclusion on this issue therefore seemed to be that a woman who refuses sex is actually increasing the chance that her husband will be infected by other women. By assuming the customary role of a compliant nurturing wife, she supposedly solves the problem with no cost to domestic harmony, helping to preserve the balance of power that sustains a man's sense of freedom. This perspective seems to be analogous to the anxiety which the women frequently expressed concerning the retaliatory behaviour of an angry husband who "*can always go to other women*".

Married women's protection from HIV infection

Men in focus group discussions could not agree on how married women should protect themselves from HIV infection, especially from their husbands. When issues of the wives' right to protection were raised, the spontaneous discussions that emerged centred on how married women can prevent infection from sources other than their husbands. In such discussions that tended to turn the focus away from husbands, men would give various protective prescriptions for married women. They stressed the need for wives to be faithful to their husbands. A few ventured to mention the use of condoms as a last resort. They were also likely to mention other non-sexual modes of prevention that are related to blood as a channel of transmission.

When discussions centred on the possibility of HIV infection from the husband various areas of agreement and disagreement emerged. Opinions on sex refusal as an option for married women were the same as those discussed in the previous section. The general agreement was, however, that refusal to have sex may not work. The insistence by some men that this method could be used by married women for HIV/AIDS prevention from their husbands was always supported by remarks that showed lack of knowledge of HIV transmission by such men. This is because they were likely to prescribe such a method but still insist that it could only be temporary.

The use of condoms came up as a possible option for HIV prevention, with men expressing their opinions about its use by married women. Discussion on condoms provoked controversy among men, just as it did among women. In general, men view condoms as an unfortunate but sometimes necessary alternative to giving up one's sexual freedom. However, they almost all concur that married women should not expect their husbands to use condoms on them. Like the women, most men recognise the value of condoms in AIDS

prevention, but some questioned their reliability and the right of married women to demand their use. In their remarks about condoms, just like the women, men frequently combined contraception and disease prevention and sometimes shifted the focus of discussion to family planning. Not surprisingly, they appeared more at ease putting the emphasis on contraception, not disease prevention. In fact, some men suggested that a woman who is trying to convince a husband to use condoms "might be lucky" if she uses the argument that having fewer children will enable them to provide food and pay fees for those they already have. Most said that it would be "inappropriate" to attempt to use condoms if the couple did not have "enough" children. Thus, in the eyes of men, women who wish to avoid pregnancy may be "lucky" in convincing a husband to use condoms.

Most remarks on this topic also suggested that the longer the duration of marital union, the less power women have to initiate behaviour change. For instance, men argued that a long-term wife who suggests using condoms would by so doing, shatter the "understanding" that has sustained their marriage. To raise the issue seemed to many men like an admission of guilt. A woman with "good behaviour", who is faithful and respectful in the presence of her husband, will not ask, because she will not want him to use condoms lest he conclude that she is HIV-positive or has another man. Men commonly remarked that if one partner brings up the subject after many years in a stable relationship, the other will have a right to begin asking questions, as they were not used to condoms. Men occasionally alluded to distrust and fear of disclosure that a woman might cause by raising the question of condoms. However, the possibility of inciting anger and retaliation were mentioned much less in discussing condom use than in similar discussions of refusal to engage in sexual activity. Despite their negative attitude towards condom use, a majority of men felt that condom use may be appropriate for a wife whose husband has openly confessed to be HIV-positive. However they were quick to add that most men would never want their wives to know about their HIV status. There were also expressions of misgivings about the reliability and ability of condoms to prevent infection.

Many men claimed to believe that with discretion and tact, women can induce men to reflect on their lifestyles and consider behavioural change in order to protect their wives against HIV-infection. They admitted, however, that this is not easy. Avoiding condom use, for example, may be sufficient incentive to convince a man to give up his extra-marital affairs, or he may be willing to use a condom if the alternative is losing his wife. In either case, the

men seemed to have been drawing from their knowledge of women's bargaining skill to make the point that at least some men can be convinced. One man offered his opinion:

> "*Men will have to do some thinking about their lives. They should avoid prostitutes. If their wives suggest they use condoms it is because they are aware that AIDS is a dreadful disease.*"

Some men acknowledged that women with no hope of influencing promiscuous husbands who would put them at risk of HIV-infection could either leave them temporarily or permanently to make a point that they must change their behaviour. However, this argument is flawed for two reasons. For one, for many women with no means of subsistence, there is no middle ground between living in the shadow of infection and both their own and their children's destitution. Secondly, temporary separation, even if it makes a husband change his behaviour may not guarantee safety to the wife if the husband is already infected.

Whereas men were more likely to emphasise confrontation rather than collaboration, the majority point of view was that men have to compromise if their wives discover their sexual exploits.

Conclusions

Throughout this paper, marital sexuality among Maragoli women of western Kenya, in the context of the HIV/AIDS risk has been discussed. It has been shown that there is a gap between AIDS knowledge and the adoption of desirable preventive behaviour. Despite the inaccurate and distorted views about AIDS, married women have a relatively high knowledge of the disease. However, they lack the capacity to adopt as well as influence marital sexual behaviour related to HIV/AIDS prevention. Monogamy and faithfulness to husbands gives some the illusion of safety, while to others, their powerlessness to act puts them in a state of personal vulnerability, denial and consequently at the risk of HIV infection.

One of the major barriers to married women's efforts to effect positive behaviour change in HIV/AIDS prevention is their subordinate economic status. There was a positive relationship between women's powerlessness and their dependence on husbands for subsistence. We have also shown that the socio-cultural values governing marital sexual behaviour among the Maragoli are an obstacle to married women's ability to influence HIV/AIDS preventive behaviour. In this community, sexual freedom and the double standards that

support it represent deeply rooted gender differences in sexual decision-making. Whereas the normative structure seemed until recently to maintain the precarious balance of power between men and women, it cannot work with the threat of AIDS.

It is the main conclusion of this paper, therefore, that HIV prevention, especially among married couples can only be achieved if both men and women come to grips with the need to change norms that control sexual relationships and deny women the right to determine their sexual lives. Normative change calls for radical intervention as it takes the problem of HIV/AIDS prevention beyond individual behaviour to societal level. At the societal level, it will require strategies to empower women economically and a basic change in cultural definitions of sexuality and gender relations.

There is urgent need for HIV/AIDS strategies to be revised. HIV/AIDS surveillance, education and condom distribution programs must continue with even greater support and determination. However, a fourth component, namely, normative change must be addressed. This approach would infuse current AIDS prevention activities with empowerment-oriented strategies which put AIDS in the context of women's sexuality and social status. The blueprint for action must, therefore, not only be informing, educating and motivating, but also enabling. This would certainly slow the spread of AIDS among married women.

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