ABSTRACT

The Role of Reproductive Health Knowledge in the Prevalence of Nonconsensual Sex in Rural Western Kenya

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In developing countries characterized by traditional gender roles in the context of women's very limited economic and social power, the issue of nonconsensual sex is even more complex than in cultures where women have greater equality with men. The goal of this study was to investigate the prevalence of and attitudes about forced sex. One hundred and twelve women from a traditional rural community in western Kenya were interviewed regarding their knowledge of reproductive health and their attitudes and experiences surrounding forced sex. The results showed that 22.73% of the sample had been forced to have sex at least once, most often by their husbands (83.33 %). According to this data, knowledge of reproductive health, though it may empower women in some ways, does not act to deter forced sex. Furthermore, the experience of sexual coercion cuts across all demographic groups. Women reported being forced to have sex when they were as young as 13, and the average age for these women to have had this experience was approximately 21 years old. Almost one-third (28%) of the women had not told anyone. Thus, the issue of nonconsensual sex is beyond the scope of the knowledge of reproductive health in this traditional community in rural, western Kenya.

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THE ROLE OF REPRODUCTIVE HEALTH KNOWLEDGE IN THE PREVALENCE OF NONCONSENSUAL SEX IN RURAL WESTERN KENYA

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By

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DEDICATION

This study is dedicated to the women of the Nyakach Plateau and women around the world who are forced to endure nonconsensual sex.

CHAPTER ONE

Introduction

Nonconsensual sex exists in many different forms. The National Intimate Partner and Sexual Violence Survey (NISVS) lists various types of sexual violence. Sexual violence is classified as rape if there is any "completed or attempted unwanted vaginal, oral, or anal penetration through the use of physical force" (NISVS 2010). The NISVS also makes the following distinction regarding the use of physical force in instances of nonconsensual sex:

> Among women, rape includes vaginal, oral, or anal penetration by a male using his penis. It also includes vaginal or anal penetration by a male or female using their fingers or an object (17).

According to the CDC, nonconsensual sex may be referred to as 'sexual coercion' if it is "unwanted sexual penetration that occurs after a person is pressured in a nonphysical way" (NISVS 2010). Thus, when discussing 'forced' and 'coerced' sex in terms of this study, experiences include both physical and nonphysical circumstances.

Forced sex occurs in all parts of the world, in vastly different cultures and societies. For instance, there is documented evidence of the prevalence of forced sex in places as diverse as "North London, England (23%), Guadalajara, Mexico (23%), Lima, Peru (22.5%), and the Midlands Province in Zimbabwe (25%)" (Adudans et al 2011). When taking a closer look into Africa, it is apparent that forced sex is an issue among a large number of women. It has been reported that in South Africa, "194 per 100,000 female population" have experienced rape (Adudans et al 2011). Another startling

finding, supplied by a study in Ghana, reports that 25% of females "reported that their first sexual intercourse had been forced" (Adudans et al 2011). A Rwandan study reports that "33% of women indicated that they had experienced sexual coercion," while a study on Tanzania found that "nearly half of the girls" obtaining a primary or secondary level education reported to experiencing forced sex (Adudans et al 2011).

Although there have been studies conducted in Kenya regarding the issue of forced sex, there is quite a dearth of information regarding the reasons behind the occurrence of forced sex. A study conducted in Nyeri, Kenya reported that "more than one in five sexually-experienced young women" between the ages of 10 and 24 years have had experiences of forced sex (Adudans et al 2011). The individuals' partners often initiated such experiences. Interestingly, it has been reported by the Center for Disease Control and Prevention (CDC) in the National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report that approximately 1 in 5 women in the United States have been victims of nonconsensual sex by use of physical force (NISVS 2010).

Findings presented by studies, such as the aforementioned study in Kenya, do not apply to all the demographics found in Kenya, much less on a more global scale. Since each community in a single country can greatly differ from another, the task of applying findings that concern topics such as forced sex becomes next to impossible if such a study solely focuses on one urban area. Forced sex constitutes a topic that cannot be regarded in the same exact manner across cultures and societies that harbor different viewpoints. Such viewpoints are affected by urbanization, financial statuses, education levels, religion, tradition, and much more.

Nonconsensual sex affects people in a number of ways. Victims can face health issues such as vaginal trauma, sexually transmitted infections, and urinary tract infections. Experiences involving forced sex may also cause great mental health issues for those who have been victimized (Adudans et al 2011). The mental and health issues caused by forceful sexual activity can affect the lives of victims for a prolonged period of time, essentially scarring the victim. As such, an individual's entire lifestyle and outlook may be greatly affected by one or multiple instances of nonconsensual sex.

Currently, there is not a study regarding the behaviors and attitudes concerning nonconsensual sex that has been conducted among the women residing on the Nyakach Plateau in rural, western Kenya. A study in this community in 2010 (Wood 2011) focused on the relationship between the knowledge of reproductive health, contraceptive use, and the occurrence of unplanned pregnancies. The 2010 study found that 63.9% of the women surveyed (n=155) reported that they were forced to have sex at some point in their lifetimes. As a result of these findings, this study aims to determine the relationship between knowledge of reproductive health and the occurrence of forced sex in a sample of women from the same community residing on the Nyakach Plateau.

CHAPTER TWO

Review of Literature

Law

There are instances in society when cultural practices or traditions do not exist in compliance with laws put in place by government officials. Although a written law exists in a nation, when the majority of the citizens and the individuals in offices of power do not abide by the particular law, culture tends to take precedence. This observance of the human interaction with governmental authority is evident when examining the issue of coerced sex in Kenya.

Countless studies have reported the high occurrence of coerced sex among African nations. Kenya is not an exception to this observation. However, when looking into the governmental aspect of Kenyan society, one would assume otherwise. The African nation of Kenya joined the United Nations' Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) in 1984 (UNTC).

The Feminist Majority Foundation presents the following regarding the purpose of CEDAW:

> The goals of CEDAW, sometimes called the "Treaty of the Rights of Women," are to abolish discrimination against women in political, cultural, family life, economic, and social arenas. The treaty seeks to end trafficking of women and violence against women, and to establish equality for women in public life, education, employment, health care, law, and property.

By joining CEDAW, countries agree to the "universal definition of discrimination against women," and are therefore held "accountable for improving the status of women"

(Choices). Even though Kenya is a member of the Convention and similar international human rights groups that do not advocate violence against women, the principles of the treaty have not been integrated into customary and domestic laws. This aspect of the differing ideals of government and cultural practice gives insight into the treatment of women. There is still a high rate of domestic abuse among households, which can be seen through studies concerning marriage, financial status, and more (Kimuna & Djamba 2008).

A study conducted in Kenya studying coercive sexual activity among younger members of society reports that various forms of sex without consent are deemed worthy of punishment under the nation's penal code. In actuality, the law is rarely implemented, and, instead, victims of nonconsensual sex are held responsible. Perpetrators of rape dodge blame because much of Kenyan society believes forced sex to be "normal and forgivable" since men cannot control their sexual desires (Erulkar 2004). In addition to accepting the legal contradiction of forced sex, Kenyan government also fails to prosecute marital rape. This concept relates to the idea that, for women, marriage constitutes a contract of submission to the groom and his family (Kilonzo et al 2009).

Although recent evaluations of the practice of Kenyan law present a system that is not favorable towards women in sexually violent situations, there are reports of a different government rule between the 1940s and 1960s. During this time, courts in Gusiiland, Kenya were more lenient towards women who reported incidences of forced sex in the sense that they required men to present a greater amount of evidence proving that the sexual act was consensual. A man's word was not enough to free him of the serious accusations. Although a man and woman were married, consent was the most

important factor when determining whether or not the woman had been a victim of sexual violence (Shadle 2008). Even though women were seen as the victims in cases regarding nonconsensual sex, the law also gave the woman's father importance. Cases involving elopement were designated as crimes "because one man had violated the rights of another man—a father's right to make a marriage for his daughter and receive bridewealth in exchange" (Shadle 2008). Cases involving abductions, although also seen as crimes against fathers, more so depended on "whether or not the woman had consented" (Shadle 2008). Shadle's research concludes that the elders of this area in Kenya "accepted that Gusii women could, and did, reject sexual advances, and that women, not men, suffered the most because of rape" (Shadle 2008).

The Developing World

Sexual health is greatly impacted by place of residence. Although there are similar aspects of urban and rural methods of living, the vast differences between residing in a city and the country tend to affect the ideas regarding women and sexual activities.

Urban and rural settings greatly differ in the social and cultural traditions practiced by members of society. Women living in urban areas are "more likely to have become sexually active" (Murray et al 2006). Certain practices accepted in one environment may not be looked upon with approval in another. Such differences in the actions of rural and urban women find their basis in the "social prohibitions" that plague different groups of people (Murray et al 2006). For example, while urban areas are increasingly exposed to western influence and a changing culture, rural areas tend to

adhere to the idea "that women cannot own property because they themselves are property" (Doss et al 2012).

In addition to cultural and social differences between the groups of people inhabiting urban and rural areas, poverty impacts the sexual health of individuals in that poverty opens up doors to transactional sex. Material exchange for sexual activity exists at a different rate in urban versus rural residences. This method of attempting to earn monetary stability in a poverty-stricken environment exposes women to an increased number of sexual partners, which corresponds with sexual violence. Although poverty is seen across both urban and rural communities in Africa, a study reports that "insofar as sexual behavior is concerned, urban settings are particularly disadvantaged," compared to rural counterparts (Dodoo et al 2007). Poor women residing in urban Nairobi are "more likely than their rural counterparts to engage in risky behaviors" (Dodoo et al 2007). This study conducted in Kenya came to the realization that "the rural poor likely do not face the same degree of challenge and survival pressures as the urban poor" (Dodoo et al 2007). The varying amount of stressors faced by those residing in urban communities, such as poverty and tight living arrangements, allow for the introduction of sex. Often age does not matter in regards to the introduction of sex, as young children become accustomed to the sexual aspects of life before reaching an appropriate age (Dodoo et al 2007). The confrontation between young children and sexual activity at an inappropriately early age also sets up the circumstances involving violence. One study conducted in Kwazulu-Natal, South Africa reports that of a sample consisting of 1130 sexually experienced women, 46% listed that their first exposure to sexual activity was coerced (Maharaj & Munthree 2007). The women that "reported being coerced at first

sex, were significantly more likely to be Black and living in an urban area" (Maharaj & Munthree 2007).

Although the aforementioned sources report that sexual behavior is more risky among women living in urban areas as a result of the immense poverty, other sources list the opposite. A study conducted among women in Nyanza Province, Kenya found that women inhabiting rural areas exhibited more risky sexual behavior. The data obtained from the rural women presented aspects of risky sexual behavior: "they had a younger age at sexual debut, were less often a virgin at marriage, had more lifetime partners, and less consistently used condoms with nonspousal partners" (Voeten et al 2004). Thus, while place of residence is an important aspect of sexual health, it is not the only factor involved in regulating the sexuality of women.

Who and Why?

As a result of differing cultural thought processes, rape is not always synonymous with sexual coercion. An individual experiences sexual coercion when he or she is pressured "to have sex against his or her will" (Erulkar 2004). An individual may be pressured or forced into having sex through "the use of violence, threats, verbal insistence, deception, cultural expectations or economic circumstances" (Erulkar 2004). Rape, however, leads to the connotation of physical strength or violence as the sole method in forcing another individual to engage in sex. In societies such as those in Kenya, the aforementioned methods of sexual coercion do not leave women with much flexibility in making decisions regarding their sexuality (Erulkar 2004). In Kenya's patrilineal societies, the most common perpetrators of coerced sexual activity are men,

both known and unknown to the female victims. One study, conducted in Kenya, reported, "of the coerced young women who were married, 45% had been coerced by their husbands, 33% by someone else and 22% by both their husband and someone else" (Erulkar 2004). While in some societies rape and coerced sex possess the same connotation of being forced to conduct sexual activity against one's will, others do not consider rape to be a synonym of coercive sex. As a result, the previous study also found that "young women who reported having been raped were more likely than those who reported physically forced sex to say that a stranger was the perpetrator" (Erulkar 2004). The study conducted in Kenya also presented that "more than one in five sexually experienced young women" experienced nonconsensual sex (Erulkar 2004). It was found that the individuals responsible for the coercive sex were intimate partners of the women. However, because the meaning of rape and physically forced sex may differ, statistics may vary when analyzing particular groups of people (Erulkar 2004).

Another study, investigating the urban poor in Nairobi, Kenya, "suggests that about 25% of teenage girls in Kenya are coerced or forced into first sexual intercourse, in most instances, by family members or people known by the victims" (Ngom et al 2003). In most cases, known males were listed as the perpetrators of sexual violence. Since many of the perpetrators of coerced sex are known males, most females do not report forced sexual activity "unless they conceive because they are mostly raped by their friends" (Nzoika 2004). This practice is put into use because of the stigma accompanying premarital pregnancy. Pregnancy outside of marriage "leads to ostracism by friends, the pain of having to bear a child and the burden of having to rear that child" (Nzoika 2004).

As such, rape and coerced sex may be seen as the norm for many young females with a strong male influence in their domestic life.

While most attention is given to family members and friends as the perpetrators of coerced sexual activity, there is a great amount of discussion "around teachers' [and students'] sexual involvement with girls at school" (Bhana 2012). A study conducted amongst girls in South Africa found male teachers and students to take sexual interest in female students. In some cases, sexual interest escalates to forced sexual activity. The association of male teachers and students with forced sex also has quite an impact on the thoughts surrounding education in the African society (Bhana 2012).

In a vastly male-dominated society, there exist many beliefs that make the practice of rape acceptable in the eyes of many individuals. One study reports that rapists typically hold a set of beliefs that contribute to their actions. Such beliefs are collectively known as rape myths, which "are attitudes and beliefs that are generally false but are widely and persistently held, and that serve to deny and justify male sexual aggression against women" (Ryan 2004). For example, some men believe that women initiate the sexual activity by dressing in a certain manner or manipulating men into becoming attracted to them. Thus, in such a culture, the act of coerced sexual activity is blamed on the woman instead of the perpetrator. In her explanation of the idea that "rapists hold rape-supportive beliefs and a sense of entitlement," Ryan lists the following example:

> Rape is a man's right. If a woman doesn't want to give it, a man should take it. Women have no right to say no. Women are made to have sex. It's all they are good for. Some women would rather take a beating, but they always give in; it's what they are for.' This man murdered his victim when she wouldn't 'give in' (166).

Thus, it is evident that gender relations between males and females play a great role in the concept of coerced sex. The belief systems of individuals are greatly influenced by culture.

In addition to using gender inequality as the reason behind the incidences of forced sex in patriarchal society, there have also been reports linking the motivation behind rape to sexually transmitted diseases. A concept known as the 'virgin cleansing myth' consists of "the idea that sex with a virgin will cure men of sexually transmitted infection" (Bowley & Pitcher 2002). Although the virgin cleansing myth has largely been observed in regions of South Africa, it is also noted "child and adolescent rape is a problem worldwide and a growing concern in sub-Saharan Africa." Virgins of any age may qualify in this mode of thinking. Thus, women in all age groups are potential targets (Pitcher & Bowley 2002).

Since many nations in Africa are areas of great conflict, it is not uncommon to see forced sex used as a weapon of war. For example, "mass rape and sexual torture of women and girls by men in conflict areas" is quite evident in the Democratic Republic of the Congo. Groups of people caught in the crossfire of political battles are usually targets. As such, "many women and girls are forced to have sex in return for safe passage, food, shelter, and other resources. Peacekeepers and aid workers are among the exploiters. Refugee camps are often unsafe, and rape occurs" (Jewkes 2007). Another study presents the fact that "sexual violence can be used as a tool for humiliation or genocide, and reports indicate that women are often abducted and used as sex slaves or unpaid labor for military or rebel groups" (Peterman & Johnson 2009). Thus, although there is great

emphasis put on the culture of nations and the incidences of rape, there is also a relation found in the literature that suggests a link between forced sex and civil unrest.

Another study, conducted in Kenya by Muchoki and Wandibba, also found rape to be used as a weapon during conflict. However, this type of conflict was within a marriage. The study reported 6% of its respondents to have "had sex with their stepdaughters after they had a conflict with their spouses. This could be interpreted as a form of punishment and torture to the spouse because of the conflict" (Muchoki & Wandibba 2009). In addition to the infliction of punishment as a motivating factor of rape, many others also increase the possibility of the occurrence of rape in African society. Muchoki and Wandibba found that "drug consumption, marital problems as an excuse for rape, inability to negotiate for consensual sex due to being shy or afraid of women, rape as a form of sexual access, psychological factors like pornographic influence and rape hallucinations, and impersonal sex and power" contributed to the occurrence of rape. Additionally, "the view of rape as a sexual act rather than an act of violence, social attitude that the women 'invited' the rape, early childhood environment, cultural practices, peer influence, and a lack of parental advice on sexual activities" were identified as sociocultural factors (Muchoki & Wandibba 2009). Both, individual characteristics and sociocultural aspects come together to create a formula for coerced sex.

Impact of Marriage

Practice of "customary law in Kenya assumes that consent to all future sexual activity is given at the time of marriage." As a result, "married women may be less able

to refuse unwanted sex with their (marriage) partners than can unmarried women not married to their sexual partners" (Hattori & Dodoo 2007). One study, consisting of a sample of 4,876 married women between the ages of 15 and 49 years, found that of the 40% of women that reported incidences of violence in their marriages, 13% of women were victims of sexual violence (Kimuna & Djamba 2008). As such, it is evident that long-held beliefs of the role of marriage play into the subordination of women in a male-dominant society.

Sexual violence against women stems from the influence of cultural gender differences. In patriarchal societies, such as those prominent in Kenya, males take on the lead role. The inequality experienced by women in Kenyan society tends to be reinforced by widely practiced marriage customs. For instance, people of the Luo tribe expect chastity from females, but boys are exempt. The lack of punishment for extra-marital relationships is "attributed to [an] increase in the mobility of men, rise in paid employment, and the cost of bride wealth" (Magadi & Agwanda 2009). The importance of marriage in a male-driven society is to possess the different factors a woman can provide. In the traditional sense, a wife provides "not only sexual companionship, but agricultural labor, reproduction, the completion of burdensome daily household chores and her presence in the household" (Magadi & Agwanda 2009). These aspects of married life allow a male to achieve adulthood Thus, marriage is held to be a right of passage. Such treatment continues to stem from the vast disparity in gender equality.

For members of most Kenyan communities, marriages are valued as agreements "between two groups, which [establish] a complex web of reciprocal rights and duties" (Kimuna & Djamba 2008). As a rule of Kenyan culture, before young women are

married, they are "usually considered as the property of their fathers and after marriage and the payment of bride wealth, they become the properties of their husbands" (Kimuna & Djamba 2008). Bride wealth is synonymous to a payment made by the groom's clan in order to acquire rights to the woman in question. Because marriages are treated as business transactions, it is assumed that marriage vows and the fulfillment of the agreed payment are exchanged with a woman's family in exchange for the rights for the groom "to have unconditional sexual access to his wife for reproductive purposes" (Kimuna & Djamba 2008).

If the bride or groom desires to end the marriage union, "the kinship group of the woman [is] to return her bride wealth excluding wealth deemed appropriate for living children if any" (Kimuna & Djamba 2008). This is usually not well accepted in a society that suffers from great poverty. Furthermore, a previous study, conducted in Nyeri, Kenya, found that "those who reported coercion had elevated odds of being separated or divorced, suggesting that coercion may have contributed to marriage dissolution" (Erulkar 2004). Since reporting coercion resulted in the end of the marriage union, the idea "that marriage is a safe refuge for young women" can be disputed because marriage may actually expose women to sexual violence (Erulkar 2004). This relationship is evident in Kenya, as "husbands cannot be accused of raping their wives because marriage is considered as blanket consent to intercourse" (Erulkar 2004). As a result, most women go on as the property of their husbands and fail to report coercive sex because their own families cannot afford to give back the dowry they received.

In addition to the women's families not being able to afford the return of the bridewealth to the groom, there are also cases in which men do not agree to a certain

value of bridewealth. A study exploring the marriage customs of bridewealth as practiced by the Gusii people of Gusiiland, Kenya presents the idea that men without the means to fulfill payment of bridewealth to the desired woman's father succumbed to using coercive sexual methods and premarital "pregnancy to seal their marriages" (Shadle 2003). However, unless the payment of bridewealth is fulfilled, most people do not consider the union to represent a true marriage. The woman does not belong to the man. This practice further confirms the value of women as property to be exchanged for other valuables such as cattle and money (Shadle 2003). This cultural practice of marriage traditions leads to an increase in sexual violence because it strips women of the ability to negotiate the events of their own sexual activity.

Another aspect of marriage customs followed by a large number of communities in Kenya is polygyny. A study conducted in rural, western Kenya further investigated aspects of marriage by obtaining information for members of the local Luo community. As an aspect of gender inequality and marriage customs, another male in their deceased husbands' families inherits widowed women. This concept of the inheritance of wives, leads to the transformation of monogamous marriages into polygamous marriages. Studies note that successful societies that practice monogamy also "lack sufficiently large differences in male wealth or status to motivate women to become second wives" (Heinrich et al 2012). When applying this finding to the Luo community of Kenya, it becomes evident that the large disparity in gender equality may be the cause for polygamy. Women may see their only chance for survival is to become a second wife in a male dominant culture (Heinrich et al 2012). As a result, "polygyny places women largely under the authority of their husband and his lineage," confirming the status of

women in a male-dominated society (Bove & Valeggia 2009). Furthermore, by treating women as property, the marriage practice of inheriting wives exposes women to mistreatment. The subordinate role of women is observed in the fact that "polygyny is associated with higher rates of domestic physical and sexual abuse" (Bove & Valeggia 2009). The practice of polygyny enters women into a competition with their co-wives for support from the dominant male in the relationship. This constant battle between women encourages the continuance of cultural views that have impacted African societies for a number of years (Bove & Valeggia 2009). In addition, because women become second wives to many males who are already married, there is an increase in the number of unmarried males. Implementing the practice of monogamy "reduces crime rates, including rape" by "reducing the size of the pool of unmarried men" (Heinrich et al 2012). This reduction, in turn, results in a balance between reproductive competitions. When taking a broader outlook, polygyny is found to be "associated with rural residence, older age, and low educational attainment" across much of sub-Saharan Africa (Clark et al 2010).

As urbanization expands, marriage customs tend to transform in order to resemble a westernized culture. Newer marriage customs in urban Kenya include "self-selection of spouses, love and emotional attachment, sexual exclusivity, sexual activity prior to marriage, lower levels of homogamy, and greater independence from parents and kin prior to marriage" (Clark et al 2010). As a result, the rate of polygamous unions seems to decrease. However, "new forms of polygynous unions" compensate for this decrease (Meekers 1992). One such form, known as "outside wives," consists of a man married through law to one woman and simultaneously involved in an "informal union with one

or more other women" (Meekers 1992). Since there are new forms of polygynous unions forming, the age-old concept of women as second-class citizens remains a large part of cultural influence. Thus, it can be assumed that even with the spread of western culture, there are large hurdles to jump in regards to gender relations in countries with strong patriarchal influences.

Family & Household Structure

Family structures and household dynamics greatly influence the sexual health of young women. As previously mentioned, women usually play the role of a subordinate member of African society since males are thought to be in control. In many cultures around the world, women are usually not the major breadwinners. Instead, women are thought to take care of the household. Thus, it can be easily assumed that women would be able to make changes in culture through teaching younger individuals. Contrary to this belief, cultural traditions have continued to thrive in African culture.

Family life as a child and as an adult may increase the exposure women have to sexual activity. The structures of family households impact the lives of young women and children in such a way that the individuals residing in the family home influence the thoughts surrounding sexual relations. For example, one study found that parents who were living together were more likely to have daughters that did not become sexually active at an early age. In addition, young girls whose fathers took part in polygamous marriages were more likely to have an early sexual debut (Murray et al 2006).

Researchers studying parental presence and the reproductive health of adolescents among poor citizens in urban areas of Nairobi, Kenya found that paternal presence

greatly impacted the sexual activity of young girls. They concluded that when a father figure takes part in the household, young girls are less likely to have experienced sexual intercourse. Their sexual debut is later. The study reported that the presence of a father in the household resulted in young girls being 42% less likely to have experienced sexual intercourse (Ngom et al 2003). Although this finding may be attributed to many different aspects of the father-daughter relationship, the researchers conducting this study report, "the authoritative role of fathers, versus that of mothers or other relatives, may deter adolescent daughters from engaging in frequent sexual activity" (Ngom et al 2003). In addition, a father's presence "played a protective role when their daughters were harassed by men who seduced them, instilling fear in these men" (Wamoyi et al 2011). Young women with very strict fathers were more protected from the sexual advances made by men because the men may have been afraid of the women's fathers. Despite the benefits of the presence of a father figure in the home, women are usually left with the responsibility to care for children.

Finding its basis in the male-dominated society that makes up most of sub-Saharan Africa, the role of women in parenting consists of the responsibility of monitoring the sexual activity of children. In most households, males are permitted to go out without much monitoring. However, daughters are closely watched in order to prevent their participation in sexual activities. If a young woman becomes sexually active, the blame is usually passed on to her mother because it was her responsibility to prevent any relationships her daughter may have with males. In addition, since young girls can become pregnant once they begin to engage in sex, they are watched much more closely than their male counterparts. Since males lack the ability of becoming pregnant,

they are given more freedom because the burdens of taking care of young children out of wedlock are not to be carried by men. Although HIV and other sexually transmitted diseases are also unwanted, pregnancy remains to be the motivation behind preventing daughters from engaging in sex since it is proof that the young woman is no longer a virgin at the time of marriage. This fact brings shame upon her family and prevents them from receiving bridewealth. In order to monitor their daughters, women will follow the young girls when they are running errands, visit their sleeping quarters during the night, ask numerous questions regarding her whereabouts, and question any new material objects that have come into her ownership for fear of her exchanging sex for material goods or money. Some women even believe they should physically inspect their daughters to ensure that they have not taken part in sexual activities (Wamoyi et al 2011).

Although parents attempt to supervise every action of their children, they are not able to spend every moment of the day with each child. The poverty-stricken areas of much of Africa require parents to leave their children for some time in order to earn a living. Thus, parents do believe it is "difficult for them to have total control over daughters because they sometimes leave home alone to go to church, market, fetch water, or visit relatives among other activities" (Wamoyi et al 2011). Parents can only monitor children to some degree.

The physical structure of a house also affects an individual's introduction to sexual activity. As a result of immense poverty across much of sub-Saharan Africa, many families reside in very small houses. These places of residence are so small in size that there are many instances in which a family must use a single room that "serves as sleeping quarters, kitchen, living room, and not infrequently, the bathroom" (Dodoo et al

2007). Thus, it is quite obvious that there exists a lack of privacy in the lives of many Africans. The lack of privacy present in homes consisting of one room also encompasses the privacy of sexual activity. Although there are situations in which parents are able to separate their children from their sexual activity by using curtains and other material to create a barrier within the single room or by initiating sexual activity after their children have gone to sleep, there is no guarantee that children will not be exposed to sex at a very early age (Dodoo et al 2007).

As a result of an early introduction to sexual activity, children tend to begin their own sex lives at a much earlier age than they would have had they not been exposed to the sexual activity of their parents. Even though parents attempt to teach children the purpose of sex and the proper time to take part in sexual activity, "the lack of sexual privacy serves to undermine the moral authority parents have over children" (Dodoo et al 2007). Although it seems that the solution would consist of parental units abstaining from sexual activity in the presence of children, the vast majority of individuals do not have the ability to make such a choice because it would result in preventing the birth of additional children.

Financial/Economic Status

Poverty has an effect on many different aspects of life. Although there is an increase in urbanization across sub-Saharan Africa, it is "the only region of the world where poverty is increasing, with close to half of Africans living on a dollar a day." In nations across sub-Saharan Africa, "monetary currency is central to existence" (Dodoo et al 2007). Since women are held in low regard when compared to men, they are not to be

the breadwinners of the family. The patrilineal emphasis put on men in Kenyan society expects men to earn money for the entire family while women handle domestic matters inside the home. Thus, men are automatically thought to be the solid foundation of the family in regards to survival. As a result, they are thought to be of more importance. Stemming from this thought process, women are thought to be unimportant in that they do not provide an income for family members. The lack of ability to earn money further fuels the societal views on women as noncontributing members of society. Thus, an endless cycle ensues.

A study conducted amongst urban women in Kisumu, Kenya found "that young women's own resources decrease their dependency on male partners and increase their power to negotiate safe sexual behaviors" (Luke & Munshi 2006). Thus, women with access to resources, such as money and food, are more likely to avoid situations such as forced sex. Because such women do not depend on men for their survival, they are given more respect as equals. In reference to the aforementioned topic of women being treated as property, financial independence gives women access to be in control while living in a very male dominated society. By becoming breadwinners, women are given value and treated as fellow citizens (Luke & Munshi 2006).

However, in a society in which women are not given any consideration, it becomes very difficult to find well paying jobs. One study found that "in the most economically deprived households of the slums of Nairobi, unemployment and unstable sources of income push many women and their daughters into commercial sex" (Ngom et al 2003). This finding confirms that women go into the life of commercial sex as a result of their low financial status. Since women are not a priority, they are usually not provided

with a good education. The lack of education radiates into other aspects of life for such women. For example, with a lack of education, because of the patriarchal society, women are unable to find work. Transactional sex does not require any education. Thus, many women see the potential in becoming sex workers. However, a life of commercial, or transactional, sex also exposes women to many sexual partners. The increase in sex partners further exposes women to sexual violence in the form of coerced sexual encounters. Transactional sex also brings women face to face with the inability to negotiate safe sex (Dodoo et al 2007).

An additional aspect of financial security in Africa involves the ownership of land. Because there is value in agriculture, land is very valuable when trying to live above the poverty line. However, women are prevented from gaining ownership of land in much of Africa because "customary law in Africa is characterized by the dominance of male community and family members over property and the lives of women" (Dodoo et al 2007). Since this outlook fuels the mistreatment of women, multiple studies have found that ownership of valuables may deter domestic violence. Financial independence may aid women in leading a way of life that does not revolve around a male as the sole provider. Although this study did not define 'domestic violence,' forced or coerced sex can be thought to fall into this category. Although women can obtain the benefits received by owning land, their husbands are usually the direct owners. Thus, access to the financial security that accompanies land ownership depends on the "stability of the marriage" (Dodoo et al 2007).

Coercive Sex & HIV

Gender inequality gives women a disadvantage when considering all aspects of society. Because women lack the power against men, forced or coerced sexual activity possesses the potential to expose women to the contraction of HIV. The violent nature of coercive sex increases a woman's chance of contracting HIV in three ways: "(1) through forced or coercive sexual intercourse with an infected partner, (2) by limiting women's ability to negotiate safe sexual behaviors, and (3) by establishing a pattern of sexual risk taking among individuals assaulted in childhood and adolescence" (What Works). Many women do not disclose their HIV statuses because of the fear of the violence inflicted by their intimate partners. In addition, relationships that do not have a strong, stable foundation result in women withholding their HIV statuses because of their fear of being left by their partner for other women, who are HIV-free.

When violence and coercive sex factor into the lives of married and adolescent women, the ability to discuss the use of condoms with intimate partners greatly diminishes. According to one source, a study conducted in Uganda, amongst a sample of 575 women, found that "24% of unmarried women who reported coerced first sex had used a condom at last sex, compared with 62% of those who reported no coercion at first sex" (What Works). A relationship between coerced sex and condom use can be seen here as women who are victims of forced sex admit to participating in sexual intercourse in the absence of condom use, while women who have not experienced forced sexual contact are more likely to request the use of condoms. Another study found that "40% of women said they would have sex if their partner refused to use a condom, and 40% said that they did not think women have the right to refuse sex with their partner" (What

Works). Thus, gender roles also play an important part of sexual health and the use of condoms. Because of their lower status in society and societal customs, women are not always thought to possess the ability to refuse sexual intercourse to members of the male gender, especially if the males initiating sex are their husbands. As a result, the negotiation of the use of a condom becomes an afterthought. Creating a domino effect, the lack of condom use opens the arena to a vast array of sexually transmitted infections and diseases, among which is HIV.

Education

The advancement of women is greatly impacted by the level of education attained. In societies such as those found across Kenya and other African countries, there exists an endless cycle of gender inequality and the mistreatment of women. Some aspects of the treatment of women as second-class citizens find a foundation in the amount of education made attainable to the female gender. Low levels of education continue the tradition of women caring for the household instead of holding the role of the main breadwinner of the household. In addition, an absence of educating women results in the acceptance of gender inequality because cultural norms continue to be accepted by the vast majority of people. The education to teach women to think of their rights and break away from the "norm" does not exist in such a patrilineal society.

One way in which a low level of education affects women is evident in the fact that women do not hold jobs or positions that pay well. Lacking the ability to be self-sufficient through earning an income hinders the ability of women to become independent members of society. Instead, women are thought to be property by the male

members of society since men are the sole providers. The idea that women are completely dependent on men results in the complete control men have over women in male-dominated societies. Thus, an uneducated woman becomes a powerless woman. Because low levels of education tend to leave women without the power of advancement, many women endure mistreatment. Thus, obtaining an education positively relates to the avoidance of forced sex. A study conducted in Kenya investigating abuse and gender based violence reported the following:

> Women who had incomplete high school education were almost twice as likely to be sexually abused. In addition, women with less than primary education had an elevated risk of being physically and sexually abused. Our assumption is that women with an education may command more respect from their husbands because they are perceived to be valuable assets (Kimuna & Djamba 2008).

Another way in which young women may be deterred from gaining a higher education is if teachers and fellow students are the perpetrators of forced sexual activity. The main idea here is that if young women avoid school, they avoid experiences of forced sex. As introduced in the section entitled, *Who and Why,* there exist cases in which male teachers and students pose a threat to young women attending school. Since the place of education becomes associated with coerced sex, a great stigma follows the idea of schooling. According to a study conducted amongst women in South Africa, "school teachers were the most common child rapists," contributing to 33% of the rapes reported by the 153 women who were interviewed (Jewkes et al 2002). The study also concluded that the inappropriate relations between students and teacher lead to unplanned pregnancies and harassment. These situations further result in the abandonment of education and a reduction in "a girl's ability to reach her economic and social potential" (Jewkes et al 2002). In fact, "the 1998 Kenya Demographic Heath Survey data show a

sharp drop in school attendance from 87% among girls aged 11-15 years, to 35% in the 16-20-year-old category" (Nzioka 2004). Thus, the occurrence of forced sex in a school setting fuels the incidence of a lack of education among young women. This lack of education goes on to subject women to being second-class citizens because of their lack of earning money and not being seen as valuable players in a male-dominated society. The cycle comes full circle when forced sex becomes the norm as a result of the view of women as property.

Although there are cases of coerced sexual activity among male teachers and female students, cases also exist in which a relationship is consensual. One study finds the basis of wanted teacher-student relations in the fact that young women look to find a partner who can financially provide for them (Bhana 2012). Even in cases such as these, the idea that women are not able to provide for themselves and are seen as objects to own opens the door to a wide array of sexual violence. The power differential among males and females is a factor of nonconsensual sexual relations.

Despite the fact that schools are prime areas of sexual violence, including forced sex, schools still provide a degree of education to the portion of women that escape sexual abuse and pregnancy. A study analyzing the attitude towards the study of science held by young girls in Kenya found that most girls were most interested in studying scientific topics that related to women's health. For instance, they were interested in obtaining knowledge of fertility and different methods of contraception. However, Kenyan science curriculum "holds no particular interest for girls" (Chetcuti & Kioko 2012). The irrelevancy of the curriculum to the lives of young Kenyan girls "reinforces the negative attitudes towards science" (Chetcuti & Kioko 2012). Thus, although young

students would like to obtain knowledge that is relevant to their sexual health, the Kenyan schooling system fails to deliver and illiteracy thrives.

A lack of reproductive health knowledge influences the intimate lives of young girls across Kenya. For instance, a woman initiating condom usage brings to mind the issues of "prostitution, infidelity, or STIs" (Nzioka 2004). These ideas are not the sole product of a young girl's education. The socialization of males, in contrast, produces the attitude that, in the atypical case in which a male initiates condom usage, the male is viewed as a responsible individual. Since condoms draw negative views of young women and positive views of young men, it is apparent that social meanings override health issues. To spare negative attention, women tend not to discuss condom use (Nzioka 2004). Contrary to this belief, a study regarding contraceptive use in Kenya found that an increase in the amount of schooling an individual receives results in an increase in the use of contraceptives (Kiragu & Zabin 1995).

A study conducted among young women in rural Kenya found that sexual activity also occurs as a result of peer pressure. In a society that does not have great knowledge of reproductive health, young adults face peer pressure fueled by others who do not possess adequate knowledge of sexual health. This study reports a first hand account of an 18 year-old girl. She states, "Some girls tell you that if you do not sleep with a man, your thing [vagina] will get blocked, so this threat forces you to go looking for boys to have sex with" (Nzioka 2004).

Many young adults also receive their education of sexual matters from peers or other adults who play a significant role in their lives. Because there is a wide lack of sexual health education that spans across all age groups in many parts of Africa, the

knowledge obtained from adults is not always protective when dealing with young adults' exposure to sexual activity. However, studies still find that open communication with parental figures does help against early sexual debut (Magadi & Agwanda 2009). Another aspect of obtaining sexual education from peers or adults is the fact that men "often take advantage of [the lack of knowledge] to emphasize notions of female availability and male sexual entitlement" (Jewkes et al 2001). Thus, societal ideas of male dominance and female submission prevail. Another study centered on the perspectives of adolescent boys in Kenya reported that although they have the knowledge regarding contraceptive use, pregnancy, and disease, males are not held responsible for a young girl's actions. The responsibility of sexual education rests with the girl's parents (Nzioka 2001). This information presents itself in a manner in which to say that the responsibility of gaining sexual health education bounces from parents to male peers, but never rests among the young girl in question. The core of this idea can be linked back to gender inequality and male dominance.

When mentioning the topic of young girls obtaining information regarding sexual health from parents, it is important to discuss the manner in which information is obtained. Since many African societies are modest when discussing issues such as sexuality, silence tends to play a large role in the communication between parent and child. Mbugua discusses the fact that many mothers rely on textbooks to guide their daughters through the early stages of sexuality. By purchasing books and placing them amongst their daughters' belongings, mothers rely on the idea that their daughters will read the information and benefit. However, the lack of communication proves to be confusing. Physically discussing topics would make for better understanding but societal

norms would be defied (Mbugua 2007). A lack of communication also contributes to the confusion surrounding what exactly constitutes sexual coercion because the issue has a different connotation for both men and women (Ajuwon et al 2001). Another method used by parents to prevent the unwanted consequences of adolescent premarital sex is through the instillation of fear. Parents urge their children to follow religion, avoid contraction of sexually transmitted infections and pregnancy, and obtain an education (Ameh et al 2009). This method fails to provide young individuals with actual understanding of sexual activity.

Although an increase in the educational status achieved by women seems to be a solution to many of the issues surrounding forced sex, there still exists the case of a perpetrator having a mother who has obtained higher education. According to a study conducted among South African men, intimate partner rape and non-partner rape are both linked to a more educated mother. Since people of higher education in such a poverty-stricken society would be able to earn a higher financial status, the study assumed the higher education of the mother to be indicative of a higher status in society. The mother's children would also be products of a higher societal status, and would not be refused sexual activity by women belonging to lower levels of society. Thus, although the higher educational status of a woman may protect her against sexual coercion, it may not protect the vast majority of women who have not obtained a high level of education (Jewkes et al 2006).

As previously discussed, a lack of education does expose women to increased sexual activity. However, literate women also have the possibility of an increase in sexual activity and multiple partners because they tend to marry at a later age. The increase in

sexual activity is observed in the form of premarital sex (Ikamari 2005). Considering the element of time involved while obtaining higher education, women may have an increased number of partners. Women with a high number of sexual partners exhibit riskier sexual behavior (Fonck et al 2005). Such behavior includes forced sexual activity. Thus, reaching a higher level of education does not always direct women in a path clear of sexual exposure. In some cases, women may be exposed to more sexual activity, as they remain single for a longer period of time.

On the contrary, increased levels of education do not always result in increased premarital sex. A study conducted in Lusaka, Zambia presented the difference between "having completed more years of education" and "currently attending school" (Magnani et al 2002). Those individuals who had completed their education or were currently enrolled showed "lower odds of having ever had sex and of having had more than one sexual partner" (Magnani et al 2002). In addition, a Nigerian study reports that more knowledge of sexual health leads to a reduced number of sexual partners (Akanle and Odu 2010). Although one may wait a longer period of time to marry, he or she may not exhibit higher levels of sexual activity.

The role of education in the lives of all individuals proves to be significant. Education equips each person with the ability to think independently about societal and cultural influences. In addition, exposure to education allows the expansion of thought processes when introduced to "new values and beliefs" (Spijker & Esteve 2011). This newfound independence allows one to break away from 'the norm.' In African society, the strong pull of gender inequality as low levels of educational attainment fuel a societal and cultural norm. Although education creates an opening for changes in cultural views,

one resource lists the idea that "the protective effect of women's education [is] muted in communities accepting of mistreatment" (VanderEnde et al 2012). Thus, even though education can provide a positive change for society in regards to gender equality, higher levels of education may not be able to penetrate societies in which the mistreatment of women is widely accepted. In addition, in communities that accept gender inequality as a natural part of life, the topic of education is also deciphered through the same mindset. Because African communities also deal with poverty, there is usually a preference for boys to attend school over girls. Since a girl marries at an earlier age and is given to the groom in exchange for bridewealth, families tend to avoid investing in her. The economic costs of education are thought to be better spent on male children (Warrington & Kiragu 2012).

The Gap

The issue of coerced sex is widely accepted as a topic of significance in various developing countries across Africa. The literature supports the fact that coerced sexual activity is not going unnoticed. While reviewing the current literature, it becomes apparent that cultural factors, such as marriage customs and the structure of families and households, play a significant role in the treatment of women in African society. In addition to culture, factors such as laws, place of residence, education status, and financial status also interact with one another to create the environments in which women face the aspects of sexual health. The basis of the aforementioned factors is found in the gender inequality that spans the vast majority of African societies. The subordinate role of women provides a gateway for the mistreatment of women. The mistreatment of

women in African societies tends to include sexual coercion. As mentioned in the literature, because of their status as second-class citizens, women are treated as property. This mindset puts men in charge and allows for the integration of forced sex and culture.

The endless cycle of gender inequality and mistreatment of women in the form of coercion approaches a stopping point with the consideration of education. Although the literature explores the effects of education on women's susceptibility to sexual violence, it lacks the specific information concerning the effects of the knowledge of reproductive health on sexual health and women's exposure to forced sex. In addition, while different African communities have been studied in regards to sexual health, coercion, and education, the culturally traditional community of the Luo tribe, found in rural, western Kenya on the Nyakach Plateau, has not been studied for patterns regarding the knowledge of reproductive health and sexual coercion.

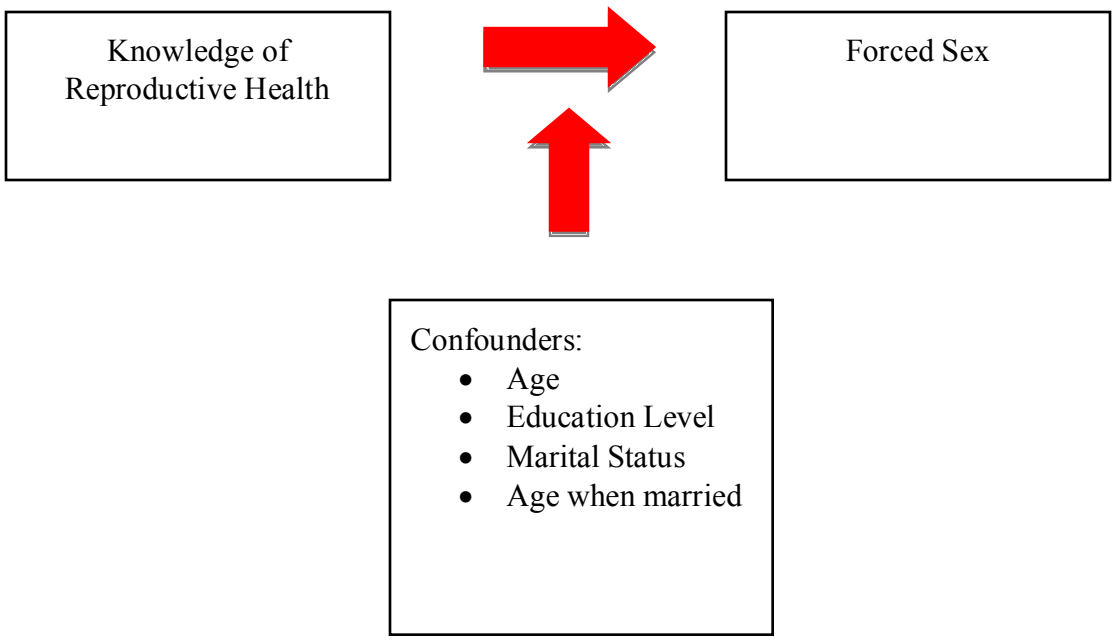
The goal of this study is to find and analyze the possible link between knowledge of reproductive health and forced sex. In addition, similar communities may use the findings of this particular study to further advance towards the closure of the gap between the knowledge of reproductive health and coerced sexual activity among their own populations. Finding the missing gap is essential to furthering the empowerment of women in a patrilineal, or male-dominated, society. More importantly, in the tradition of community-based research, this study aims to provide information to help this particular group of people with their unique characteristics to achieve their goals of a healthy community.

CHAPTER THREE

Hypothesis

With the general objective of the investigation of reproductive health knowledge and coerced sex, this study proposes to test the primary hypothesis that: women with greater knowledge of reproductive health will be less likely to be victims of forced sex than women with little or no knowledge of reproductive health. This hypothesis will be tested while adjusting for these potential confounders: age, education level, marital status, and age when married.

Figure 1:



In addition to the proposed hypothesis, this study aims to analyze and obtain information regarding the attitudes and behaviors toward the issue of forced sex exhibited by the women in a rural, western, Kenyan community.

CHAPTER FOUR

Methodology

Background

Members of the Luo tribe living on the Nyakach Plateau are the focus of aid from a non-profit group called Straw to Bread based in the U.S. Their efforts span a wide array of medical and public health interventions and are guided by the wishes and goals of the community itself in a partnership. In 2009, a healthcare assessment was carried out through informal conversations with members of the Luo community who were familiar with life in the Luo villages and a number of health issues that affect them. The information gained through these conversations revealed that women are seen as the essential sources for all health information. However, further dialogue between team members and community women conveyed the lack of information regarding health possessed by the women.

This finding prompted a study in 2010 regarding the knowledge of reproductive health. Data was collected through interviews with women of the Luo tribe who resided on the Nyakach Plateau. The women's study found inadequate levels of the knowledge of reproductive health and reports of a large amount of forced sex. In an effort to improve knowledge levels, the principal investigator of the study, Shannon Wood, put together reproductive health curriculum. In 2011, the following summer, the curriculum was presented to a female representative from each village. Additional surveys were also

obtained to better gauge the occurrence of forced sex in the Luo community of the Nyakach Plateau. This study is based on the surveys completed in 2011.

Study Design

This cross-sectional study utilized data collected through interviews conducted from May 20-27, 2011. The interviews were guided by a questionnaire compiled by principal investigators, Dr. Lisa Baker and Shannon Wood. The questions included in the questionnaire were gathered from the World Health Organization (WHO), the DHS violence section, and the research team's 2010 survey. All the information and questions gathered from the aforementioned sources was then adapted to fit the particular community of study. The results concluded through both of these studies will be used in the future implementation of community-led violence interventions.

Sample

The women who were interviewed made up a convenience sample that was recruited by the local women's health educators and by word-of-mouth. They were each invited to participate and signed an informed consent form before the interview began.

Conducting the Interviews

Baylor University students taking part in the Straw to Bread annual medical/public health mission trip conducted the interviews for this study. The students communicated with the Kenyan women through the use of female translators. Each translator was chosen by the on-site project coordinator for her level of education and

ability to communicate in English. The on-site project coordinator for this study was Habil Ogola, a local leader and member of the Luo community on the Nyakach Plateau. A total of 112 questionnaires were completed through interviews with women in central locations in six different villages. The following villages were included in this study: Kadero, Katieno, Komoro, Naki, Ramogi, and Soko. Surveys were also completed through interviews conducted at the temporary clinic, which is setup by Dr. Lisa Baker and the medical mission team. Each village has a different number of surveys completed for this study due to weather and the number of consenting women.

Before students were approved for the interview process, they were trained using an *Interview Guide*, which included tips for the interviewer (*Appendix*). These materials, put together by the principal investigators, were used to relay to the interviewers ways in which to develop comfortable settings for the participants. In addition, interviewers were taught the importance of separating the signed consent forms from the completed surveys.

In order to work well with village officials and translators, a schedule was determined ahead of time in regards to when and where the interviewers would meet with the participants. Interviewers and participants were paired into groups of two and relocated to a secluded area in order to maintain the confidentiality of the participant's responses. Before beginning an interview, the interviewer explained the purpose of the survey and consent form. If the individual did not decide to participate in the interview, the interviewer thanked her and moved on to another woman in the village. However, if the individual did consent to participate in the interview, the consent form was signed and placed in a separate folder. At any time during the interview, which was approximately

30 minutes in duration, the participant was given the option to skip questions she did not want to answer. In addition, she was also able to bring the interview to a complete stop. Once the interview was complete, the survey was placed in an unmarked folder in order to preserve the anonymity of the participant. Each participant was also encouraged to contact the on-site project coordinator if questions arose following the interview. The women who participated in the surveys were thanked for their time and responses. The project was approved by the Baylor University Institutional Review Board.

The Survey

The instruments, or surveys, utilized for data collection in this study employed questions that were based on the questions in the Kenya 2010 survey. This previous survey was developed with Dr. Eva Doyle and the work of Ami Bouassa Semalon, *Healthcare in Sub-Saharan Africa: A Needs Assessment for a Medical Clinic in Rural Kenya (2010)*. Information regarding violence was gathered from WHO and the 2006 Kenya DHS. These sources helped to guide the surveys into gathering more information involving sexual violence in the form of forced sex.

The survey used to gather data presented many questions to the participating women in a straightforward manner. These questions resulted in yes or no answers. Other questions provided room for open-ended responses in that the women were able to describe thoughts or situations. While certain questions were geared toward each participant's private life, others attempted to gain insight into the viewpoints the participant had regarding her community as a whole. Such questions helped to provide a basic summary of the common outlook on reproductive health held by members of the

community. As a whole, the survey questions addressed the following topics: demographics, general health, knowledge of reproductive health, family planning, and forced sex.

Data Analysis

Each trained interviewer used the *Interview Chart* to conduct each individual interview and to fill in the corresponding responses on the surveys (*Appendix)*. In addition, open-ended questions were analyzed to identify themes and common responses.

Each survey response was double entered into Excel, using a codebook created by the principal investigator. The database was then checked for discrepancies and transferred into SAS version 9.3, which was then used for the quantitative analysis. Descriptive statistics were based on frequencies of all the variables that were calculated with univariate analysis to determine the central tendency, range, and standard deviation of each distribution.

In order to conduct data analysis, the study used the results of the survey questions to create specific variables using the following methods:

Knowledge of Reproductive Health: This variable was based on nine separate questions in the original survey regarding reproductive health. If a woman answered a question correctly, one point was given. The points were totaled for a possible score ranging from 0 to 9. The questions are listed in *Chapter* 5 (*Table 1*) with the frequency of correct responses.

Forced Sex: Several questions were asked to determine the extent, perpetrator, and context in which women perceived themselves to have been forced to have sex. This self-reporting hinges on a woman's own definition of whether she has been forced and does not specify particular behaviors. In addition to asking a woman if she has been forced, another question was included that asks if a woman has been physically forced in order to distinguish between threats other than physical that a woman might perceive as forcing her to comply. All of the questions regarding behaviors and attitudes surrounding the concept of forced sex can be found in the *Appendix, questions 52-71*.

Bivariate and multivariate analysis was done to test relationships between variables. The Chi square statistic was used for discrete variables, and Pearson's correlation was used for continuous variables. The t test and analysis of variance was used to test differences between means in groups of two or more variables, respectively. Logistic regression was used to analyze the relative contribution of variables to the "forced sex" variable and to control for confounders. Alpha was set at .05.

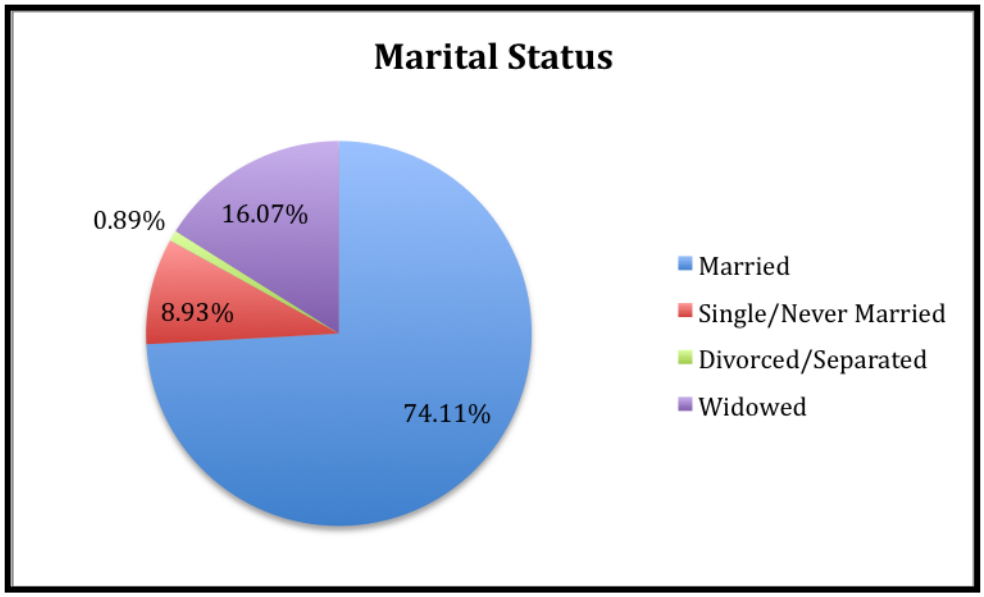
CHAPTER 5

Results

Characteristics of the Sample

This sample of 112 women ranged from 18 to 80 years in age. The median age was 32.0 years (SD=13.37 years). Eighty percent of women were of childbearing age (less than or equal to 46 years of age). At the time of the interview, 73.08% of the women were currently living with their husband or partner (*Figure 2*).

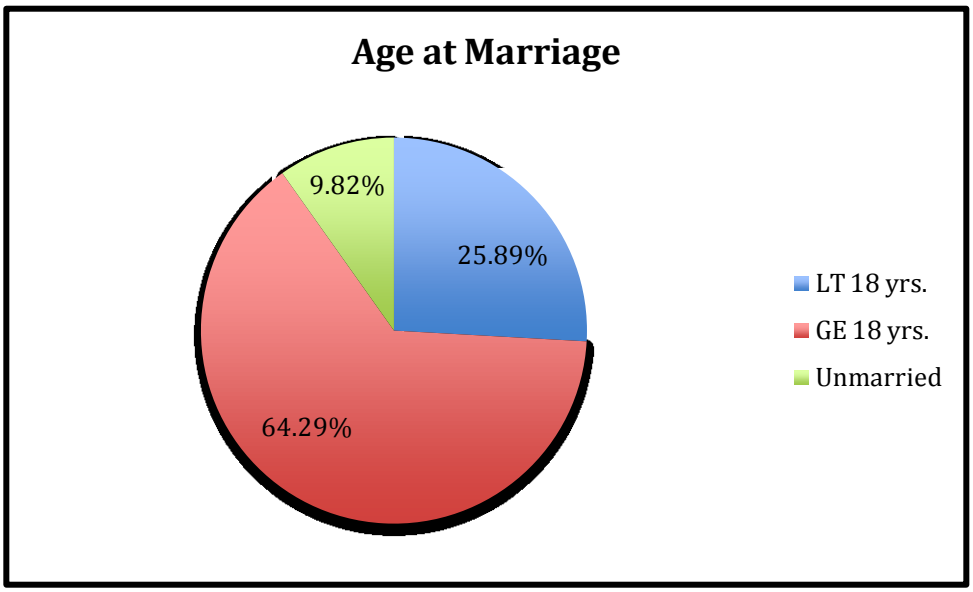
Figure 2:



Each woman who was married at some point in her life was asked to report the age at which she married. The age when women married ranged from 12-35 years, with the median age at marriage being 18.0 years (SD=3.28 years).

Interestingly, 25.89% of the women in this sample were less than 18 years of age when married (*Figure 3*).

Figure 3:



The data showed that 95.45% of the women interviewed (n=110) had children, the number ranging from 0 to 12. The mean number of children was 4.51 (SD= 2.72).

Education Level

Approximately 88.39% of the sampled reported having at least some schooling, while 11.61% had never studied in school. At the time of the interview, 3.09% of the women were currently enrolled in school. About half (55.36 %) of the women completed primary school education, while only 33.04% completed a secondary school education, university/trade school, or technical training (*Figure 4*). The level of education was negatively associated with age in this sample (F=8.03, p=0.0055), with the older women

having less schooling than the younger women. In addition, there was a statistically significant relationship between marital status and education (χ^2= 11.0853, p=0.0039). Among the women who were never married (8.93%) (*Figure 5)*, 80% have completed more than a primary education. Among the women that have ever been married, only 28.43% have surpassed a primary level education.

Figure 4:

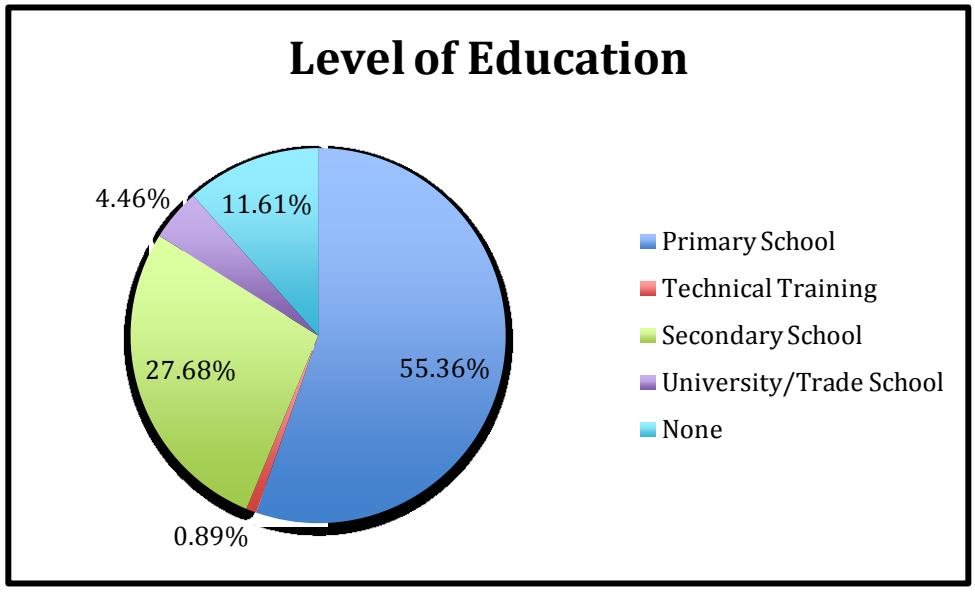
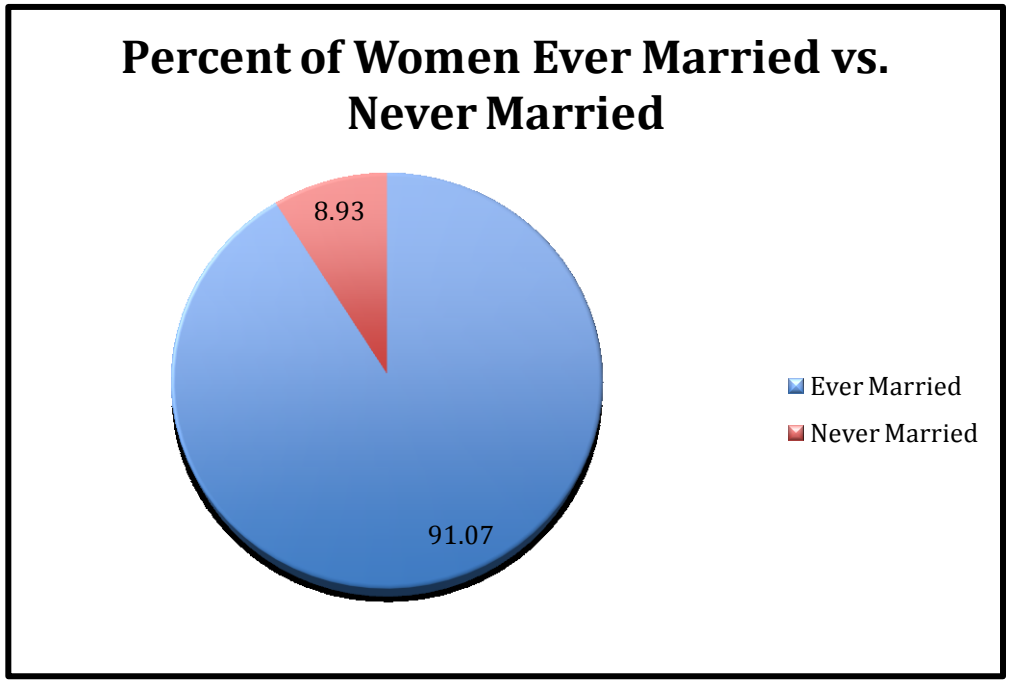


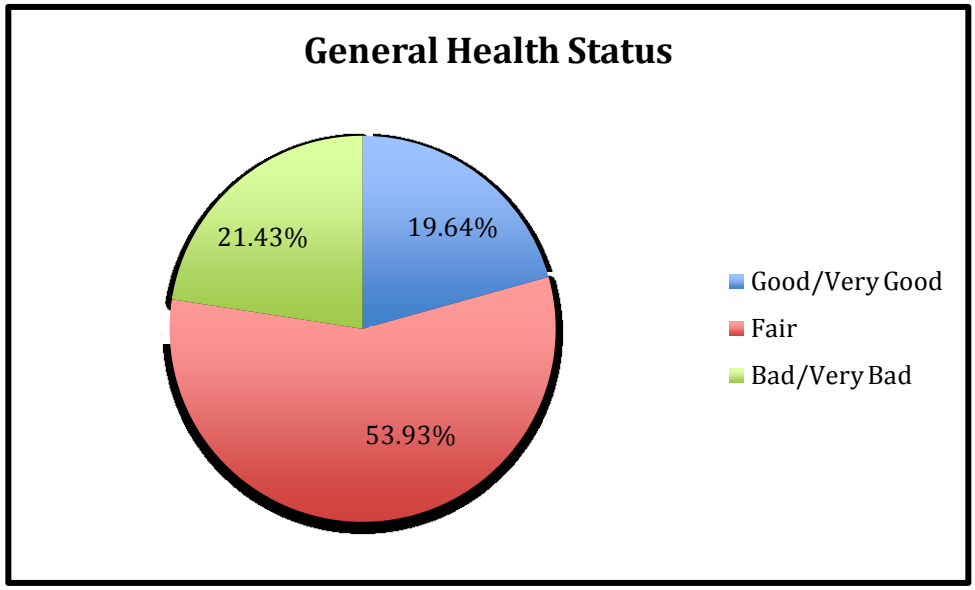
Figure 5:



General Health

Women were questioned on the topic of their individual general health status at the time of the interview. Approximately half of the women (53.93%) reported that they were in fair health. The percentage of women who reported good or very good health was about equal to the percentage of women who reported bad or very bad health. The distribution of these responses is presented in *Figure 6* below.

Figure 6:



Knowledge of Reproductive Health

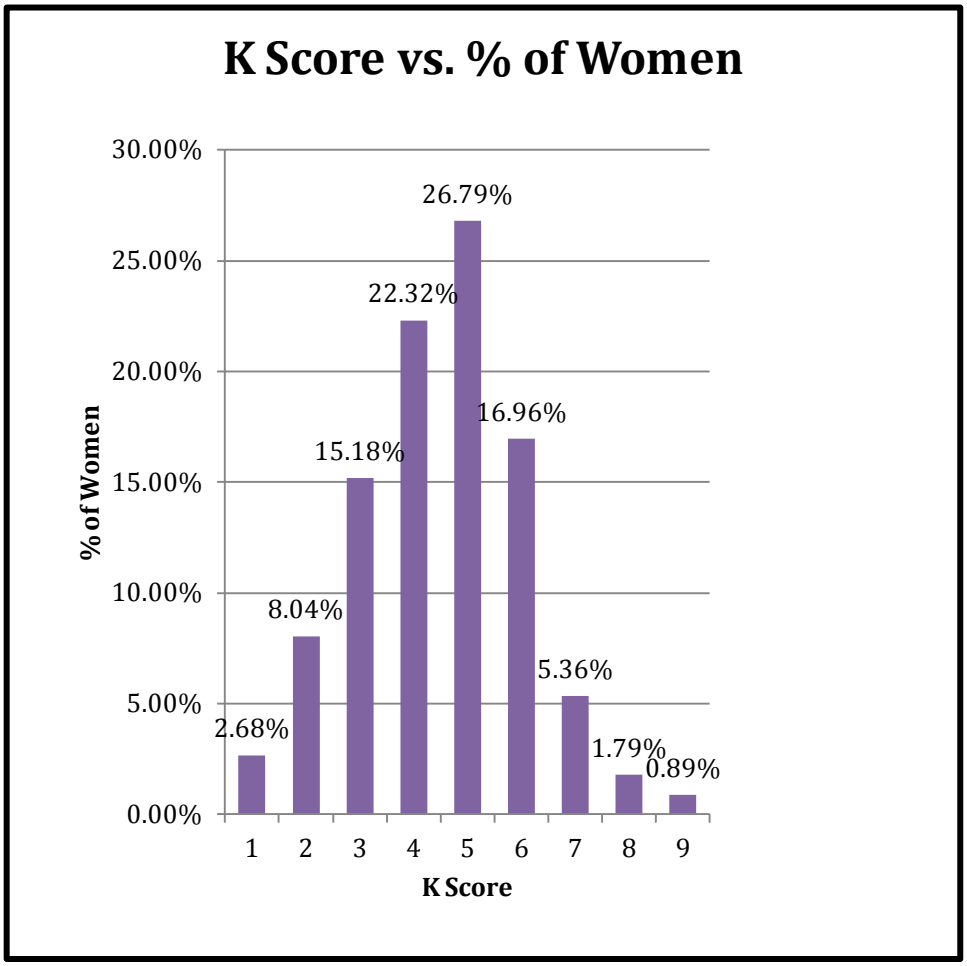
A total of nine individual questions regarding reproductive health were asked in order to gauge the level of reproductive knowledge observed amongst the women interviewed in this study. One woman answered all nine questions correctly, while none of the women partaking in the survey answered all nine incorrectly. This indicates that each woman who participated in the study had some knowledge of reproductive health. The questions and their corresponding response frequencies for correct responses are listed in *Table 1*.

Table 1:

Reproductive Health Questions	Correct (%)	Incorrect (%)
How many times per month does a woman normally get her (menstrual) period?	92.86	7.14
Can a woman get pregnant during her period?	27.68	72.32
Can a woman get pregnant the first time she has sex?	62.50	37.50
During which part of a woman's menstrual cycle is she most fertile (more likely to get pregnant)?	11.61	88.39
How long does a normal pregnancy usually last?	87.50	12.50
Is it bad for the baby if a pregnant woman drinks alcohol during pregnancy?	66.96	33.04
Is it bad for the baby if a pregnant woman smokes during pregnancy?	74.11	25.89
Name some ways that people can get HIV/AIDS.	17.86	82.14
Name some ways that people can protect themselves from getting HIV/AIDS.	8.04	91.96

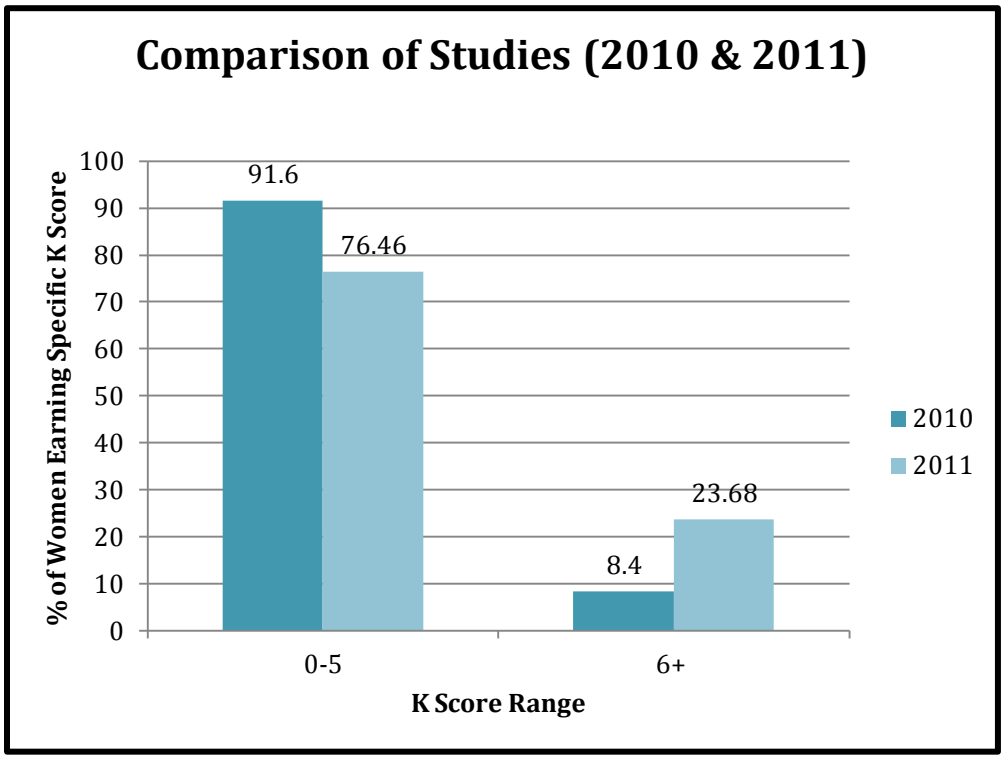
The percentages of women who received each K Score are listed in *Figure 7.* The compiled Knowledge Score (K Score), or number of reproductive health questions each woman answered correctly, ranged from 1 to 9, with a mean K Score of 4.49 (SD= 1.56).

Figure 7:



The percentage of correct responses in this study was markedly higher than in the 2010 study (Wood 2011) (*Figure 8*).

Figure 8:



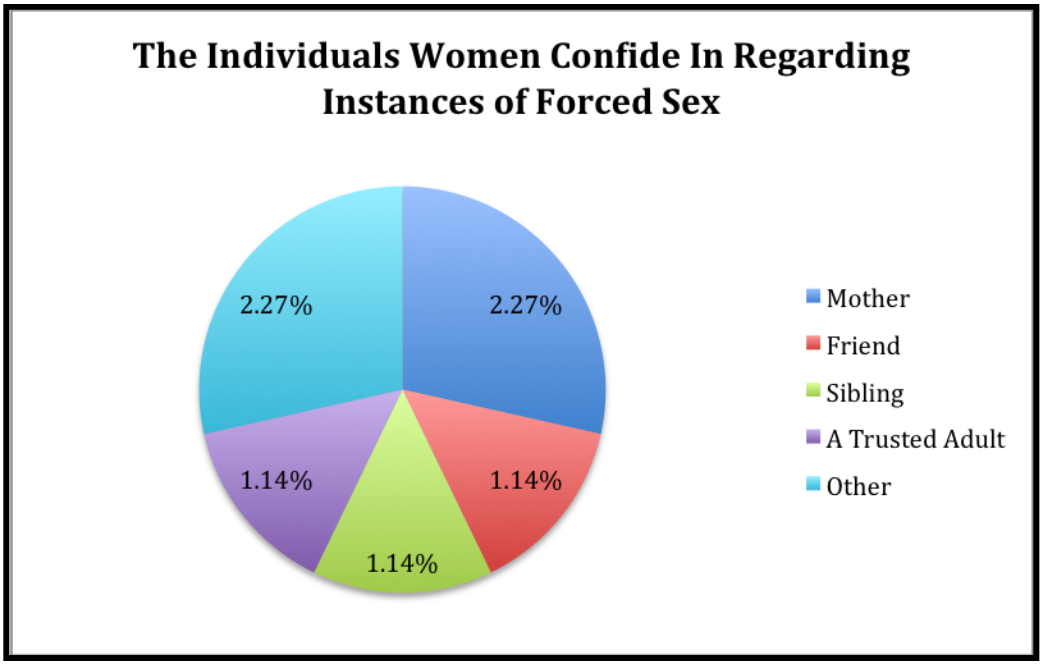
During the next step of analyzing the relationship between the knowledge of reproductive health and forced sex, extreme scores of 1, 8, and 9 were excluded because there were only one or two people with these scores. With a small sample size, we did not want to over-interpret results that were based on responses of very few people in a category. When these outliers were excluded, the mean reproductive health knowledge score was 4.80 (SD=1.22).

Forced Sex

Of the women interviewed, 22.73% reported that they had been forced to have sex. This prevalence is quite different than the 63.9% found in the first study. The ages

of these women when they were forced to have sex ranged from 13 to 35 years. The median age when forced was 20.5 years (SD=5.06 years). The mean value for the number of times these women were forced was found to be 5.01 times (SD=20.83). In addition, 68% of the women who were forced to have sex did tell another member of the community about the incident, while 28% did not tell anyone (*Figure 9).* Among the women who reported instances of forced sex, 13.76% were physically overpowered, while 86.24% were not physically overpowered.

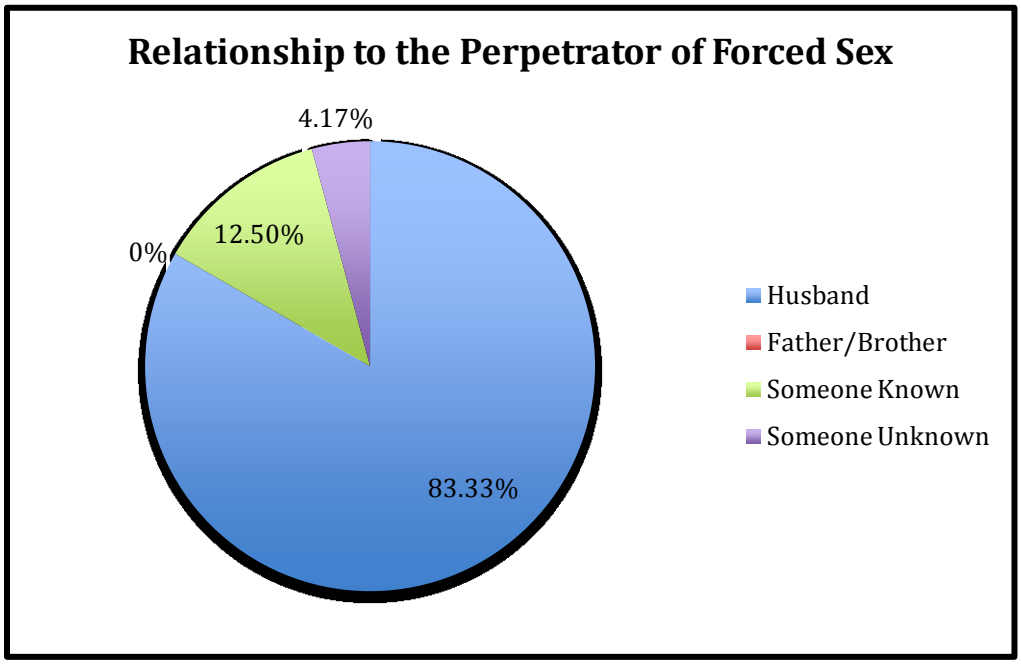
Figure 9:



The relationships to the persons forcing the women to have sex and the corresponding frequencies are listed in *Figure 10.* The vast majority (83.33%) of the 22.73% of women who said they had been forced to have sex identified the perpetrator as

their husband. Greater than 95% of women said the person was someone they knew, and no one identified the person as a father or brother.

Figure 10:



A great majority of the women included in this study (79.63%) stated that they did not know anyone else who had been forced to have sex. Only 16.67% knew, with certainty, of another individual forced to have sex and 3.70% of the women did not know if they knew someone else who had been forced. However, when asked how common the problem of forced sex is, 42.20% of women interviewed said forced sex was very common. Approximately half (47.66%) of the sample reported that their mothers were not forced to have sex, but more women (52.34%) reported that they did not know if their mother had ever been forced.

The participants answered various other questions regarding the issue of forced sex, listed in *Table 2*. Surprisingly, not everyone thought that forced sex should end

(95.33%). About a third of the women (36.45%) said that they believe that it is their husband's right to have sex with them whenever he wants, and twice that many (64.76%) said that their husbands themselves believe that it is their right.

Table 2:

Individual Force Questions	**Yes (%)**	**No (%)**
Would you like forced sex to end?	95.33	4.67
Do you feel it is your husband's right to have sex with you whenever he wants?	36.45	63.55
Does your husband feel it is his right to have sex with you whenever he wants?	64.76	35.24

Factors Affecting Knowledge of Reproductive Health

In attempting to adjust for the potential confounders of age, age when married, and education level, K Score was regressed on age, age when married, and education level. There was a significant association in the overall model (F=4.69, p=0.0017) (*Table 3*). The compiled Knowledge Score (K Score) in this portion of the study excluded scores of 1, 8, and 9, as previously explained.

Table 3:

Predictors of Reproductive Knowledge

Variable	SS	F	P
Age	0.1119	0.07	0.7887
Age When Married	13.4812	8.71	0.0040
Education Level	15.4693	4.99	0.0087

Total Model: F=4.69, p=0.0017, R^2=0.170966

This model was able to explain 17.10% of the variance in regards to the K Score (R^2=0.170966). The current age of the women in the sample did not significantly relate to the amount of knowledge of reproductive health observed by women (p =0.7887) when adjusting for the other two variables. However, age when married did show significant association with K Score (F=8.71, p=0.004). An increase in the age when women married positively related to an increase in the K Score. In addition, education level was also significantly related to the K Score (F=4.99, p=0.0087). A higher education level resulted in an increase in K Score. Thus, while education level and age when married are both significantly related to knowledge of reproductive health, they are also independent of one another.

The relationship between knowledge of reproductive health and if women felt as though it was their husbands' right to have sex with them whenever their husbands wanted (*Table 2*) was significant (p=0.0287*)*. Adjusting for the age when married confirmed a significant relationship between the age when a woman is married and if she feels as though it is her husband's right to have sex with her whenever he wants

(p=0.0497). Women who married at a younger age and had more knowledge of reproductive health were more like to say 'yes' when asked this question.

A significant relationship was found between knowledge of reproductive health and if women think their husbands feel as though it is a husband's right to have sex with his wife whenever he wants (t=3.44, p=0.0009) (*Table 2)*. Women with less knowledge were more likely to think that their husbands feel as though it is his right to have sex with her whenever he wants. However, as the table below presents, there was an overwhelming amount of women in the 'Adequate Knowledge' category that responded 'yes' to the question (*Table 4*). Thus, women with more knowledge of reproductive health were more likely to say that their husbands did think it was a husband's right to have sex with his wife whenever he wanted.

Table 4:

Does your husband feel it is his right to have sex with you whenever he wants?	**Adequate Knowledge**	**Very Little Knowledge**	**Percent (%)**
No	✓		35.24
Yes		✓	10.48
Yes	✓		54.29

Primary Hypothesis

Women with greater knowledge of reproductive health will be less likely to be victims of forced sex than women with little or no knowledge of reproductive health.

No significant association was found between the amount of reproductive health knowledge exhibited by women and the likelihood that they would be victims of forced sex after adjusting for possible confounders of age, age at marriage, and education (χ^2=1.4072, p=0.9235) (*Table 5).* The prevalence of forced sex in this community cannot be explained by the amount of knowledge of reproductive health, and this relationship does not become statistically significant after controlling for age, age when married, or education level.

Table 5:

Regression of Forced Sex (Yes or No) on Knowledge, Adjusting for Confounders

Variable	Odds Ratio	95% CI	p
K Score	1.137	0.775-1.668	0.5104
Age	1.007	0.970-1.045	0.7262
Age When Married	1.070	0.894-1.281	0.4588
Education Level (none vs. secondary)	1.384	0.250-7.659	0.8604
Education Level (primary vs. secondary)	1.462	0.455-4.702	0.6835

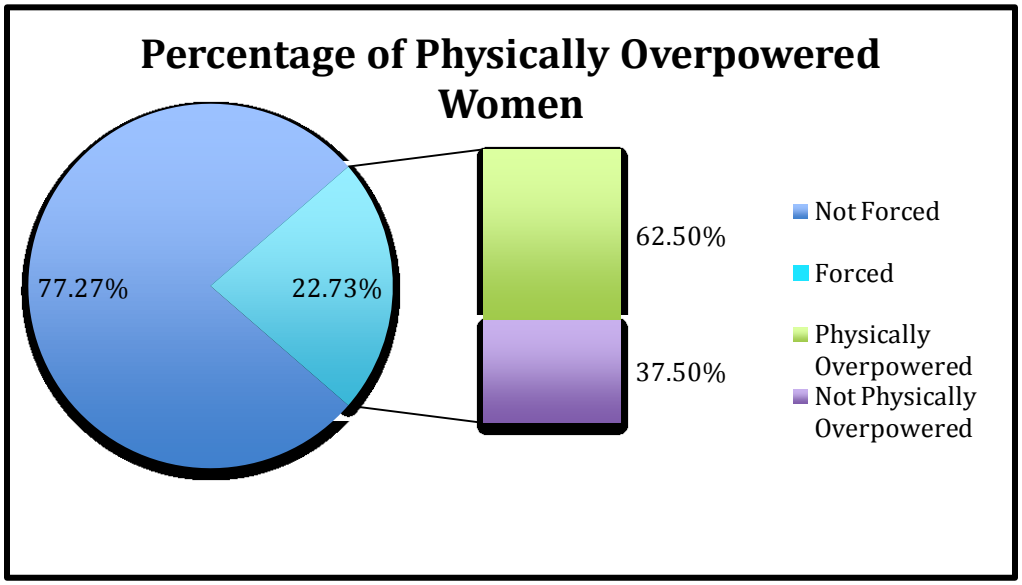
Total Model: χ^2=1.4072, p=0.9235

There was an association close to statistical significance (χ^2=3.6138, p=0.0573) between women with greater knowledge of reproductive health and whether or not they thought forced sex was a common problem, but after controlling for the potential confounders of age, age when married, and education level, none of the variables was significant, most likely due to the increase in degrees of freedom in the regression

equation. Additionally, the amount of knowledge of reproductive health a woman possessed did not relate to the number of times she was forced to have sex.

As mentioned previously, 13.76% of the total sample was physically overpowered to have sex. Of the overall group who were forced (22.73% of the total sample), nearly twice as many (62.50% vs. 37.50%) reported that they were physically overpowered versus not physically overpowered to have sex (*Figure 11)*. There was a trend in the data suggesting that greater knowledge of reproductive health lessened the likelihood of a woman to be physically overpowered when forced to have sex (χ^2=2.4628, p=0.1166).

Figure 11:



CHAPTER SIX

Discussion

Primary Hypothesis: Women with greater knowledge of reproductive health will be less likely to be victims of forced sex than women with little or no knowledge of reproductive health.

The absence of a significant relationship between knowledge of reproductive health and decreased forced sex is astounding. This study found that the knowledge of reproductive health observed by women is not preventive of the occurrence of forced sex, though there is a suggestion in the data that knowledge might be a deterrent for nonconsensual sex that is forced through physical violence.

As discussed in *Chapter Two,* in male-dominated communities, such as the Luo community, it is apparent that males harbor total control of women. In societies that are completely dependent upon male individuals, obtaining an education for a female can prove to be quite difficult because males are given priority to be educated. From the point of view of the members of the African community, it is understandable that a male receives an education before a female because without prioritizing, families would see great difficulty in progressing to a higher standard of living. However, this seemingly necessary 'priority' given to men essentially enables the endless cycle of the oppression of women. Within marriages, women are not treated as equals because they are not the primary breadwinners. Obtaining an education, financial stability, and the oppression of women are all intertwined in the intricate study of how societies function. Thus, although

each woman in this study possessed some idea of important reproductive health information, it is probable that she did not have enough knowledge to become independent in a society dominated by men.

The fact that women do not have 'enough' knowledge is certainly related to the fact that sex, and particularly the issue of forced sex, is not an appropriate topic to be discussed. This lack of information can give males an opportunity to use this gap to their advantage. As a result of this, there still exists the opportunity for a male to force a woman into sexual relations.

In order to test the relationship between the knowledge of reproductive health and the prevalence of forced sex, data was obtained via interviews of women residing in a rural, western, Kenyan community. The community focused on was that of the Luo tribe. A compiled Knowledge Score (K Score) was calculated by evaluating each of the nine questions that concerned important facts regarding reproductive health (*Table 1).* Each of the women had some knowledge of reproductive health, as no individual received a K Score of zero, but almost no one got every answer correct. Women who had obtained a higher education level had greater knowledge of reproductive health. These women were not likely to have been exposed to reproductive health knowledge in an educational setting, so it is not clear where they learned the limited amount that they know.

Women who were married at an older age and had more education had more knowledge of reproductive health. This aspect of the sample may be attributed to the fact that by marrying at an older age, women are more likely to pursue higher levels of education because they have more time to do so. In very traditional communities, such as that of the women included in this study, marriage comes with many responsibilities that

do not include furthering one's education and obtaining independence through getting a job and earning money. Once married, most women are expected to care for the entire household and have children, and they are not encouraged to get an education. Thus, marrying at an older age puts off some of these tasks. Education level decreased with age, most likely indicating the increasing opportunity for younger women, even though it is still very limited. Apart from its effect on education, current age by itself is not related to reproductive health knowledge.

Physically Overpowered

This study did uncover the following trend: Greater knowledge of reproductive health may lessen the likelihood of a woman being physically overpowered when forced to have sex. This relationship is interesting in that, although women with knowledge of reproductive health are no less likely to be forced to have sex, they may be less susceptible to being victims of physical violence. This aspect of the study may also be linked to the dominant role filled by men in many African societies. In a community that gives all power to males, it may not be necessary for the male members to exert physical violence in order to receive what they want from subordinate members of society. Males are more likely to be held in higher regard because they are more educated and most likely have a stronger financial position when compared to women. As a result, women may submit to anything that is asked of them. Thus, the physical aspect of forced sex is circumvented due to voluntary submission. However, one must remember that 'voluntary submission' does not imply that the woman wants to take part in the sexual activity. Simply put, she most likely thinks she does not have any other choice. The stakes are

high for women who have little or no education and no economic power. Although a woman does have some knowledge, she may not be in the position to stand up for herself as a result of all the societal factors working against her. Education cannot always provide a protective effect if the vast majority of the community is accepting of the mistreatment of women. It appears, however, that physical violence may be where some women who are better informed about their own reproductive health will draw the line.

The Right to Have Sex

Contrary to the notion that education empowers women, the participants in this study who had greater knowledge of reproductive health were *more* likely to state that their husbands had the right to engage in sexual activity with their wives whenever they wanted. This is one of two findings that are in direct contrast to the literature about the effect of education on women's empowerment, and it is indeed puzzling. In answering this question, they did not speak to the issue of whether or not wives had the right to refuse sex, but it is implicit in the question that a husband's right would require that a woman submit. In addition, these women were also more likely to state that their husbands also thought the right to have sex with his wife was entitled to a man whenever he wanted.

Possible explanations for this finding include the methodological issue of random or systematic error and small sample size. However, if the finding represents the reality of the situation, then we must conclude that, in this traditional, tribal community, the right to have sex is still strongly linked back to powerful cultural beliefs and practices. Since women do not have the ability to thrive on their own in male-dominated society,

they must play the role of subordinates. As previously discussed, women are treated as property and may be used to fulfill all the needs of their husbands once they are married. Essentially, the marriage is treated as a contract: the husband will provide for his wife, while his wife will take care of the household and children. Sexual activity is a given in the marriage contract. Once again, in a culture accepting of males as the sole leaders, women cannot overcome the oppression that is so ingrained in the way of life.

The second finding that is puzzling is that women with more reproductive health knowledge were less likely to think that forced sex was a common problem in their community. Besides the usual possibility of random error, one explanation might be that these women, whom we have learned do not communicate freely about these topics, are more likely to talk with like-minded women and men. The more knowledgeable women may simply reflect the underlying assumptions of the community, or they may truly underestimate the extent of the problem more than their counterparts who are less knowledgeable, with its associated variables of less education and younger age at marriage.

Given the older cultural view of gender roles, it is encouraging to see that, in this rural, traditional Luo community, two-thirds of this sample of women did *not* think that it is their husband's right to have sex whenever he wants. From this standpoint, it is perhaps also a sign of a cultural shift that only one-third thinks that their husbands believe that they are entitled to sex with their wives at any time. Even in a community of great poverty and a large number of poorly educated women, there are some indications of the winds of change. There appears to be a lag between the more modern viewpoint

among women compared to the pace of change among men in moving away from a belief in male domination.

Communication

Not only is reproductive health not taught systematically in schools, but women in this study indicated that issues about forced sex were almost never discussed in spite of the belief that it was prevalent. Although most traditional communities deem the topic of sex as inappropriate, more open conversation about this topic would immensely help the situation seen among the women. Most women did not know anyone else who had been forced to have sex, but half of those still considered forced sex to be a serious problem in their community. Still, only one out of 6 women knew with certainty of someone else being forced. These statistics are alarming, because if women would communicate with one another, more would know of the issue. Communication would also facilitate the banding together of the women against an issue as traumatic as unwanted sex.

Potential Errors

Potential sources of error in this study may have included the language barrier that would especially impact answers to very sensitive and infrequently discussed topics such as forced sex. Interviews were conducted with the help of a trained translator, however it is possible that there may not have been the exact equivalents in Luo vocabulary for English terms. Translators did provide the opportunity for the women to receive clarification on any subject matter they did not understand, and open-ended questions were included to allow women to give answers that were more nuanced and

complete. In addition, when discussing a sensitive topic like forced, nonconsensual sex in a traditional society, there is room for incomplete answers and the withholding of information. Since the community focused on was very male-dominated, women may have not reported instances of forced sex for fear of trouble.

The outcomes of this study may have been improved if a larger sample size was attainable. As a result of the time involved in conducting the interviews and the number of available translators and interviewers, more interviews could not be completed in the time allotted to complete data collection. Thus, more time and researchers would have allowed for more data collected, resulting in less potential error in the study.

The difference between the 2010 study and this study were in the areas of the prevalence of forced sex and the amount of reproductive health knowledge (Wood 2011). Possible reasons for these discrepancies include: 1) the first study overestimated and when more details were sought, then a more accurate picture emerged; 2) both were relatively small samples given the total population, and neither was a random sample; 3) selection bias of second sample which was recruited largely by village leaders of the women's groups and may have included women who were experiencing less forced sex. This final interpretation would be supported by the fact that the knowledge level of the second sample was higher than that of the first sample (*Figure 7*), thus, following the hypothesis that more knowledge is associated with less forced sex. The fact that the knowledge score was higher in this study than in the previous study could, of course, be due to the sampling issues.

There has been no formal assessment yet of an intervention that grew out of the first study's finding that knowledge was lacking. It is possible that the two samples

reflect a real change in knowledge as a result of the influence of this program. It is impossible to know if these women are the same since great care was taken to keep the interview results anonymous. Research is being planned to evaluate the effect of this educational program, and these results will help us better understand the discrepancy.

CHAPTER SEVEN

Conclusion

This study presents insight into the attitudes and behaviors that fuel intimate relationships in a rural Kenyan community that relies on traditional practices. The goal of this study was to find the link between the knowledge of reproductive health among women and the likelihood of nonconsensual sex. The fact that the findings did not support this association stems from the complex web of beliefs and values surrounding reproductive health knowledge and forced sex in traditional, male-dominated communities with few paths to education and economic power.

The level of knowledge of very basic reproductive health was low among many of the women. The system needs changing so that individuals can be empowered to make choices and improve their lives. Within the context of such poverty of economics and education, it is not surprising that a minimal amount of reproductive health knowledge would lack having an impact on an entrenched social practice of forced sex. Even though reproductive health is not routinely taught at school, there is a significant relationship between education and knowledge about sexual health.

Efforts to implement change can be carried out through including sexual education as a part of a regular school education. In many cultures, including that of the Luo people residing on the Nyakach Plateau, general education does not include reproductive health education. While working toward changing this situation, it is also essential that communication gaps between adults and children be bridged by finding

some common ground around which these topics can be broached. In order to change the lives of the next generation, adults must make an effort to instigate conversation with both girls *and* boys.

Future programs and projects should be implemented with the goal to facilitate conversation regarding sexual health, to give accurate information, and to examine the cultural beliefs that perpetuate forced sex. This 'knowledge of self' would then allow for women to develop more confidence. They would be able to see a life outside of submission to men. Confidence would allow for independence, thus changing the society existing today. In a sense, by obtaining sexual health knowledge in addition to general education, women would have the tools necessary to become agents of change in their communities. The societal influences that cause male dominance, female submission, and even forced sex might change if women had more knowledge to enable them to challenge the pattern.

Another way in which sexual health education would help is through the idea that even if women cannot abolish the dominant role of men in their societies, they may still be able to develop the means to avoid bad outcomes and escape unwanted situations. Education provides the possibility for women to steer clear of situations of coercive sexual activity and lets them become more apt in picking up signals and signs of such trouble.

The findings of this study provide greater understanding of the reproductive knowledge and sexual behaviors and attitudes of the Nyakach Plateau community. Changes may be implemented by considering all the factors of traditional life that play an important role in the lives of women.

APPENDIX

Interview Guide

Kenya 2011

Interviewer's Introduction

1. Hello, my name is….
2. I am with Baylor University.
3. We want to learn more about your health and the health of the village. We interviewed many women last year and now need to know some more information to be better able to understand your health.
4. May we ask you a few questions?
5. This should only take about 30 minutes of your time.

Informed Consent Form

1. I brought a copy of a form that explains why I am interviewing you today. It is called a "consent form."
2. I am going to read the form to you so that you can ask questions.
3. Then, if you are willing to let me interview you, I will ask you to sign the form.
4. [Cover informed consent form with the participant. Answer questions that arise. Get their signature on the form. Place it in a folder that is separate from the *Interview Chart* you will complete.]
5. Thank you for signing the consent form.

Explain Interview Process

1. I have a form or paper guide (*Interview Chart*) that I will use to ask you questions and record your answers.
2. I will not place your name on this paper. It will only have my name on it and today's date.
3. But I do need to ask you a few questions (for example, your age, the number of people in your household) so that we can understand more about the group of women we are interviewing.
4. Let's begin with those questions.
5. Don't forget that, for any question, you can say "I don't know" or just ask me to skip that question and I will skip it. And, we can stop this interview at any point if you wish to do that.
6. Are you ready? Let's begin.

[Use *Interview Chart* to ask and record answers. When finished, thank participant, and leave. See "*Tips for the Interviewer*" on the next page for useful tips to use during the interview.]

Individual Interview Guide

Tips for the Interviewer

1. *Body language matters!*
    a. Relax. Breathe deeply. (It will help you relax.)
    b. Adopt an "open stance" in body posture
        i. Feet flat on floor, shoulders "relaxed-but-squared," arms to side
        ii. Avoid crossing arms, covering mouth, etc (conveys disagreement).
    c. Make appropriate eye contact. Include the whole group with eyes/stance.
    d. Work on your facial expressions!
        i. Smile and laugh when appropriate. But only laugh when *they* do.
        ii. Convey interest and respect for what is being said.
        iii. Encourage people to speak with appropriate head nods, eye contact, etc. But do not "over-do it." (Nodding your head constantly can make you appear to be insincere.)
        iv. Use open, pleasant, relatively-neutral facial expressions.
            1. Avoid looking surprised or judgmental as they speak.
            2. Breathe! A tense face may *appear* to be disapproving.
            3. Express empathy when appropriate, but avoid *all* strongly emotional expressions. (You can inadvertently influence responses.)

2. *Use an active listening process.*
    a. Ask a question.
    b. Turn toward/look at the person(s) speaking.
    c. Listen first! (No writing yet! Use body language tips.)
    d. Repeat back to them what you just heard *as* you begin to record it.
        i. Example: "So, women in your village….(insert what they said)"
        ii. Conveys that you value what they said and want to get it right. Also enhances data validity!
    e. Record (write down) their response as they confirm it.
    f. Then, ask the next question.

3. *Continually assure the participant(s).*
    a. Treat participants as though they are partnering with you to gather important and interesting information about women in the village.
    b. Insert occasional words of encouragement where they naturally fit throughout the interview. Examples:
        i. This is useful/helpful information.
        ii. Thank you for bringing that up.
        iii. Very interesting! Thank you. This is important information.

INTERVIEW CHART

Date: Interview #:____	Interviewer:	Village:

I-Demographics: I'd like to begin with a few simple questions about you and others who live in your household.

1-**How old are you?** *(Write in)* *Age (years):* _____	2- **Are you married, single…?** *(check one)* ___single/ never married(1) ___married(2) ___divorced/separated(3) ___widowed(4)	3-**Are you currently living with your husband/partner?** *(check)* ___no(0) ___yes(1)
4-**Do you have children?** ___no (0) ___yes(1)→ ↓	5-**How many children do you *have*?** *total number:*_____	6-**How many of your children *live* with you in your household?** *number:*_____
7-**Did you ever study in a school?** ___no (0) ___yes(1)→ ↓	8-**Are you studying in a school now?** ___no(0) ___yes(1)	9-**What is the highest level of schooling you have completed?** ___primary/elementary school(1) ___technical training(2) ___secondary school(3) ___university or trade school(4)

II-General Health: Now, I would like to ask you some questions about your health.

10-**How is your health in general? Would you say it is…***(read choices and check one)* __*very good(5)* ___*bad(2)* __*good(4)* ___*very bad(1)* __*fair(3)*	11-**Have you had any of the following health problems over the past 12 months?** *(Read choices and check all that apply)* __breathing problems(1) ___diarrhea(2) __pain when urinating(3) __typhoid(4) __vaginal discharge(5) ___malaria (6) __worms or amoebas(7) __sickle cell(8)	**12-Have you ever had vaginal discharge?** ___no(0) ___yes(1) __not sure(99) **If so, how long did you have this problem?** Number of days: _____ **If so, how often have you had this problem in the past year?** ___ once (1) ___twice (2) ___three or more times (3)
13- Have you ever had sores in your genital area? ___no(0) ___yes(1) __not sure(99) **If so, how long did you have this problem?** Number of days: _____ **If so, how often have you had this problem in the past year?** ___ once (1) ___twice (2) ___three or more times (3)	**14-Have you ever had warts in your genital area?** ___no(0) ___yes(1) __not sure(99) **If so, how long did you have this problem?** Number of days: _____ **If so, how often have you had this problem in the past year?** ___ once (1) ___twice (2) ___three or more times (3)	**15- Have you ever had pelvic pain while you were pregnant?** ___no(0) ___yes(1) __not sure(99) **If so, how long did you have this problem?** Number of days: _____ **If so, how often have you had this problem in the past year?** ___ once (1) ___twice (2) ___three or more times (3)
16- Have you ever had pelvic pain while you were not pregnant? ___no(0) ___yes(2) __not sure(99) **If so, how long did you have this problem?** Number of days: _____ **If so, how often have you had this problem in the past year?** ___ once (1) ___twice (2) ___three or more times (3)	**17-Have you ever been tested for HIV/AIDS?** ___no(0) ___yes(1) __not sure(99) **Have you ever tested positive for HIV/AIDS?** ___no(0) ___yes(1) __not sure(99) **If you have tested positive, have you ever received treatment?** ___no(0) ___yes(1) __not sure(99)	**18-Has your husband/partner ever tested positive for HIV/AIDS?** ___no(0) ___yes(1) __not sure(99) **If he tested positive, has he received any treatment?** ___no(0) ___yes(1) __not sure(99)
19-In What month and year was your last HIV test? *Write in:*	**20-Have you ever used intravenous drugs?** ___no (0) ___yes(1) __not sure(99)	**21-Have you ever eaten things that weren't food?** ___no (0) ___yes(1) __not sure(99)
22-How many times have you been to the local clinic in the last year? Number:____	**23-Did you go to the church last summer when the group came and set up a clinic with Mama Lisa?** ___no (0) ___yes(2) __not sure(99)	**24- Did you participate in the survey last year about reproductive health?** ___no (0) ___yes(1) __not sure(99)

III-Knowledge: I'd like to learn more about the things you know about health. I'm going to ask you some questions. If you don't know the answer, it is okay to say so. We hope to find ways to help people in the village know more about this information in future. But it is still okay to say "I don't know."

25-How many times per month does a woman normally get her (menstrual) period? *Write in:*	**26-Can a woman get pregnant during her period?** __no(0) __yes(1) __don't know (99)	**27-Can a woman get pregnant the first time she has sex?** __no (0) __yes(1) __don't know (99)
28-During which part of a woman's menstrual cycle is she most fertile (more likely to get pregnant)? during her period (1) right before her period (2) right after her period (3) in the middle of her cycle/ ovulation (4)	**29-How long does a normal pregnancy usually last?** *Number of months:*	**30-Is it bad for the baby if a pregnant woman drinks alcohol during pregnancy?** __no(0) __yes(1) __don't know (99)
31-Is it bad for the baby if a pregnant woman smokes during pregnancy? __no(0) __yes(1) __don't know (99)	**32-Name some ways that people can get HIV/AIDS.** *Write in:*	**33-Name some ways that people can protect themselves from getting HIV/AIDS.** *Write in:*

IV-Family Planning: We would like to know more about how women in your village plan their families. If you don't know the answer you can say you don't know. And you can skip the question if you don't want to answer it.

34-At what age did you marry? *Age :*	**35- At what age did you have each of your babies?** *Ages:*	**36- Have you ever wanted to get pregnant but were unable to?** __no(0) __yes(1) __don't know (99)
37-Have you ever had problems with a pregnancy? __no(0) __yes(1) __don't know (99)	**38-If you had any problems during pregnancy, what were they?** *Write in:*	**39-Have you ever had babies die before they were born?** __no(0) __yes(1) __don't know (99)
40-If you have lost any babies (before they were born), what caused their deaths? *Write in:*	**41- Have you ever had any children die after they were born?** __no(0) __yes(1) __don't know (99)	**42- If so, how old were they?** *Ages:*
43-If so, what were the causes of their deaths? *Write in:*	**44-How many total children have you lost?** *Write in:*	**45-Do women in the village usually plan the number of babies they want to have?** __no(0) __yes(1) __don't know (99)
46-Who usually helps a woman in your village decide how many babies she will have? *(check all that apply)* husband(1) mother-in-law(2) mother(3) doctor/nurse(4) midwife(5) don't know(99) other(5)→	**47-How many babies do women in the village usually have?** Write in: don't know(99)	**48-How often do they have babies?** every 1-2 years(1) every 3-4 years(2) every 5 or more years(3) don't know(99) other(5)→
49-Do you know someone who has had more babies than she wanted? __no(0) __yes(1) __don't know (99)	**50-Have you had any unplanned pregnancies?** no(0) yes(1) don't know(99)	**51- If so, how many unplanned pregnancies have you had?** Number:
52-Have you ever been forced to have sex? __no(0) __yes(1) __don't know (99)	**53- If so, how many times have you been forced to have sex?** Number:	**54- How often are you forced to have sex?** daily (1) weekly (2) monthly (3) rarely (4)
55- How many people have forced you to have sex? Number:	**56- What is your relationship to the person who is forcing you to have sex?** *(check all that apply)* husband (1) father/brother (2) someone you know (3) someone you don't know (4)	**57- How many of your pregnancies have resulted from forced sex?** Number:

58- When was the first time you were forced to have sex? Age: _____	**59: Can you describe the situation in which you were first forced to have sex?** *Write in:*	**60-Did someone ever physically overpower you and force you to have sex?** __no(0) __yes(1) __don't know (99) **If yes, were you injured?** __no(0) __yes(1) __don't know (99)
61-Has anyone ever made you feel you had sex without physically making you? __no(0) __yes(1) __don't know (99)	**62- How common of a problem do you think forced sex is?** __ not common (0) __ very common (1) ___ don't know (99)	**63-Would you like forced sex to end?** __no(0) __yes(1) __don't know (99)
64-Are there differing opinions about forced sex? __no(0) __yes(1) __don't know (99)	**65- Do you feel it is your husband's right to have sex with you whenever he wants?** __no(0) __yes(1) __don't know (99)	**66- Does your husband feel it is his right to have sex with you whenever he wants?** __no(0) __yes(1) __don't know (99)
67-Do you know anyone else who has been forced to have sex? __no(0) __yes(1) __don't know (99)	**68-Do you know if your mother was ever forced to have sex?** __no(0) __yes(1) __don't know (99)	**69-Is there anything you think we can do to help prevent forced sex?** __no(0) __yes(1) __don't know (99) **If so, what?** *Write in:*
70- Do you tell anyone that you have been forced to have sex? __no(0) __yes(1) __don't know (99)	**71- If so, who did you tell?** ___ mother (1) ____ friend (2) ___ sibling (3) ____ adult you trust (4) ___ other (5) Write in :	**72- Have you given or received money or goods in exchange for sex?** __no(0) __yes(1) __don't know (99)
73- Have you ever used a scientific method of birth control? __no(0) __yes(1) __don't know (99)	**74- If so, which methods?***(check all that apply)* ___ pill (1) ___ shot (2) ____ condom (3) ____ patch (4) ____ coil/IUD (5)	**75- Are you currently using birth control?** __no(0) __yes(1) __don't know (99)
76- If so, which method? *(check all that apply)* ___ pill (1) ___ shot (2) ___ condom (3) ____ patch (4) ____ coil/IUD (5)	**77-Do you think women in your village know enough about family planning methods** to be able to take care of themselves? __no(0) __yes(1) __don't know (99)	**78-Is there anything women in the village need to know to be able to better plan their families?** __no(0) __yes(1) __don't know (99)
79- If so, what? *Write in:*	**80- Can you name all the methods you've heard about for preventing pregnancy?** *Write in:*	**81- Of the ones you' named (in #65), which ones would you be most comfortable using? Rank them from most to least comfortable.** *Write in:*

Interviewer Comments

That's all the questions I have for you. Thank you for answering them.
[Note from researcher: insert statement here about next steps or ways in which the participant can get more information. For example: "We will be using this information to learn more about how to help people in the village with their health. If you have any questions about this, please come visit us at the clinic."

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