Gender-based violence and the risk of HIV and AIDS among women in Ngaka Modiri Molema district, North West province

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DECLARATION

I Goitseone Emelda Leburu declare that: **Gender-based violence and the risk of HIV and AIDS among women in Ngaka Modiri Molema district, North West province**, is my own unaided work and that all the sources I have used and quoted have been duly indicated and acknowledged by means of complete references.

Signature.....

G. E LEBURU (Researcher).

Date 05 - OCTOBER - 2015

ABSTRACT

GBV and HIV and AIDS are social problems that affect the quality of life and the social functioning of many people including women worldwide. They contribute negatively to the physical, social, emotional and psychological well-being of an individual. Both men and women can be perpetrators of violence, but the majority of the perpetrators of such violence are usually men against women. The aim of this study is to gain an understanding of various forms of gender-based violence and the risk of HIV and AIDS consequent upon GBV. While the relationship between gender-based violence and HIV and AIDS is documented, the scarcity of researched information focusing on the nature of the relationship between GBV and HIV and AIDS in South Africa is sparse.

The study adopted a qualitative research method to understand GBV and HIV and AIDS risk factors among women. Thirty (30) women from selected organizations participated in both focus groups and in-depth interviews. A literature review was undertaken to contextually understand the background of GBV and HIV and AIDS globally and in South Africa; and secondly to gain a thorough understanding of risk factors posed by GBV and HIV among women. Relevant theoretical frameworks that explain the women's status in relation to men were used to validate data- based arguments about the relationship between GBV and HIV and AIDS risk factors. Results of the literature review revealed that the interconnection between GBV and HIV and AIDS is not linear, but cyclical thus pointing out that various risk factors link GBV to HIV and AIDS.

Data analysis established the following as contributory factors of the GBV and HIV and AIDS relationship:

- Unequal power relations between men and women.
- Traditional gender roles that condone men's masculinity over and above women's capabilities.
- Culture of drinking: alcohol is readily available in the researched community and this propagates GBV and enhances opportunistic HIV incidence
- Economic status: Low economic status of women makes them vulnerable to negotiate for safer sex and to openly discuss and engage in sexual issues that affect the relationships with their partners.

It is concluded that there is incongruence between the existing legislative frameworks that address GBV with the level of knowledge by service users or practitioners implementing the legislations. The findings compel further investigation regarding the efficiency and effectiveness of GBV ameliorative services in the North-West Province.

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- In conclusion, I commend all the courageous women who participated in this research. I am grateful and dedicate this dissertation to you all.

DEDICATION

This dissertation is dedicated to all the women who willingly participated in the study – who are survivors of gender-based violence.

I acknowledge and firmly believe that: ..."in all these things we are more than conquerors through HIM who loved us" (Romans 8:37).

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ABREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti-Retroviral Viral
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
DVA	Domestic Violence Act
FG	Focus Group
GBV	Gender-Based Violence
HBC	Home Based Care
HBO	Home Based Organisation
HBF	Heinrich Böll Foundation
HIV	Human Immunodeficiency Virus
IFSW	International Federation of Social Workers
IPV	Intimate Partner Violence
IVEP	Integrated Victim Empowerment Programme
NWU	North-West University
PEP	Post Exposure Prophylaxis
RTI	Research Triangle Institute
RSA MDG	Republic of South Africa Millennium Development Goals
SCIHDC	Soul City Institute for Development Communication
STIs	Sexually Transmitted Infections
TLAC	Tshwaranang Legal Advocacy Centre

CHAPTER 1

BACKGROUND TO THE STUDY

1.1. INTRODUCTION

Gender-based violence (GBV) is a complex but a common phenomenon worldwide. According to Vanwesenbeeck (2008:26), this type of violence does entail a combination of physical, sexual and emotional violence, deprivation and often some neglect. It also encompasses domestic violence, often referred to as intimate partner violence (IPV). Physical and psychological violence by intimate partners, including coercive behaviours falls under the nomenclature of GBV. Vanwesenbeeck (2008:26) also include to this description other forms of GBV such as forced marriages that are sociologically categorised as cohabitation, denial of the right to use contraception or to adopt other measures of protection against Sexually Transmitted Infections (STIs). In still other situations, examples of GBV entail violence during pregnancy, and induced abortions.

The implication from the provided explanations is that GBV against women is mostly directed at the sexual integrity of women. In some cultural practices, this type of violence can even include gruesome acts such as female genital mutilation and to some extent, obligatory inspections for virginity

In reality, both men and women can be perpetrators of GBV. However, the majority of perpetrators in the South African situation are men. For the purposes of this study, GBV is interrogated from statistics and records of violence perpetuated by men against women, by both intimate partners and non-intimate partners.

Oguli-Oumo, Mokolomme, Gwaba, Mogegeh and Kiwala (2002:1) posit that GBV is widely acknowledged as constituting a gross human rights violation as well as a constraint to different forms of development. GBV again continues to be endemic in different forms, and in different settings of both developing and developed nations. This form of violence cuts across status, class, religion, race and economic barriers. It occurs at home, in society, in the immediate community, at the workplace and in

various institutions. What further entrenches this apparent violent culture is that most societies have forms of GBV that are generally condoned by and even reinforced by some cultural practices.

Morrison, Ellsberg, and Bott (2004:3) postulate that in many societies (rural communities in particular), women are expected to still perform traditional gender roles, specifically being submissive and sexually available for their husbands at all times. This is considered both a right and an obligation for men to use violence in order to "correct" or to reprimand women for perceived transgressions of these roles.

Ellsberg and Betron (2011:1) state that the situation for unmarried women can even be more stigmatising since some cultural practices expect them not to be intimately involved, thus preferring to suffer in silence than to risk the shame and discrimination that invariably results from disclosing such domestic violence. GBV is increasingly recognised as a critical driver of the HIV and AIDS epidemic in many settings, particularly in Sub-Saharan Africa including South Africa where the incidence of HIV infection is growing at alarmingly high rates among young women.

UNAIDS FACT SHEET (2014:1) draws a real, yet frightening picture indicating that in 2013, there were 35 million (33.2 million-37.2 million) people living with HIV globally. Since the start of the epidemic, around 78 million (71 million-87 million) have become infected with HIV and 39 million (35 million-43 million) people have died of AIDS-related illnesses. Sub-Saharan Africa, in 2013 recorded 24, 7 million (23.5 million- 26.1 million) people living with HIV. Women accounted 58% of the total of people living with HIV in Sub-Saharan Africa.

Ellsberg and Betron (2011:1) are of the opinion that GBV in most cases does put women and girls at a great risk of HIV infection through multiple pathways. For example, women who have been sexually assaulted face the risk of infection from their assailant. Women living with violent partners are often unable to negotiate safer sex, and to protect themselves from unsafe and coerced sex. At the same time, women living with HIV are more likely to suffer violence of all forms as a result of their status (often perceived as embarrassing), both from intimate partners as well as from family and community members – a form of victim-blaming approach.

According to Amdie (2005:7), not only does GBV put women and girls at a great risk of HIV infection, it can also make women vulnerable to HIV through three main mechanisms. First, there is the possibility of direct transmission through coerced sexual acts. Secondly, the trauma associated with violent experiences can impact negatively on later sexual behaviour, by increasing the women's HIV risk-taking behaviour. Third, violence or the threat thereof may limit women's ability to adopt safe and HIV protective sexual practices within other on-going relationships and may hinder them from using HIV related services such as Sexually Transmitted Infections treatment, Voluntary Counselling and Testing and Prevention of Mother to Child Transmission services.

It is against this background that this study seeks to explore GBV and the risk of HIV and AIDS among women in Ngaka Modiri Molema district, North West province in South Africa.

1.2 PROBLEM STATEMENT

The legal status of women in South Africa changed with the 1996 Constitution (Act 106 of 1996) which contains clauses that advocate for and promote women's rights. The clauses make explicit reference to GBV as a gross violation of human rights from which women in particular should be protected. The clauses further endorse that all women ought to be free from all forms of violence, from either public or private sources. Other Acts were passed since then, for example, the Domestic Violence Act (Act 116 of 1998). This Act protects victims of domestic violence by making provision for the issuing of court protection orders. Promotion of Equality and the Prevention of Unfair Discrimination Act (Act 4 of 2000) makes provisions to prevent and prohibit unfair discrimination, harassment and promote equality. The act also overt reference to the protection of women.

Irrespective of some of these legal instruments being in place, their applications over the years have been ineffective. The condition of women, particularly women in rural areas including those in the North West province, remains wholly the same in terms of being discriminated against amidst constitutional changes since the demise of apartheid. The main problem lies in the incongruence between the economically wanting condition and the elevated position of most women in South Africa – a form

of vulnerability and predisposition to violence for most women and ultimately to the contracting of HIV and AIDS.

1.3 RESEARCH QUESTIONS

Given the research problem defined above, the following research questions are posed in this study:

- What is the prevalence of gender-based violence and HIV and AIDS infection among women in North-West province?
- What are the most salient HIV and AIDS risk factors and behaviours among women?
- What are some of the programmes and policies put in place to address GBV and HIV and AIDS in North-West province, and by extension, South Africa?
- What guidelines can be recommended from a social work perspective that can further be researched, to address the problems of GBV and HIV and AIDS in Ngaka Modiri Molema District in the North-West province?

1.4 RESEARCH AIM AND OBJECTIVES

The aim of this study was to explore GBV and the risk of HIV and AIDS among women in the demarcated areas of the North West province of South Africa, so that the risk factors of this interconnection be identified, further clarified and clearly defined, for subsequent research. The aim of the research was achieved through the following specific objectives:

- To explore the prevalence of gender-based violence and HIV and AIDS infection among women in the North West Province;
- To explore HIV and AIDS risk factors and behaviours among women;
- To establish some programmes and policies put in place to address GBV and HIV and AIDS in North West province, and by extension, South Africa, and
- To recommend guidelines from a social work perspective that can further be researched, to address the problems of GBV and HIV and AIDS in Ngaka Modiri Molema District in the North-West Province.

1.5 ASSUMPTIONS OF THE STUDY

The following are the assumptions of the study:

- Violence against women puts them at a great risk of contracting HIV and AIDS.
- The culture of "silence" that surrounds human sexuality and violence against women provides fertile ground for the spread of HIV and AIDS epidemic.
- Unequal power relations between genders lead to violence against women and to their extreme exposure to HIV and AIDS virus.

1.6 SIGNIFICANCE OF THE STUDY

Studying GBV and HIV and AIDS as intersecting issues is essential in understanding both the phenomena and how they affect the social functioning of women and the society at large. Understanding these phenomena can provide valuable information that could be useful in generating new knowledge to an existing body of knowledge.

1.7 DEFINITION OF CONCEPTS

The following are the definition of concepts that obtain in this research:

1.7.1 Gender: According to Giddens (2006:1017), gender refers to the social construct and expectations about behaviour regarded as appropriate for members of each sex. Gender does not refer to physical attributes, but to socially formed traits of masculinity and femininity. In the case of this study, the term gender will mean the social and psychological learned characteristics associated with being a female or male.

1.7.2 Gender-based violence: GBV is any behaviour within an intimate or non-intimate relationship that causes physical, psychological or sexual harm to the other party, and includes physical aggression, psychological abuse, forced intercourse and other forms of sexual coercion and various controlling behaviours (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002:3). This type of violence can be perpetuated by both women and men. However, in this study, most perpetrators are men where the women are victims and/ or survivors. For this study, GBV against women will denote violence directed at negatively affecting and demeaning the personhood in women.

1.7.3 HIV and AIDS: HIV is the abbreviation for Human Immunodeficiency Virus. It damages the body's immune system making it more vulnerable to the effects of

opportunistic infection (Van Dyk, 2005:244). On the other hand, AIDS is the abbreviation for Acquired Immune Deficiency Syndrome. It is defined as the presence of an opportunistic infection or disease in a previously healthy person with no other causes for immune deficiencies (Hecht, Adeyi & Semini, 2002:39). In this study, the presentation of the terms as "HIV and AIDS" over and above the familiar presentation of "HIV/AIDS" is used deliberately to indicate that though the two terms are mutually inclusive, they are different, meaning that most people in this study who are infected with the HIV virus do not necessarily have AIDS.

1.7.4 Powerlessness: Powerlessness is defined as a perceived lack of personal or internal control of certain events or certain situations (Larsen & Lubkin, 2009:256). For the purpose of this study, powerlessness is used to denote lack of ownership and control of processes that affect an individual, including lack of decision-making opportunities and/or abilities.

1.7.5 Sexual assault: Sexual assault is the full range of forced acts, including forced touching or kissing, and verbally coerced intercourse, vaginal, oral and anal penetration. Both men and women can be sexually assaulted and can commit sexual-assault (Abbey, Zawacki, Buck, Clinton & McAuslan, 2001:50). The vast majority of sexual assaults, however, involve male as perpetrators, with women as victims. This opinion and belief is consistently upheld in this study, and will also denote any form of violence directed at the sexual integrity of women.

1.7.6 Violence: It refers to the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation (Dahlberg & Krug, 2002:4). For the purpose of this study, the term violence will mean any form of intention to instil pain and power over another.

1.8 THEORETICAL FRAMEWORK

For the purposes of this study, a feminist theoretical framework driven by an ecological and strength-based perspective are used in order to understand the dynamics associated with GBV and the risk of HIV and AIDS among women in Ngaka Modiri Molema.

1.9 LITERATURE REVIEW

In this study, a review was conducted on GBV as a risk for HIV and AIDS among women, which included the prevalence of various forms of violence directed against women, the prevalence of HIV and AIDS among women, some programmes that are implemented in South Africa and in the North West province to address GBV and HIV and AIDS. Different theoretical frameworks relevant to the study were also reviewed.

Both international and local literature dealing with the theme was sourced. The following data bases were utilised to inform and guide the literature review process: Ebscohost - including Academic Search Premier, Master File Premier, Psyc Info and Eric. Google and E books were also used, including journal material, research articles and reports, together with policy documents.

1.10 STRUCTURE OF THE RESEARCH REPORT

Chapter 1: Background to the study

Chapter 1 provides background information on the phenomenon of GBV and HIV and AIDS risk factors among women globally and locally. Information on the aims of the study and objectives is also highlighted.

Chapter 2: Literature review and theoretical framework

This chapter offers a systematic literature review to explain the phenomena of GBV and HIIV and AIDS among women, the inter-play between gender-based violence and HIV and AIDS, including theoretical frameworks upon which the study is based in order to understand the problems of GBV, HIV and AIDS comprehensively.

Chapter 3: Methods and procedures regarding the research investigation

Chapter 3 provides the methodology that the study adopted, specifically the qualitative research paradigm used. This chapter further describes the research design, and the sampling procedures from the population of the study. Data collection methods are explained with specific reference to in-depth interviews and focus group discussions. Information on ethical considerations is also provided.

Chapter 4: Data analysis, interpretations and presentations of research findings

The fourth chapter discusses the findings of this study, which encompass data analysis, interpretations, and presentations. A qualitative analysis of GBV and HIV and AIDS risk factors among women in the demarcated area of study is undertaken. The discussion provides biographical profiles of participants. Analysis, interpretation and presentations of participants' views on the phenomena of GBV and HIV and AIDS are provided.

Chapter 5: Discussions of the findings, conclusions, limitations and recommendations

Chapter 5 presents a discussion of the research findings, conclusions, limitations, implications and recommendations for further research. The findings are consolidated to reflect against the research objectives set at the onset of this study, with recommendations made on the basis of specific research findings of this study.

1.11 CONCLUSION

This chapter highlighted the background to the study, defined the problem statement, set out research questions and provided the aim and objectives of the research study. Assumptions of the study preceded the significance of the study, which was followed by the definition of concepts used. An indication of the different theoretical frameworks used in the study is highlighted, and this is followed by a brief explanation of how literature was sourced and reviewed. The structure upon which the study is based is structurally is defended.

CHAPTER 2

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 INTRODUCTION

Literature review is an evaluative exercise of information gathered. Its main purpose is to describe, summarise, evaluate, clarify and contextualise the information at hand. A clear theoretical basis for the research study is also provided to frame the study's approach and foreground its perspectives (Boote & Beile, 2005:4).

Through this literature review, a selected and limited number of topics that are central to the topic of GBV against women and HIV were reviewed and comprise: the prevalence of various forms of violence directed against women, prevalence of HIV and AIDS among women, the interconnection between GBV and HIV and AIDS, HIV and AIDS risk factors among women and programmes that are implemented in Ngaka Modiri Molema, South Africa, to address GBV and HIV and AIDS. A detailed discussion then follows on the different theoretical frameworks used in this study.

2.2 PREVALENCE OF VARIOUS FORMS OF GENDER-BASED VIOLENCE AMONG WOMEN

Morrison, Ellsberg and Bot (2004:117) stipulate that GBV manifests itself in different forms, some of which are brutal acts such as murder of a targeted woman on account of sexual orientation, forced pregnancy, honour killings, burning or acid throwing, female genital mutilation, dowry-related violence and rape in armed conflict, trafficking of women for commercial sex work, and sexual harassment and intimidation at work. Morrison et al (2004:118) further indicate that some GBV cases are subtle and not clearly recognisable. They are not openly acknowledged as in psychological violence and/or abuse. Still in certain cultural spheres, domestic violence is a private matter hidden from the public gaze and therefore outside the scope of public interference. In other grossly intolerant situations, same sex relations are not accepted and therefore "corrective rape" is socially sanctioned and justified. In sum, these different forms of GBV are presented under the following categories, which though different, are to an extent intertwined:

2.2.1 Physical violence:

Seilberger (2011:694) describes physical violence as an act that may result in pain, injury, impairment, and to a large extent can even lead to death of the one who experiences this type of abuse. This type of violence can present in many forms which includes beatings, shaking, tripping, punching, burning, pulling of the hair, slapping, gripping, pushing, pinching, kicking and the use of physical restraints. In the researcher's opinion and observation, this type of violence is more prevalent than all other types of violence, partly based on the fact that it can easily be recognised.

In summary, physical violence against women, particularly IPV, is a major public health problem and constitutes the highest level violation of women's human rights, based on its visibility and cruelty (WHO Fact Sheet, 2013:1).

Research findings (Turmen, 2003:410) estimate that at least one in every three women globally has been beaten, forced into sex, or abused in their lifetime. Krug, Mercy, Dahlberg and Zwi (2002:185) in their study also found that between 10% and 69% of women globally are reported to have been physically assaulted by an intimate partner during their lifetime, and of these women, about 20% reported having been both physically and sexually abused as children. This statistical scenario can rightfully serve to reflect that GBV has become a second nature for some women in most settings, and in certain situations, GBV has been internalised by these very women, with a danger of socialising their girl children into viewing violence against them as a natural progression of life.

Recent global prevalence of GBV against women clearly shows how this problem knows no boundaries, no colour, and no socio-economic status. The given figures by WHO Fact Sheet (2013:1) clearly indicate that about 35% of women worldwide have experienced either intimate partner violence or non-partner sexual violence in their lifetime, with the highest form of violence against women reported in South East Asia region (37.7%), followed by Eastern Mediterranean region (37.0%). The African region, forever portrayed as the worst comparatively speaking, surprisingly takes the third place at 36.6% (See Annexure 1).

On average, 30% of women worldwide who have been in a relationship reported also that they have experienced, at one stage or the other, some form of physical violence by their partner. Also, as many as 38% of murders of women are committed

by an intimate partner, often bearing no legal consequences thereof (WHO Fact Sheet, 2013:1).

Seedat, Van Nieker, Jeweks and Suffia (2009:1011-1013) postulates that in South Africa, physical violence is the second leading cause of death and an equally leading cause of disability, mostly among women. For instance, the overall injury death rate among the targeted women as in 2009 was recorded as 157.8 per 100 000 population, nearly twice the global average. In the same breath, the rate of intimate femicide in the year 2009 was also recorded as six times the global average rate.

A worrying point in the researcher's opinion is that all this violence against women in South Africa takes place in a democratic dispensation wherein "women issues" are placed high on the government's agenda. The question then is: Where do we go wrong as South Africans?

2.2.2 Sexual violence

According to Chatora (2013:12), sexual violence constitutes any forced sexual encounter, any attempt to obtain forcefully sexual acts, or even any unwanted sexual comments otherwise directed against a person's sexuality using coercion by any person regardless of their relationship to the victim. It must categorically be pointed out that these sexual acts need to be disapproved by the person who the acts are directed towards, in order to constitute a criminal act.

Millions of women all over the globe who are directly exposed to some form of sexual violence, and an even greater number who are forced to live with the fear of its pervasiveness, seemingly have made it their "new normal" way of domestic life.

Turmen (2003:410) takes this observation further by pointing out that, globally, girls, may be up to three times more likely to experience sexual abuse than boys. Often they are the majority of most incest victims, which is sometimes not reported (even when discovered) for fear of losing their livelihood, especially when the perpetrator is the "breadwinner" in the family. Of the almost two million children being exploited in prostitution and pornography worldwide, 80% to 90% are girls. In the fast increasing global trafficking market, over a half-million human beings are forcibly transported across international borders each year. An estimated 80% of these victims are helpless women and girls, and most of them are suspected to be trafficked into the

commercial sex industry (Turmen, 2003:410). This situation is indicative of the fact that unequal power relations account for the prevalent sexual exploitation against most girls and women.

A multi-country study conducted by Bywaters, McLeod and Napier (2009:110) on domestic violence and women's health in 15 sites and 10 countries found that the proportion of women who had experienced sexual violence by intimate partners in their lifetime ranged from 15% to 17%, with prevalence for most sites between 29% and 90% reported. South Africa notoriously known as a violent country has one of the highest rates of sexual violence against women and children reported in the world. It is rated amongst the leading countries when it comes to violent crimes such as murder and rape against women, in spite of its most progressive constitution. The violent situation in South Africa approaches endemic proportions.

As an illustration of this pervasive form of violence, a study of young women in South Africa (Turmen, 2003:411) found that 30% of the girls said their first intercourse was forced, 71% had experienced sex against their will, and 11% had been raped in their life time.

On this account of sexual pervasiveness against most women, the North-West Province reported from as far back as in 2008 an average of 5039 incidents of rape and 485 cases of indecent assault in that year, with a reported average of 2900 cases of domestic violence in the same year – all perpetuated against women. Sexual offences are singled out by the South African Police Service as a serious problem in the province, with the ratio of reported offences per 100 000 of the population in 2008 being higher than the national average (Integrated Provincial Strategy to Prevent and Combat Sexual Offences, 2008:8-10). For the period 2009/10 – 2012/13, all the sexual offences increased from a ratio of 137.9 per 100 000 population to 155.7, a 6.2% increase as in December 2013 (South African Police Service Crime Statistics Overview RSA, 2012/2013:26).

Manifestations of the reported sexual assaults are the risk of contracting STIs, including HIV infections -which not only negatively affect the victims physically, socially and psychologically, but significant others as well (Kalichman & Simbayi, 2004:68).

In real and historic terms, this researcher deduces that the situation from the provided information above might be more serious if all cases were reported and fairly handled by those in authority, which is rarely the case. Sexual violence does affect women's power and ability to negotiate the conditions of safe sexual intercourse, especially condom use. Sexual violence and rape can also negatively affect women's use of services such as testing for HIV and the extent to which they feel able to discuss their HIV status with others and seek social support. In other instances, this psychological scarring has possibilities of even turning into a vicious cycle where a person who has been sexually violated against in turn sexually abuses and molests others, especially young helpless girls, and predisposing them to various challenges including contracting at an early age of their developmental life, HIV and AIDS.

2.2.3 Emotional violence

Mullender (2002:23-24) posits that men who have been physically violent often deliberately use demeaning psychological tactics to reinforce their control over the targeted women. Once the fear of further attacks is established, threats, gestures and glares suffice to maintain the atmosphere of fear and intimidation for women.

Emotional violence in the opinion of Iwaniec (2006:28) in its extreme forms conveys that someone is worthless, flawed, unloved, unwanted and endangered. This form of violence includes spurning, terrorising, isolation, exploitation, denying emotional responsiveness, and entails verbal and nonverbal behaviours of belittling someone, shaming and degrading them, threatening them, as well as imposing severe restrictions on them.

From this researcher's opinion and personal experience as a woman, emotional violence is not visibly seen on the victims. This inscrutable aspect does make it difficult for the victim to be believed, nor can it be used as part of evidence when reporting the incident to the police (who are mostly not trained in psychotherapy). Perpetrators, as a result, tend to get away with this type of violence. In worse scenarios it has the possibilities of culminating in mental ill-health which in the South African courts can be a ground for divorce (apparently favouring the perpetrator).

2.2.4 Economic violence

Economic violence may take the form of the perpetrator making the victim beg for money or withholding money, for basic needs such as food and sanitary towels (Marsh & Melville, 2011:349). In other instances, this type of violence can also entail forcefully taking and even controlling the money of the victim (the woman) by the perpetrator (the man).

Findings from a study conducted by the Development Research in Africa (2011:73) revealed that approximately 48% of women respondents have been and still are victims of economic abuse. Various indicators were used during the survey to create an understanding of the nature of this abuse. This included having the victims' income spent on the "other woman/women", having their clothes torn off, their belongings sold and their valuable possessions damaged spitefully beyond repair. Other indicators further revealed that 34% of the perpetrators had exclusive control over household money, 27% were prevented from knowing about family income/ finances, 26% were prevented from using or accessing family income, with an additional 13% of the respondents indicating that they were abused and attacked because of household expenditure. This type of violence tends to perpetuate dependency of the victim on the perpetrator, and entrenching further power over the victim.

From the different types of violence demonstrated above, the question that has been posed and once more reiterated by the researcher of this study is: why do some women in South Africa continue to stay in such violent relationships? WHO (2012:3) postulates the following as the possible reasons:

- fear of retaliation;
- lack of alternative means of economic support;
- concern for their children;
- lack of support from family and friends;
- stigma or fear of losing custody of children associated with divorce; and
- hope that the partner will change.

Despite these barriers, many abused women eventually leave their partners, often after multiple attempts and years of violence. By the time that they gather the courage to leave abusive partners, most are infected with the HIV virus, and some

even end up retaliating by killing their partners. Alternatively, some abused women end being killed themselves - an eventuality termed femici de.

2.3 PREVALENCE OF HIV AND AIDS INFECTION AMONG WOMEN

As purported by the WHO (2006:27), promising developments and global efforts have been made in the recent years in order to address the HIV and AIDS epidemic, including increased efforts to address access to treatment and prevention programmes. However, the number of people living with HIV continues to grow as does the numbers of deaths due to AIDS related illnesses.

Shannon, Leiter, Phaladze, Hlanze, Tsai, Heisler, Lacopino and Weiser (2012:1) alluded to a frightening reality that, of the 33 million people estimated to be living with HIV worldwide, about 70% are in sub-Saharan Africa, with 58% comprising young African women. Still, a further reality is that among HIV positive adolescents and young adults aged 15–25 years in sub-Saharan Africa, 70% are women. The situation reported by Shannon et al (2012: 1) is a startling contradiction of the 2008 UN global HIV estimates which suggested stabilisation in the sex-ratio of HIV prevalence in some settings such as Botswana and Swaziland. In many regions of the world, new HIV infections are heavily concentrated in women. The main question posed by this researcher, then, is "why the skewed bias towards women"? Is it because testing them is part of the medical routine when pregnant? One wonders whether women's access and utilisation of the medical facilities should be used to inform on statuses. Still again, does this indicate the possibilities of being sexually violated and abused, including being raped? The possibilities can also suggest rape inside marriages or within an intimate relation. Another indication is that of ill-informed and violent intimate partners refusing to practice safer sex by wearing a condom, resulting in repeated re-infections.

The South African National Antenatal Sentinel HIV & Syphilis Prevalence Survey in (2011:12) points out that the overall HIV prevalence amongst antenatal women in South Africa in 2011 was 29.5%, a decrease of 0.7% from 30.2% in 2010, presumably because of a shift from the South African government denial position under the Mbeki administration of the causal link between HIV and AIDS and poverty, and from claims that anti-retroviral drugs (ARV) are ineffective and lethally toxic in the face of scientific evidence to the opposite (Mbali, 2004:104). The 2011

HIV prevalence estimate was is in line with estimates from 2007 - 2009. However, the national HIV prevalence estimate amongst the women surveyed has remained stable around 29% over the past five years.

Statistics South Africa (2013:4) takes the HIV prevalence picture even further by providing the HIV prevalence estimates and the total number of people living with HIV from 2002 to 2013 in South Africa (See Table 1). Reasons for the high HIV prevalence among women are not provided in this table. It can, however, be assumed that the prevalence estimates are informed by past trends and present behavioural and factual information. A closer look again at this table reveals that the total number of HIV prevalence in South Africa increased from an estimated 4 million in 2002 to 5.26 million by 2013. For the period 2013, an estimated 10% of the entire population was HIV positive, with approximately 17, 4% of these women being HIV positive as opposed to 15.9 % comprising HIV positive adults (men and women) within the age range 15-49.

From the figures provided, it is evident that the brunt of the HIV epidemic is borne by women, who are mostly in their reproductive and productive years. The implication from the presented scenario can suggest possibilities of high rates of sexual abuse and violence against most South African women, in both intimate and non-intimate relationships manifesting in high rates of HIV and AIDS.

Table 1: HIV prevalence estimates and the number of people living with HIV in South Africa, 2002-2013

Year	Prevalence				Incidence	HIV+
	Women 15-49	**Adult 15-49**	**Youth 15-24**	**Total population**	**Adult 15-49**	population (millions)
2002	15.9	15.1	13.6	8.7	1.26	4.00
2003	16.0	15.1	12.8	8.9	1.27	4.10
2004	16.1	15.1	12.0	8.9	1.28	4.18
2005	16.2	15.1	11.4	9.0	1.32	4.25
2006	16.4	15.2	10.9	9.1	1.29	4.34
2007	16.5	15.3	10.5	9.2	1.21	4.46
2008	16.7	15.4	10.1	9.3	1.12	4.59
2009	16.9	15.5	9.7	9.5	1.03	4.74
2010	17.1	15.6	9.3	9.6	0.98	4.88
2011	17.2	15.7	9.0	9.8	0.95	5.01
2012	17.3	15.8	8.7	9.9	0.87	5.13
2013	17.4	15.9	8.5	10.0	0.85	5.26

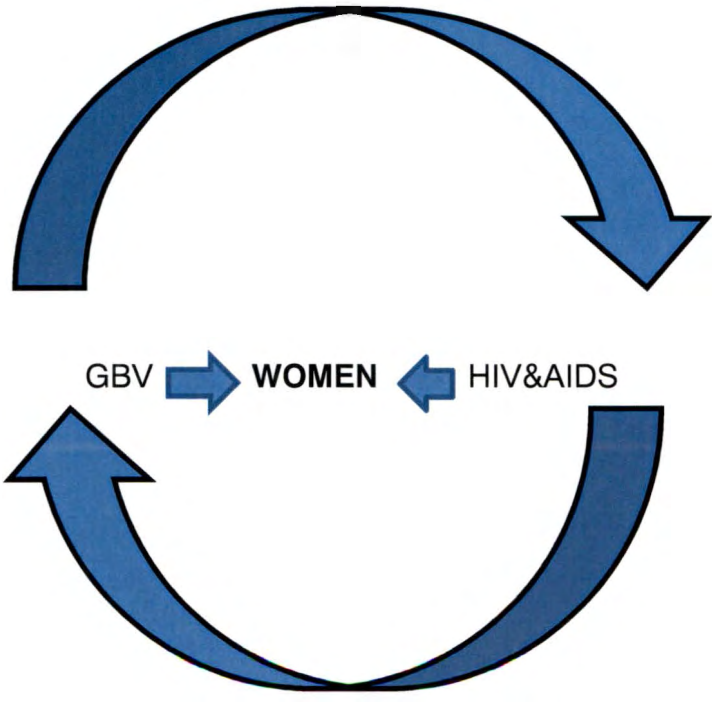
Source: Statistics South Africa (2013).

The North-West Province had nearly half a million HIV positive people, the fourth largest in South Africa in 2008 (The South African Sentinel HIV & Syphilis Prevalence Report, 2008:21). The South African National Antenatal Sentinel HIV & Syphilis Report (2011:4) further point to an increase in HIV prevalence among women in the North-West Province from 29.6% in 2010 to 30.2% in 2011, presumably related also to the high rate of reported rape cases of sexual violence in the province (See Annexure 2).

2.4 THE INTERCONNECTION BETWEEN GBV AND HIV AND AIDS

The interconnection between GBV and HIV and AIDS is a complex phenomenon which is not linear but cyclical. This implies that GBV against women does not by itself serve as a causative factor of HIV and AIDS, nor do HIV and AIDS by itself cause GBV. Ahikire and Mwiine (2012:9) see the cyclic link between HIV and GBV, particularly violence against women as preconditioning factors of each scourge and as a result of the interplay between them, the scourge becomes self-reinforcing (See Figure 1).

Figure 1 Cyclic and reinforcing nature of HIV and AIDS and GBV.



The WHO (2004:1) describes this interconnection as complex and can be understood through the interplay of biological, socio-cultural and economic factors, further elaborated as follows:

2.4.1 Biological Factors

Biological factors are about the understanding of a person at intrapersonal or individual level (see 2.6.2.2). The point being made here is that much as environmental risk factors of GBV and HIV and AIDS are to be known and highlighted, the starting point ought to be "self-knowledge" of one's biological makeup and functioning, in comparison to men's (bearing in mind that there is no universal woman).

From a biological point of view, the research undertaken by Turmen (2003:411) showed that women are more susceptible to HIV infection than men. For instance, male to female transmission of HIV can be between two and four times higher than female to male, simply because of physiological differences between men and women. The presence of STI's also increases the risk of transmission and acquisition of HIV, as most STIs are asymptomatic in women, with diagnosis and treatment being made more difficult as a result.

Accordingly, WHO (2004:1) pictured the biological risk of transmission in a violent sexual encounter to also being determined by the type of sexual exposure (for example, whether it is vaginal, anal or oral). HIV transmission risk can equally be higher with the degree of trauma encountered as a result of vaginal lacerations and abrasions which can occur when force is used.

Young women are especially vulnerable to HIV infections through sexual intercourse because the immature and undeveloped genital tract of girls is more likely to sustain tears during sexual activity, especially with an older and more experienced partner, creating a higher risk of HIV transmission (Turmen, 2003:412).

The implication of the highlighted biological and or physiological susceptibility of women to HIV infections than men, point to a need for more gender specific prevention and intervention mechanisms which are to be tailor-made, over and above generic ones.

2.4.2 Cultural factors

Centre for Disease Control and Prevention (2005:1) alludes to the fact that religious beliefs, customs and cultural traditions sometimes place women and young girls directly in the path of HIV and AIDS. For instance, in the South African situation, the

paying for "lobola" also termed "bride price" – a common practice with most South African cultures previously used to serve as modest gifts intended to promote links between families - is now seen and used as an income generating venture by some families. This is now turning young girls into commodities expected to live up to the customary expectations regarding child rearing and other sexual duties towards their husbands. In such practices, young women are often without a say and cannot negotiate for safer sex.

Lack of education or knowledge from Turmen's (2003:415) perspective and research about sex can also be an important determinant of HIV and AIDS risk for most women. Many cultures, for instance, value ignorance about sexual interaction as a feature of femininity. In some societies, girls are even taken out forcefully from school by their families to care for sick family members or to perform other household chores, thereby jeopardising their education and future prospects (some form of preparation and initiation into their expected traditional gender roles). This inequality affects a woman's ability to make informed decisions, especially on risks pertaining to HIV infection.

From the forgone discussion, there is a need in most cultural practices where there is discrimination against the sexual integrity of women, for its adherents to be culturally competent in terms of sensitivity to women issues, and to ensure its dynamism in line with democratic trends.

2.4.3 Partnering with riskier older men

Whilst age does not serve as a determining factor in an intimate partner relationship, young women seem more attracted to older men for a variety of reasons, including economic survival. A study by Karim and Karim (2010:318) found that the conditions under which women have sex is mostly determined by their male partner's use of violence and gender-role expectations about love, sex and compliance with the male partner's desires. Because male partners are usually older, the power and maturity advantage that they hold creates an environment conducive for sexual coercion. Older partners may also provide financial benefits, thus making the young women's power to negotiate safer sex difficult. This trait is coupled in most cases by physical strength and elements of unequal power relations. Violence in such a space may

also be a contributing factor to the spread of HIV and AIDS epidemic, with some men seeking to spread infection deliberately (Mcube & Haber, 2013:113).

A review of over 40 studies WHO (2004:3) from sub-Saharan Africa suggests that a significant proportion of young girls have sexual relations with men five to ten years older than themselves. While girls are able to initially choose the older sexual partner for their economic selfish reasons, once in the relationship, it is the older men who control the sexual relationship and sexual activity including condom and contraceptive use, in most situations through the use of violence.

In South Africa, the findings from Wechsberg, Parry and Jewkes (2010:2) revealed that that over the years, social norms have favoured age-disparate sex, where older men have sexual relations with younger women. Also, in other circles, having sexual relations with a young virgin girl has been regarded as safe, with possibilities of self-cleansing of one from the HI virus. Many children as a result have been falling prey to such merciless violence and abuse which spiral to the prevalence of incest rape and HIV and AIDS among young women.

There can be no policy prescribing who should engage in intimate relations with whom. However, on this score, the South African law does prohibit adults from engaging in sexual relations with children under the age of 18 years – an offence termed statutory rape. This offence disregards the fact whether the act is consensual, on account that the child in question is still a minor. What exacerbates the problem on a practical level though can be the non-reporting of such cases or even the blackmailing game from either parties based on selfish motives of money and power, with possibilities of resulting in high rates of HIV and AIDS infections and a way of putting the vicious cycle of sexual violence against young women once more in motion.

2.4.4 Violence as a direct result of HIV and AIDS infection

The President's Emergency Plan for AIDS Relief Report (2006:6) found that women and girls who are raped or sexually coerced do not, in most cases, have the ability to negotiate condom use, nor do men who are mostly the perpetrators of such violence offer to use condoms as a protective measure. Vaginal lacerations and trauma from

sexual violence further tend to increase the risk of acquiring HIV or any form of STI's. Violence also prevents women from accessing appropriate HIV information, being tested, disclosing their status, accessing services, and accessing treatment, care, and support (The President's Emergency Plan for AIDS Relief Report, 2006:6).

Accordingly, the findings from Wechsberg, Parry and Jewkes (2010:2) in South revealed that gender norms over the years have placed men in control of sexual relations. Such norms have allowed most men overtly and covertly to prescribe and dictate the circumstances and frequency of sex, whether a condom should be used or not, and to an extent culturally condoning marital rape and physical violence against women.

From the provided accounts above, it can be deduced by the researcher of this study that the situation in the South African situation is unique and complicated in the sense that not only is GBV perpetrated by men against women who are not their intimate partners, but instead IPV is common including rape inside marriage – regarded legally as a crime, with most cultures in the South African situation and in the North West province in particular condoning the action and crime. To further complicate the situation, the victims can even be innocent children (mostly girl-children) owned by the perpetrators themselves through incest – a deliberate and malicious spread of the HIV virus within the entire household.

2.5 SOME PROGRAMMES AND POLICIES IMPLEMENTED IN SOUTH AFRICA TO ADDRESS GBV AND HIV AND AIDS

Most programmes implemented by women's groups, other pressure groups which are faith-based, including those spearheaded by both men and women, and the government have attempted to address violence against women for many years in South Africa. Many of these programmes are often of a small scale, in most cases not adequately resourced, operating in isolation and on a piecemeal basis, and may not be scaled up easily (WHO, 2004:4). On the other hand, a growing number of HIV and AIDS and reproductive health programmes are also beginning to address violence against women. Many of these interventions have, however, not yet been fully formally evaluated and, therefore, there is not enough evidence that they work or qualify as part of good practice – a start though they might be in the right direction (WHO, 2004:4).

For the purposes of this research study, two of the long running programmes are looked into – one governmental and the other a non-governmental venture. These are the Integrated Victim Empowerment Programme (IVEP) and the Soul City Institute for Health and Development Communication (SCIHDC). They operate under the provisions of the Domestic Violence Act (Act 116 of 1998) and the Domestic Violence Act as amended (Act 55 of 2003). The rationale for choosing these is that the programmes and policy have been implemented and evaluated by different researchers and users.

2.5.1 Integrated Victim Empowerment Programme (IVEP)

The Integrated Victim Empowerment Programme (IVEP) is a governmental approach aiming to facilitate access to different services offered to people who have individually or collectively suffered a form of harm, trauma and material loss through violence, crime, natural disaster, and human accident and through socio-economic conditions (National Policy Guidelines for Victim Empowerment, 2007:5). It is the process of promoting the resourcefulness of victims of crime and violence by providing opportunities to access services available to them as well as to use and build their own innate capacity and support networks that can facilitate acting on their own choices (National Policy Guidelines for Victim Empowerment, 1997: 6).

The IVEP is ideally meant to be used by service providers in the South African governmental sectors dealing with either victims or survivors of violence. IVEP, according to the Fourth Draft of the Integrated Victim Empowerment Policy (2007: 6-8), is guided by and enshrined in the principles of "Ubuntu" and "Batho Pele", and entails the following:

- **Empowerment:** Victims of violence ideally are to be afforded back their lost power and to be provided with an enabling environment, opportunities to use and build their own support networks, and act on their own choices and sense of responsibility. As a starting point, they are expected to own, control their problem-solving processes, with their active involvement in any decision that involves them. In other words, self- determination is a principle that ought to be the key factor.

- **Human dignity:** Women as victims of violence do not constitute a homogeneous category. They ought to be respected as unique human beings who are like no other, afforded privacy, and have their decisions respected without judgment in relation to the circumstances and conditions of their victimization.
- **Participation and self-determination:** Victims of violence are to be given the opportunity to participate in activities and processes that are aimed at their empowerment. In addition, victims should be actively involved in all of the stages of the intervention processes according to their individual need, capacity and desire.
- **Accountability, effectiveness, and efficiency:** Service providers who intervene with victims and perpetrators of crime and violence should be responsible for the delivery of appropriate, efficient and quality services which are sensitive to the needs of victims and survivors.
- **Restorative Justice:** Restorative justice refers to a process for resolving crime by focusing on redressing the harm done to the victims, holding offenders accountable for their actions, and often also engaging the community in the resolution of that conflict (United Nations, 2006:5). The approach to services within Victim Empowerment should focus on restoring justice. The perpetrator should be held accountable for his/her actions, and where possible should make peace and some form of amends to the victim. This approach is also based on the understanding of crime as an act against the victim, family and the community. It advocates for more active involvement in the justice process by victims and the community at large. It is also aimed at holding perpetrators directly accountable to the people whose rights they have violated and at restoring the loss and harm suffered by the victim as a result of the violence encountered (Fourth Draft of the Integrated Victim Empowerment Policy, 2007: 6-8; United Nations, 2006:5).

Irrespective of service providers being expected in the South African situation to comply with issues of IVEP in their delivery of services to victims and survivors of crime and violence, this in most cases seem not fully realised. Patriarchy appears practically alive in the South African situation. In the opinion of the researcher, victims of violence (mostly women) are lumped together with no agency whatsoever

pertaining to the contextual dynamics of their cases. They tend to suffer disrespect at the hands of most police officers who cannot even take down comprehensive statements, and in most instances are not adequately trained to deal with violent cases sensitively.

A case in point is the findings of the Portfolio and Select Committees on Women, Children and Persons with Disabilities which conducted public hearings on the Domestic Violence Act (Act 116 of 1998) on the 28 and 29 October 2009, and revealed the following information (Mathews, 2012:1-2):

- Most South African police stations lack facilities for private consultation due to the absence of trauma rooms or Thuthuzela Centres. As a result, such victims of sexual violence (mostly women) often have to provide statements in environments that are not conducive to confidentiality or privacy.
- In some instances, ill-equipped counsellors assigned to trauma rooms are ill-equipped to deal with the counselling needs of victims of GBV. The training of these volunteer counsellors is also not monitored or evaluated.
- There is also often inadequate supervision of volunteers, including a high turnover of volunteers at police stations and trauma rooms.
- It was noted that there appeared to be a disincentive by police officers to record incidents of GBV against women including domestic violence, abuse and rape as this would negatively affect their overall performance rating.
- In addition, it was also highlighted that GBV and domestic violence registers were not maintained in the manner required of bearing comprehensive and useful information for appropriate intervention (Mathews, 2012:2).

From the above scenario, most victims of violence who report the incidences of violence seem violated and suffer abuse for the second and subsequent times at the hands of such ill-equipped service providers (mostly men). This constitutes a form of secondary victimisation.

Secondary victimisation can be defined as unsympathetic, disbelieving and inappropriate responses that victims of crime, sexual assault in particular, experience at the hands of service providers in general and the criminal justice

system in particular, resulting in further and additional trauma for the victim (Dey, Thorpe, Tilley & Williams, 2011:32). Secondary, victimisation has many negative connotations which have often manifested in some of the following outcomes:

- A victim withdraws her own case, and suffers in silence, resulting in a vicious circle.
- Victims are excluded or alienated from their own case, with perpetrators gaining an upper hand.
- The victim is not provided with information about key events, decisions or processes during the investigation phases or criminal trials.
- A victim feels intimidated in the presence of the accused while in court during cross-examinations often aimed at degrading or destroying the victim's credibility – a situation which can be extremely traumatic.
- A victim experiences a sense of being misunderstood or wrongly interpreted and thus feels disempowered (Dey et al, 2011:32).

Such behaviour points to the need for structural changes coupled with attitudinal changes especially in the South African Police Service and the Justice system. The two state departments are apparently still dominated by men who seem to be still investigating themselves. Women are equally expected not to participate in their own abuse or violence, especially when not supporting each other and when not interrogating the apparent "innocence" of texts (programme and policies).

2.5.2 Soul City Institute for Health and Development Communication (SCIHDC)

The SCIHDC programme aims at improving generally the health status of South African women through the reduction of HIV and AIDS by providing social change through mass media, social mobilisation and advocacy services (USAIDS, 2009: 139). Soul City is a communication strategy intervention, recognised in South Africa and beyond for its capability and potential in creating public awareness and challenging individual and collective beliefs and attitudes about violence against women in particular. In Soul City, a series of television and radio drama episodes and information booklets highlight clearly aspects such as domestic violence, sexual harassment, date-rape and HIV and AIDS. Soul City has also established a

partnership with South Africa's National Network on Violence against Women in order to convey information on women's rights, connect its audiences to needed services, create training materials on violence against women and advocate for legislative changes that are still repressive and discriminatory against women (WHO, 2004:4).

SCIHDC is already 16 years in operation. As a South African based regional health and development communication programme, it carries out the following activities as part of edutainment:

- Soul City- promotes health and social change among adults through television, radio and print;
- Soul Buddyz- targets children mainly within the ages of 8-12 years, including their teachers and caregivers;
- Advocacy campaign- aims at promoting social change and influencing existing legislation on HIV and AIDS and violence especially against women; and
- One Love campaign- aims at discouraging the norm of multiple and concurrent partnerships (USAID, 2009:139).

All the SCIHDC series underwent some type of evaluation which included a national survey carried out in 2004 by the WHO (2004:4) in order to examine aspects of Soul City as they relate to HIV and AIDS messaging at the community level. Evaluation of these series pointed out the need for the implementation of a national legislation on domestic violence by mobilising funds for training service providers and educating communities. About 16 million South Africans are said to have been reached by the Soul City since its inception through its use of educational entertainment about social and health issues including violence and HIV and AIDS, and on how the Domestic Violence Act (Act 116 of 1998) should be used to benefit victims of violence in domestic settings.

The question, then, posed by the researcher of this study is: with such a wide coverage by Soul City, how do women use the material acquired against GBV and HIV and AIDS? Are the victims of violence able to connect with the material aired and have their consciousness raised, in the absence of face to face interaction? Indeed, popular entertainment through edutainment can get people talking in their

own private spaces and thinking from their own understanding of the subject matter. Agreeing with Japheth (2013:17) on this point, edutainment does not only reach large audiences, it makes a difference to the quality of their lives in the process of seeking to:

- Impact on people's knowledge and attitudes to help them make informed choices about issues pertaining to aspects such as GBV and HIV and AIDS;
- Shift norms and attitudes which are not in line with current trends;
- Influence behaviours;
- Stimulate public discussion and debate;
- Link people to services where they can access help and support;
- Impact on the people's social, cultural, economic and political environment.

This should, however, be looked at against minimal disadvantages of edutainment which, in the opinion of this researcher, include the reality that not everybody owns a television set or radio. On the other hand, one can own these resources, but still be unable to use them based on the fact that not all people as yet in South Africa are connected to an electric grid. Even more, some cannot afford to buy electric coupons. In other households, viewership can be controlled and restricted too.

2.5.3 Domestic Violence Act (Act 116 of 1998), and the Domestic Violence Act as amended (Act 55 of 2003)

The Domestic Violence Act (Act 116 of 1998) was passed after recognising that there is a high incidence of violence in South Africa and that there was some ineffectiveness in services available to victims of violence in domestic settings. There was also a recognition that most victims of domestic violence are among the most vulnerable members of South African society. The purpose of the Domestic Violence Act is to afford victims of domestic violence protection from domestic abuse and violence by ensuring that relevant organs of the state give full effect to the provisions of this Act, thereby conveying a message that the state is committed to addressing the problem of domestic violence (Domestic Violence Act 116 of 1998:3).

The Domestic Violence Act is very explicit about the different types of abuses and violence it responds to. The conditions under which a protection order can be applied for and issued are clearly indicated. The duties of police officers at the scene of a domestic violence incident need to be well indicated (Domestic Violence Act as amended, Act 55 of 2003: 1; 2; 5 & 6).

Much as this Act managed to grant voice and protection to victims of domestic violence which seemed to be mostly women, weaknesses in implementation were explicit. The investigation from the Tshwaranang Legal Advocacy Centre (TLAC) and the Heinrich Böll Foundation (HBF) regarding the implementation of the Domestic Violence Act pointed to some challenges experienced which show that there have been gaps in implementing this Act. Some of the discernible gaps were:

- The application form was only available in English which further complicated the application process for applicants (84%) who did not speak English as a first language;
- Applying for protection orders was time-consuming. Only 23% of the applicants spent less than an hour in court; the remainder waited between two to six hours which results in some applicants giving up all hope.
- Applicants were also not always guaranteed to receive support on the same day. This was often dependent on the availability of magistrates.
- Waiting periods between applying for an interim protection order and returning to court for the final protection order hearing varied across the courts - some from as little as two weeks, while at other courts the waiting period for the final protection order hearing could take up to six weeks;
- For those employed (56% of the sample), taking time off from work to go to court was challenging and posed financial strains. This was further worsened by delays and the need to return to court multiple times. Time-delays also held significant implications for those who needed protection from abuse;
- Court Clerks did not always fulfil their duties as prescribed by the DVA inclusive of not always providing applicants with sufficient information on what to do or what to expect following the court's granting of the interim protection order; and

- Several complaints were levelled against the police, including delays in attending to call outs, attempts at mediating cases instead of arresting the perpetrator (Lopes, 2013:2).

The results of a hearing on the monitoring of the implementation of the Domestic Violence Act by the South African Police Service conducted by the Portfolio and Select Committees on Women, Children and Persons with Disabilities, on the 28 and 29 October 2009, revealed some of the following as key issues:

- Non–compliance – In the case where firearms were involved, these were not always confiscated after being used to threaten victims and the license of the alleged perpetrator suspended.
- Lack of resources - There had been, for example, instances where the police claimed that they had no vehicles available and situations where the areas from which victims called were not in their jurisdiction, particularly in rural areas. As a result, service was not rendered.
- Serving of protection orders- It was noted that protection orders often did not serve the purpose they are intended for in that they were not adequately enforced and the victim continued to suffer abuse despite the serving of the protection orders (Matthews, 2012:1).

From these two research findings, it is evident that most victims of domestic violence/ abuse have various problems with the Domestic Violence Act, which range from language problem in which the Act is written which cannot be comprehended by all, long processes followed in applying for protection orders, long waiting periods for protection orders, non-compliance by the police, lack of resources which compromise quality of service, and the lack of enforcement mechanisms of protection orders. From these observations, one can conclude, therefore, that the implementation of the Domestic Violence Act is problematic.

2.6 THEORETICAL FRAMEWORKS

2.6.1 Feminist theories

As posited by Kirst-Ashman (2007:76), feminism is a philosophy that agitates for equality between men and women and sunders both the beliefs and actions that

differentiate people on the basis of biology and gender. The theory often necessitates providing education and advocacy on behalf of women. It considers the diversity and personal accomplishments of women in relation to their men counterparts. The rationale for the usage of this theory in this research is that a feminist perspective challenges the idea that the potential of both women and men are limited by gender. Rather, the theory proposes that women are not in opposition to men but that they should be empowered to develop their abilities and capabilities in order to achieve optimal wellbeing (Abbott, Wallace & Tailor, 2005:267).

At the very onset of the debate, it must be borne in mind that women do not constitute a homogeneous category, but are different in their individual and collective struggles. There are a variety of feminist theories, but for the purpose of this study, liberal, radical and socialist feminism are used to interrogate and understand the situation of women experiencing GBV and HIV and AIDS in the South African situation.

2.6.1.1 Liberal feminism

Liberal feminism is characterised by its focus on equality. It is based on the belief that men and women have the same rational capacities and capabilities. The argument put forth is that men and women should be treated equally, which does not in any way suggest "sameness". If women are provided with the same educational, occupational and political opportunities, the argument goes that they will realise their true potential and no longer be subordinate to men (Abbott, Wallace & Tailor, 2005:267).

Furthermore, liberal feminism places great premium on rationality, autonomy and choice. Liberal feminists view reason as an important characteristic that is fundamental for moral and political autonomy. Proponents of this theory such as Rwalsian, Baehr and Chamber argue that women's exclusion from the public sphere may inhibit their full capacity to develop and exercise their rationality (McLaren, 2002:5). Therefore, they advocate for full participation and legal equality for women. This theoretical framework also advocates the working together of women with men within existing legal, political and economic institutions. Ideas such as rights, freedom, justice and equality are seen as objectives to achieve parity for women (McLaren, 2002:5-6).

Liberal feminists believe that men and women are essentially the same species of humanity, though biologically different, because the capacity to reason in all human beings is the defining characteristic (Giddens, 2006:461). Consequently, liberal feminism argues that relations between the two are not and ought not be gendered. Therefore, the gender differences in such areas as physical capacities ought not to be seen as important and should not be the basis for determining access to resources and opportunities (Abbott, Wallace & Tailor, 2005:267).

Payne (2005:253) alludes to an additional factor of liberal feminism in that it also seeks equality between men and women in workplaces and caring responsibilities, which until recently have been dominated by men in most countries in the world including in South Africa. The answer is to promote equal opportunities by legislation, and altering the socialisation processes so that children do not grow up accepting their gender inequalities as the norm.

Contextualising the liberal theory within the South Africa situation, it is clear that since 1994, with the onset of democracy, South Africa became known internationally for good performance in terms of how gender equality has received prominence. Starting with her most progressive Constitution (Act 108 of 1996) and its strong provisions in respect of equality, this to an extent laid the basis for her apparent strong commitment to the gender equality discourse (RSA MDG Country Report, 2013: 5). South Africa has also, since 1994, introduced a variety of policies and legislations that have directly addressed gender disparities (Republic of South Africa Millennium Development Goals- RSA MDG Country Report, 2013:5).

The OECD Development Centre (2012) as cited in the RSA MDG Country Report (2013: 5) clearly state that on paper, South Africa has made sterling progress. It is ranked 4th out of 87 countries in the 2012 index and was the top-ranked country in Africa, in terms of her commitment to gender issues (women issues in particular). As an example, South Africa's success in bringing about gender equality has been most visible in the area of politics, particularly in the National Parliament. In 2009, 43% of the members of parliament in executive positions were held by women (Gender machinery, 2009:3).

The question posed by this researcher is: "Do these impressive numbers of women politicians serve as a genuine measure of commitment to women empowerment or are they merely party political affirmations? The reason behind the question is that women issues seem to be confined only to the Ministry created for such, which has over the years lacked stability, and very rarely have issues which include GBV against women and its interconnection with HIV and AIDS debated in parliament rigorously from a gender perspective (women's perspective), by the very women parliamentarians across party political affiliations. Again, have annual commemorations such as the 16 days of activism of violence against women yielded any positive result in limiting GBV against women?

Even though the government has consistently supported gender equality, efforts to achieve women's equality have yet to make noticeable impact in the lives of the majority of women, particularly the rural black women. By implication, policy changes advocating for equality between men and women are not accompanied by behavioural changes (bearing in mind that behaviour cannot be legislated against). For instance, most women still seem to constitute the "reserve army of labour" – where they are the last to be hired and the first to be fired in the South African situation – a possibility which can further entrench the economic dependency of most women on abusive and violent partners, resulting in a high rate of HIV and AIDS infections through sexual abuse.

The conclusion from the aforementioned points made is that equality on paper between men and women should be accompanied by structural changes, and a commitment by all in ensuring the implementation of what is legally constituted on paper.

2.6.1.2 Radical feminism

Radical feminism focuses on one aspect of culture, namely, patriarchy. Attempts are made to highlight how patriarchy is bred through the socialisation process, which begins in the family, and how patriarchy infiltrates into other sectors of society like religion, education, the economy and politics (Giddens, 2006:269). The main argument put forth by radical feminism is that patriarchy leads to gender inequality and subordination of women to the extent that females do not have control over their

sexuality (Kambarami, 2006:1). Additionally, radical feminists define patriarchy as a social system in which men appropriate all social roles and keep women in subordinate positions. They further state that this social system has managed to survive for so long because its chief psychological weapon is its universality as well as its longevity (Kambarami, 2006:1-2).

Radical feminism further argues that the family brews patriarchy by socialising its young into accepting sexually differentiated roles. In most African cultures, from a tender age, the socialization process differentiates the girl child from the boy child (Giddens, 2006: 489). The argument of this theory is based on the notion that males are socialized to view themselves as breadwinners and heads of households, whilst females are taught to be obedient and submissive housekeepers and carers. As a result, women are expected to bear those traditionally defined and prescribed roles and qualities, which fit them into a relationship of dependence on men. These qualities include gentleness, passivity, submission and striving to please men always (Kambarami, 2006:3).

The implications are that children perform their roles based on their gender and become socialised in such discriminatory traditional gender roles by the very fabric that discriminates against women. This further entrenches gender division of labour, of access to resources and of opportunities, with possibilities of most women accepting violence perpetrated against them as a cultural given.

Leclerc- Madlala (2000:15) draws a practical picture of some African cultures which allow the husband to marry as many wives as he wants as part of polygamy, and can even have extra-marital affairs as a bonus. When such a scenario happens, it is the wife who is blamed for failing to satisfy her husband or for failing to curb his desire to do so. However, should the married woman engage in an extramarital affair, she is labelled as "loose" and this can even be regarded as legitimate grounds for a divorce. In addition, married women are expected to be sexually passive and submissive to their husbands, for, after all, men are the initiators of sex and also set the conditions for the sexual encounter. On the same note, women are expected to satisfy the sexual desires of their husbands and partners. As a result, when a

husband wants sex, the wife should comply because that is part of the marriage contract (Kalichman & Simbayi, 2004:18).

Based on the above given accounts of how patriarchy is sustained and entrenched, the suggestion would be on making "the private" sphere of the home "public" and therefore open to scrutiny and intervention. At the same time, there is a need, especially in this 21st century to move away from traditional gender roles that are prescriptive and defining women universally solely in reproductive terms. Emphasis needs to be placed on strategic gender roles that consider people's differences, including recognition of the productive capacities in women

2.6.1.3 Marxist feminism

Socialist feminists argue that under capitalism, material and economic factors underlay women's subservience to men because patriarchy has its roots in private property. Capitalism intensifies patriarchy by concentrating wealth and power in the hands of a smaller number of men as wage earners; as well as possessors and inheritors of property. Secondly, for a capitalist economy to succeed, it must define women as consumers, persuading them that their needs will be met through their increasing consumption of goods. Capitalism relies on women to offer labour for free in homes, caring and cleaning. Socialist feminists have called for a restructuring of family, the end of slavery and introduction of collective means for carrying out child-rearing, caring and household maintenance at a cost (Giddens, 2006:470).

Social feminists view sexual and gender division of labour as helping to create and maintain gender differences and gender discrimination (Leclerc- Madlala, 2000:19). The sexual division of labour takes places within the home and public sphere. In the domestic sphere, the sexual division of labor includes reproductive work such as bearing and rearing children and other household tasks such as shopping, cooking and cleaning. In the public sphere, the sexual division of labour includes divisions along traditional gender lines such as more men in manual jobs that require heavy lifting and more women in service sector and secretarial office work. The sexual division of labour perpetuates and reinforces gender differences which are evident in multiple social relations (heterosexual marriage, traditional family arrangements including women as primary caretakers of children, women's economic dependence

on men and the state). Thus Marxist feminists call for a change in the sexual division of labour and the social relations supported by such a division (McLaren, 2002:11).

Various legislations to address gender-division of labour and opportunities are constantly addressed in South Africa through policies such as: Basic Conditions of Employment Act (Act 75 of 1997) which aims to improve the lives of vulnerable workers such as domestic workers. This Act, among others, ensured that minimum wages were instituted for domestic workers in 2002, for instance. The Employment Equity Act (Act 55 of 1998) aims to promote equal opportunity in employment, with women being declared as one of the designated groups. The Preferential Procurement Policy Framework Act (Act 63 of 2003) provides a framework for measures in favour of women, black people and persons with disabilities in particular.

South Africa has made progress in terms of women empowerment and the reduction of discrimination towards women in the workplace, yet this has only been the beginning of a longer journey, particularly with regards to the progress that has still to be made in the private sector. In government, Acts such as the Employment Equity Act (Act 55 of 1998) passed in 1998 resulted in about 44% of women representation in legislature, 43% of women representation in Cabinet, and women make up 40% of local government elected positions (The International Women's Forum, 2011:22). In 2009, the representation of women at senior levels of the public service increased to an average of 36.1%, and women made up 26% of the higher courts and 40% of the lower courts (The International Women's Forum, 2011:22).

The question whether the women in positions of power, who are affirmed, truly become empowered or serve only as tokens of affirmative action, are central to the writer of this research study. In most cases, systems and structures of discrimination remain intact or are merely reformed with women added on to give the company a façade of democratic look. In worse scenarios sexual harassments against financially strained women become used as a gateway to positions of power, resulting in an escalation of HIV infections in the work place.

Despite the policies and legislations which emphasise women economic empowerment, there are challenges that hinder women's participation in the economic sphere. Women's access to finance is one such challenge that restricts women to establishing their own businesses. This situation has resulted in most women being confined to smaller informal businesses that are highly unregulated, unprofitable, and unsustainable, resulting in poverty with a female face (feminisation of poverty). Some of the poverty-stricken women are resorting to transactional sex which in itself is violent and can be a precursor to the spreading of the HIV virus.

2.6.2 Ecological perspective

The ecological perspective is used to understand the coping patterns of people and their environment so that a better match can be attained between a person's needs and the characteristics of his or her environment (Zastrow, 2009:49). This perspective gives attention to both internal and external factors of the person's physical and social environment. It does not view people as passive reactors to their environments, but rather as being involved in dynamic and reciprocal interactions with them (Zastrow, 2009:49). This perspective is used to understand the interdependence and interrelationship between women and their environment.

Payne (2005:150) further explains that the ecological perspective focuses on the interrelational transactions between systems, and stresses that all existing elements within an ecosystem play in equal measures in maintaining a balance of the whole. Ecological approach as Payne (2005:150) further explains can be best understood when one looks at persons, families, cultures, communities and policies to identify and intervene upon strengths and weaknesses in the transactional processes between people and their environment: they are "people in environment" (PIE). The relationship between them and their environment is reciprocal: each influences the other over time.

A focus on person-in-environment assists people to address problems, needs and aspirations that are associated with obstacles that impede successful accomplishment of transitional and environmental tasks. People generally experience problems when there is a poor fit between the needs and wants and the resources available in their environments (Compton, Gallaway & Cournoryer, 2005: 7).

2.6.2.1 Various environments within which women can be understood

There are various environments (factors) within which people can be understood. For the purpose of this study, the different environments within which women can be understood are looked into as provided by Swanepoel and de Beer (2006:11-13) including the viewpoints of Chirimuuta (2006: 71), and these are:

2.6.2.1.1The psychological environment: This consists of the attitudes people display towards life around them. Most women in South Africa experience life in their own different ways, which in turn makes them unique and different from each other. Thus, one cannot refer to their universal problems. Different dynamics of their GBV and HIV and AIDS issues are to be highlighted.

2.6.2.1.2 The social environment: This consists of institutions such as the primary institution of the family and the secondary institutions such as the school and church, clubs and interest groups that have a bearing on people. For example, most institutions like some churches in South Africa emphasise women subservience. Women are taught to be humble and submissive to their husbands. This can also be seen in children where boys tend to grow up believing that they possess more power and control over girls – a form of gender division of resources and opportunities.

2.6.2.1.3 The political environment: This entails different power structures, either traditional coercive or democratic. Political systems and parties, policies, legislative and state institutions are also examples of the political environment. Within this type of environment, it is about gaining access to resources in order to satisfy needs.

2.6.2.1.4 The cultural environment: The cultural environment consists of the values and mores of a society. These values and mores are often spoken of as constituents of the tradition of a people. Culture creates and contains taboos and provides a framework according to which people act and react to daily.

2.6.2.1.5 The economic environment: This refers to the rate of employment, presence and activity of commerce and industry, and the presence and scope of informal economic activities. The society is also economically layered so that very poor, and those who are better off are found in distinct societies (Swanepoel & de Beer, 2006:11-13; Chirimuuta, 2006:71).

2.6.2.2 Risk factors associated with GBV against women within the ecological practice perspective

In an attempt to understand the risk factors associated with GBV against women, Heise (2005:2) suggests that there may not be one single factor, but rather a whole range of variables which can increase or reduce a woman's risk for experiencing GBV. It must be acknowledged though, that risk factors are not causes, and that the risk factors are complex and occur at four different levels that are embedded in concentric circles (see Figure 2).

Figure 2: The ecological practice perspective

Source: WHO - World Report on Violence and Health, 2002.

2.6.2.2.1 Individual level

The first level identifies biological and personal historical factors that increase the likelihood of becoming a victim or perpetrator of GBV. Some of these factors are age, education, income, alcohol abuse, or historical of abuse (WHO, 2002:15). As an illustration, alcohol abuse is an epidemic in South Africa. The reason for looking into alcohol abuse and GBV in this study is based on the fact that from personal experience, the euphoria from the alcohol is blamed and would in most cases serve as circumstantial evidence, over and above the perpetrators taking responsibility. The use of alcohol in South Africa is among the highest in Africa, and in the world with a total adult per capita alcohol consumption of 9.5 litres of pure alcohol per year. Furthermore, alcohol is seen as a critical driver of violence and the second highest contributor to the burden of disease after HIV/AIDS (Peltzer, 2014:14).

The problem of alcohol abuse by men and the aggravated incidence of GBV against women is a global problem. A cross-sectional survey conducted in Nigeria found that a history of alcohol consumption by male partners was significantly associated with reports of physical violence against their female intimate partners (Balogun, Owoaje & Fawole, 2012:6). One American study used the "Sexual Expressions Survey" tool as a questionnaire to ask participants to describe events that constitute various types of sexual assault against women. The findings indicated that the alcohol consumption of the male perpetrators was linearly related to their aggressiveness against women (Smyth, 2013:261).

In a survey among men in South Africa, Peltzer (2014:14) found that perpetration of violence against women was correlated with a greater likelihood of problematic drug and alcohol abuse from the male perpetrator. The study further argued that alcohol increases sexual aggression as much as it increases the desire to commit violent sexual acts, and some men purposely drink as an excuse to engage in non-consensual behaviours.

The study by Phetlho-Thekisho (2009:259) conducted in the North West province found a strong correlation between binge drinking by men and interpersonal violence against non-intimate and intimate women partners. Men in the study indicated that they drink alcohol excessively as a form of recreation, because to them it is a way of life, a cultural practice, and a cultural belief – thus in turn gathering courage to be sexually violent against their women folk in public drinking places and within their households.

2.6.2.2.2 Relationship level

The second level includes factors that increase GBV against women's risk because of relationships with peers, intimate partners, and family members. A person's closest social circle-peers, partners and family members can influence their behaviour and contributes to their violent behaviour. Learning about violence within a family constitutes a form of orientation and internalising nascent violent dispositions from the relational aspect.

As found in a study conducted in South Africa by Khumalo, Msimanga and Bollach (2013:9), GBV has a significant effect on children, whether those children are also direct victims of abuse or witnesses to the violence itself. The researchers found that witnessing family violence in childhood is highly associated with a greater likelihood that the children become either perpetrators or victims of violence later on in their lives. With a grown-up woman who experiences GBV, studying her life history often points to a history of violence against her in her family of orientation. The study further found that with most men, their history of violence started in childhood where they either witnessed violence between parents they were exposed to, or faced in childhood. McDonald, Jourilie, Tartand & Minze (2008:95) in the same breath equally showed that children in families characterized by men's severe intimate-partner violence are more likely to externalise and internalise violence problems than children in families with no violence.

2.6.2.2.3 Community level

The third level explores the settings, such as schools, workplaces, and neighbourhoods, in which social relationships occur and seeks to identify the characteristics of these settings that are associated with becoming victims or perpetrators of GBV. Unemployment is a factor experienced in most settings.

The frustrations of unemployment and irregular employment have been linked to violence in general in South Africa. A case in point is the notorious and brutal xenophobic attacks on foreign nationals in 2008 which have been blamed on the high rate of unemployment in South Africa and have become a regular phenomenon in recent years (Neocosmos, 2010:9). Also, the high levels of violence in South Africa could be attributed to the violent legacy of apartheid and equally high rates of unemployment which involve gross economic and political inequality. Apart from its impressive Constitution, South Africa still has highest inequalities of affluence and poverty existing side by side. There are between 45% and 55% of the population categorised as poor and between 20% and 25% living in extreme poverty based on the high rates of unemployment in the country (Mcube & Harber, 2013:3).

The implication is that with most men being unemployed, and therefore unable to financially support their families, GBV against their women partners is used to exert their apparently lost authority.

These facts are supported further by a longitudinal study conducted on risk and protective factors in intimate partner violence in Bangalore in the south of India (Krishna, Suneeta, Rocca, Hubbard, Subbiah, Edmeade & Padion, 2010:139-140). The study population was characterised by high levels of unemployment. Over two thirds of women who had ever experienced domestic violence reported that their husbands had difficulty finding or keeping a job.

2.6.2.2.4 Societal level

The fourth level views broad societal aspects that help create a climate in which GBV is promoted. These aspects can include the health, economic, educational and social policies and factors that help to maintain economic or social inequalities within a society. Poverty as both a social and an economic factor is looked into.

Poverty affects millions of South Africans and is prevalent in low socio-economic communities such as townships, informal dwellings, and among people who are homeless, unemployed and lack access to basic services. Poverty in South Africa bears a history of unequal race relations, and these inequalities have manifested themselves mostly along gender, spatial and age dimensions. Its concentration lies predominantly with black African women living in rural areas, characterised by lower incomes and less job opportunities (National Development Agency, 2014:10-12). With such limited options, most poverty-stricken women end up relying economically on their male partners who are sometimes abusive and violent. Others without any source of income also sometimes engage in transactional sex.

A research conducted by Dunklea, Jewkes, Brown, Grayd, McIntyre, & Harlow (2004:1590) on the transactional sex among women in Soweto, South Africa, found that 21% of women attending antenatal clinics reported having engaged in sexual relations for material gain with a man other than their intimate partners. The report further indicated that the women who reported such transactional sex had a 100% chance of testing HIV positive at the time of the interview. Transactional sex was also more likely to be indulged in by women who also reported having experienced in their life time violence by male intimate partners. In other words, poverty poses as a preconditioning factor to violence against women, in instances where women compromise an action and behaviour for material gain and survival.

It can be concluded from the discussion on the ecological practice perspective that a holistic view of women is provided through understanding them in relation to their reciprocal and adaptive transactions with their environment.

2.6.3 Strength-based perspective

In order to understand and use the strength's perspective, it is imperative to firstly understand the term strength. As postulated by Greene (2008:182), strength involves the capacity to cope with difficulties, to maintain functioning in the case of stress, to bounce back in the face of significant trauma, to use external help as a stimulus for growth, and to use social support in the case of difficulties. Strengths can equally encompass any personal or environmental attribute that has the potential to stimulate growth and solutions. In terms of individuals, strengths can be aspirations, competencies and confidence, and in terms of communities, strengths can be opportunities, social networks, resources and tangible services (Greene, 2008:182).

Glicken (2011:66-67) further explains strength's perspective as a wellness approach that tries to identify and then use people's positive behaviours in the course of helping them cope with difficult situations. Conceptualizing and internalizing can help a person see that their innate and inherent strategy they possess in their lives can be used to deal with areas of their lives that are problematic. The focus of treatment/intervention on this approach is on their strength, over and above deficits. The strength perspective view people in a hopeful and optimistic way, regardless of the complexity of the problem or the difficulty the person is having in resolving the problem (Glicken, 2011:67).

In the case of the present research study, this theoretical perspective is useful in tapping the capacities of women encountering GBV and also battling with HIV and AIDS. Strength's perspective can also be useful in stimulating their personal power.

The strength-based approach represents a paradigm shift—a movement away from a deficit-based approach which can lead to a long list of things considered to be 'wrong' including what an individual cannot do. It fails to provide sufficient information about strengths and strategies to support a person in achieving an enhanced social functioning and utilising the capabilities (State of Victoria Report, 2012:6).

South African women – black women in particular have experienced challenges over the years. Pre-democratically, they suffered a threefold oppression of gender, race and economics (as workers). For instance, from the researcher's experience as a black South African woman, some cultures presently uphold the productive roles of women over and above their reproductive roles. This can include cultural prescriptions of when a woman is to get married, when to have a child, the gender of the child and in certain instances, even the number of children to bear. Failure to meet some and or all of these cultural prescripts irrespective of whether it is their fault, the women in question would be labelled derogatively such as "lefetwa" (the one who is passed-by by marriage) or "moopa" (the one who cannot bear a child). Having internalised most of these behaviours, most black women would enter, for example, the institution of marriage for the wrong reasons where they end up being victims of abuse and GBV.

Saleebey (2009:15-18) identifies six guiding assumptions of strength-based perspective, that ought to be taken as points of departure in further strengthening the inner capacities of women experiencing GBV. The assumptions are:

- Every individual, group, family and community has strengths- the strength's perspective is about discerning these resources, and/or sometimes hidden assets.

- Trauma associated with GBV and/or HIV can be injurious, but can also be a source of challenges and opportunities too for victims and survivors.

- People are best served, when collaborating with them. This means that both women victims and/or survivors of GBV ought to be included in the problem-solving process as partners. After all, they are embodied subjects of their own story.

- Every environment has resources- No matter how deprived a person's community, neighbourhood or family system is, each has abundance of untapped resources (Poulin, 2009:44). These resources ought to be identified

and used to the advantage of the women in question. Not only are these resources non-human, they are about the innate capacities of human beings as well.

2.7 CONCLUSION

In conclusion, the chapter consisted of literature review and theoretical frameworks. A thorough review of literature from various sources was conducted to understand the background of GBV and HIV and AIDS globally and in South Africa, and to gain thorough understanding of women's status in relation to men and factors that contribute to the phenomenon of GBV and HIV and AIDS. Result of literature review revealed that the escalating rate of GBV and HIV impact negatively on the total wellbeing of women specifically, and the quality of human life in the communities generally. Various theoretical frameworks were analysed to gain a deeper understanding of the investigated phenomenon. Feminist theoretical framework explained the women's status in relation to men and provided ways to redress existing inequalities between men and women. Ecological perspective provided an analysis of the various human ecosystem levels within which women's condition can be understood holistically in relation to GBV instituted against them. The strength's perspective was useful in creating an enabling environment in which the women's innate capacities can be tapped into, in order to move from being victims of GBV and HIV and AIDS to being survivors.

CHAPTER 3

METHODS AND PROCEDURES REGARDING THE RESEARCH INVESTIGATION

3.1 INTRODUCTION

This chapter gives a description of the research methodology used to conduct the study, the research design and sampling procedures. Data collection methods are discussed where attention is placed on in-depth interviews and focus group discussions. Information is also provided on data analysis and a discussion of ethical considerations, and ensuring that these were observed and adhered to throughout this study.

3.2 NATURE OF THE RESEARCH

Basic research is employed in the study. Basic research is concerned with determining whether or not an effect or causal relationship exists. Furthermore, basic research is beneficial in that the study is intended at expanding people's understanding of how the world operates (Bickman & Rog, 2009:1). As Connaway and Powell (2010:2) puts it, basic research is interested in deriving new knowledge and is at most indirectly involved with how that knowledge will be applied to specific real situations. The reason for choosing basic research was to derive new knowledge on possible risk factors of the interconnection between GBV and HIV and AIDS among women.

3.3 RESEARCH PARADIGM

The study used qualitative research. This research approach is concerned with understanding the processes, social and cultural contexts which underlie various behavioural patterns and is concerned with exploring the "why" questions of research (Maree, 2010:51). The choice of using qualitative research over and above quantitative research was based on the following conceptual dimensions as highlighted by Marshall (2006:100):

- It has the ability to provide complex textual descriptions of how people experience a given research issue.

- It provides information about the "human" side of an issue – that often entails contradictory behaviours, beliefs, opinions, emotions, and relationships of the individuals.
- Qualitative methods are also effective in identifying intangible factors, such as social norms, socio-economic status, gender roles, ethnicity, and religion - whose role in the research issue may not be readily apparent.
- Qualitative research can also help in interpreting and better understanding the complex reality of a given situation, in this case the violence experienced by women as perpetrated by their intimate male partners.

In the case of this research study, qualitative research enabled the researcher to gain an in-depth understanding of the women's life experiences, their perceptions with regard to unequal power relations in intimate relationships, GBV and the risk of HIV and AIDS.

3.4 DEMARCATION OF THE FIELD OF STUDY

The setting of the investigation is the North-West Province in Ngaka Modiri Molema District. The North-West Province lies in the North of South Africa on the Botswana border (See Annexure 3 & 4). The province is mostly rural in nature. Mahikeng (previously known as Mafikeng) is the capital city of the province. The province comprises of four district municipalities namely: Ngaka Modiri Molema, Dr Kenneth Kaunda, Dr Ruth Segomotsi Mompahti and Bojanala. The population of the province is estimated at 3.2 million, with 51% women against 49% men, presumably indicating how men have migrated to industrialised areas in search of employment opportunities, leaving women to manage the household single headedly (National Development Agency, 2011:5).

Agriculture and mining are practised and source economic labour from part of the district's population structure. A big proportion of those who are economically active work in the agricultural and mining sectors, followed by those in relatively poorly paid elementary jobs such as domestic work which is largely done by women (Ngaka Modiri Molema District Municipality Profile, 2011:4-5).

Unemployment in 2011 stood at 42.3% in the district, with more than 60% of the population living below the poverty datum line. Based on the rural-urban divide, basic service provision is unequally distributed between the urban and rural parts of the district, exacerbating poverty to the already poor lot of rural women (National Development Agency, 2011:7).

Educational and skill levels are generally low in the district. For instance, functional literacy (the proportion of residents over 20 years of age who have a primary education or higher) is only 35%, with less than 2% of the total population having acquired any form of tertiary education (Ngaka Modiri Molema District Municipality Profile, 2011:4-5).

The rationale for the choice of this setting is informed by the findings of Department of Health (2010:50) which revealed that the HIV prevalence amongst 15-49 year old antenatal women in the North-West Province in 2009 was 30% - the fourth highest province in South Africa. Also, the South African National Antenatal Sentinel HIV & Syphilis Report (2011:45) recorded HIV prevalence rate amongst antenatal women within the age range 15-49 years in Ngaka Modiri Molema district – the demarcated area of this study - to be at 24.9% (See Annexure 5). The question that need to be asked and answered is whether the apparently high HIV prevalence rate in the demarcated area is connected to GBV in the same area?

3.5 RESEARCH DESIGN

The researcher used phenomenology as a research design. The rationale for using phenomenology is that it focuses on people's perceptions of the world in which they live and what it means to them and people's lived experiences (Langdridge, 2007:4). For the purpose of this study, focus was on the perceptions and lived experiences of selected women in the demarcated area of study in relation to GBV and the risk of HIV and AIDS.

3.6 STUDY POPULATION

Gray (2005:82) defines a population as "the total number of possible units or elements that are included in the study". In this research study, the population comprised of women working in a total of 30 Home based organisations (HBO's) in

the Ngaka Modiri Molema district, rendering Home-based care (HBC) services which include among others providing support and caring for women who are infected with the HIV virus.

3.7 SAMPLING

The term sample always conjures the simultaneous existence of a population of which the sample is a smaller section thereof. It is made up of a set of individuals selected from a population (Gravetter & Forzano 2003) cited in De Vos et al (2005:223). In the case of the current study, large numbers of HBO's in the demarcated area of the study made it impossible for the entire population to be studied. This situation pointed to a need for a small portion of the population to be studied and sampled.

3.7.1 Sampling methodology

The researcher employed non-probability sampling methodology, specifically the purposive sampling method. According to Maree (2010:9), non- probability sampling implies that participants are selected because of some defining characteristics that makes them the holders of information.

In the case of this present study, each member sampled complied with the following eligibility criteria:

- **Gender:** Women rendering HBC services in the Ngaka Modiri Molema district, in the Mahikeng and Lichtenburg areas (demarcated area of study), qualified for inclusion in this study.
- **Marital Status:** Women who are married (western or customary), unmarried but living together or separately, but involved in a consistent sexual relationship also qualified as participants in this study.
- **Age:** The participants were women from the ages 18- 45 years. According to UNAIDS (1999:119), this is the most vulnerable group and HIV infection rates continue to rise among persons of this age.
- **Geographical Location:** Participants were residents of Ngaka Modiri Molema disctrict District, in the Mahikeng and Lichtenburg areas, of the North-West province.

3.7.2 Type of sampling

Purposive sampling was used. According to Leedy and Ormrod (2013:215), in purposive sampling, people are chosen, as the name implies for a purpose. In the case of this study, the purpose was selection of sampled women who directly work with victims of GBV and HIV and AIDS, and who stood a chance of either being victims and/or survivors of GBV themselves, for the purpose of providing rich descriptive data on GBV and the risk of HIV and AIDS among women in the demarcated area of study.

3.7.3 Sample size

According to Patton in De Vos et al (2005:328), there is no rule for sample size in qualitative inquiry, the sample size depends on what needs to be known, the purpose of the inquiry, what is at stake, what will be useful, and what will contribute to data credibility. In De Vos et al (2005:194), a sample size is referred to as elements of the population considered for the actual inclusion in the study. From a total of about 30 HBO's rendering HBC services, which include providing support mainly to women infected with the HIV virus, a total of 3 HBO's were selected based on their location of 1 in a rural area with the remaining 2 from an urban areas respectively. The rational for the urban-rural inclusion was based on the fact that Ngaka Modiri Molema district – the demarcated area of study, comprises of both rural and urban areas. Investigating both ends of the continuum was essential in order to get a balanced view of both women in the rural and urban areas. From a combined total number of approximately 60 women rendering HBC services in the selected HBO's, a total of 30 women were purposefully selected for inclusion in this study based on the judgement of this researcher, a woman who is rendering similar services in her capacity as a social work practitioner.

The total number of participants was also determined on the basis of the saturation criterion used, which is defined by Greeff (2008:294) as the point where the researcher stops (interviewing more participants) once the same information is repeatedly provided with nothing new forthcoming from those interviewed. This is adhering to the principle of saturation.

3. 8 DATA COLLECTION METHODS

The researcher triangulated in-depth interviews, and focus groups (See Annexure 6). The aim was to enhance data trustworthiness and credibility, defined by Maree (2010:80) as the extent to which results are consistent overtime with credibility determining that the research truly measured that which it intended to measure.

3.8.1 In-depth interview

An in-depth interview is a qualitative research technique that involves conducting intensive individual interviews with a small number of respondents to explore their perspectives on a particular idea, programme or situation. The advantage of in-depth interviews is that they provide much more detailed information (Boyce & Neale, 2006:2-3).The in-depth interviews are conducted on a dyad basis (one interviewer and one participant), as described by Warren and Karner (2010:2).This enables the researcher to focus entirely on one participant at a time.

In addition, the aim of an in-depth interview is also to see the world through the eyes of the participants, and also to obtain rich descriptive data helpful to understand the participants' construction of knowledge and social reality (Nieuwenhuis, 2007:87). Five participants from each HBO in the demarcated area of the research study were selected to participate in in-depth interviews, bringing the total in-depth interviewees to 15.

3.8.2 Focus groups

Kitzinger (2005:58) stipulates that a focus group (FG) is useful in exploring and examining what people in a group situation think, how they think, and why they think the way they do about issues of importance to them without pressuring them into making decisions or reaching a consensus. It is valuable for permitting a group of participants to develop their own questions and frameworks as well as in stating their needs and concerns in their own words and on their own terms. This type of data collection method allowed the researcher to explore women's diverse perspectives about power, GBV and HIV risk factors to women in a group. In focus groups, the researcher also discovers how issues are articulated, censured and opposed.

FGs are also productive in widening the range of responses, activating forgotten details of experience and realising inhibitions that may otherwise discourage

participants from disclosing information as individuals (Maree, 2010:82). Three focus groups were conducted comprising of 5 members per group from each HBO. According to Phetlho-Thekisho (2009:92) citing Schurink (2002), the number of focus group members ought to be small enough for all the participants to be given the opportunity to share insights and large enough to provide diversity of perceptions.

3. 9 DATA ANALYSIS

Data analysis is a process of bringing order, structure and meaning to the mass of collected data. Its main purpose is to reduce data into an intelligible and interpretable form so that the relations of research problems can be studied, tested, with conclusions drawn (Fouche, 2009:339).

Content analysis was used to analyse the data. According to Maree (2010:101) content analysis is a systematic approach to qualitative data analysis that identifies and summarises content. This type of analysis also involves inductive, deductive and iterative processes where one looks for similarities and varieties in texts that corroborate or disconfirm theory.

The content of the data was analysed on two levels: the first and basic level of analysis involved a descriptive account of the data, namely what the participants actually said, with nothing read into it and nothing assumed about it. The second and higher level of analysis was interpretive, which means that it was concerned with interpreting the data and trying to understand what was meant by the response, or what was inferred or implied. It is sometimes called the latent level of analysis (Nieuwenhuis, 2007:101).

3.10 DATA COLLECTION PROCEDURE

Preliminary visits to the selected sites were conducted. This was to acquaint the leaders, and gatekeepers, as well as the people on these sites about the purpose of the study and to get their cooperation (See Annexure 7& 8). The information was communicated in the language understood by the participants and the researcher, which was Setswana. The researcher first went around the area in order to acquaint herself with some of the cultural practices dominant in the area. This was done in order to establish and enhance a working relationship with the community members.

3.11 ETHICAL CONSIDERATION

Ethical approval was obtained for the study - no NWU – 00235-14-A9 (see Annexure 9), from the Ethics Committee of the North-West University. Ethical clearance was also obtained from the management of the selected HBOs from where information was gathered. Approval was also obtained from the Municipal managers and traditional leaders under whose jurisdiction the HBOs are situated.

The researcher in this study also adhered to the following ethical principles:

3.11.1. Informed consent

Strydom in De Vos et al (2005:59) explains that informed consent entails all possible or adequate information on the goal of investigation. Additionally, the procedures followed during the investigation are sufficiently communicated to the participants in order for them to make an informed consent. Participants were briefed about the purpose of the research study. The briefing sessions were followed by the completion of a consent form, the conditions of which were binding to the researcher (See Annexure 9).

3.11.2 Privacy and confidentiality

Qualitative researchers must provide virtually ironclad guarantees of confidentiality. This means that every effort is made to ensure that the identities of participants are never revealed or linked to the information they provide without their permission (Padgett, 2008:67). In order to protect the privacy of the participants, the researcher ensured that interviews took place at a venue away from the public eye and that no unnecessary disturbances occurred. The research participants did not provide their real names during the in-depth interviews and focus group discussions in order to ensure confidentiality and to protect their identity.

3.11.3 Avoidance of harm

In order to avoid causing both physical and emotional harm to participants, emotionally provocative topics were avoided. The responsibility for protecting the respondents against harm reaches further than mere efforts to repair, or attempts to minimise such harm afterwards. Participants were thoroughly informed about the aims of the study. Such information offered them an opportunity to withdraw from the investigation if they wished to do so (Strydom, 2005:59).

Hennink, Hutter and Bailey (2011:68) are of the opinion that a researcher should refrain from posing questions or activities that may make participants experience feelings of embarrassment or shame or social harm in terms of how an individual is viewed or treated by others. On this score, pre-arranged services with practising social workers were on stand-by should a participant need any treatment during or after the interview sessions. Before the commencement of data collection, meetings were conducted with the management of the organisations and prospective research participants to inform them about the purpose of the study, data collection methods and possible research questions to be discussed in both in-depth interviews and focus group discussions. The potential impact of the investigation was also highlighted. In further beefing up the aspect of avoidance of harm on the participants, the WHO (2012:4) ethical and safety recommendations for research on domestic violence against women were used and adhered to (See Annexure 10).

3.11.4 Debriefing

Debriefing sessions during which participants get an opportunity after the study to work through their experience and its aftermath are one possible way in which the researcher is able to assist participants minimise harm. Through debriefing, problems generated by the research experience can be corrected (Strydom, 2005:59). Considering the potential emotional strain, the participants might have experienced, the researcher ensured that provision was made for participants to debrief at the end of each interview in order to make sure that no one went home feeling distressed. The researcher was ready to offer any participant with referral information for local support services specialising in violence against women and HIV and AIDS should the need for such support have arisen. Contact details for additional information, debriefing or counselling were provided to participants (Freeman, 2012:46).

3.12 CONCLUSION

The research followed a qualitative approach and design. It sought to listen to the women's stories on power, GBV and HIV and AIDS. The study used non- probability sampling methodology specifically purposive sampling technique with a total of 30 women selected as research participants. Saturation criterion was used to ensure that information provided by the participants was not repeated. Participation in the study was voluntary and methodologically triangulated through the usage of in-depth

interviews, focus groups and document analysis in order to enhance data trust worthiness and credibility. Content analysis is used for analysing data with an observance and adherence of research ethics.

CHAPTER 4

DATA ANALYSIS INTERPRETATIONS AND PRESENTATION OF RESEARCH FINDINGS

4.1 INTRODUCTION

In this chapter, the researcher presents the findings and the analysis of data obtained. The data was generated through in-depth interviews and focus groups comprising of women in the selected organizations rendering HBC services. As such, this chapter is an actual rendition and thick description of women's views and opinions regarding the problems of GBV and HIV and AIDS and their perceptions of unequal power relations in intimate relationships. The chapter starts with the presentation of the research findings which includes the biographical information of participants and interpretation of women's views regarding their perceptions and experiences of GBV and HIV and AIDS. It concludes with a summary of the interpretations of the research findings.

4.2 PRESENTATION OF THE FINDINGS

In analyzing and interpreting the data gathered through in-depth interviews and FG's, the researcher read every transcript of the interview more than once and listened to the tape-recorded interviews. Findings are presented under nine themes. The themes provide an overview of the profile of the participants, their experience of unequal power relations in intimate relationships, prevalence and women's experiences of GBV, the prevalence of HIV and AIDS, whether or not the women do engage in discussions about HIV and AIDS in their household, whether or not violence between intimate partners should be kept private, the interconnection between GBV and HIV and AIDS, the underlying causes of GBV and HIV and AIDS, and awareness of any policy and programme or service that is used to address GBV and HIV and AIDS.

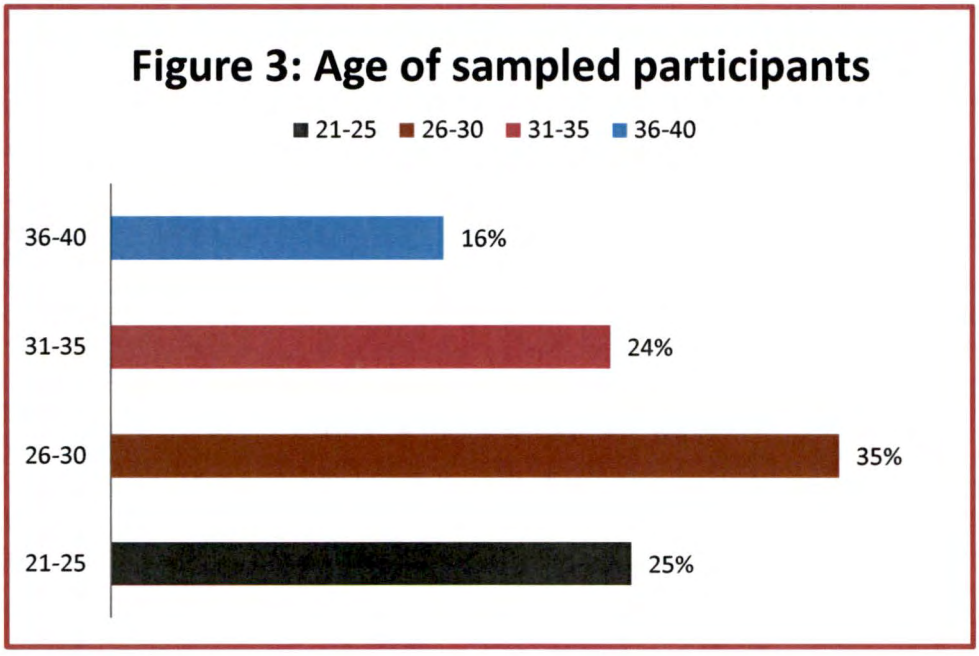
4.2.1 Characteristics of research participants

A total of 30 women rendering HBC services in the selected 3 HBO's participated in the study. Two of the organisations were situated in an urban area with one organisation situated in a rural area. The rational for the urban-rural inclusion as pointed out in 3.7.3 was also to determine whether the unequal service delivery and

absence of resources for rural women compared with their urban counterparts does have an influence on their experiences in GBV and the risk of HIV and AIDS – After all, the Ngaka Modiri Molema district comprises of both rural and urban areas. From these organisations, 15 women participated in in-depth interviews (See Annexure 11) and the other 15 participated in focus group discussions comprising five participants per group and per organisation (See Annexure 12).

4.2.1.1 Age of the sampled participants

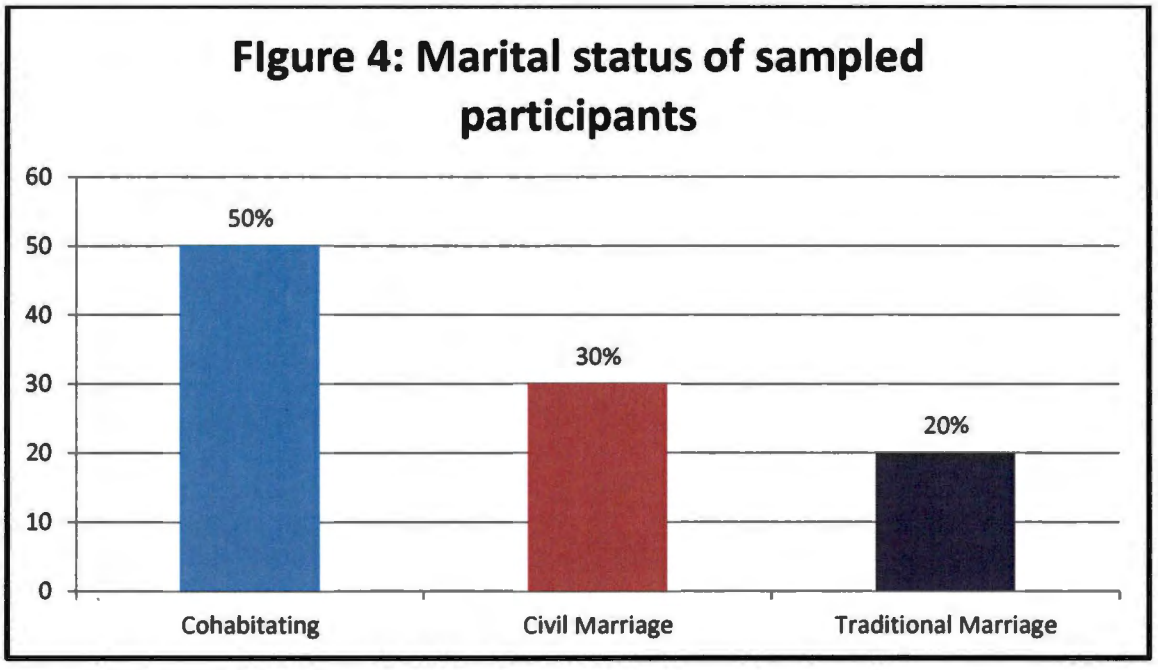
From the total number of participants interviewed in both in-depth interviews and focus groups, majority of the participants (35%) fell in the age group 26-30, followed consecutively by 25% in the age category 21-25, with 24% falling within the 31-35 age categories. The lowest age category (16%) were between the ages 36-40 (See Figure 4). The results indicate that women engage in intimate relationships in their adult years, compared to their teenage and early adult years (26-30). The remaining 40% are well in their advanced years of adulthood. Much as chronological age is not a determinant of maturity, physical growth coupled with experience can serve as a buffer to making uninformed choices that can result in GBV against women, a situation that can predispose them to HIV and AIDS.



4.2.1.2 MARITAL STATUS

It was noted that all participants were either legally married, traditionally married or cohabitating with their partners. The results revealed that the majority of the

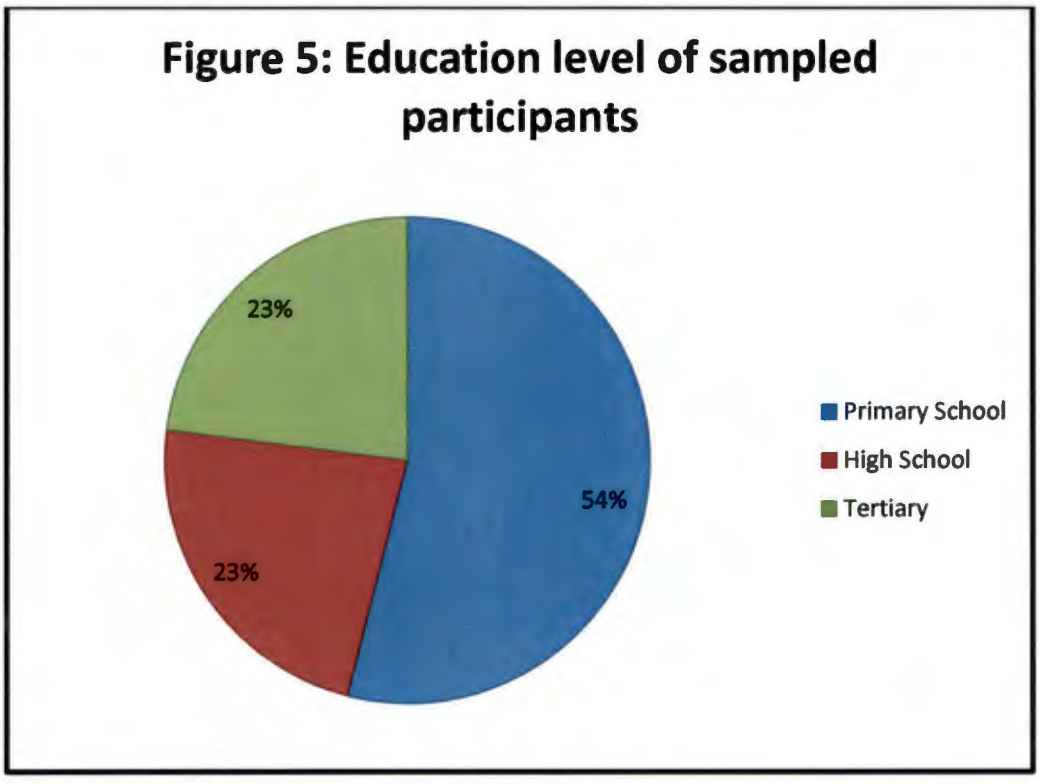
participants (50 %) were cohabitating with partners, 30% were legally married and 20% were traditionally married (See Figure 4). Cohabitation has no legal bounds which can give those practicing it the option to quit should such a need arise. On the other hand, cohabitation based on its accompaniment with insecurity and jealousy can also fuel GBV and in turn HIV and AIDS. With the participants gravitating towards cohabitation, this can also indicate that there is a desire among women participants to make informed choices before binding themselves. It might in certain instances also be the case of: "once bitten twice shy". With the rest of the 50% in civil and traditional marriage, this could have been a progression also from cohabiting first. For the legally and traditionally married, in most cases the bride price, commonly known as "lobola," has been paid by their intimate partners, with the implicit expectation of adhering to some traditional prescripts.



4.2.1.3 Level of Education

One of the functions of formal education generally is to transmit culture, and knowledge from one generation to the other. Figure 5 below shows that the majority of the participants (54 %) have acquired primary school education, with the remaining 46% sharing equally at 23% for each category of high school and tertiary education. The majority of those with high school education did not complete grade 12 (matric), with those who reported to have received tertiary education stating that they completed advanced certificates in short courses. Educational level can serve

as a marketing capacity for a job prospect and even creating enabling possibilities of starting one's business. The majority of the participants (54%) are functionally literate, that is, they are able to read and write, hence having acquired unskilled jobs at the HBC organisations. The remaining 23% with high school education and those with tertiary education (23%) were able to acquire higher and skilled positions in their present jobs. The implication can be that economic empowerment has possibilities of instilling independence in women – thus limiting their chances of staying in abusive and sexually violent relationships, and in turn contracting HIV and Aids including STI's partly because of not being able to negotiate for condom use and for safer sex.



4.2.1.4 Occupation of participants

All the research participants were formally employed. With twenty years into democracy in South Africa, this trend can be indicative of changes relating to women empowerment, a departure from the pre-democratic period, which confined women solely to domestic work, performed for household members, for free. The participants' educational background enabled them to secure a stable job to earn a living. Much as the HBC services are about caring for others, the difference from the past caring roles is that this is performed outside the confines of the home, and that the role played is remunerated for.

4.2.1.5 Main source of income

Results indicate that most of the participants (77%) depend on their combined salary with that of their intimate partners, giving the families more buying power and ensuring some form of economic stability in their different households. Thirty-three percent of the participants said they were economically independent though in an intimate relationship. This can also mean that some intimate male partners are not gainfully employed, implying a reverse in traditionally prescribed roles where men are expected culturally to be the only "bread winners".

4.2.1.6 Monthly income

Seventy percent of the participants reported to be surviving on a monthly income of R3000.00>, with the remaining 30% surviving on a monthly income of between R2000.00- R2999.00. The implication can be that the majority of the participants are living below the poverty datum line, meaning that they are able to acquire for themselves and their families life essentials, which can include a roof over their heads and basic foodstuffs.

4.2.2 Power relations between the women and their intimate male partners

In response to the question: In your past and present relationships, who held/holds the decision-making power? All participants unanimously agreed that in their past intimate relations, power relations were very unequal between their intimate partners and themselves. Most said they were much younger chronologically and not yet working for a salary, which made then economically dependent on their intimate partners. Some of the participants further indicated that even though presently they are consulted in certain areas pertaining to the running of the household, the final decision is still predominantly that of their male partners.

As some women indicated:

"Presently I am consulted on major buys, especially because I am a salary-earner myself. I must however emphasise that though he involves me, he ultimately decides alone by virtue of being the head of the household, especially in bigger projects of the household such as the buying of a car. I grew up witnessing my father being a sole decision-maker and have automatically opted for that style though with us it's not as rigidly practiced as in my family of orientation"

"In our culture, it is given that our intimate male partners ought to be given the leading role, failing which the relationship is bound to fail. This we follow even when the partners are not gainfully employed. The teachings are further emphasised in the church we are part of, where submission to male partners is expected in order to sustain our marriages and/or relations. Again, our culture looks down on a woman who does not afford her husband the space to lead and control any household activity including controlling the whole household members"

There were mixed reactions on the part of being able to negotiate for condom use and safe sex. The majority of older women indicated that based on their age, and the time span of their relationship (which is longer), it feels odd to even think of condom use, or even bring up the subject of safety in their sexual activities.

Some women alluded to facts such as:

"Our culture does not allow us to talk freely about sex and sexuality matters, either with our intimate male partners, or even to our children. Culturally, the subject of sex and sexuality are taboo issues. On the other hand, bringing up the matter of safety in a sexual relation and sexual activity can even raise suspicion which can lead to GBV against the woman, leading to more strains in the relationship"

"I have been legally married to my present husband for over ten years. In those years, I have never initiated any sexual activity, let alone suggest that we should practice safer sex. When I got married, I was taught by both the men and women elders that a man is the initiator of sex. You are frowned upon as being *loose* or *morally wanting,* when as a woman, you initiate a sexual activity. At the present moment, I am fully aware of the women my husband is having intimate relations with, yet bound by our cultural beliefs from confronting him about these extra-marital affairs"

"I do negotiate for condom use and safer sex with my partner some days especially when I do not feel safe. Otherwise, he does not like the idea of even engaging in discussions about condom use. The practice is however not consistently followed based on disagreements and fights between us".

The women participants also indicated that lobola or bride paid during both the traditional and civil marriages affords the menfolk ownership of the whole

relationship process, control over the woman's body, and decision-making power in the relationship.

"Men who are seen not to be culturally in control in their families lose the respect in their social circles and would be called demeaning terms such as: *o tshereane* (he has lost it as a man), *ke seka monna* (he is not a fully-fledged man)."

It can be concluded that power relations are unequal between the women participants and their partners based on their cultural beliefs. Condom use and safe sex are also inconsistently practiced in the area of study.

4.2.3 Prevalence and women's experiences of GBV

In response to the question: what is the rate of GBV among women in your area?

The women participants acknowledged the high rate of violence against them in their communities, and within families. Though GBV is more prevalent within intimate relationships, it manages to escape public attention based on the fact that most women victims are reluctant to lay a police charge against their husbands or intimate male partners. Again, the women want to protect their marriages or relationships at the expense of personally suffering abuse perpetrated by their intimate male partners, including their children. Within communities, most designated areas for GBV are at alcohol drinking places such as shebeens, night clubs and at taverns.

In response to the question: what is your understanding of gender- based violence? All the participants understood GBV against women. Most made reference to all types of GBV which included physical, sexual, and economic violence. An overwhelming majority made reference to emotional and psychological violence as well. The participants pointed out that the perpetrators of such violence get away with it simply because it does not visibly scar, though it has the capacity of totally breaking a person from inside.

In response to the question: have you ever personally experienced any form of gender-based violence?

Some women provided the following accounts:

"My intimate partner would sometimes expose private matters about me in public when pretending to be under the influence of alcohol, and this would include my inability to bear children. As a way of putting me down, he would use demeaning words such as: *Ke go folositse mo tereneng ya mafetwa (It's a favour that I choose to marry you), o sekobo (you ugly thing) ga o motho wa go ratwa (should I leave you, nobody will ever love you*".

"My ex-boyfriend was abusing me economically, emotionally and physically. He did not give me money to buy household necessities, yet he wanted to bath, eat and dress in clean clothes. On top of that, he even instructed me never to wear trousers and isolated me from my friends and relatives. He spent most of his time with his friends while I was home dressed in loose shabby dresses. He was suspicious over everything I was involved in. One morning of the weekend, when he arrived home from a shebeen, he wanted conjugal rights without having even taken a bath, I refused and hell broke loose and I was slapped and repeatedly raped. During the time of this ordeal, I was heavily pregnant and miscarried based on the heavy blows I got from him. A charge was laid at the local police station at the insistence of my neighbour, which I later withdrew after he promised to change his violent behaviour. We have since parted."

"With me, it was more of emotional violence coupled with sexual intimidation. My past boyfriend would vaginally inspect my private parts using his fingers to make sure that I did not sleep with any men when he was at work. After that painful inspection, he would then forcefully sleep with me against my will. My inability to fall pregnant aggravated the violence and abuse which resulted in him sleeping around even with my knowledge, under the guise that he wanted children. Today, we have three of our own children and supporting three other children born out of our union."

Participants pointed out to the high rate of rape against women in their communities. With women raped at alcohol drinking places, GBV is always blamed on their state of having been drunk and the women having called for that violent feat."

"Violence of all forms against women in our community is aggravated by the fact that the police do not take us seriously when we lay charges against our intimate male partners. They still in this era call that a private matter, which should be solved privately. When I report the matter to the family elders (uncles), all would remind me

of my wedding vows. My mother-in-law who is most influential in my household would ask: *o mo dirile eng gore a go keteke sekanakana (*what did you do to your man to receive such punishment)".

The conclusion can be that GBV of all forms is prevalent in the demarcated area of study, with sexual violence taking a lead, and manifesting in a high rate of HIV and AIDS for most women in the area of study.

4.2.4 The prevalence of HIV and AIDS

In response to the question: what is the rate of HIV and AIDS in your area? All the participants unanimously alluded to the fact that the rate of HIV and AIDS are high in their communities.

As one participant explained:

"Almost every week-end, we bury people who die from the HIV and AIDs virus in great numbers, mostly women. Irrespective of these high death rates, disclosure about one's HIV status is still a secret, simply because of the stigma attached to the virus."

"The culture of silence in my community about one's HIV status even prevents people from accessing free treatment which involves taking antiretroviral therapy. A person can rather secretly access the help of traditional healers who themselves are not well informed about the virus, thus worsening their health condition."

One can deduce from the responses above that the high prevalence of HIV and AIDS in the demarcated area of study is mainly exacerbated by stigma attached to the virus, and the discrimination of people infected with the virus, resulting in non-disclosures and possibly defaulting in treatment when on ARV's.

4.2.5 Whether the women engage in discussions about HIV and AIDS in their households

All of the in-depth interviewees indicated that their culture does not make it very easy to freely discuss sex and sexuality matters with their partners, and even children. They acknowledged that they are well-informed about the epidemic based on the fact that that they work closely with women who are infected. The women indicated further that they have undergone extensive training on the subject of HIV and AIDS,

yet found it difficult to put all their valuable knowledge to use. Openly addressing the topic on HIV and AIDS is culturally uncomfortable.

"Our men folk are reluctant to go for tests, and instead rely on the results of their women partners, who only get tested when they are pregnant and attending antenatal clinics. Some choose not to accept the positive status of their partners and thereby refusing to practice safer sex, a situation that results in reinfections."

Most of the women participants who were legally married and those traditionally married pointed out how difficult it was for them to even suggest the use of a condom by their partners. They acknowledged this difficulty even when having reasons to doubt the faithfulness of their intimate partners.

On this topic, the following sentiments by different women were echoed:

"I have on a number of occasions tried to introduce the topic on HIV and AIDS to my intimate partner. He either keeps quiet, or changes the subject. For the years that we have been together, he has never shown any interest. I buy relevant and easy to read books addressing the virus, but to no avail."

"With me, though my partner also shows reluctance, I have made it my business to educate him about HIV and AIDS, including contracting STI's. When he goes on work outings, or even holidays without me, I make a point that I pack in his luggage bag some condoms. He does not personally articulate the subject of HIV and AIDS verbally, but sometimes he would come with a condom, implying that we should use it at that time. For me, this is a start, though a slow one."

The women participants further indicated that culture is to blame for lack of openness regarding free discussion on HIV and AIDS. They however articulated their satisfaction with some progress that has been made so far. In the past, they said, HIV and AIDS were associated with sorcery, or sometimes termed the "white man's disease". These days, even in traditional communities, men and women know that the disease is mainly contracted sexually and that people can die from it.

The women participants indicated further that in their communities, one myth that hold strong is associating full figured women or men appearing fit with good health and therefore free from the HIV and AIDS virus.

The implication from the responses above is that some cultural believes in the area of study still prevent free discussions in households on sex and sexuality matters including discussions on HIV and AIDS categorised as taboo issues – thus contributing to lack of factual information about the phenomena, thus contributing to the high rate of HIV infection in most families and communities.

4.2.6 Whether violence between intimate partners should be kept private

In response to the question: do you think that violence between a man and a woman is a private or a public affair?

All participants agreed that violence between intimate partners is a private matter which should be kept as such, especially for married couples. The only time such violence should pose a worrying matter and be made public is when it is repeatedly done and committed in the presence of children.

The women participants provided the following accounts:

"After all, no human being is perfect and as a result, we are not the first lot to suffer violence. We grow up with the knowledge that violence between two intimately connected adults is a private matter. Our parents suffered in silence and here we have grown into the women we are. There is a saying in the Setswana culture that: *ga gona ntlo e e sa neleng.* Meaning there is no household devoid of challenges".

"I think it depends on the type of violence that one is experiencing as well as the duration of the violence. There are certain things you disclose to outsiders, and those you keep silent about."

"With rape inside marriage or with my intimate partner, I would never report it outside the confines of my family, though I am aware where to go to for help. I would rather start with a family conference comprising of the elders. If this does not help, my next option would rather be to go to the church priest, or even the social workers – they are more private than being seen at a police station, where there is no privacy.

It can be concluded that most participants prefer to suffer in silence than exposing the violence they encounter in their households under the guise that "no family is perfect". – a situation which can spiral into rape inside marriages with a high prevalence of HIV and AIDS resulting.

4.2.7 The interconnection between GBV and HIV and AIDS

In response to the question: do you think that any form of gender-based violence against women does increase the risk to HIV infection?

Most of the participants indicated that they were able to see with ease the connection between GBV against women and HIV and AIDS.

The following experiences were provided:

"I know of a young school-going girl who was raped whilst walking home one night from visiting friends in my community, roughly at about 10h00 in the evening. The assailants were a group of boys who apparently knew her very well. After repeatedly taking turns in raping her, they stabbed her in her private parts with a sharp instrument and left her to die. No protection during the rape was used. The matter went to court and all those involved were found guilty, though they have now served their sentences and are all free. The woman in question is HIV positive and struggling to come to terms with her condition"

From the few women who acknowledged openly their HIV positive status, all of them indicated that they were once coerced into having unprotected sex by a casual partner they suspected of sleeping around.

"Most of the women we render services to also from time to time would indicate that they got infected after being forcefully raped by people they do not know in their communities."

In response to the question: have you ever felt forced to have sex in exchange for food, money, alcohol, etc., with any man other than your partner?

Only a handful of women affirmed that they once had sex in exchange for alcohol that a stranger offered from a drinking place.

"I was oblivious of what was going on because of my drinking stupor, and only realised the following morning when I woke up next to this man who was last buying me alcohol drinks at the tavern. From that horrible incident, I decided never to go unaccompanied to a tavern anymore."

All participants indicated that GBV and HIV and AIDS do affect them negatively as women. They bear the brunt of unwanted and unplanned pregnancies, become easily infected with STI's and HIV compared to their men folk, and then they suffer the consequences of being called promiscuous and loose. They also indicated that when seeking help from most service providers, these providers institute violence against them for the second and subsequent times by not treating them with dignity.

The conclusion can be that the participants realised and saw a connection between HIV and AIDS based on the rape cases they witnessed in their communities, including being raped within their intimate partner relations.

4.2.8 Underlying causes of GBV and HIV and AIDS

In response to the question: what are the underlying causes of gender-based violence and HIV?

The women unanimously agreed that alcohol is the main cause for the high rate of GBV and HIV and AIDS in their communities. Alcohol, they indicated, is freely available and affordable to the young and old in the community. Again, with high alcohol intake, the perpetrators often blame their actions on liquor.
The following sentiments were echoed by the women:

"I grew up in a family where both parents abused alcohol. They were drinking almost every day and when they were drunk, my father would sometimes just sleep with my mother in full view of us as children. We later learnt from relatives after their passing on that both were HIV positive."

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"At drinking places, young women who get cash-strapped would often sell themselves to men in exchange of alcohol."

Participants also indicated that culture in a way does pose as a risk factor to GBV and HIV and AIDS.
As one participant indicated:

"In my culture, the beating of women, as long it is done within certain parameters by their intimate partners, is allowed and condoned as a form of instilling discipline. Violent men generally command respect in the community culturally, based on the fact that their behavior is manly. Beating your woman shows the man you are. In the same breath, culture would not look down upon a man who sleeps around with different other women, whilst legally married. After all he is the bull."

Participants also made reference to the fact that most poverty-stricken women tend to stay in a physically and sexually abusive relationship simply because of not having any other option. Some participants also made reference to psychologically abused women, who settle for any sub-human treatment from their intimate male partners. If infected with the HIV virus, they put the blame on themselves.

Participants made reference to the fact that in these present times, older men enter into relationships with young women they can overpower very easily.

"My younger niece of 16 years had an affair with a man thrice her age. When the relationship started, it was based on an exchange of very expensive gifts, outings, and money. After some time, the young woman wanted to quit on account that her school work was suffering. The older man became violent and refused to even wear a condom. After the pregnancy and HIV positive tests, the older man has since vanished. For fear of the family being ridiculed, the matter has never been reported to the police."

It can be concluded that the main risk factors of GBV and HIV and AIDS in the area of study was articulated by participants to be alcohol. Alcohol, they indicated is freely available and affordable in their communities and abused by most perpetrators (mostly men) together with women – resulting in a situation which increases their vulnerability to GBV and in turn to HIV and AIDS.

4.2.9 Awareness of any policy, programme or service that are used to address GBV and HIV and AIDS

All focus group discussants indicated that they were knowledgeable about the existence of the Domestic violence Act which they or a person they know have ever attempted to use.

The following accounts are provided:

"Much as I know the Domestic Violence Act by name, I am not fully conversant with the contents thereof, except for the process of an application for a protection order which I once applied for. This act is written in English and in legal terms which makes it difficult to be understood by an ordinary person. At the same time, the process of applying for a protection order is lengthy and not adhered to by my violent partner. I ended up abandoning the idea"

"With me, my lawful husband threatened to leave me should I pursue the protection order route after several violent episodes directed against me"

"A close relative of mine did apply for a protection order against her husband who was very abusive more than once. The protection order did help, though tension resulted between the couple at first, but later on, the matter was resolved amicably, and the beatings have since been reduced"

"On another occasion, my younger cousin who was cohabiting with her police officer boyfriend – an extremely jealous and violent man, applied for a protection order against him. The process of acquiring the protection order was not smooth at all. The other police officers were openly taking his side. Eventually, she managed to acquire it. The conditions of the protection order were never respected by the boyfriend who owned a gun that was never confiscated irrespective of his violent nature. On a particular day after finding her speaking to another man, he did not know, he shot her dead and eventually killed himself with the protection order in force"

All the participants in the focus group discussions indicated to be knowledgeable of the Soul City programme especially after viewing Soul City episodes more than once

on television. The participants agreed that the episodes were educative on the subject matter of HIV and AIDS, yet they were not regular viewers.

In response to the question: do you know the type of help you can get from a health facility when you are raped?

The majority of the participants indicated that they know the type of help they can get from a health facility in the event of being raped. They mentioned the ordinary clinic and the Thuthuzela Care Centre.

The following sentiments were expressed:

"Yes I am aware of the Thuthuzela Care Centre where rape survivors can get help which include counselling and short-term anti-retroviral treatment of Post-Exposure Prophylaxis (PEP) that can reduce the possibility of HIV infection, after being exposed to the virus. During our training on this subject matter, the trainers stressed that this treatment should be administered within 72 hours after a possible exposure to the HIV virus"

Much as the Thuthuzela Care Centre sounds so useful, it is out of reach for most women in my community. It is about 30 kilometres away and is situated on our local hospital premises. My worrying factor is that most rape cases occur during ungodly hours at night or early morning hours when public transport is not available. Sometimes not being able to raise transport money the next day and subsequent days does prevent many women from seeking help"

In response to the question: what do you recommend should be done to address the problems of GBV and HIV and AIDS?

The majority of the focus group discussants indicated that the starting point should be for the local police to render services fairly with respect. The women also pointed out the difficulties that culture creates for them in the form of societal expectations.

As one participant pointed out to:

"Our culture in a way does condone violence among men and against women as a form of discipline and to show-off one's prowess. At the same time, sleeping around by men with different women when even married is not frowned upon as in the case when a woman does that. These double standards I would suggest should be done away with"

"Most of the older women – the mothers-in laws are always influential in our intimate relationships with their children (their boys). In conflict and violent situation, instead of advising their boys to stop their bad behaviour, they advise us to persevere as they did, which is in a way entrenching bad and discriminatory behaviour"

It can be concluded that most participants are most familiar with the Domestic Violence Act and its protection orders, issued against perpetrators of violence. Participants in their great numbers alluded to the application problems of the Act and the difficulty they had in fully understanding how it works based on the fact that it is written in English which is not their mother tongue – thus rendering its intended value ineffective. Participants recommended that the main thing that might alleviate problems of services is, if most members of the police service can change their attitudes and be more helpful to women complainants laying charges of violence perpetrated against them.

4.3 CONCLUSION

This chapter analyzed and presented the findings of the research study. The first part of the findings which was on the biographical data of the participants was presented graphically and in brief discussions which involved statistical analysis in the form of numbers and percentages. However the latter part of the findings were presented qualitatively in themes and presented verbatim.

CHAPTER 5

DISCUSSIONS OF THE FINDINGS, CONCLUSION, LIMITATIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The study sets out to investigate GBV and the risk of HIV and AIDS among women in Ngaka Modiri Molema District, North-West Province. The aim was to further come up with appropriate interventional guidelines addressing the link between HIV and AIDS.

In this chapter, the results of this study are discussed broadly by putting against other studies. The chapter then addresses the basic assumptions put forward in chapter one. Thereafter, the limitations of this study are highlighted, with recommendations made against aforementioned aim for further debate, followed by recommendations for further research, with a summary and conclusion of the entire study.

5.2 DISCUSSIONS OF THE RESEARCH FINDINGS

5.2.1Biographical information of participants

All the participants selected were women rendering HBC services from selected HBOs which involved among others caring and providing support to HIV infected women. The majority fell within the age range of 21-30 years, and mainly cohabitating with their intimate male partners. Most of the participants had acquired at least primary education, and were all in full time employment. Their main source of support was mainly from their combined salaries with that of their intimate male partners, with the majority of women surviving on a monthly income of more than R3000.00 a month.

From the provided findings, it can be concluded that the profile of women can qualify them as women in development. They are functionally literate, are in full time employment, and have from what is presented postponed the idea of formalising their union with their intimate partners by cohabitating, presumably whilst determining the next appropriate move in terms of their marital statuses. One factor that stood out was their earning power that has possibilities of ensuring some form of financial independence, over and above to their reliance on social grants. All these qualities, it would be expected would allow them some form of openness to

discussions around GBV and HIV and AIDS matters, which to some extent was not the case.

5.2.2 Unequal power relations

A substantial number of participants indicated that compared to what they perceived in their families of orientation and past intimate relations, male partners had more power or somehow oppressed their female intimate partners. However some women reported having been consulted on matters that involve the running of their households.

It can be concluded that much as most intimate male partners seem not to be overtly exerting their power over the women participants on grounds that the women in question are income earners, most of the very women appeared to have abdicated and surrendered their decision making power based covertly on cultural pressures. The apparent cultural allegiance for the participants came at a price in that their culture silenced the discussions on topics involving sex and sexuality, GBV and HIV and AIDS, including on negotiations for condom use and on practices of safer sex. The results indicated the inconsistencies and sometimes total absence of safe sex practices, with possibilities and probabilities of culminating in the spread of STIs and HIV and AIDS.

These results substantiate previous findings. The research undertaken by Langen (2005) suggested that powerlessness diminished the woman's ability to make healthy decisions including negotiations for safer sex in order to protect herself against sexually transmitted infections. Jewkes, Dunklea, Nduna, and Shai (2010) equally provide strong temporal evidence in their study to support a causal association between intimate partner inequity and new HIV infections.

5.2.3 Women experiences of GBV

All participants alluded to the fact that in their lifetime, they had together with other women in their communities experienced GBV of all forms, particularly sexual violence inside their intimate relations. From the responses of the women participants they preferred to suffer in silence than exposing the families' "dirty linen in public".

It can be deduced that sexual violence instituted against the women participants and other women in their communities within families manifest in high prevalence of HIV and AIDS. Privacy around such a criminal act of sexual violence enables the crime to escape intervention and apprehension. The study by Kalichman and Simbayi (2004) found that 44% of women they surveyed had a history of sexual assault and there was a close association between sexual assault history and the risk of STIs, including HIV infections.

5.2.4 The culture of silence and stigma surrounding HIV and AIDS

All participants indicated that irrespective of different forms of education, women in the community experienced GBV that provided a fertile ground for HIV and AIDS infections.

It can be concluded that the culture of silence and stigmatization surrounding HIV infection does contribute to the virus not being contained. This culture of silence also prevents most women in the demarcated area of study from also accessing treatment facilities which involve using ARVs.

The study by Duffy (2004) revealed that stigmatization resulted in silence, secrecy, and denial that affected care and treatment. This had implications for prevention for most diseases with a long subclinical phase such as HIV and AIDS.

5.2.5 Alcohol abuse and the partnering with older men as main risk factors for the spreading of GBV and HIV and AIDS

Participants in the study singled out alcohol abuse as one of the main contributing factors to the spread of GBV and HIV and AIDS. The possibility for younger women partnering with elder men in the demarcated area of study was influenced by alcohol intake and its abuse.

It can be concluded that the affordability and accessibility of alcohol in the demarcated communities of this study made it easy to be abused by both men and women – thus increasing the women's vulnerability of falling prey to GBV and ultimately to HIV and AIDS. Also, having most women partner with older men who in turn sexually abuse them was in most cases propelled by their state of poverty state, together with serving the interests of their poverty stricken families.

Similar findings from a study by Kalichman, Simbayi, Cain and Jooste (2007) found that alcohol consumption was associated with the risks for STIs, including HIV and AIDS. A study also by Longfield, Glick, Waithaka and Berman (2004) found that participants in their study reported that young women's primary incentive for becoming sexually involved with older male partners financial and material gain, whereas men commonly seek younger partners for sexual gratification. This phenomenon raised probabilities of violence to be instituted against the younger women, and thereby raising chances of them being infected with STIs including HIV infection.

5.3 OBJECTIVES OF THE STUDY REVISITED

In drawing the conclusions based on the findings of this study, it is imperative to structure the discussion that follows according to the initial objectives:

- To explore the prevalence of gender-based violence and HIV and AIDS infection among women.
- To explore HIV and AIDS risk factors/behaviour among women.
- To establish some programmes and policies put in place to address GBV and HIV and AIDS in South Africa.
- To recommend strategies and programmes in order to deal with the problems of GBV and HIV and AIDS in Ngaka Modiri Molema District in the North-West Province.

5.3.1 Prevalence of GBV and HIV and AIDS infection among women:

The first objective of this research was to investigate the prevalence of gender-based violence and HIV and AIDS infection among women. This objective was achieved. A review of the results reveals that the majority of the samples reported high rates of GBV against women within families in intimate partner relationships. Within the communities, GBV occurs mostly around alcohol-drinking places which include shebeens, night clubs and taverns, and does manifest in both physical and sexual violence. Literature review findings also indicate that GBV against women knows no boundaries, no colour, and no socio-economic status. It is concluded that there is a high rate of GBV against women within intimate and non-intimate relationships. In intimate relations, emotional and sexual violence against women precede all other

forms of violence and abuse, and they escape public attention and intervention based on the reluctance of women to make private family matters into the public domain.

Findings from this study further confirm the high rate of HIV and AIDS among women who are still in their reproductive and productive years, pointing towards possibilities of sexual abuse and violence against women in both intimate and non-intimate relationships. On the other hand, the reluctance of men to go for testing result in reinfections and the spreading of the HIV virus.

It can be concluded that non-disclosure among community members of their positive HIV status to their intimate partners, families and communities based on the culture of silence and stigma attached to the virus, makes treatment inaccessible, and adds to the spreading of the virus – confirming the assumption as stated in chapter one that: the culture of "silence" that surrounds human sexuality and violence against women provide fertile ground for the spread of HIV and AIDs epidemic.

5.3.2 The interconnection between HIV and AIDS and gender-based violence.

Paraphrased narratives of sampled women revealed that most HIV positive women have in their life time encountered various forms of sexual violence, either from a non-intimate male partner or an intimate male partner. It is concluded that the connection between GBV and HIV and AIDS is cyclical and reinforcing, thus accepting the assumption made in chapter one that violence against women does put them at a greater risk of contracting HIV and AIDS.

5.3.3 HIV and AIDS risk factors/behaviour among women:

The third objective was to explore HIV and AIDS risk factors and behaviours among women. The results of this study revealed unequal power relations between men and women, which is culturally entrenched.

It can be concluded that cultural patterns followed by women does not freely encourage discussions with intimate partners on condom use, sex and sexuality, and safer sex, with insistence to practice these taboo issues raising suspicions leading to GBV against the women - accepting the assumption made in chapter one that unequal power relations between genders lead to violence against women and to their exposure to HIV and Aids virus. Much as lobola previously served as a token of

appreciation among families, it currently further entrenches the ownership and control pattern of women by men which include demanding of sex when they feel like, and committing rape inside the marriages under the guise of being drunk.

5.3.4 Programmes and policies put in place to address GBV and HIV and AIDS in South Africa:

The fourth objective was to critique some programmes and policies put in place to address GBV and HIV and AIDS in South Africa:

The results of this study revealed that women were knowledgeable about the application of a protection order and not about the contents of the Domestic violence Act as a legal document based on the fact that it is written in English and therefore not understood. The Thuthuzela Care Centres though not easily accessible were also known for administering mainly Post-Exposure Prophylaxis after a rape incident. The women were also not knowledgeable about the existence of the Integrated Victim Empowerment Programme that render victims of violence by service providers. It was therefore not adequately utilized. With the Soul City programme, though known, it was not watched by women in the study.

It can be concluded that there is incongruence between the existing policy, and programmes with regard to knowledge by the people meant for, coupled with their incorrect application by service providers. The situation points to structural, systemic and attitudinal problems which promote the victimisation of women.

5.3.5 Strategies and programmes to deal with the problems of GBV and HIV and AIDS

The fifth objective was to recommend strategies and programmes to deal with the problems of GBV and HIV and AIDS in Ngaka Modiri Molema District in the North-West Province. It can be concluded in this study that there is a need among police officers to make effective their services when dealing with women who are victims of GBV. The custodians of culture, who are older women, should be involved in addressing the double standards that favour men over women and lead to GBV over women.

5.4 LIMITATIONS OF THE STUDY

- Since GBV and HIV and AIDS are sensitive issues especially in most traditional settings, participants in isolated instances found it difficult to provide candid responses.
- Another limitation was that some participants were not free to share their sex and sexuality experiences. They regarded the phenomenon as culturally inappropriate.
- Some questions posed necessitated the participants to recall events in their past, in which case accuracy may have been compromised.

5.5 THEORETICAL FRAMEWORKS OF THE STUDY REVISITED

The feminist theories used pointed to a need that equality on paper between men and women should be accompanied by structural changes, and a commitment by all in ensuring the implementation of what is legally constituted on paper. Implications drawn from these theoretical debates are that patriarchy can be addressed by making "the private" sphere of the home "public" and therefore open to scrutiny and intervention. At the same time, there is a need to move away from traditional gender roles that are prescriptive and defining women universally, solely in reproductive terms. Emphasis need to be placed on strategic gender roles that consider people's differences, including recognition of the productive capacities in women.

The ecological practice perspective enabled women in the study to be understood holistically within their different environments - cultural, economic. physical, psychological and political environments, including how women in turn influence the environments. Through the individual, relational, community and societal levels, possible risk factors to GBV and HIV and AIDS were identified.

With the strength-based approach advocating for the recognition of women's innate capacities and capabilities – a shift away from a deficit-based approach which fixates women as victims and therefore helpless and forever vulnerable. The strength-based approach suggests that women be involved in decision making processes as active participants.

5.6 RECOMMENDATIONS FOR THE STUDY ON AREAS FOR FURTHER DEBATE

As a social worker the researcher in this present study moves from the premise that social work as a profession is practice-based and is an academic field that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to the profession. Underpinned by theories, and models from the humanities and indigenous knowledge, social work engages people and structures to address life challenges, whilst at the same time enhancing wellbeing (International Federation of Social Workers, 2014:1).

Against the background, the following recommendations are made on:

With twenty years into democracy, it is recommended that social workers should be at the forefront in advocating for a move from a concentration on women issues at macro level to gender issues. The essentialist position which assumes that women issues can only be dealt with by women has proven ineffective. It should be borne in mind that women do not constitute a homogeneous category, nor in their quest for equality will sameness with men be advocated. The argument put forth in this recommendation is that women do not live or operate in a unisex planet. The question of lumping them with children in the present Ministry of women and children is another concern that fixates them as vulnerable, defenseless and helpless, when in actual fact they can share the platform with men as collaborators and partners in dealing with problems of GBV and HIV and AIDS.

Concerning the outdated legal frameworks that address gender- based violence – the Domestic Violence Act 116 of 1998, there is a need for its review in terms of language and application. With the Integrated Victim Empowerment Programme, a commitment of service providers such as the police and members in the Justice Department is essential. Pronouncement of service providers victimizing women secondarily should be followed with stiffer punishment.

In affirming women, either in the work place or in any position of power, it is recommended that training should not always be a solution, instead as indicated in

chapter 2, their innate strength, capacities, and capabilities should be acknowledged. Through their struggles in experiencing GBV and HIV and AIDS, they have acquired valuable life experiences that can be tapped to among others re-write their own story, from which both the boy child and the girl child can learn from.

Custodians of culture from different community-based organisations, including faith-based organisations should be identified and mobilised as stakeholders to address the position of culture in communities. In the present 21st century with its challenges and demands, culture cannot afford to be static, but dynamic, and to rigorously address aspects such as traditional gender roles that are discriminatory to women, condoning of violence against women by some cultural beliefs, the culture of silence to violence within households, the question of not practising safe sex by most men, and sex and sexuality topics forever being regarded as taboo issues.

5.7 RECOMMENDATIONS FOR FUTURE RESEARCH

Based on the findings of this research, the following areas are suggested for future research:

- It is recommended that similar studies be conducted in different settings for comparability of research findings.
- The researcher also recommends further similar studies to include and explore both qualitative and quantitative research paradigms.
- Finally, the researcher recommends the inclusion in the sample HIV positive women, with a history of violence instituted against them.

5.8 SUMMARY OF FINDINGS

This study contributed in pointing out the interconnection between GBV against women and HIV and AIDS. This connection is however not linear but circular, meaning that GBV and HIV and AIDS are reinforcing. Cultural discrimination, structural and systemic problems, including attitudinal problems all point to possible causative factors of GBV and HIV and AIDS. Through the theoretical perspective used, groundwork was laid for understanding holistically the risk factors of GBV and HIV and AIDS among women. It is hoped that these findings will enrich the discipline of social work in its dealing with the problem of GBV against women and HIV and AIDS.

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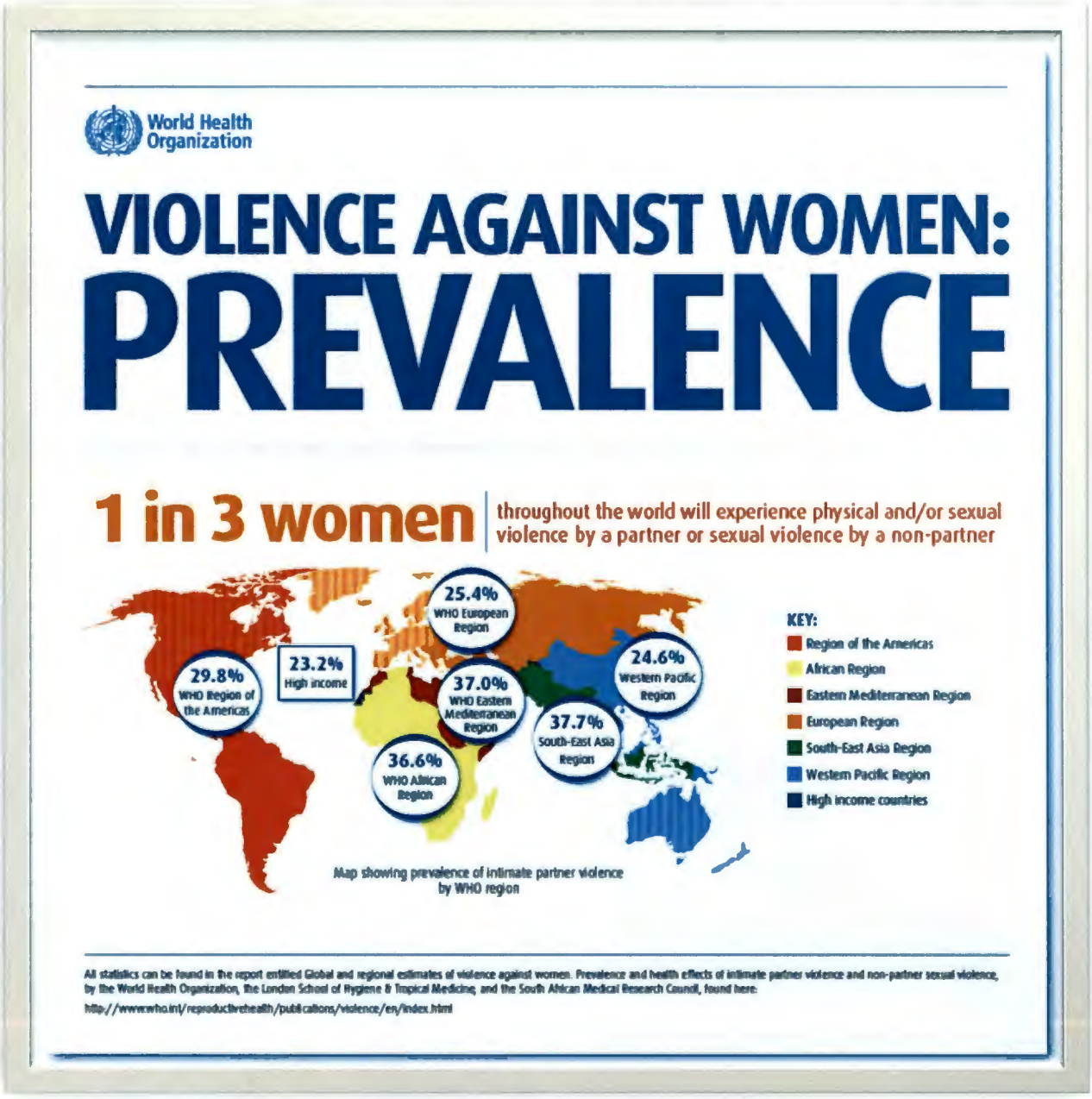
ANNEXURES

ANNEXURE 1

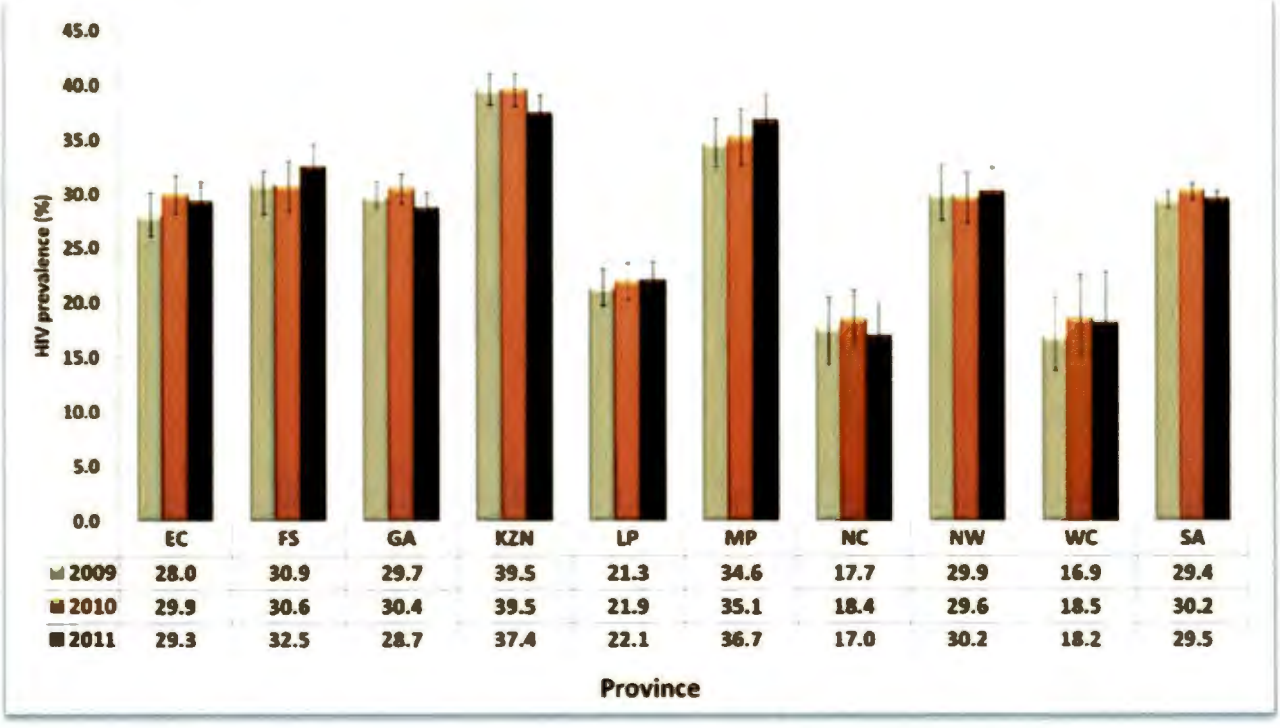
VIOLENCE AGAINST WOMEN GLOBAL PREVALENCE - 2013



Source: WHO- Global and regional estimates of violence against women, 2013.

ANNEXURE 2

HIV PREVALENCE TRENDS AMONG ANTENATAL WOMEN BY PROVINCE IN SOUTH AFRICA, 2009 – 2011.



Source: National Antenatal Sentinel HIV & Syphilis Prevalence Survey in South Africa (2011: 15).

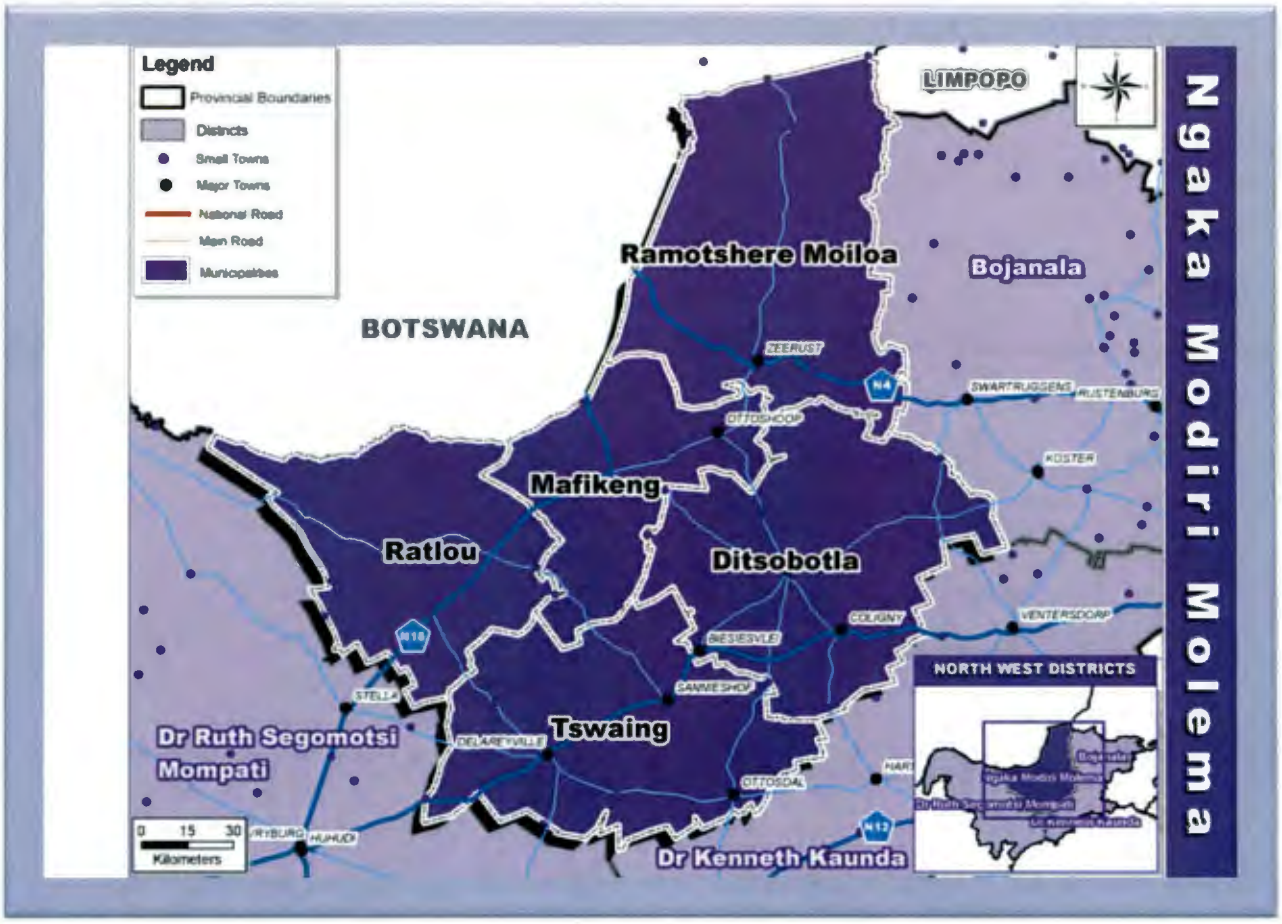
ANNEXURE 3

MAP OF THE NORTH-WEST PROVINCE

Source: Google www.sacarrental.com/north-westprovince-map.htm.

ANNEXURE: 4

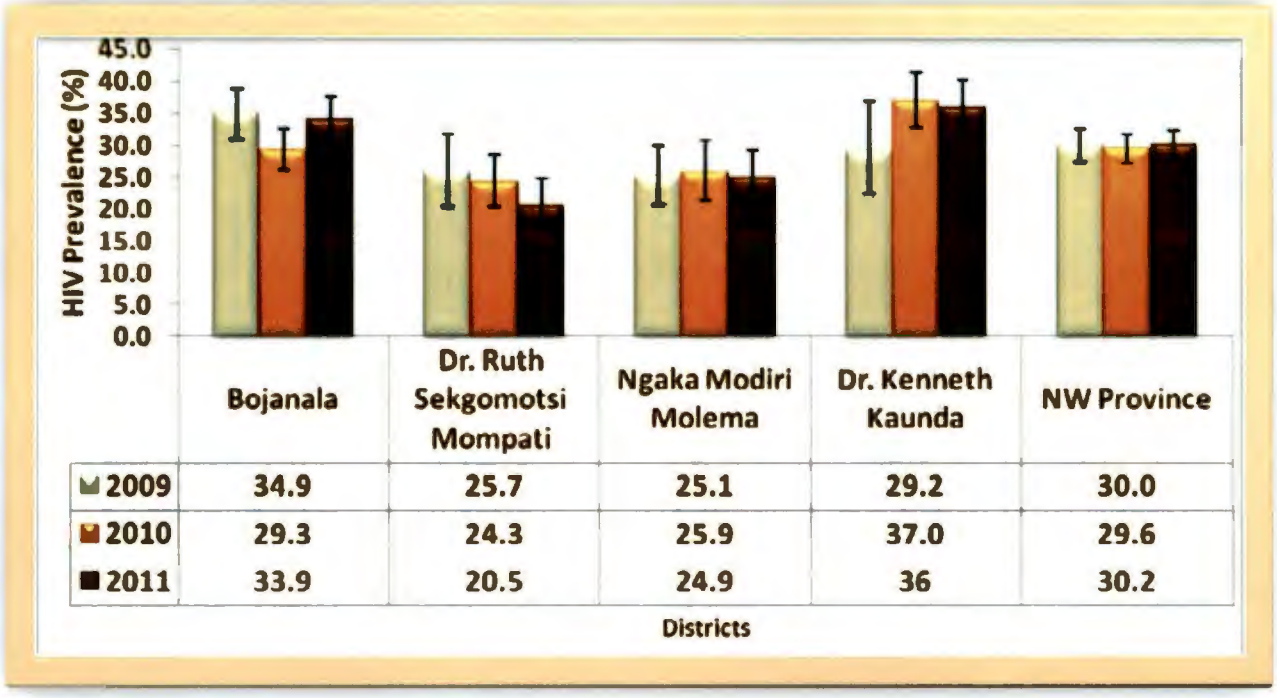
NGAKA MODIRI MOLEMA DISTRICT MAP



Source:Googlehttp://www.mapsharing.org.za/maps/image/data/NorthWest/NgakaMolema.jpg.

ANNEXURE: 5

HIV PREVALENCE TRENDS AMONG SURVEY PARTICIPANTS BY DISTRICT IN THE NORTH WEST, 2009 TO 2011



	Bojanala	Dr. Ruth Sekgomotsi Mompati	Ngaka Modiri Molema	Dr. Kenneth Kaunda	NW Province
2009	34.9	25.7	25.1	29.2	30.0
2010	29.3	24.3	25.9	37.0	29.6
2011	33.9	20.5	24.9	36	30.2

Districts

Source: National Antenatal Sentinel HIV & Syphilis Prevalence Survey in South Africa, 2011: 45.

ANNEXURE 6

GENDER-BASED VIOLENCE AND THE RISK OF HIV AND AIDS AMONG WOMEN IN-DEPTH INTERVIEW SCHEDULE

6.1 Biographical data of participants

1. Age	N	%
21 -25		
26 -30		
31 -35		
36 -40		
41 +		
Total		

2. Marital Status	N	%
Legally married		
Traditionally married		
Cohabiting		
Total		

3. Highest level of education

	N	%
No schooling		
Primary education		
High school education		
Tertiary education		
Total		

4. Employment **N** **%**

Formal employment		
Informal employment		
Unemployed		
Total		

5. Main source of income

N **%**

Own salary		
Combined salary		
Social grant/s		
Dependent on partner		
Dependent on other		
Total		

6. Combined monthly income

N **%**

Less than R1000.00		
R1000.00 – R1999 00		
R2000.00 R2999.00		
3000.00>		

6.2 In-depth interview questions

1. Unequal gender power relations questions

- In your past and present relationship who held/hold the decision making power?
- Can you negotiate for safer sex in your present intimate relationship?

2. Gender-based violence questions

- What is your understanding of gender- based violence?
- Have you ever personally experienced any form of gender-based violence?
- Have you ever felt forced to have sex with your intimate partner for fear of violence?
- Do you think that violence between a man and woman is a private or a public affair?
- Do you know the type of help you can get from a health facility when you are raped?

3. HIV and AIDS sexual behaviour questions

- Have you ever wanted to use condoms but felt afraid to suggest this with your partner?
- Do you think that any form of gender-based violence against women does increase the risk to HIV infection?
- Do you have any reason to doubt the faithfulness of your intimate partner?

6.3 Focus group questions

- What is the rate of gender-based violence among women, and HIV and AIDS in your area?
- What are the underlying causes of gender-based violence and HIV?
- How does gender-based violence and HIV and AIDS affect you as woman?
- Are you aware of any policy, programme or service by the government that addresses gender-based violence and HIV and AIDS?
- Have you ever discussed HIV and AIDS with your regular partner?
- Where would you go to seek help if faced with a situation of gender based violence?
- Have you ever felt forced to have sex in exchange for food, money, alcohol, etc., with any man other than your partner?
- Do you use any form of protection against HIV and AIDS?
- In your opinion, what do you recommend should be done to address the problems of gender-based violence and HIV and AIDS?

ANNEXURE 7

SAMPLE OF A LETTER DIRECTED TO THE MUNICIPAL MAYOR – NGAKA MODIRI MOLEMA

NORTH-WEST UNIVERSITY
YUNIBESITI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT
MAFIKENG CAMPUS

Faculty of Human & Social Sciences

Department of Social Work

Private bag

Mmabatho, 2735

Email:

Cell:

Dear Sir/Madam

APPLICATION FOR PERMISSION TO CONDUCT RESEARCH

I wish to introduce myself as Goitseone Emelda Leburu – a student at the North- West University (Mafikeng Campus), studying towards a Master of Social Work degree (MSW). As part of the requirements of my degree I am engaged in a research study. The Study aims to investigate: Gender-based violence and the risk of HIV and AIDS among women in Ngaka Modiri Molema District, North West Province.

In order to achieve the aim of the study, I will have to interview women who are part of two Home-Based Care organisations situated in the Mahikeng and Lichtenburg areas.

This letter serves to humbly ask for permission from your office to conduct this research in the designated settings which are under your jurisdiction. Permission will be sought from the managers of those organisations, including directly from the women in question. All the relevant research ethics those of respect, and confidentiality, to mention a few will be adhered to.

The study has been approved by the NWU Research Ethics Committee. A copy of the approval letter is herewith attached.

Thanking you

.....

G.E Leburu (Ms) Researcher

ANNEXURE 8

SAMPLE OF A LETTER DIRECTED TO THE MANAGERS OF THE SELECTED HOME-BASED CARE ORGANISATIONS

NORTH-WEST UNIVERSITY
YUNIBESITI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT
MAFIKENG CAMPUS

Faculty of Human & Social Sciences

Department of Social Work

Private Bag

Mmabatho, 2735

Email:

Cell:

Dear Sir/Madam

APPLICATION FOR PERMISSION TO CONDUCT RESEARCH

I wish to introduce myself as Goitseone Emelda Leburu – a student at the North- West University (Mafikeng Campus), studying towards a Master of Social Work degree (MSW). As part of the requirements of my degree I am engaged in a research study. The Study aims to investigate: Gender-based violence and the risk of HIV and AIDS among women in Ngaka Modiri Molema District, North West Province.

In order to achieve the aim of the study, I will have to interview women who are participants in your Home-Based Care services. This letter serves to humbly ask for permission from your office to conduct the said research in your organisation. Permission will also be sought from the women in question. All the relevant research ethics those of respect, and confidentiality, to mention a few will be adhered to.

The study has been approved by the NWU Research Ethics Committee. A copy of the approval letter is herewith attached.

Thanking you

.....

G.E Leburu (Ms) - Researcher

NNEXURE 9: NORTH-WEST UNIVERSITY APPROVAL OF PROJECT

NORTH-WEST UNIVERSITY
YUNIBESITI YA BOKONE-BOPHIRIMA
NOORDWES UNIVERSITEIT

Private Bag X6001, Potchefstroom
South Africa 2520

Tel (018) 299-4900
Faks. (018) 299-4910
Web http://www.nwu.ac.za

Ethics Committee
Tel +27 18 299 4849
Email Ethics@nwu.ac.za

ETHICS APPROVAL OF PROJECT

The North-West University Research Ethics Regulatory Committee (NWU-RERC) hereby approves your project as indicated below. This implies that the NWU-RERC grants its permission that provided the special conditions specified below are met and pending any other authorisation that may be necessary, the project may be initiated, using the ethics number below.

Project title: **Gender based violence and the risk of HIV and AIDS among women in Ngaka Modiri Molema district, North West**

Project Leader: Dr NG Phetlho-Thekisho
Student: GE Leburu

Ethics number NWU-00235-14-A9

Approval date 2014-04-07 **Expiry date** 2019-04-06

Special conditions of the approval (if any): None

General conditions:

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, please note the following:

- *The project leader (principle investigator) must report in the prescribed format to the NWU-RERC:*
  - *annually (or as otherwise requested) on the progress of the project.*
  - *without any delay in case of any adverse event (or any matter that interrupts sound ethical principles) during the course of the project.*
- *The approval applies strictly to the protocol as stipulated in the application form. Would any changes to the protocol be deemed necessary during the course of the project, the project leader must apply for approval of these changes at the NWU-RERC. Would there be deviated from the project protocol without the necessary approval of such changes, the ethics approval is immediately and automatically forfeited.*
- *The date of approval indicates the first date that the project may be started. Would the project have to continue after the expiry date, a new application must be made to the NWU-RERC and new approval received before or on the expiry date.*
- *In the interest of ethical responsibility the NWU-RERC retains the right to:*
  - *request access to any information or data at any time during the course or after completion of the project.*
  - *withdraw or postpone approval if:*
    - *any unethical principles or practices of the project are revealed or suspected.*
    - *it becomes apparent that any relevant information was withheld from the NWU-RERC or that information has been false or misrepresented.*
    - *the required annual report and reporting of adverse events was not done timely and accurately.*
    - *new institutional rules, national legislation or international conventions deem it necessary.*

The Ethics Committee would like to remain at your service as scientist and researcher, and wishes you well with your project. Please do not hesitate to contact the Ethics Committee for any further enquiries or requests for assistance.

Yours sincerely

Laurens

Prof Amanda Lourens
Chair NWU Research Ethics Regulatory Committee (RERC)

ANNEXURE 10

CONSENT FOR PARTICIPATION IN THE RESEARCH STUDY

I volunteer to participate in this research study conducted by Ms Goitseone Emelda Leburu, from the North-West University, Mafikeng Campus. I understand that the study aims at investigating "Gender-based violence and the risk of HIV and AIDS among women in Ngaka Modiri Molema District, North West Province"

1. My participation in this study is voluntary. I understand that I will not be paid for my participation. I may withdraw participation at any time without penalty.

2. I understand that if during the interview session I feel uncomfortable in any way, i have the right to decline to answer any question or to end the discussion.

3. The interview will last approximately 55 minutes. Notes will be written during the interview. In certain instances a tape recorder will be used. If I don't want to be taped, I will not be able to participate in this study.

4. I fully understand that the researcher will not identify me by name, and that my confidentiality as a participant in this study will remain anonymous.

5. I fully understand the explanations provided to me, and have had all my questions answered to my satisfaction.

6. I voluntarily agree to participate in this study

My Signature/Thumbprint..... Date.....

Signature of the Researcher..... Date.....

ANNEXURE 11

WHO (2012) ETHICAL AND SAFETY RECOMMENDATIONS FOR RESEARCH ON DOMESTIC VIOLENCE AGAINST WOMEN ADHERED TO

- **The safety of respondents and the researcher is paramount, and should infuse all project decisions.**

In order to enable the participants explain the research to others, it may be necessary to frame the research as a study on family relations. The explanation can be used to describe the survey to the community and to other members of the household. Once the participant and interviewer are alone, further information should be provided to her as part of the consent procedures.

- **Prevalence studies need to build on current research experience about how to minimize the under-reporting of violence**

The extent to which women will discuss their experience of violence is also influenced by the gender, skill and training of the interviewer. Since most violence against women is perpetrated by men, experience to date suggests that participants feel most comfortable talking about violence with other women. There is thus a need for the careful pre-testing and piloting of the research questions and the importance of monitoring the quality of the study's implementation.

- **Protecting confidentiality is essential to ensuring both safety and data quality of women**

Particular care should be taken during the presentation of the research findings that the information presented is sufficiently aggregated to ensure that no one community or individual can be identified.

- **The study design must include a number of actions aimed at reducing any possible distress caused to the participants by the research**

The interviewer should affirm that no one deserves to be abused, and to inform the respondent of her rights under the law.

ANNEXURE 12: PROFILE OF SAMPLED IN-DEPTH INTERVIEWEES

Location of the HBC	Participant	Age category	Marital Status	Education	Occupation	Main Source of income	Combined monthly income
Urban	1	31-35	Cohabitating	High School	Formally employed	Social grants and combined salary	R3000.00+
	2	31-35	Cohabitating	Primary School	Formally employed	Own salary and social grants	R2000.00-R2999.00
	3	31-35	Traditionally married	High School	Formally employed	Combined salary	R3000.00+
	4	26- 30	Cohabitating	High School	Formally employed	Combined salary	R3000.00+
	5	41+	Traditionally married	Tertiary education	Formally employed	Combined salary	R3000.00
Urban	6	26-30	Cohabitating	Tertiary education	Formally education	Combined salary	R3000.00+
	7	31-35	Cohabitating	High School	Formally employed	Combined salary and social grants	R3000.00+
	8	41+	Legally married	Tertiary education	Formally employed	Own Salary	R2000.00-R2999.00
	9	36-40	Cohabitating	High School	Formally employed	Combined salary	R□000.00+
	10	26- 30	Legally married	Primary School	Formally employed	Combined salary	R3000.00+
Rural	11	41+	Legally married	High School	Formally education	Combined salary & social grants	R3000.00+
	12	36-40	Traditionally married	Tertiary education	Formally employed	Combined salary	R2000.00-R2900.00
	13	41+	Traditionally married	Tertiary education	Formally employed	Own salary& Social grants	R3000.00+
	14	36-40	Cohabitating	Primary School	Formally employed	Combined salary & Social grants	R3000.00+
	15	26- 30	Legally married	High School	Formally employed	Combined salary	R3000.00+

ANNEXURE 13: PROFILE OF SAMPLED FOCUS GROUP DISCUSSANTS

Location of the HBC	Participant	Age category	Marital Status	Education	Occupation	Main source of income	Combined monthly income
Urban	**1**	21-25	Cohabiting	High School	Formally employed	Own Salary	R2000.00-R2999.00
	2	31-35	Cohabitating	Primary School	Formally employed	Combined salary	R3000.00
	3	21-25	Traditionally married	High School	Formally employed	Own Salary	R2000.00 R2999.00
	4	26- 30	Cohabitating	High School	Formally employed	Combined salary	R3000.00+
	5	41+	Legally married	High School	Formally employed	Combined salary	R3000.00+
Urban	**6**	21-25	Cohabitating	Tertiary education	Formally education	Own salary	R2000.00-R2999.00
	7	31-35	Legally married	Primary School	Formally employed	Own Salary	R3000.00+
	8	21-25	Cohabitating	Tertiary education	Formally employed	Own Salary	R2000.00-R2999.00
	9	36-40	Legally married	High School	Formally employed	Combined salary	R3000.00+
	10	31-35	Cohabitating	High School	Formally employed	Own Salary	R2000.00 R2999.00
Rural	**11**	36-40	Legally married	Primary School	Formally education	Combined salary & social grants	R3000.00+
	12	31-35	Cohabitating	High School	Formally employed	Combined salary	R3000.00+
	13	36-40	Legally married	Primary School	Formally employed	Combined Salary	R3000.00+
	14	36-40	Cohabitating	High School	Formally employed	Combined salary & Social grants	R3000.00+
	15	26- 30	Traditionally married	High School	Formally employed	Own Salary	R2000.00 R2999.00