

# A comprehensive programme addressing HIV/AIDS and gender based violence



**M S Jansen van Rensburg**

## ABSTRACT

A survey was administered to 304 respondents participating from three areas near Welkom, South Africa. Face-to-face interviews were conducted with women from randomly selected households to evaluate the impact of a service provision programme targeting women living with HIV/AIDS and gender based violence. Gender based violence (GBV) awareness and knowledge was high. Respondents had high perceived levels of risk. They reported making various behavioural changes to avoid GBV. The respondents were aware of their legal rights pertaining to GBV. HIV/AIDS knowledge levels and attitudes were acceptable. Behavioural changes included condom use, abstinence and being faithful to one partner. Disclosure of HIV was lower than disclosure of GBV. Awareness and knowledge of female condoms were high, yet usage low. Participants reported that they would be able to introduce condoms to a relationship and negotiate usage with relative ease. Perceived levels of GBV and HIV were high, and stigma levels towards the affected women were also relatively high. The awareness and knowledge levels of GBV and HIV of older respondents were lower than younger respondents. The key findings of this study support the notion of using a holistic approach, targeting more than one issue. There is lower stigma levels associated with combined conditions, which might allow easier access to vulnerable groups. Coordination and collaboration of services are however needed to enable this benefit.

*Keywords: HIV/AIDS and GBV, holistic, comprehensive programme.*

## RÉSUMÉ

Une étude a été faite auprès de 304 participantes venant de trois quartiers près de Welkom, en Afrique du Sud. Des chercheurs de terrain, bien formés, ont mené des entretiens en tête-à-tête avec des femmes de foyers sélectionnés au hasard avec le but d'évaluer l'impact du programme de service visant des femmes qui vivent avec le VIH/SIDA et la violence contre les femmes. La prise de conscience et la connaissance de la violence contre les femmes étaient élevées. Les participantes montraient des niveaux élevés du risque perçu. Elles avouent avoir changé leur comportement afin d'éviter la violence contre les femmes, ainsi que dénoncer le malfaiteur. Elles connaissaient leurs droits par rapport à la violence contre les femmes. Les niveaux de connaissance du VIH/SIDA et des attitudes étaient satisfaisants. Le changement de comportement inclut entre autres, l'utilisation du préservatif (même si cela n'était pas fait régulièrement), l'abstinence et être fidèle à un seul partenaire. La divulgation de sa séropositivité était plus basse que celle de la violence. La prise de conscience et la connaissance du préservatif féminin était élevé. Cependant, son usage était très bas car il n'est pas facilement disponible. Les participantes ont signalé qu'elles pourraient proposer un préservatif et négocier son usage sans beaucoup de difficulté. Les niveaux perçus de la violence contre les femmes et le VIH étaient élevés. Le niveau de stigmatisation envers des femmes infectées était relativement élevé. Le niveau de conscience et de connaissance de la violence contre les femmes et du SIDA chez les participantes plus âgées était plus bas par rapport à celui de participantes plus jeunes. Tandis que tous les trois quartiers ont montré une évidence de valeur des activités de "LifeLine", la valeur des interventions à Odendaalsrus était moins importante. Il y a un besoin de réorganiser des activités prioritaires par le biais de "LifeLine". Les résultats de cette étude soutiennent la notion de l'utilisation d'une approche holistique visant plus d'un sujet. Le niveau de stigmatisation liée aux conditions complexes est moins élevé. Cela peut permettre l'accès plus facile aux groupes vulnérables. La coordination et la collaboration des services sont toutefois nécessaires afin de permettre la rentabilité. Les résultats des interventions de GBV et de VIH confirment d'autres études. Le manque des documents et davantage d'études sur la rentabilité des interventions complètes est abordé dans cette description d'une approche qui a pour but d'aborder la violence contre les femmes et le VIH en se servant d'une approche holistique.

*Mots clés: VIH/SIDA et GBV, holistique, programme compréhensif*

**Madri Jansen van Rensburg** is a research psychologist working in the Non-Governmental sector. She has done research in the Southern African Development Community region in HIV and Gender Based Violence. She has a special interest in resilience of communities and individuals. She assists LifeLine Southern Africa in research on traumatic interventions and emotional wellness.

*Correspondence to: Madri Jansen van Rensburg, e-mail: madrijvr@webmail.co.za*

## A comprehensive programme addressing HIV/AIDS and gender based violence

### INTRODUCTION

National HIV prevalence in South Africa is estimated at 29.9%. The incidence of HIV in the Free State Province was 12.6% in 2005 (Shisana, Rehle, Simbayi, Parker, Zuma, Bhana, Connolly, Jooste, Pillay, *et al.*, 2005). According to the latest national antenatal survey, nearly 40% of women aged between 25 and 29 years are HIV positive. Women in the early twenties and early thirties show lower rates at around 30% prevalence. Older women and teenagers have prevalence below 20% (Department of Health, 2004).

Women worldwide have a one in five chance of being a victim of rape or attempted rape. Regarding abuse and gender based violence (GBV) the estimate is one in three women (Heise, Ellsberg & Gottemoeller, 1999; UNFPA, 2005; UN Millenium Project, 2005).

Statistical estimates of different countries vary between 10% and 69% (Heise *et al.*, 1999). The incidence of gender based violence in South Africa is even higher, with one in every two women having a chance of being raped in their lifetime, and a woman being raped every 26 seconds. One in four women is believed to be in an abusive relationship, and a woman is killed by her intimate partner every six days (Vetten, 1995; Vetten & Bhana, 2003; www.powa.co.za).

The results of GBV include emotional distress, mental health problems, poor reproductive health, and a high risk for contracting HIV (Heise *et al.*, 1999). There is also a circular relationship between GBV and HIV, in that GBV is often seen as the result of HIV infection, but GBV could also contribute to risk factors associated with HIV infection (Dhai & Noble, 2005; Dunkle, Jewkes, Brown, Gray, McIntyre & Harlow, 2004; Wingood, Diclemente, Harrington, Lang, Davies, Hook, Oh & Hardin, 2006).

Violence against women was widely regarded as a private matter, but is now seen as a violation of human rights. In South Africa, the Domestic Violence Act came into effect in 1999. However, difficulties in enforcing the laws, inadequate legal systems, and a lack of women's awareness of these systems have thus far prevented any significant decrease in incidence (Amnesty International, 2004). Previously, women remained silent and studies showed that many people in South Africa (including the victims) believed that sexual assault victims were to blame (Population Council, 2004). The same "silence" is observed

regarding HIV. Especially women find it difficult to disclose their status and access services. For women subjected to GBV and living with HIV the situation could be even worse. This lack of awareness and feelings of shame are exacerbated by the absence of services targeting this specific group of women who are subjected to both conditions.

Although projects are responding to the needs of these of women, studies on a holistic approach that targets the specified group are needed (Chege, 2005; Jansen van Rensburg, Serumaga & Nkadimeng, 2003; in press). Results from an intervention study in the Limpopo Province of South Africa indicated that such an approach was beneficial in reducing physical and sexual abuse (Kim *et al.*, 2002; Pronyk, Hargreaves, Kim, Morison, Watts, Phetla, Busca, & Porter, 2006).

The LifeLine movement was established in 1963 in Australia, with the first South African LifeLine centre opening in 1968. LifeLine Southern Africa currently works in South Africa, Namibia and Botswana improving emotional wellness through 20 individual centres. LifeLine South Africa also provides services through a National Crisis Helpline, the National AIDS Helpline and the National Gender Wellness Helpline. LifeLine Free State opened in 1971 and provides services to traumatised persons in the Northern Cape and Free State provinces of South Africa. LifeLine Free State now uses a holistic approach in dealing with issues of traumatised and destitute persons. The new approach amongst other issues includes gender based violence and HIV/AIDS, implemented through a community outreach programme. The new strategy operates and targets communities in the Matjhabeng District Municipality in three townships; namely Welkom (Thabong), Odendaalsrus (Kutlwanong) and Virginia (Meloding).

The project is a community programme integrating HIV/AIDS and GBV. The operational strategies included social mobilisation activities, coupled with training and development of local leadership from different community structures, with a view to contextualising GBV and HIV/AIDS within the community itself. While the target groups are direct beneficiaries of the programme, LifeLine endeavours to engage all structures and organisations with a vested interest in the impact area, including churches, schools, women's groups, etc. LifeLine also utilises its strategic

## A comprehensive programme addressing HIV/AIDS and gender based violence

position to strengthen relationships with NGOs, CBOs, the Departments of Health and Social Development and others.

This study was commissioned to investigate the outcomes of the LifeLine project on women in the targeted communities. The study focussed on outcomes regarding GBV and HIV/AIDS. The aim of the study was to describe the awareness and use of services, perceptions of accessibility, and value of services related to GBV and HIV/AIDS. Services are generally targeted at women who are living with HIV or alternatively at women exposed to GBV. Services for the group of women who are both living with HIV and subjected to GBV are lacking. The LifeLine activities focused on a holistic approach to include this specific group of women who are subjected to both conditions. Thus the study found it important to describe the awareness and perceived availability of support to three groups of women in the community, including: women living with HIV/AIDS; women subjected to GBV; and women living with HIV/AIDS and subjected to GBV.

It was however also important not only to focus on those women who are at present or in the past affected and infected. As the holistic approach of LifeLine includes prevention of these conditions (through knowledge and awareness) it followed that the study population would be women in the community, regardless of whether they were presently subjected to GBV or living with HIV/AIDS. The study results would therefore describe the ability of women in the community to recognise the need to search for help and the perceived availability of support. The study used a random household survey targeting women of different ages.

### METHODOLOGY

The assessments used a quantitative semi-structured questionnaire, administered in face-to-face individual interviews. The questionnaire contained sections on:

- Background information
- Gender-Based Violence knowledge, awareness and attitudes
- Knowledge, awareness and attitudes of HIV/AIDS
- Availability of support and care
- Relationships and condom use
- The intersection between gender based violence and HIV.

The questionnaire was based on the Behavioural Surveillance Surveys of Family Health International (Family Health International, 2000). The sections on GBV were adjusted accordingly and the questionnaire was developed in consultation with LifeLine to ensure that the tool covered the projected outcomes of their project. Open-ended questions were included to capture unexpected outcomes to some extent. The measurement of stigma (reported as positive attitudes) used the indicators (external stigma indicators) and tools developed by the POLICY project and the Siyam'kela project (Siyam'kela, 2005).

This stigma measurement was reported using a combined stigma score that was calculated from a combination of items on seven external stigma indicators which included: avoidance, rejection, moral judgement, stigma by association, unwillingness to invest in people living with HIV/AIDS, discrimination, and abuse. It is important to consider the combined score, since displaying stigma in one item indicates that stigma exists. Stigma levels are only low for those individuals who report no stigma on all seven indicators.

A local team of fieldworkers and a supervisor were recruited from the project site and trained on issues relating to survey ethics, interviewing techniques and a review of the questionnaire. The team included women with diverse ages, backgrounds and work experiences. The diversity was necessary to enable cross reference between team members and to allow for cultural and other differences and preferences from the respondents. All members of the team were fully conversant with the local languages.

The assessments were conducted in three areas where LifeLine Free State Oxfam activities were taking place. The areas included Welkom, Odendaalsrus and Virginia. A total sample size of 304 was calculated, based on the total female population ( $n=212\ 753$ ) of the area, a confidence level of 95%, and a confidence interval of 5.5. A stratified sampling method was used to ensure representation of the population sizes of each of the three areas (Welkom 57%,  $n=172$ ; Virginia 21%,  $n=65$ ; Odendaalsrus 22%,  $n=67$ ).

Random sampling of individual households was used, by selection of every third house in smaller areas and every fifth house in larger areas. A quota sampling

## A comprehensive programme addressing HIV/AIDS and gender based violence

method was used to purposefully select participants for different age groups proportionally at each of the three sites, with a slightly higher focus on recruiting younger participants. Only women older than 15 years of age were interviewed.

LifeLine communicated with the Departments of Health and Social Development throughout the project and permission from all the relevant stakeholders, including local authorities, was obtained. Results were also shared with the stakeholders by LifeLine Free State.

There was strict adherence to correct ethical procedures. The basic rights of participants were respected and they were treated within the context of their community system. Participation in the study was voluntary, and respondents were allowed to withdraw at any stage or to withhold information. Confidentiality was maintained throughout the study (including handling of questionnaires, data entry and analysis). No names or addresses were noted on the questionnaire or any other document. Fieldworkers did not wear any identifying clothes, logos or badges related to LifeLine, GBV or HIV activities, to limit bias in the study, but also to reduce possible linking of participants to GBV or HIV. Participants were never asked to disclose either abuse or HIV status. Questions on prevalence were only included to estimate the perceived problems in the community and not as measures of actual or estimated prevalence, and were phrased as such in the questionnaire. The decision to use these estimates was made since this study was not a prevalence study and including it would allow for reporting bias. Training of fieldworkers included sessions on research ethics and informed consent. Verbal informed consent (including information on the study, confidentiality, anonymity, benefits and risks) was obtained from all participants. A referral list was available for referral to relevant services if a need was expressed by any participant.

Various steps were taken to ensure that bias and errors were limited. The development of the tools and methodology were done in collaboration with the stakeholders to ensure relevancy. Comprehensive training was conducted with the fieldworkers, including role-plays of different challenging situations. Piloting of the questionnaire, the sampling strategy and the data gathering process also took place prior to the

data collection. Quality control of the completion of questionnaires was done at four different stages including:

- Editing of completed questionnaires by the specific field worker directly after the interview
- Editing of the questionnaire by the supervisor directly after completion by the field worker
- Revision by an independent person prior to data entry
- Revision by data capturer.

### CHARACTERISTICS OF THE RESPONDENTS

The average age of the respondents was 34.8 years (min: 15; max: 79). Most of the respondents were between 20 and 24 years old. Most of the respondents (39%) completed senior secondary school and another 30% completed up to grade 10. Nearly all the respondents (94%) were either fully or semi-literate (see Table 1). There were no statistically significant differences between the three areas.

TABLE 1. SAMPLE DESCRIPTION PER SITE

Age in years	Odendaalsrus	Virginia	Welkom	Total	%
15-19	3	9	29	41	14
20-24	11	6	35	52	17
25-29	12	6	20	38	13
30-34	8	15	18	41	14
35-39	9	9	19	37	12
40-44	6	10	12	28	9
45-49	4	2	13	19	6
50-54	3	1	6	10	3
55-59	3	2	10	15	5
60+	8	5	10	23	7
<b>Total</b>	<b>67</b>	<b>65</b>	<b>172</b>	<b>304</b>	<b>100</b>
<b>Education in grades</b>					
None	0	2	0	2	0.5
Primary school	20	25	34	79	26
Grade 8					
grade 10	16	19	55	90	30
Grade 11					
and 12	26	17	75	118	39
Don't know	5	2	8	15	5
<b>Total</b>	<b>67</b>	<b>65</b>	<b>172</b>	<b>304</b>	
<b>Literacy level</b>					
Fully literate	47	43	138	228	75
Semi literate	14	18	27	59	19
Illiterate	6	4	7	17	6

### RESULTS

More than half of the randomly selected participants (n=154, 51%) had heard of LifeLine and 27% (n=82)

## A comprehensive programme addressing HIV/AIDS and gender based violence

had participated in activities of LifeLine. The average time since their involvement was less than six months, with more than 78% (n=61) being involved less than six months ago. All respondents (100%) felt that the involvement with LifeLine activities had an impact on them gaining new knowledge. LifeLine also had an influence on behaviour changes as reported by most respondents (98%).

### **Gender based violence knowledge and attitudes**

GBV awareness levels were high amongst the women who participated in the research, with 94% (n=285) reporting having heard of GBV. However, a small percentage (17%, n=51) reported that they felt being abused on the basis of gender was acceptable. There were differences between the research sites for GBV knowledge (p=0.000) and for accepting GBV (p=0.001). Respondents from Odendaalsrus had lower awareness levels. There were no differences between age groups.

The respondents' knowledge about different types of abuse was high. The types of abuse that were most widely known were sexual (63%), physical (60%), emotional (41%) and verbal abuse (35%). Economical/financial abuse (either not maintaining a female partner or exploiting them for financial gain) was mentioned less frequently (17%). This was consistent with other studies (Henning & Klesges, 2003; Jewkes, 2000; Jewkes, Levin & Penn-Kekana, 2002, 2003; Mashishi, 2000).

Respondents were asked to indicate how many people were abused in their community on the basis of their gender. The scale varied between none (0%), some (25%), half (50%), most (75%) and all (100%). More than half of the respondents' perceptions were that most of the population (more than 75%) were abused. Only 1% believed that no person was at risk, and 10% believed everyone was at risk. There were no differences in perceptions in the three areas or between different age groups.

Many of the respondents felt that they were at risk of being abused (65%, n=185). Respondents from Virginia perceived themselves to be less at risk for GBV than the other two sites (p=0.029).

The reasons why the respondents felt they might be at risk is listed in Table 2 and included environmental or

circumstances that were not safe; behaviour or activities that put them at risk; and characteristics of partners, including a history of abuse.

Women felt that they were at risk of abuse, but that they could change some aspects to stop abuse or prevent future abuse. These changes did not put blame on the "victim", but empowered them to react to violence directed at them. Respondents were asked to indicate whether they had taken steps to avoid being abused or to stop being abused. The number of respondents who had made changes to avoid becoming victims of abuse or to stop being abused was 122 (43%). There was a difference both between research sites (p=0.014) and between age groups (p=0.040). Women in Virginia made more changes in their behaviour (48%, n=30) than those in Odendaalsrus (43%, n=23) or Welkom (41%, n=69). Older age groups reported making fewer changes to avoid abuse, with fewer respondents above 45 years of age reporting having made changes (less than 30%, compared to more than 50% of those younger than 45 years).

Most of the prevention efforts (85%) were related to changing their own behaviour (in avoiding circumstances and environments that had a higher risk) and leaving or reporting abusive partners (see Table 3). The negative aspect was that, in an attempt to protect themselves, many women were isolating themselves, as they reported not going to visit friends, or locking themselves in their homes.

TABLE 2. RISK FACTORS FOR GBV

	Number	%
Live alone	29	16
Live with kids / grandparent	8	4
Environment not safe	10	5
Work late or at night	10	5
Walk at night	20	11
Own behaviour puts at risk	8	4
Going to taverns	5	3
Partner/husband abused in past	12	7
Alcohol/drug abuse - abuser	8	4
Abuse high in community	20	11
Incidence of rape high	38	21
Crime levels high in community	7	4
Unemployed	3	2

## A comprehensive programme addressing HIV/AIDS and gender based violence

TABLE 3. BEHAVIOUR CHANGES

	Number	%
<b>To avoid GBV</b>		
Changes in self (protect, not alone, stopped drinking)	104	85
Leave abusive partner	8	7
Report to police/protection order	3	2
Disclose abuse	2	2
Community/street group	2	2
<b>To avoid HIV</b>		
Condom	130	61
Abstain	42	20
Faithfulness	31	15
Tested for HIV	2	1
Care when handling blood	3	1
Trust partner	2	1
Careful	3	1
Trust God	1	0.5

A large percentage of respondents (85%, n=243) were aware that there were legal measures a person could take to stop GBV. Most of the respondents would report the abuse to the police (57%) and to social workers (20%). Fewer respondents reported seeking help from health care workers. This might have been due to a lack of confidence that health care professionals would be interested in the cause of abuse, and not because it was not perceived as a health problem (Jansen van Rensburg & Van Staden, 2005; Jewkes, 2002). A large percentage (87%, n=249) knew about their legal rights. Older respondents were less likely to know the legal rights that protect them from GBV. This age difference was statistically significant (p=0.11).

Most of the respondents felt that women were more at risk of GBV than men (81%, n=229), while 18% (n=52) felt that both sexes were at the same risk level. There were no differences between the three sites, but there were differences between the age groups (p=0.002), with older respondents more frequently reporting that both sexes were at the same risk. Biological and behavioural factors were mostly given as reasons why women were more at risk (see Table 4).

A large percentage (95%, n=272) indicated that they thought it was advisable to disclose abuse. Most respondents would disclose to a family member (including a parent or child) or close friends and neighbours (see Table 5). There were no differences

TABLE 4. REASONS FOR WOMEN BEING MORE AT RISK

	GBV		HIV	
	Number	%	Number	%
Biological	105	35	61	20
Social	80	26	59	19
Cultural	69	23	41	14
Behavioural	104	34	94	31
Gender imbalances	59	19	18	6

TABLE 5. DISCLOSURE

	GBV		HIV	
	Number	%	Number	%
Spouse / partner	25	9	50	17
Parent/s	106	37	128	43
Children	30	10.5	34	11
Other family	23	8	28	9
Close friend	29	10	20	7
Colleague	1	0.5	1	0.3
Neighbour	27	9.5	3	1
Social worker	6	2	5	2
Health care worker	3	1	7	2
Counsellor	7	2.5	11	4
No-one	7	2.5	11	4
Police	19	7		
Teacher	1	0.5		
Other			2	0.7

between the three research sites or different age groups.

The most common sources of information about GBV were radio and television (see Table 6). LifeLine was mentioned 16% of the time, which is a good indication of the value attached to LifeLine's role in knowledge distribution regarding GBV.

#### HIV knowledge and attitudes

HIV/AIDS knowledge levels were high compared to previous studies and national levels (Shisana *et al.*, 2005). Most respondents had heard of HIV/AIDS (99%, n=302). There was a difference between the three areas (p=0.028). At Virginia and Welkom all the respondents had heard about HIV, while 3% (n=2) did not know about HIV in Odendaalsrus.

A large percentage of the respondents (97%, n=294) knew that one could die of HIV/AIDS. Although most of the respondents knew there was no cure for HIV/AIDS, some still believed there was a cure for HIV/AIDS (16%, n=48). Most of the respondents

## A comprehensive programme addressing HIV/AIDS and gender based violence

TABLE 6. INFORMATION SOURCES

	GBV		HIV	
	Number	%	Number	%
Radio	235	77	246	81
TV	150	49	169	56
School	52	17	67	22
Church	62	20	64	21
Work	20	7	16	5
Family	37	12	33	11
Partner	4	1	4	1
Friend	40	13	53	17
Health facility	46	15	107	35
LifeLine	50	16	62	20
Other NGO	7	2	20	7
Other: Newspapers (print media)	16	5		
Other: Own experience	4	1		
Other: Community	11	4		

(93%, n=280) knew that a healthy-looking person could be HIV-positive. There was a difference between the age groups, with more of the older age groups believing that there was a cure for HIV ( $p=0.013$ ) and believing that a healthy-looking person could not be HIV-positive ( $p=0.050$ ). This lack of clarity regarding a cure especially in older age groups is consistent with national levels (Shisana *et al.*, 2005)

Many people believed that they could personally get infected with HIV (69%, n=208), compared to 37.7% of women nationally and 46.1% of all respondents in the Free State Province (Shisana *et al.*, 2005). The perceived risk levels for the Free State were the highest of all the provinces in South Africa. Most of the respondents were aware that there were ways to avoid getting infected (95%, n=286). A large percentage of the respondents reported that they had made personal changes to avoid getting HIV/AIDS (70%, n=212). Most of the respondents (47%, n=100) made changes less than 12 months ago, which corresponds to the time since the LifeLine Free State Oxfam project started.

The changes made to behaviour in order to avoid HIV transmission were investigated using an open-ended question, and responses are described in Table 3. Condom use was the most frequently-used method (61%), followed by abstinence (20%) and faithfulness (15%).

TABLE 7. SOURCES OF SUPPORT

	GBV		HIV		GBV and HIV	
	N	%	N	%	N	%
Hospital	7	3	20	9	23	11
Clinic	61	26	182	86	152	74
Hospice			4	2	1	0.5
Doctor			4	2	1	0.5
Police	115	49	1	0.5	61	30
Social workers	98	42	41	19	46	22
Church	34	15	28	13	35	17
School	3	1				
LifeLine	25	11	32	15	29	14
AIDS helpline			2	1	1	0.5
Lovelife	5	2	6	3	3	1.5
Lesedi Lechabile	1	0.5	5	2	3	1.5
HIV group	2	1	7	3		
Counsellor/ political party	1	0.5	2	1		
FAMSA	4	2			2	1
POWA	1	0.5				
Women's group	1	0.5				
Street committee	1	0.5				
Blockman	1	0.5				
Neighbours	1	0.5				
Human rights group					1	0.5
HIV organisation					3	1.5
Family					1	0.5

Most of the respondents felt that women were more at risk than men for contracting HIV (54%, n=163), while 43% (n=126) felt that both sexes were at the same risk level. Only 3% (n=8) felt that men were at higher risk. There were no differences between the three sites or between age groups. The belief that women were more or equally at risk was mostly contributed to behavioural factors. This was consistent with the reasons listed for women being more at risk of GBV as listed in Table 4. Biological factors were regarded more frequently as a risk factor for GBV than for HIV.

Stigma and discrimination are seen as primary barriers to effective prevention, and provision of treatment, care and support. It was therefore important to consider the levels of stigma in this community. More specifically, it would be useful to compare levels of stigma towards women living with HIV and stigma towards women living with HIV and subjected to GBV. The stigma scale used seven indicators of external stigma. A person demonstrates stigma when they do not reject all seven indicators. The combined HIV stigma levels seemed to be very high, with only 8% having positive attitudes on all seven stigma indicators. A slightly higher percentage (19%) had positive attitudes on six of the seven indicators.

## A comprehensive programme addressing HIV/AIDS and gender based violence

A large percentage (88%, n=266) indicated that they thought it was advisable to tell others of their HIV status. Disclosure of HIV status was significantly lower than disclosure of being abused. Disclosure would mostly be to family members and did not include friends or neighbours, as with disclosure about abuse (see Table 5). There were no differences between the three research sites or different age groups. Disclosure of HIV status differed from disclosure of abuse. Disclosing HIV status would more often be to partners and family members, while those being abused would disclose also to strangers and community members.

The most common sources of HIV information were the mass media (radio and television) and health facilities (see Table 6), consistent with the national survey by Shisana *et al.* (2005). LifeLine was mentioned by 20% of the respondents. This places LifeLine as a well-recognised source of HIV/AIDS information in the Welkom area.

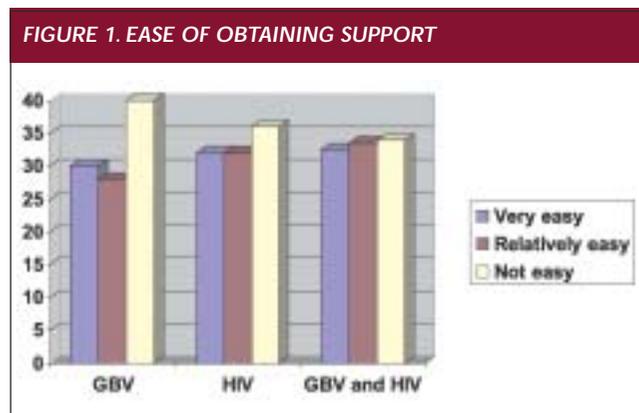
The majority of respondents (79%) indicated that they knew about their legal rights concerning HIV. There was a statistically significant difference between respondents of different age groups, with women older than 35 years of age being less aware of their rights ( $p=0.044$ ).

### Support and care

Social support and medical and other care were investigated for the same three groups: women who were abused; women who were living with HIV/AIDS; and women who were both abused and living with HIV/AIDS.

Care and support were least available to women who were subjected to GBV (see Figure 1). The same percentage (32%) of women living with HIV and women living with HIV and GBV reported that it was very easy to obtain support. There were no differences between respondents from different areas or age groups.

Support for women who were living with HIV/AIDS and support for women living with HIV/AIDS and abuse were provided mainly by health care institutions (74%). The police and social services were most frequently mentioned as sources of support and care for women subjected to GBV (see Table 7). NGOs, FBOs and private organisations also provided support.



LifeLine was mentioned more than any other NGO or community structure as a source of support for all three categories of women.

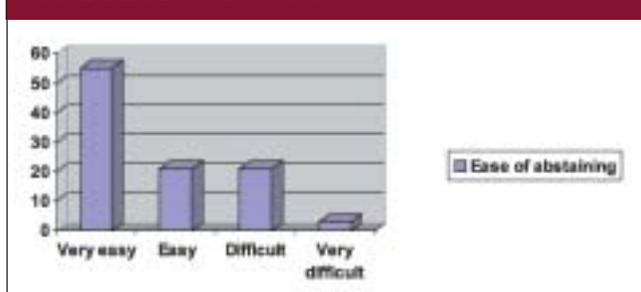
### Relationships and sexual behaviour

This section reflects the relationships and sexual behaviour of the respondents of the study and is not indicative of behaviour of women living with abuse, HIV or women subjected to both conditions. Most of the respondents (77%) reported having had only one sexual partner in the past 12 months. This is lower than the national levels of 98.2% of women. There was a statistically significant difference between the three research sites ( $p=0.005$ ). Respondents in Odendaalsrus reported having more partners than the other two sites.

The average time that respondents remained faithful was four years (46.9 months). The time ranged from one month to 45 years. There was a statistically significant difference between the age groups, with older people having stayed faithful to one partner for longer than younger respondents. A large percentage of respondents reported ever having decided to abstain (40%, n=111). There was a difference between the sites, with fewer respondents from Odendaalsrus reporting having abstained ( $p=0.046$ ). There were also differences between the age groups, with older respondents (older than 60-years old) reporting more often to have abstained ( $p=0.000$ ). The most common reasons to abstain were to avoid getting a disease, lack of interest and having no partner available. Respondents reported that it was very easy to stick to a decision to abstain (see Figure 2). There were no differences between respondents from different areas or age groups.

## A comprehensive programme addressing HIV/AIDS and gender based violence

FIGURE 2. EASE OF ABSTAINING



Respondents knew what a female condom was (64%, n=193). There was a statistically significant difference (p=0.000) between age groups regarding knowledge of female condoms. Few respondents older than 55 years knew what a female condom was. Fewer (15%, n=44) reported ever using a female condom. The most important reason for not using a female condom was cited as unavailability.

Most of the respondents knew what a male condom was (92%, n=281). There was an age difference noted regarding knowledge of male condoms, with more respondents older than 60 lacking knowledge (p=0.000). A large percentage of respondents had used a male condom (72%, n=204). There were some age groups who have not used male condoms. This difference was significant at p=0.000. The age groups that did not use male condoms were those younger than 19 years (who reported not engaging in sex) and those older than 55 years of age. The most important reason for not using a male condom was related to the fact that no sexual intercourse was taking place.

Two items measured condom use. Respondents were asked how frequently they used a condom (always, sometimes, never), and whether they had used a condom during the last sexual intercourse. Most of the respondents were not using condoms consistently. Only 32% reported always using a condom. The difference between age groups (p=0.026) was due to the young respondents, who had not engaged in sex yet, reporting never using condoms. A large percentage (52%, n=139) reported having used a condom during the last sexual intercourse, but this measure does not include consistent condom use. The significant differences between age groups (p=0.000) was due to the decrease in condom use in groups older than 40 years of age. The main reason for using condoms was to avoid getting a disease (47%, n=120) and to avoid pregnancy

(32%, n=83). The age differences (p=0.000) were due to a higher number of respondents between 30 and 34 years using condoms to avoid pregnancy. The findings regarding condom usage (including the age differences) are consistent with the national survey (Shisana *et al.*, 2005)

Respondents were also asked to indicate how easy it was to introduce condoms into a stable relationship. Respondents found it relatively easy to introduce condoms into a relationship, with 50% (n=135) reporting it was easy. Odendaalsrus was statistically significantly different (p=0.008) in that respondents there mostly found it very easy to introduce condoms. The differences between age groups (p=0.000) were due to more of the respondents older than 35 reporting it was not easy.

The main source of condoms was clinics. The differences between age groups were due to younger respondents also using hospitals and other sources of condoms (p=0.000). Most respondents indicated that it took under 30 minutes to obtain a condom (48%, n=129). A significantly higher number of respondents from Odendaalsrus reported obtaining condoms in less than 15 minutes (p=0.017). Older respondents reported taking longer to obtain condoms than younger respondents (p=0.000).

Participants reported that they normally decided themselves to use condoms during sexual intercourse. More of the respondents older than 40 years of age reported joint decisions with their partner than younger respondents, who more frequently reported making decisions independently (p=0.000).

A few respondents (24%, n=64) reported having sexual intercourse without giving their consent. A condom was used in 37% (n=24) of these cases. It was normally the respondent who decided to introduce the use of condoms (58%, n=14). These findings are important since it indicates that respondents subjected to sexual abuse were able to negotiate condom use to some extent. There were differences between age groups (p=0.000) in that more respondents from the younger age groups reported being involved in sexual intercourse without consent. The differences in ages regarding who negotiated condom use (p=0.002) were due to respondents in the 25 to 39 year age group

## A comprehensive programme addressing HIV/AIDS and gender based violence

making joint decisions. This was probably also due to negotiation skills.

### **Gender based violence and HIV/AIDS**

Respondents were asked if they knew a woman subjected to each of the three conditions. The responses were alarmingly high, with 54% knowing a woman who was abused, 74% knowing a woman living with HIV/AIDS, and 34% knowing a woman subjected to both conditions at the same time. According to Jewkes (2002) and Jewkes, Levin and Penn-Kekana (2002, 2003), more than 45% of women reported being injured by a partner in the previous year, which seems to corroborate the findings of this study. The percentage of women knowing a woman living with HIV seems to be high, taking into consideration high estimates of HIV prevalence (30.9%) for African women between 15 and 49 years in the Free State Province (Shisana *et al.*, 2005), and 23.9% for women between 20 and 64 years (Dorrington, Johnson, Bradshaw & Daniel, 2006). Although these were not measures of prevalence, they give some indication of the openness and acceptance of the different conditions. It could be argued that women would be less inclined to discuss and disclose abuse. However, this is not an acceptable reason for the high percentages, since this study indicated that women would be more inclined to disclose abuse than HIV status.

Stigma scores towards women subjected to GBV and living with HIV/AIDS were calculated in a similar manner as described in the section regarding stigma towards women living with HIV. Combined stigma scores indicated that 33% of respondents had positive attitudes towards women who were both abused and living with HIV/AIDS. This was higher than the 8% that had positive attitudes towards women living with HIV/AIDS.

The attitudes towards women affected by both conditions were more positive than attitudes to women only affected by HIV. This more positive attitude towards women who were affected by GBV and HIV/AIDS indicates that a holistic approach, specifically working with women affected by both conditions, would allow access to women who might not be reached when targeting a specific group. It would be important to measure the changes in GBV and HIV prevention efforts in future studies in this

population. Pronyk *et al.* (2006) found improvements in empowerment and in the status of women and a reduction of physical and sexual abuse three years after the initiation of a holistic intervention.

### **CONCLUSIONS**

GBV awareness and knowledge levels were high. Unfortunately, indications were that perceived GBV levels were very high, with more than half of the women in the communities being abused. Respondents also perceived themselves to be at risk, mostly attributed to an unsafe environment and women's own behaviour. Changes took place to guard against GBV, and these changes were mostly to report violence and to leave the abusive partner.

HIV/AIDS awareness and knowledge were high. Behavioural changes included a huge increase in condom use, abstaining and being faithful to one partner. It is significant that more value was placed on abstinence than on being faithful. The reasons for abstinence were also related to avoiding contracting a disease, rather than lack of a partner or religious or cultural reasons. Women were seen as being more at risk than men, or at similar risk. The reason for the risk was mostly behavioural. Disclosure of HIV status was lower than that of abuse. Disclosure was to a family member rather than friends or neighbours. LifeLine was mentioned as a major source of information and support.

Women were making changes to their behaviour to avoid contracting diseases, such as deciding to abstain from sexual intercourse. Usage of female condoms was low, while usage of male condoms was higher, but condom use (male and female) was inconsistent. Introducing condoms into a relationship was regarded as relatively easy, but not for older age groups. Women mostly reported that they made the decision to use a condom themselves, although younger respondents made more joint decisions. Negotiating condom use was common and regarded as relatively easy.

Nearly a quarter of all respondents had been subjected to sexual abuse (having sex without their consent). Negotiation skills were used to great effect, with more than a third of the women being able to convince the perpetrator to use a condom. This, together with the behavioural changes made to avoid GBV and HIV, indicated that women were empowered to make

## A comprehensive programme addressing HIV/AIDS and gender based violence

decisions and negotiate with others to guarantee those changes. Unfortunately, incidences of women subjected to GBV, women living with HIV/AIDS, and women living with HIV and GBV were very high. Stigma levels were also very high (especially towards women living with HIV/AIDS).

Age differences mostly involved older age groups being less aware and knowledgeable. The older respondents were less aware of GBV, HIV/AIDS and their legal rights regarding both GBV and HIV. Differences between the three areas were mostly related to the lower overall incidence of GBV in Virginia, with more behaviour changes related to avoiding GBV reported in Virginia. Lower awareness and knowledge levels and higher stigma levels for both GBV and HIV were evident in Odendaalsrus.

It can be concluded that knowledge and awareness levels regarding HIV and GBV were high. It is recommended that interventions focus on empowerment of women to enable increased behavioural change and addressing stigma. The younger age groups (especially those younger than 35 years) were very well targeted during the intervention. It would be wise to implement strategies targeting specifically older women. Interventions and strategies combining GBV and HIV issues increased awareness and lowered stigma. This might indicate that a more holistic approach, in which more than one social challenge is addressed, has better outcomes.

An implication of this study is that interventions and studies are needed where conditions are addressed together, without one being seen as causing or contributing to the other condition. Services are limited to each of the groups concerned and resources wasted, as the same service is provided to different target groups. The target groups should be combined, as there is a significant overlap in the beneficiaries. Combining the groups would lower stigma levels towards women living with HIV, which would in turn increase access to the services. This would be achievable through collaboration between organisations such as LifeLine with health care services that are reportedly relied on heavily by women. Coordinated and complementary services would prevent vulnerable women from “falling through the cracks” when referred from one service to the next, as different issues are addressed by different service providers.

The study further promotes that GBV should not just be mainstreamed in existing HIV programmes, or HIV prevention, care and treatment included in existing GBV programmes. There is a need for programmes that focus on general community (and women in particular) empowerment to be multidisciplinary and multisectorial, and to address various issues (such as HIV and GBV in combination with each other and with additional issues such as poverty reduction or other empowerment projects).

This study also advocates with Pronyk and co-workers (2006) that GBV should form part of the national AIDS strategies. This is addressed to some extent in the National Strategic Plan 2007-2011 in Key Priority Area 4 (Human Right and Access to Justice). It, however, does not promote comprehensive (holistic) programmes addressing GBV and HIV in combination. There is also a lack of funding dedicated to drive this process of incorporating aspects of HIV in GBV programmes and vice versa.

This study provides a description of the awareness levels of women regarding GBV and HIV/AIDS. Comparative studies between groups and intervention studies to measure the changes in violence levels or assessing services are recommended for other comprehensive programmes. The findings of the study also provide baseline information for future follow-up studies to measure whether the services for women subjected to GBV and HIV/AIDS have improved.

### REFERENCES

- Amnesty International (2004). *It's in our hands: Stop violence against women*. London: Amnesty International.
- Chege, J. (2005). Interventions linking gender relations and violence with reproductive health and HIV: rationale, effectiveness and gaps. *Agenda Special Focus*, 114-123.
- Department of Health (2004). *National HIV and syphilis antenatal sero-prevalence survey in South Africa, 2003*. Pretoria: Department of Health.
- Dhai, A., & Noble, R. (2005). Ethical issues in HIV. *Best Practice & Research Clinical Obstetrics & Gynaecology*, 19(2), 255-267.
- Dorrington, R. E., Johnson, L. E., Bradshaw, D., & Daniel, T. (2006). *The demographic impact of HIV/AIDS in South Africa. National and provincial indicators for 2006*. Cape Town: Centre for Actuarial Research, South African Medical Research Council and Actuarial Society of South Africa.
- Dunkle, K.L., Jewkes, R.K., Brown, H.C., Gray, G.E., McNtryre, J.A., & Harlow, S.D. (2004). Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. *Lancet*, 363(9419), 1410-1411.
- Family Health International (2000). *Behavioural Surveillance Surveys: Guidelines for repeated behavioural surveys in populations at risk of HIV*. Arlington: Family Health International.
- Heise, L., Ellsberg, M., & Gottemoeller, M. (1999). *Ending violence against women. Population Reports Series L, No. 11*. Baltimore, Maryland: Population Information Program, Johns Hopkins University School of Public Health.
- Henning, K.R., & Klesges, L.M. (2003). Prevalence and characteristics of psychological abuse reported by court-involved battered women. *Journal of Interpersonal Violence*, 18, 857-871.
- Jansen van Rensburg, M.S., Serumaga, D., & Nkadameng, H. (2003). *HIV/AIDS and violence against women: a longitudinal study*. Paper presented at the 10th Reproductive Health Priorities Conference, Indaba Hotel, Johannesburg.
- Jansen van Rensburg, M.S., Serumaga, D., & Nkadameng, H. (in press). HIV and women abuse: Case management. *New Voices in Psychology*.

# A comprehensive programme addressing HIV/AIDS and gender based violence

- Jansen van Rensburg, M. S., & Van Staden, F. J. (2005). Physically abused women's experiences and their expectations of medical practitioners. *South African Family Practice*, 47(5), 47-51.
- Jewkes, R. (2000). Violence against women: An emerging health problem. *International Clinical Psychopharmacology*, 15, S37-S47.
- Jewkes, R. (2002). Preventing domestic violence: most women welcome inquiries, but doctors and nurses rarely ask about it. *British Medical Journal*, 324, 253-254.
- Jewkes, R., Levin, J., & Penn-Kekana, L. (2002). Risk factors for domestic violence: findings from a South African cross-sectional study. *Social Science and Medicine*, 55, 1603-1617.
- Jewkes, R. K., Levin, J. B., & Penn-Kekana, L. A. (2003). Gender inequalities, intimate partner violence and HIV preventive practices: findings of a South African cross-sectional study. *Social Science and Medicine*, 56, 125-134.
- Kim, J., Gear, J., Hargreaves, J., Makhubele, B.M., Mashaba, K., Morison, L., Motsei, M., Peters, C., Porter, J., Pronyk, P., & Watts, C. (2002). *Social interventions for HIV/AIDS intervention with microfinance for AIDS and gender equality. IMAGE Study: Monograph No 2: Intervention*. Accornhoek: Rural AIDS and Development Action Research Programme.
- Mashishi, A. (2000). Wife battering: an exploration of the abuse of African women at two shelters in Johannesburg. *Society in Transition*, 31(1), 82-87.
- Population Council (2004). *Sexual coercion: Young men's experiences as victims and perpetrators*. New York: The Population Council.
- Pronyk, P., Hargreaves, J., Kim, J., Morison, L., Watts, C., Phetla, G., Busca, J., & Porter, J. (2006). *Effects of a structural intervention for the prevention of intimate partner violence and HIV in South Africa: a cluster randomised trial*, presented at the XVI International AIDS Conference, Canada. Abstract no. THPE0252.
- Shisana, O., Rehle, T., Simbayi, L.C., Parker, W., Zuma, W., Bhana, A., Connolly, C., Jooste, S., Pillay, V., et al. (2005). *South African national household survey on HIV prevalence, incidence, behaviour and communication, 2005*. Cape Town, HSRC Press.
- Siyam'kela (2005). *Measuring HIV/AIDS related stigma: HIV/AIDS stigma indicators: a tool for measuring the progress of HIV/AIDS stigma mitigation*. Pretoria: Centre for the Study of AIDS.
- UNFPA. (2005). *State of World Population*: www.unfpa.org.swp/2005/english.
- UN Millennium Project (2005). *Taking action: Achieving gender equality and empowering women. Task force on education and gender equality*. London and Sterling, Virginia: Earthscan.
- Vetten, L. (1995). "Man shoots wife". *A pilot study detailing intimate femicide in Gauteng, South Africa*. Johannesburg: People Opposing Women Abuse.
- Vetten, L., & Bhana, K. (2003). Violence, vengeance and gender: *A preliminary investigation into the links between violence against women and HIV/AIDS in South Africa*. Available: www.powa.co.za/Display.asp?ID=21.
- Wingood, G.M., Diclemente, R.J., Harrington, K.F., Lang, D.L., Davies, S.L., Hook, E.W. 3rd, Oh, M.K., & Hardin, J.W. (2006). Efficacy of an HIV prevention programme among female adolescents experiencing gender-based violence. *American Journal of Public Health*, 96(6), 1085-1090. www.powa.co.za.

Full text version of

SAHARA *J* available online at

www.sahara.org.za