Addressing Intimate Partner Violence among Pregnant Women in Kenya: From Observation to Intervention

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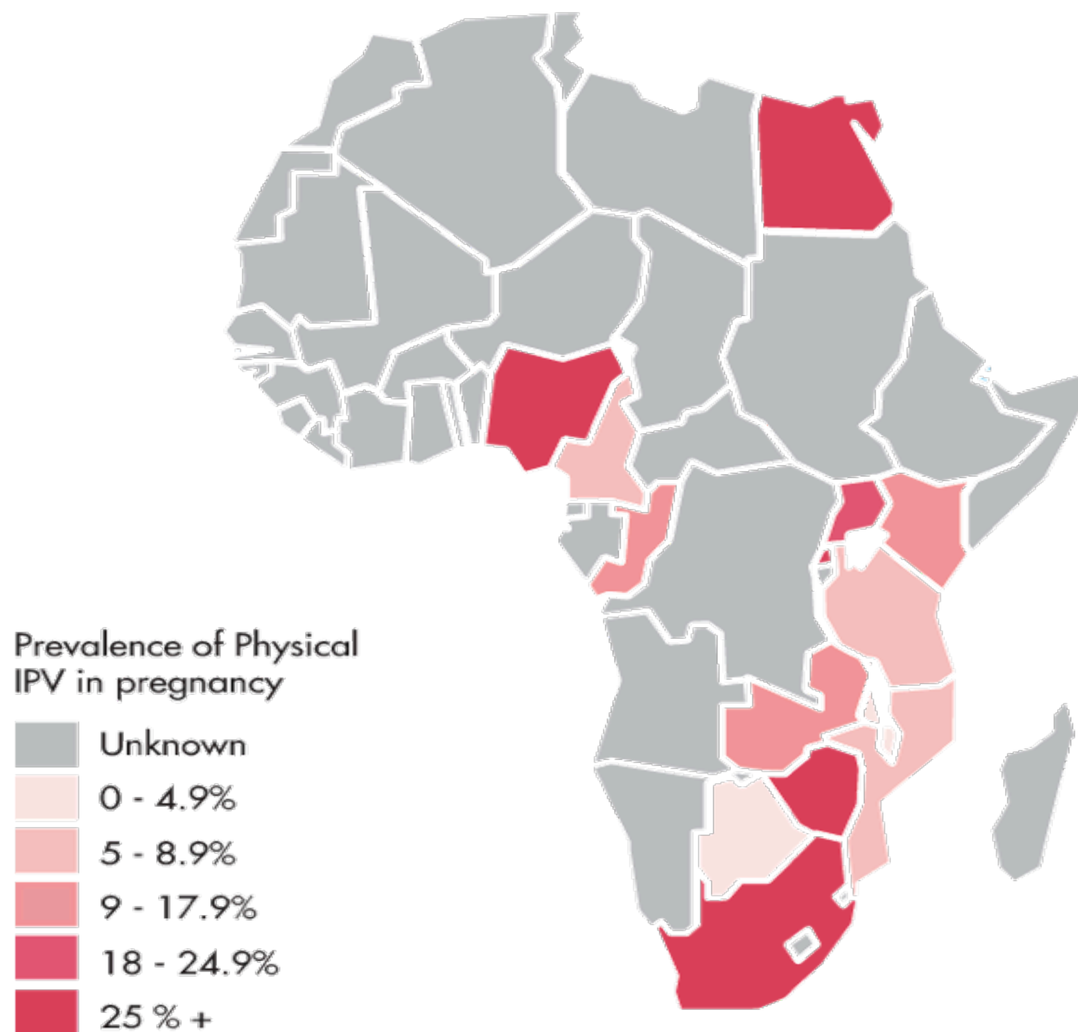
In sub-Saharan Africa, between 2% to 57% of women experience IPV during pregnancy (1), an estimate that is higher than most other regions globally (2)



1. Shamu S, et al. (2011) PLoS One; 2. Devries KM, et al. (2010) Repro Health Matters.

IPV among pregnant women leads to:

- Miscarriage, pre-term delivery, induced abortions, stillbirths [a]
- Stress, depression, anxiety [b]
- Lack of fertility control [c]
- Worse uptake of prenatal care [d]
- Poorer HIV testing uptake [e]
- Non-adherence to HIV medications [f]

a. Okenwa L (2011), Martin SL (2006) b. Ludermir AB (2010), Rodriguez MA (2008); c. Pallitto CC (2004), Martin KR (2010), Miller E (2010) d. Perales MT (2009), Heaman MI (2005), Lipsky S (2005); e. Medley A (2004), Turan (2011),Tchendjou PT (2011); f. Mepham S (2011), Lopez EJ (2010), Rose RC (2010)

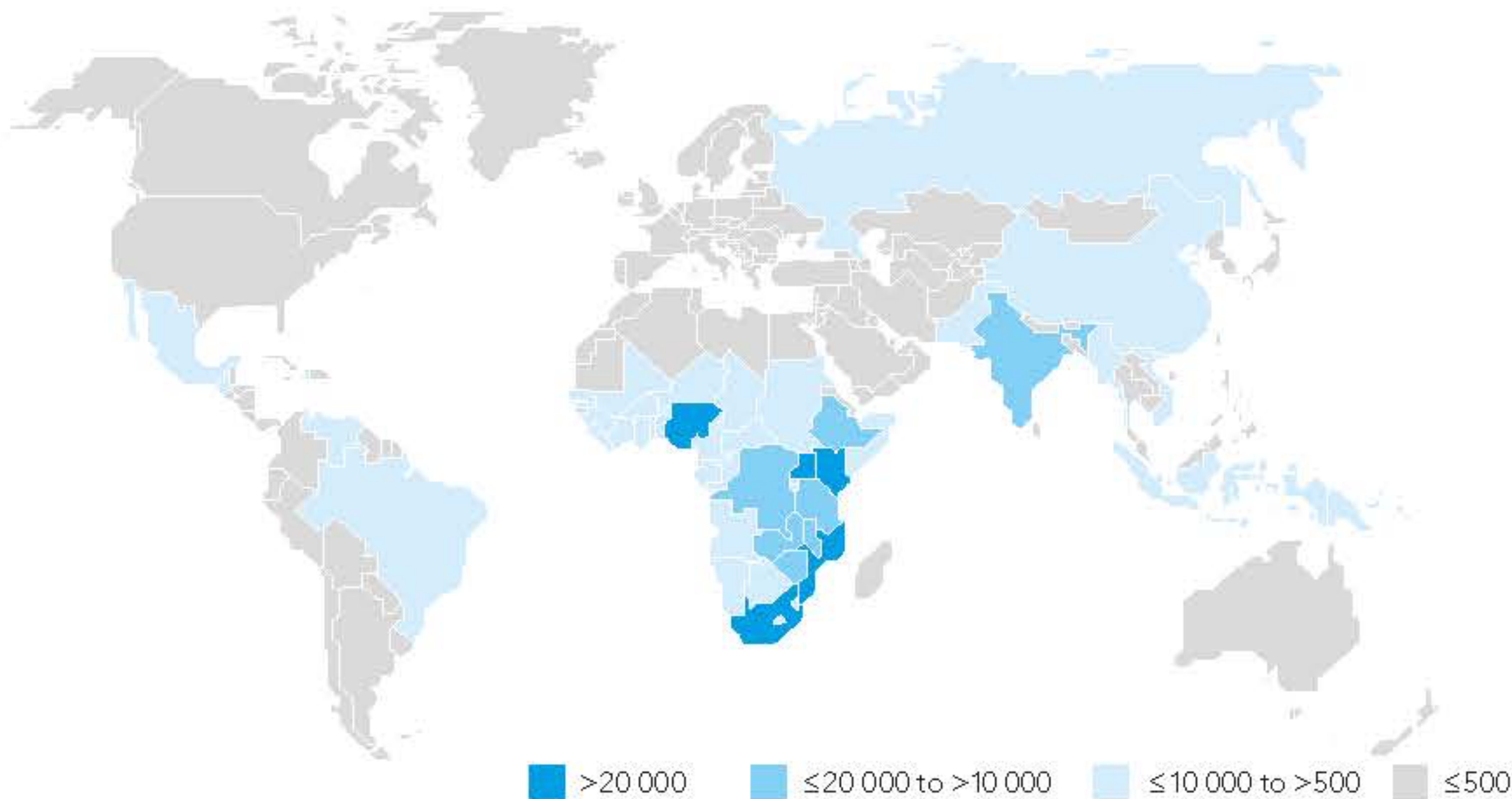
Kenya Background

- HIV prevalence: 6%
- 1.6 million people are HIV positive
- HIV infection 3 times higher among women aged 20-24 years than men the same age group

Mother-to-Child Transmission (MTCT) of HIV

- HIV can be transmitted from mother to child:
  - During pregnancy
  - During labor and delivery
  - During breastfeeding
- Without intervention, the overall MTCT rate is **15-45%**
- In industrialized countries the rate of MTCT has been reduced to **1-2%** though use of antiretroviral medications by HIV-infected pregnant women
- Goal is to ELIMINATE new infections among children and KEEP THEIR MOTHERS ALIVE

Kenya is one of several countries with high mother-to-child transmission of HIV (MTCT)



UNAIDS (2011) Global plan towards elimination of new HIV infections among children by 2015

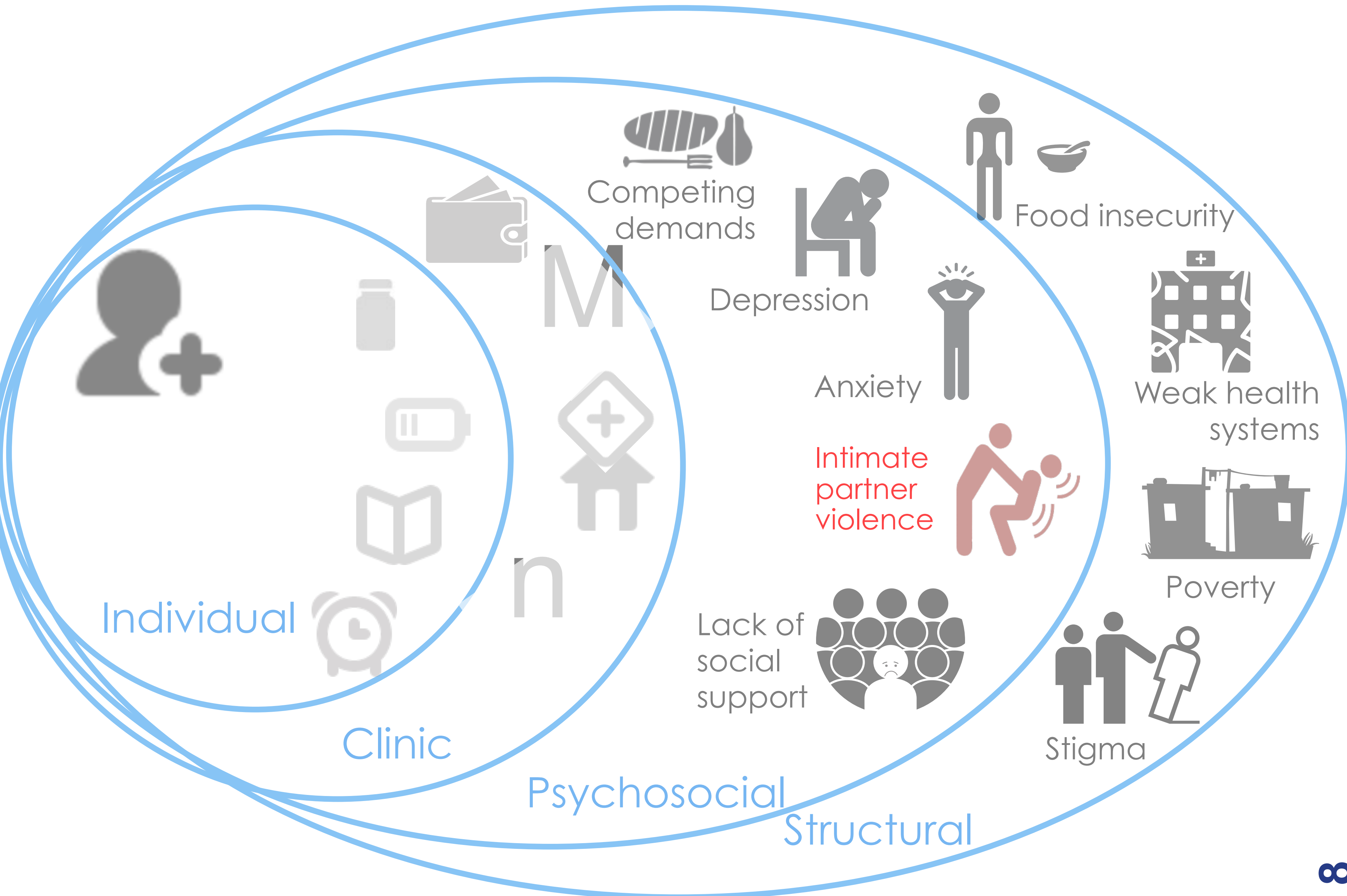
Kenya Background

IPV worsens women's ability to adhere to HIV prevention and care

- Women who anticipate male stigma or violence twice as likely to refuse antenatal HIV testing [1]
- Women who fear violence or a relationship break-up are less likely to enroll in HIV care [2]
- HIV-positive Kenyan women are twice as likely to experience GBV than HIV-negative counterparts [4]

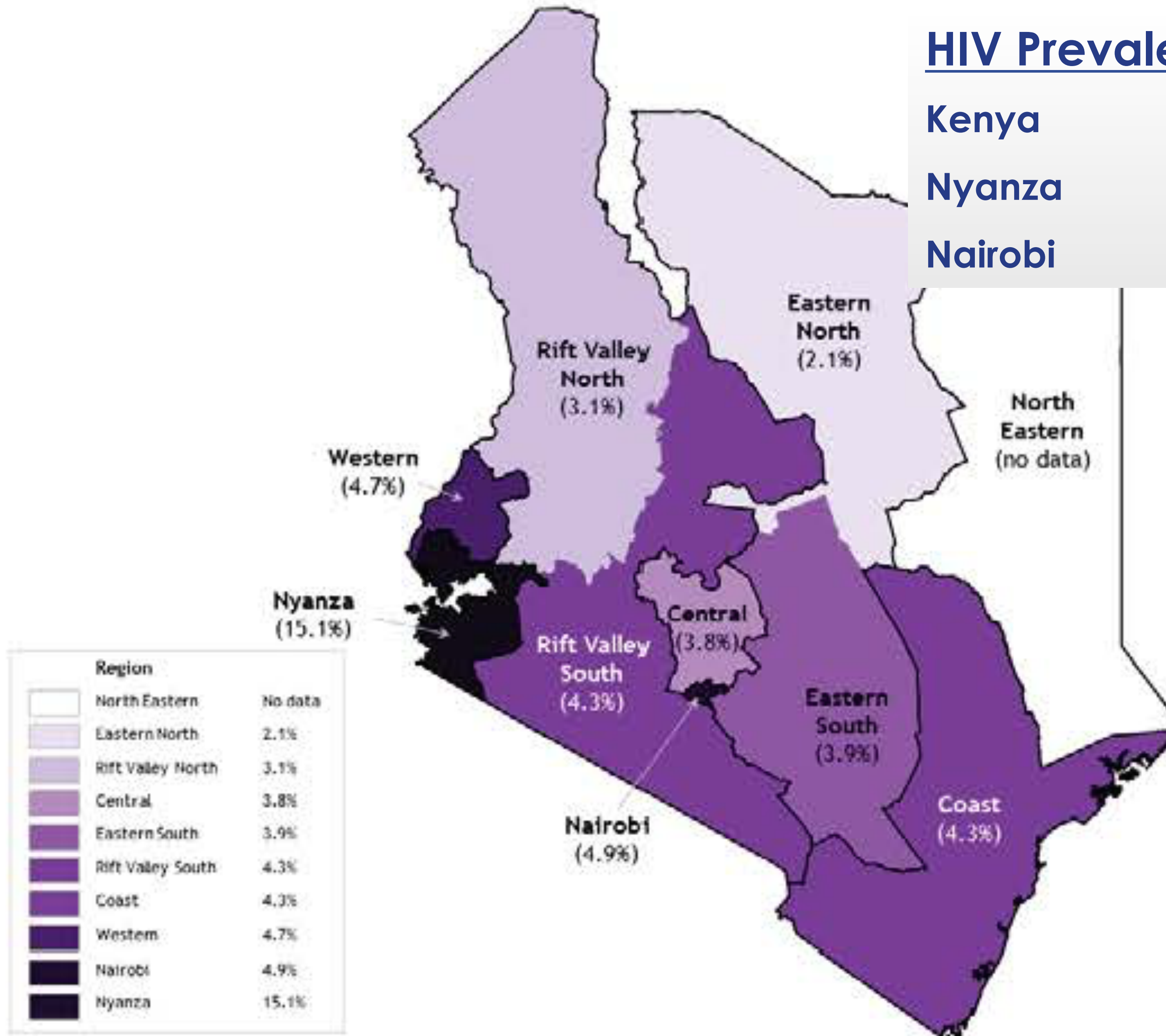
1. Turan (2011) Aids & Beh, 2. Hatcher (2012) Aids & Beh, 3. Ahmed (2006) AJPH, 4. Fonck (2005) Aids & Beh

Women face many barriers to PMTCT



Setting: Nyanza Region

Nyanza Region has higher HIV than elsewhere in Kenya



HIV Prevalence KAIS 2012

Kenya	**5.6%**
Nyanza	**15.1%**
Nairobi	**4.9%**

Kenya Background

Nyanza Region also has higher rates of IPV than elsewhere

Province	Percentage who have ever experienced physical violence since age 15[1]	Percentage who have ever experienced sexual violence[1]
Nairobi	28.5	14.5
Central	34.1	19.5
Coast	31.8	16.4
Eastern	33.3	17.4
Nyanza	56.6	31.6
Rift Valley	35.6	19.0
Western	44.5	24.7
North Eastern	31.9	5.8

- Source: Kenya Demographic Health Survey (2010)

Research platform

- A Kenya Medical Research Institute (KEMRI)-UCSF Collaboration
- PEPFAR-funded
- Provides HIV-related services, training, and research in the former Nyanza Province, Kenya
- Works closely with the Kenyan Ministries of Health

Examining Pregnancy, HIV-related Stigma, and IPV in Kenya

Qualitative Pilot Study	Observational Study	IPV screening/ referral pilot	Integrating IPV prevention pilot
The effects of HIV on utilization and provision of maternity services in Kisumu	Maternity in Migori and AIDS Stigma (MAMAS Study)	*The Gender-Based Violence (GBV) Study*	The effects of a home-based couples intervention to enhance PMTCT and family health in Kenya (Jamii Bora Study)
2006	*2007*	*2010*	2014
UCSF Center for AIDS Research	*U. S. National Institute of Mental Health*	*UCSF Center for AIDS Research*	*U. S. National Institute of Mental Health*

Major Conclusions from Initial Qualitative Pilot Study*

- Uptake: Fears of HIV testing and unwanted disclosure cause women to avoid ANC clinics and health facility deliveries

- Quality: Health care workers' fears of HIV infection and resultant stigma negatively affect the quality of care

*Turan et al., *AIDS Care,* 2008. Turan et al., *Journal of Obstetric, Gynecologic, and Neonatal Nursing (JOGNN),* 2008.

Observational Study

The MAMAS Study

Maternity in Migori and AIDS Stigma Study

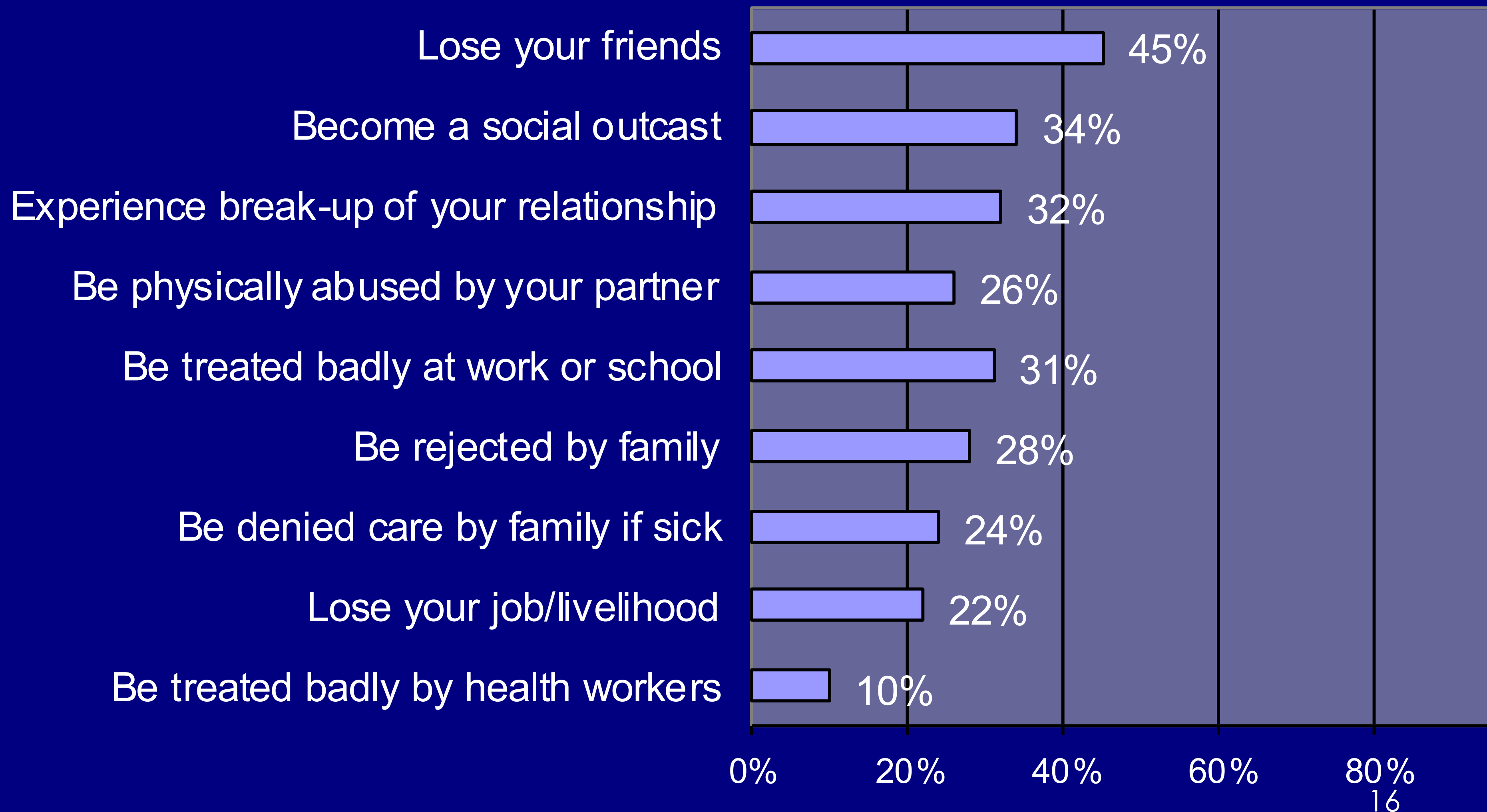
Investigating the relationships between women's perceptions and experiences of HIV/AIDS stigma and their use of essential maternity and HIV services

- 1 777 pregnant women who didn't know their HIV status were interviewed before their first ANC visit
- 614 were followed-up in late pregnancy and after the birth

Funded by US NIH/NIMH R34MH102103

Observational Study

Rates of anticipated HIV/AIDS stigma among pregnant women were high



Observational Study

Stigma increased women's Refusal of HIV Testing

- Women who anticipated male partner stigma were more than twice as likely to refuse HIV testing, after adjusting for other individual-level predictors*
- Other variables in the model:
  - Anticipated stigma from other family members (ns)
  - Anticipated stigma from other people (ns)
  - Total perceived community stigma score (ns)
  - Knowing someone with HIV (OR =.52)
  - Lack of knowledge of male partner's HIV testing status (OR=1.77)

* Turan et al., AIDS & Behav, 2011.

Observational Study

Partner response to HIV testing and disclosure was a major concern

"There are those who normally chase away their wives saying that they should just go, because he already thinks that the child is also having the disease. He will threaten to beat you up so your heart will be troubled because you have the disease, you are pregnant, and the man has chased you to go back to your home, all those will be painful. There is one story I heard about ...that a man beat up his pregnant wife recently when she went to the clinic and was found with the virus."

(Pregnant Woman)

Observational Study

Intimate partner violence was a clear priority for future work

- In the MAMAS Study, 27% of women experienced violence from a male partner during pregnancy or after the birth (n=475).
- Intimate partner violence during pregnancy was related to women's voluntary and forced migration (being sent packing).*
- This led us to develop an intervention study focused on IPV in the same setting.

*Turan, Hatcher, Romito, et al., 2015, *Global Public Health*

IPV study

To develop, implement, and evaluate an IPV intervention based at health care facilities used by pregnant women

* Adapted from WHO (2010) *Preventing intimate partner and sexual violence against women: taking action and generating evidence.*

Establish Relationships with Key Partners; Define Nature of Problem

- Methods:
  - Meet with local health leadership to assess relevance of GBV.
  - Focus Groups with:
    - Pregnant Women (n=29)
    - Male Partners or Relatives of Pregnant Women (n=32)
    - Health workers (n=16)
  - In-depth interviews (n=20) with
    - Ministry of Health
    - Ministry of Gender and Social Services
    - Non-governmental orgs
    - Health Service Providers,
    - Police and Judiciary
    - Community leaders

Social Context and Drivers of IPV*

"If the husband knows that they have tested [for HIV] they might be beaten, like now if the mother attempts to mention that 'I was tested and you are supposed to go for the same', the mother can end up being chased to go to her motherland …. So you see most families break."

(Health service provider 6)

*Hatcher et al., 2013, *Culture Health and Sexuality*

Women's Responses to Intimate Partner Violence*

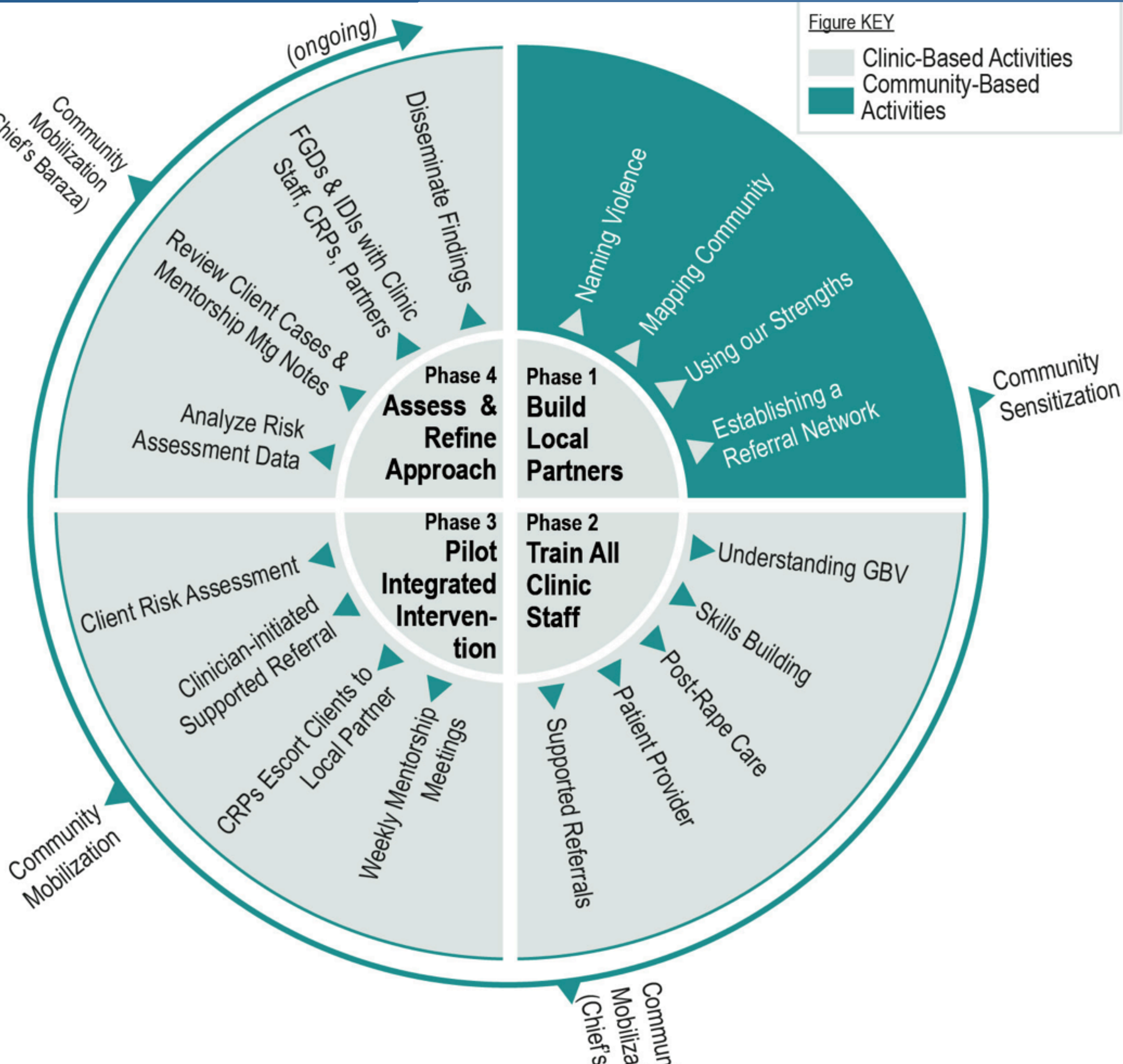
*Odero et al., 2014, *Journal of Interpersonal Violence*

Identify effective programs; Develop policies & strategies

- Methods:
  - We convened a 2-day Stakeholders meeting in rural Nyanza
  - We developed an intervention plan using formative research and stakeholder input

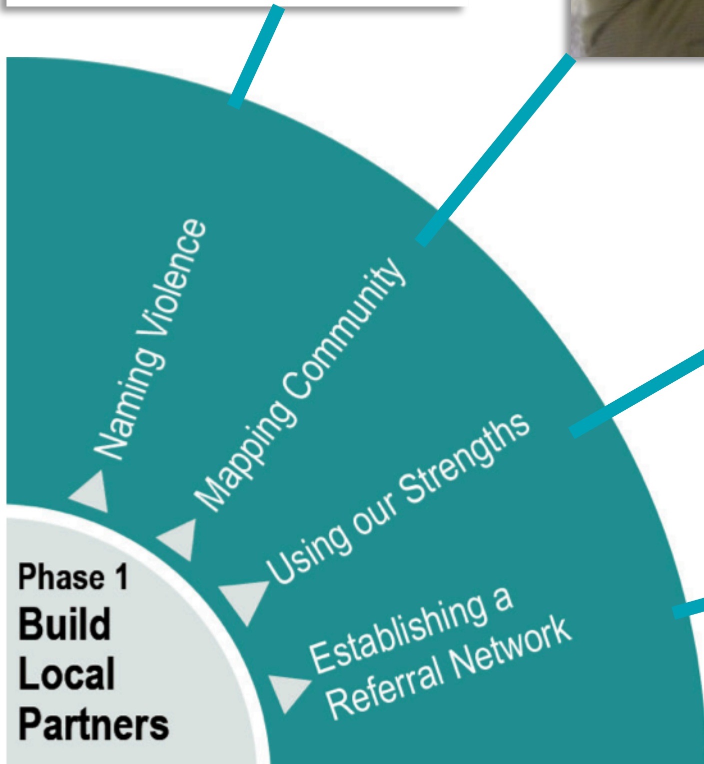
IPV screening/ referral pilot

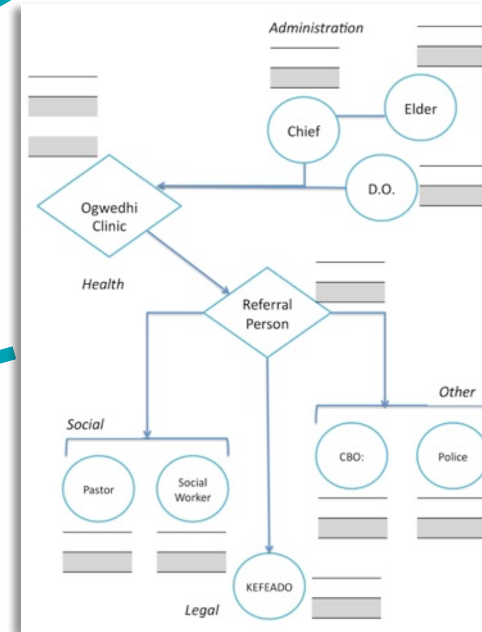
Create Action Plan*



*Turan, Hatcher, et al. (2013) *AIDS Research and Treatment*

Local Partners Meeting





Community Awareness Events

IPV screening/
referral pilot

Training for all clinic staff*

- Gender and human rights
- Gender-Based Violence (GBV) sensitization
- Links between GBV and HIV
- HIV-related stigma
- Role of the health sector
- Privacy and confidentiality
- Screening tools and techniques
- Sexual violence and post-rape care
- Supported referral protocols
- Provider safety and self-care
- Communication skills

* Adapted from GBV curricula for health workers from Kenya, India, South Africa, and Latin America

Say: "I always ask the following questions because some people are in relationships where they don't feel safe and this affects their health."

QUESTIONS:	**YES**	**NO**
If you told your partner that you came here for health services today, would s/he react angrily or negatively?		
Has your partner (or another person close to you):		
Pushed, grabbed, slapped, choked, hit, or kicked you?		
Threatened to hurt you, your children or someone close to you?		
Taken away money/resources that you/your children need to survive?		
Sent you back to your maternal home?		
Forced you to have sex when you did not want to?		
Has your partner tried to get you pregnant when you didn't want to be? (women only)		
If you wanted to use a condom or another family planning method, would you be afraid to ask your partner?		
Are you worried your partner (or another person close to you) will be angry and/or hurt you if s/he finds out you were tested for HIV?		
Do you feel unsafe returning to your home today?		

If the client answers YES to any of these questions, their health and safety may be in danger! Offer to phone the community GBV Referral Person (tel: 0xxx, xxx xxx), who can assist him/her with getting further social, economic, medical, legal, and counseling services.

Referral:	**Yes**	**no**
Did you provide counseling?		
Did you refer the client to the GBV-referral person?		
Did you refer the client to another person / place? If yes, to where/whom? …………………………		
Did you fill in a P3-form?		

Date:	**Sex of Client:** **Female** **Male**
HCW:	**Age of client:**

TIPS:

1) **Be supportive and listen attentively**
2) **Remind patients that all questions are confidential, are offered to further support clients - not to get someone into trouble**
3) **If you have time during the visit, provide counseling or emotional support**

Note: A negative response to screening does not mean that abuse is not present. It may indicate that the person is not comfortable disclosing abuse at this time.

KEMRI-UCSF, Ogwedhi GBV Pilot Intervention, October 2010

faces Kenya Medical Research Institute UCSF

Clinic staff began to screen all pregnant women visiting the antenatal care clinic for GBV

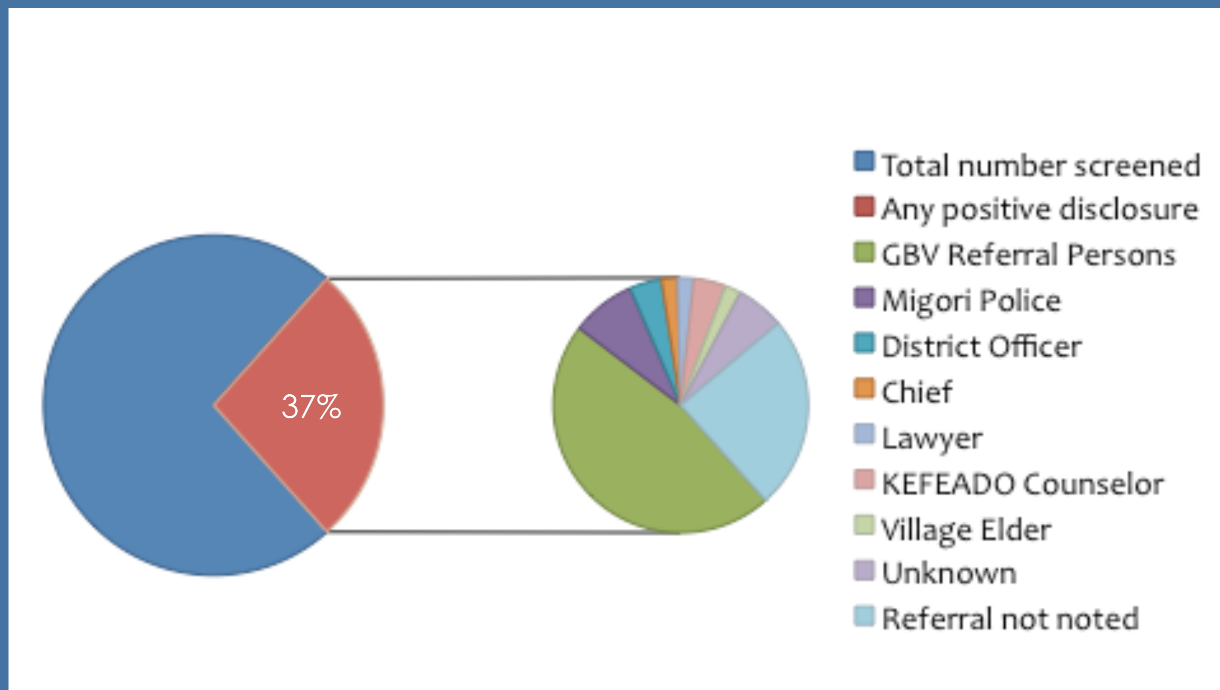
Community referral persons (volunteers) offered 'supported referrals' to link women with near-by services

IPV screening/ referral pilot

Evaluate learning

- *Actually it has really helped women because before the start of the GBV pilot, women were just beaten but they did not take any action. But now they know where to go. [Referral Person, male]*

  Now men fear beating women or doing such violence because they know they may be arrested or there may be steps taken for them if they do that. [Health worker, female]

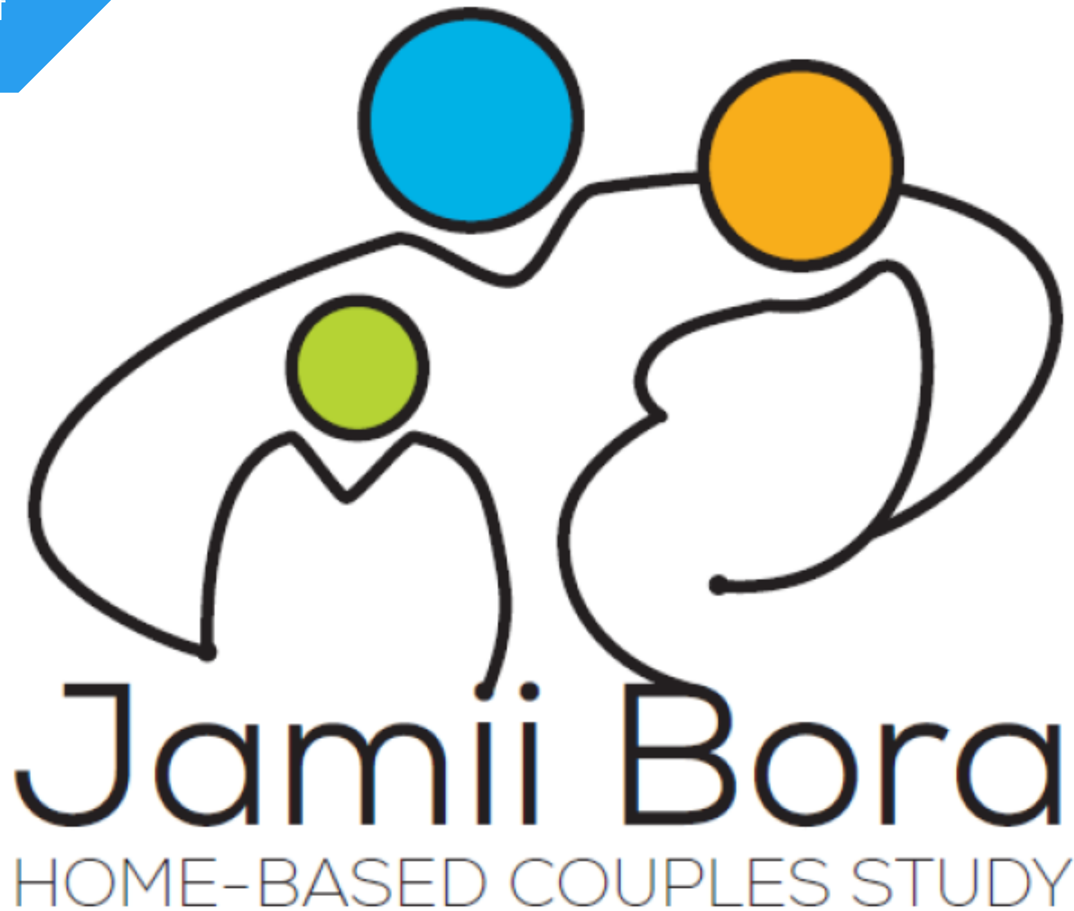


Evaluate & refine approach

Remaining Challenges

- Women reluctant to press charges for fear of "breaking the family" and being left without a home or resources.
- Both service providers and clients often preferred to "solve things at home" instead of seeking outside help.
- Extended family members and village elders in some cases supported the violent man over the woman.
- Criminal and legal procedures for reporting GBV cases could not be completed locally but rather had to be carried out in the nearest town.

Integrating IPV prevention pilot



Study Overview

NIMH R34MH102103

Jamii Bora (Better Family) Study

- GOAL: To develop and pilot a home-based couples intervention for safe HIV testing and disclosure for couples, alongside information and counseling for family health during the perinatal period.

- RATIONALE: Engaging both partners of a couple during pregnancy has the potential to enhance health decisions, increase healthcare utilization, and ultimately improve maternal, paternal, and infant health.

Couple Interdependence Conceptual Framework*

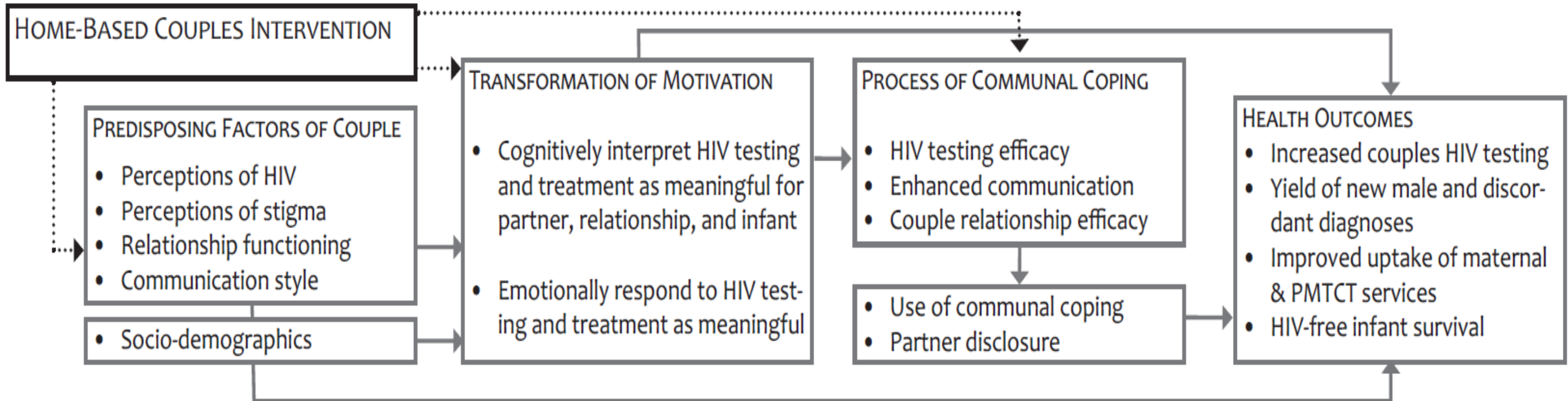


FIGURE 1. Conceptual framework for home-based couples intervention based on Interdependence Model

*Adapted from Lewis et al., 2006

Study Sites

Home-Based Couples Intervention sites:

- Five low-resource rural health facilities rural Migori County, Kenya

Integrating IPV prevention pilot

Who Participated in the Study?

- **127 pregnant women** who were currently in a stable relationship with a male partner, but who had not disclosed their HIV status
  - 63 were randomized to the intervention group (couple home visits)
  - 64 were randomized to the control group (standard care)
  - About half were HIV+ at baseline (by design)

- **96 male partners** of these women (76%) could be located and agreed to participate in the study
  - 52 in the intervention group
  - 44 in the control group

Integrating IPV prevention pilot

The Home-Based Couples Intervention

1

2

3

Jamii Bora Intervention

- 3 home home-based visits for pregnant women and male partners
- HIV-positive, HIV-negative, and Discordant
- visits by couple counselors: 1 male & 1 female

Visit content:

- Maternal, child, and family health information
- Couple relationship & communication skills
- Offers of Couple HIV Testing and Counseling (CHTC)
- Linkage to services

Jamii Bora
HOME-BASED COUPLES STUDY

Content of the Home Visits

- Couple HIV Counseling and Testing (CHCT) including mutual disclosure of HIV status
- HIV Linkage to Care
- Maternal, child, and family health information
- IPV prevention messages
- Couple communication skills

1. Introduction

This section introduces the purpose of the Resource Book and how to use it during the Jamii Bora Study.

1.a	Using the Resource Book	2
1.b	About Jamii Bora	4

2. Jamii Bora Basics

Here, we introduce HIV Testing in light of international guidelines and the protocol for Jamii Bora Study.

2.a	HIV Background	10
2.b	Living with HIV	12
2.c	Serodiscordance	14
2.d	Gender-based Violence	17
2.e	Stigma and Discrimination	20

3. First Home Visit

This section addresses key topics for the first Jamii Bora home visit.

3.a	HIV Education	26
3.b	Pregnancy Care	28
3.c	Nutrition in Pregnancy	33
3.d	Avoiding Malaria in Pregnancy	35
3.e	Male Involvement in Pregnancy	37
3.f	Couples Communication: "I Language"	39
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4. Second Home Visit

Topics for the second home visit are presented here.

4.a	Preventing Mother-to-Child Transmission	46
4.b	Preparing for Childbirth	48
4.c	Infant feeding	49
4.d	Child Welfare Clinic	54
4.e	Couples Communication: Initiator-Receiver	55

5. Third Home Visit

The third home visit addresses the final set of topics.

5.a	What to Expect Postpartum	60
5.b	Male Involvement Postpartum	61
5.c	Family Planning after Birth	63
5.d	Tuberculosis	65
5.e	Voluntary Male Medical Circumcision	66
5.f	Couples Communication: Negotiation	68

IPV Content in the Jamii Bora resource book for home visitors

What is the Cycle of Violence?

Most GBV within relationships falls into what's called the "cycle of violence":

- During the 'Violence' stage, many women seek assistance.
- During the 'Calm' stage, many women 'forgive' the abuser and may return to the relationship. During the calm stage, the abuser may apologize, buy gifts, or make special effort to create an atmosphere of love and peace in the family. This is the stage when women may hope that the abuser loves them and will change. They may believe the promises that the abuser makes, and the abuser may be sincere about his promises.
- Over a period of time, tension begins to build again and the woman and others in the family feel anxious and fearful that violence will occur again. During this time, the woman usually tries hard to pacify the man and maintain normalcy in the family. During the 'Tension' stage, the woman may think about how to stay safe and may consider taking action.
- Eventually, the tension is broken with a violent episode. This pattern keeps repeating itself unless it is broken.

Sometimes a victim may use violence against their abusive partner. It is possible that if a woman recognizes she is in the tension building phase she may want to get it over with and may 'push the abuser's buttons' or find a way to instigate the violence so the incident will be over more quickly.

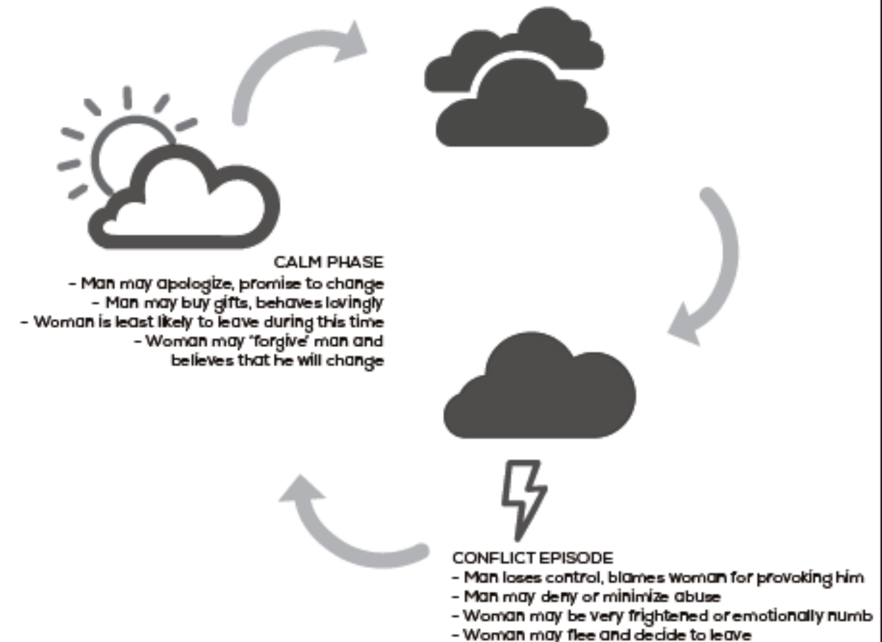
- *Many victims feel guilty about using this tactic or resistive violence in order to defend themselves.*
- *It is important to be supportive to them and help them understand why they resort to this method and how they have been conditioned to use violence to deal with their own feelings of anger and frustration.*

Working with couples who have a GBV history

When counselling men and women in the cycle of violence:

- Explaining the cycle of violence may be a helpful tool to help men and women reflect upon their own relationship. Use the Job Aid to carefully walk participants through the cycle, and see whether this applies to them.
- It is important to avoid blaming either person for staying in the relationship.
- It is also important to be careful to not pressure men or women to take actions they are not ready to take.
- Whatever support you choose to offer the participants living with the abuse, bear in mind where they are in the cycle of violence and whether they are ready to break the cycle or not.
- If you are uncertain whether a couple is ready for CHTC, wait and ask your supervisor. Do not push a couple towards CHTC if they are unready.

Because prior violence in a relationship is a significant predictor of future violence, providers should consider any information that comes up about past violence to determine whether CHTC is appropriate and safe for a couple. -PEPFAR (2014)



Citation	Adapted from WHO (2013) Global Prevalence of Intimate Partner Violence; Walker (1979). The Battered Woman.
Picture Source	Hatcher, et al. (2013). Safe + Sound Training Manual; AED and ICRW. (2007). Understanding and challenging HIV stigma toolkit.

Data Collection

Questionnaires:

- All women at baseline (clinic)
- All participating men at men at baseline(home or clinic)
- All women and men at 3 months after the expected due date of the baby

Qualitative in-depth interviews (n~24):

- Men and women from both study arms, couple counselors, and healthcare providers

Results: Processes

- Of the 52 couples enrolled and randomized to the home visit arm, 49 couples completed one or more home visits and 30 couples completed all 3 visits.
- Four new HIV-positive cases and 7 discordant couples were identified through Couples HIV Testing and Counseling during a home visit, and all were successfully linked to care.

Integrating IPV prevention pilot

Intervention effect on Couples HIV Testing

- **64%** of women in the intervention arm engaged in Couples HIV Testing and Counseling with their male partner during the study period, compared to **23%** of women in the control arm.
- Relative Risk=2.78; 95% CI: 1.63-4.75

* Turan et al., 2018, *AIDS Patient Care and STDs*.

Results: Other Perinatal Health Behaviors

- **Any male partner attendance at antenatal care visits** (52% intervention versus 43% control, p=0.42);
- **Giving birth in a health facility** (87% versus 79%, p=0.28);
- **Exclusive breastfeeding** (91% versus 76%, p=0.06);
- **Maternal postpartum check-up** (72% versus 50%, p=0.03).
- **Infant postnatal check-ups** were universal in both study arms (100%)
- **Postpartum family planning use** was very similar in the two groups (79% versus 77%, p=0.77).

Intimate Partner Violence

- 20 pregnant women (15%) reported experiencing any IPV in the past six months in the baseline questionnaire
  - 10 of these women who reported severe IPV were not included in the couple randomized part of the study
- 18 postpartum women (16%) reported experiencing any IPV in the past six months in the follow-up questionnaire three months after the birth
  - Home visit arm - 5 women (9.4%)
  - Standard care arm – 4 women (7.7%)
  - Not randomized – 9 women (100%)
- Under-reporting of IPV in studies where both members of the couple are enrolled?

*Hatcher et al., 2017, AIDS Impact Conference, Cape Town, South Africa

Table 1: Unadjusted effects of socio-demographics and HIV status on recent IPV at follow-up

	IPV at follow-up Unadjusted OR (95% CI)
Socio-demographics	
Age (years)	**1.07 (1.00 to 1.17)** ◦
Gravidity	1.17 (0.93 to 1.47)
Polygamy	**3.24 (1.12 to 9.33)***
Poorest asset quintile	0.86 (0.26 to 2.86)
More than primary education	**0.31 (0.11 to 0.92)***
IPV	
Any IPV at baseline	**31.0 (7.09 to 135.49)*****
HIV status	
HIV positive	**5.09 (1.61 to 21.74)****
New HIV diagnosis	2.48 (0.87 to 7.13) ◦

◦ $p<0.10$ * $p<0.05$ ** $p<0.01$ *** $p<0.001$

OR: odds ratio; CI: confidence interval; IPV: intimate partner violence

HIV status worsens IPV at follow-up

Table 2: Estimated effects of HIV status on recent IPV at follow-up

	IPV at follow-up Adjusted OR (95% CI)
Any IPV at baseline	**25.13 (4.84 to 130.50)*** **
HIV positive	**5.22 (1.09 to 24.93)***

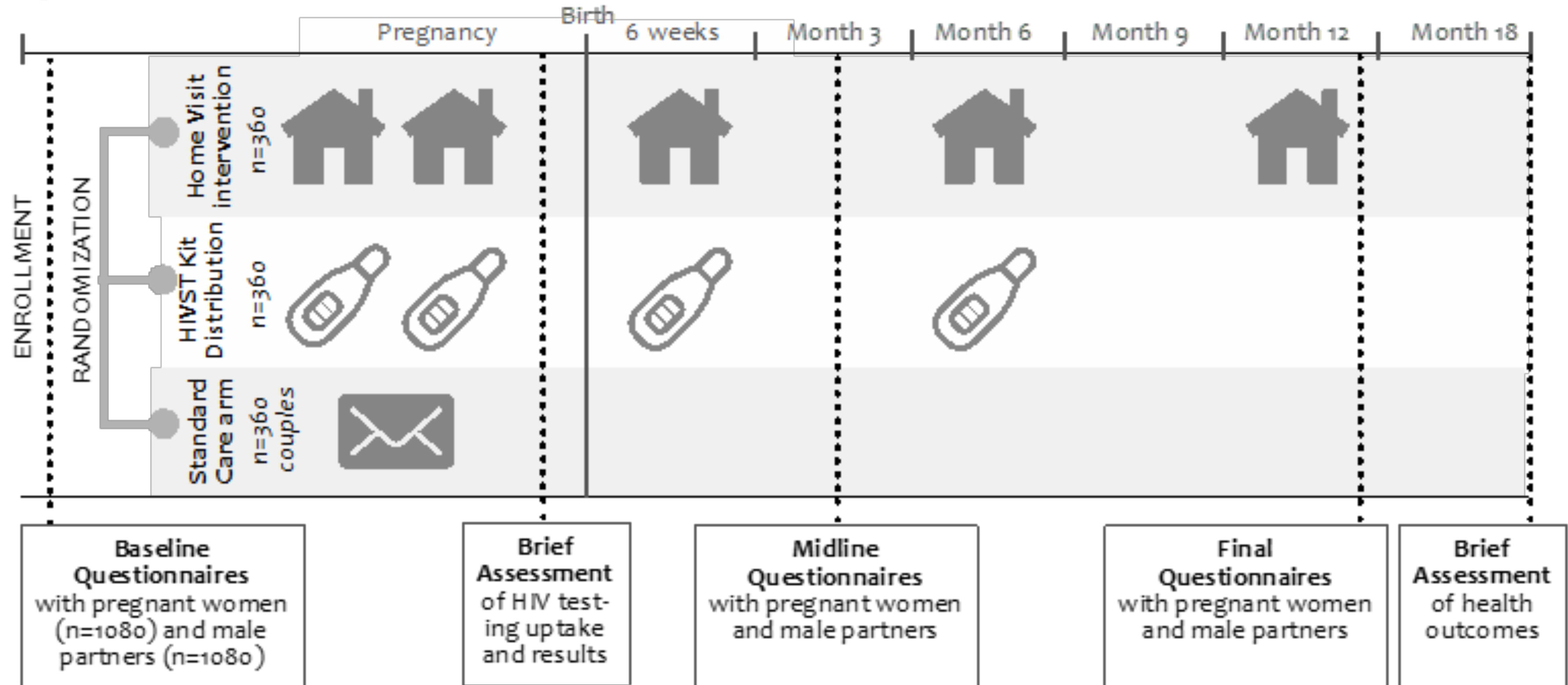
* $p<0.05$ ** $p<0.01$ *** $p<0.001$

Model adjusts for age, polygamy, and education; OR: odds ratio; CI: confidence interval

Next Steps

- U.S. NIH-funded R01 Study (pending) to test the Jamii Bora strategy on a larger scale
  - Incorporation of more IPV and mental health content and support
  - Linking of HIV-negative partners to PrEP
  - Longer follow-up to assess postpartum ART adherence, retention in care, and infant outcomes

Jamii Bora Trial: Design of Study



Conclusions

- Anticipated and experienced IPV during pregnancy adversely affect women's health care access, health behaviors, and mental & physical health.
- Screening and referral interventions at health clinics, even in low-resource rural settings, have the potential to assist women at risk for or experiencing IPV.
- Including IPV prevention in family health interventions can enhance benefits for maternal, paternal, and infant health.

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