

Experiences of Gender-Based Violence among HIV-Positive Rwandan Women beyond the Period of Disclosure and Implications for HIV Programming

by

Jessica Johnson

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APPROVAL

Name: Jessica Johnson

Degree: Master of Public Health

Title of Project: Experiences of Gender-Based Violence among HIV-Positive Rwandan Women beyond the Period of Disclosure and Implications for HIV Programming

Examining Committee:

Chair: Dr. Rochelle Tucker
Assistant Professor of Health Science

Dr. Nicole Berry
Senior Supervisor
Assistant Professor of Health Science

Dr. Carrie Miller
Supervisor
Assistant Professor of Health Sciences

Dr. Marina Morrow
Internal Examiner
Assistant Professor of Health Science

Date Defended/Approved: April 12, 2010



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ABSTRACT

The relationship between gender-based violence (GBV) and HIV has gained prominence in the field of public health. In the context of Rwanda, poverty and the lasting affects of the 1994 Rwandan Genocide further complicate this relationship. In partnership with Women’s Equity in Access to Care and Treatment, an HIV treatment centre in Kigali, Rwanda, this study uses qualitative research methods to capture the experiences of GBV among HIV-positive Rwandan women. Participants spoke to the variety of ways that living openly with HIV shaped their experience of GBV and interacted with their experience of gender inequities in access to land and resources. Women framed their experience of GBV as including; being prevented from seeking medical care and an inability to assert agency in sexual relationships. Exploring how women jointly experience GBV and HIV can provide insight into future public health practice and research on the relationship between GBV and HIV.

Key Words: Gender-based violence (GBV), HIV/AIDS, Rwanda, Disclosure period, Gender

To the Women of Rwanda

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INTRODUCTION

The inter-relationship between gender-based violence (GBV) and HIV has been extensively identified as a critical factor increasing risk for heterosexual transmission of the HIV-virus, particularly for women (Gielen, 2000; Greig et al., 2008; van der Straten et al., 1998; Maman, 2002). Maman (2002) notes that our current focus on GBV and HIV has been primarily on acts of sexual violence and stigma, when in fact there are many diverse ways that HIV and GBV interact in the lives of women. Much of our knowledge of the association also comes from studies that examine the link between GBV and HIV around the period of initial disclosure of HIV-positive status (Gielen, 2000; Greig et al., 2008). As Gielen (2004) maintains, a woman can disclose her status many times, suggesting that violence triggered by disclosure may occur at various stages throughout an HIV-positive women's life. While studying GBV associated with or provoked by disclosure is certainly important, it does not sufficiently explore the role of GBV in HIV positive women's lives. GBV that occurred before HIV infection is likely to continue post-infection (Gielen, 2000). GBV may begin at any time in a woman's life, and logically, all incidents of GBV among HIV-positive women are not likely directly related to their initial disclosure of their HIV-positive status (Gielen, 2000). Additionally, being HIV positive could both transform the meaning of GBV for women and create new forms of GBV not previously experienced. Understanding how GBV affects HIV-positive women once they have already disclosed their HIV-positive status to their partner is, therefore, an important topic

of investigation. This study, set in the context of post-genocide Rwanda explores how women who are living openly with HIV experience GBV.

In the context of sub-Saharan Africa where women make up a disproportionate 60% of HIV-positive adults, the intersection of HIV and GBV is further complicated by the impoverished status of women and gender inequities in women's access to income and land (Anderssona, 2008; Cohen, 2005; Martin & Curtis, 2004). Specific to Rwanda, wide spread GBV occurring during the 1994 genocide resulted in virtually simultaneous HIV-infection of thousands of Rwandan women (Cohen, 2005). The goal of this study is to inform and improve GBV screening and reduction strategies as a part of holistic anti-retroviral (ARV) treatment programs that includes counselling, legal assistance and family support services for individuals living with HIV. Doing so could have a significant impact on both GBV and HIV prevention efforts.

BACKGROUND

Gender Based Violence

A serious global health, human rights, and development issue, GBV has far reaching and devastating consequences for both individuals and societies (USAID, 2008). As an umbrella term, GBV encompasses any harmful act that is "perpetrated against a person's will and that is based on socially ascribed (gender) differences between males and females" (IASC, 2005). GBV is inclusive of, but not limited to, sexual abuse, rape, domestic violence, psychological torture and sexual harassment. GBV is a significant contributor towards underlying

gender inequities and is perpetuated by inequitable legal and political structures that disempower women (Greig et al., 2008; van der Straten et al., 1998).

GBV is not confined by geography, race, culture, social class or religion; it is a worldwide concern (USAID & UNICEF 2008). The culmination of 35 studies, conducted in a variety of countries, reported that up to one half of all women surveyed experienced lifetime physical abuse by a partner (Heise *et al.*, 1994). Victims of GBV suffer damaging physical and psychological consequences, such as post-traumatic stress disorder and trauma, many cases of which are chronic (Jansen van Rensburg, 2007; Van der Straten et al., 1998; Goodman, 1993; Brown, 1995). GBV also has consequences for societies at large as victims of GBV are often unable to contribute as active members of labour markets and social systems (USAID, 2008). In addition, women remain vulnerable to GBV because of gender inequities in legal rights in many countries in sub-Saharan Africa (Andersson, 2008). Inequitable legal rights for women may result in what Izumi (2007) terms 'property grabbing' where women experience GBV when they are forced from their land without a means of legal recourse.

Gender Based Violence and HIV

The feminization of the HIV epidemic is a prominent global health concern that is placing increased emphasis on examining the association between GBV and HIV (USAID/WHO, 2004; Piot, 1999). Fonk (2005) highlights the importance of the interplay between HIV and GBV as HIV-positive women have twice the risk

of HIV-negative women for experiencing GBV at some point in their lifetime. Thus, many countries are facing what Ghanotakis (2009) terms the "twin epidemics of GBV and HIV/AIDS". The HIV epidemic continues to be a major challenge in global health with roughly 2.7 million new infections in 2007 (WHO, 2009). It is estimated that among the 37 million people living with HIV worldwide, more than half of these cases are women (Martin & Cutris, 2004). This trend is even more apparent in sub-Saharan Africa where there are 14 infected women for every 10 infected men (Grieg, 2008).

Despite the advancement and scale up of ARV-treatment and HIV prevention campaigns in many countries, there remain gender inequities that perpetuate HIV transmission and present barriers to HIV testing and access to care (Greig 2008). GBV is a contributing factor in HIV infection rates and the need to address GBV in the fight against HIV has been underscored (Ghanotaki, 2009; Dunkle, 2004). In fact, several researchers have documented the importance of dual intervention strategies aimed at both HIV and GBV as a means of reducing the prevalence of HIV (Ghanotakis, 2009). The Interagency Gender Working Group (CHANGE) (2005) notes that HIV prevention efforts are so severely undermined by GBV that it is crucial for GBV to become an integral component of any HIV prevention program. The reasoning behind the widespread support for the integration of GBV and HIV prevention strategies is that GBV is viewed as having a circular relationship with HIV (Jansen, 2007). Sexual coercion, sexual violence and physical violence are causal factors of HIV

and the stigma associated with HIV status disclosure is in turn related to acts of GBV (Jassen, 2007; Greig, 2008). To date, researchers have primarily contextualized the relationship between GBV and HIV in two ways, either HIV that results from GBV exposure or GBV that results from HIV disclosure.

Gender Based Violence and HIV in the Rwandan Context

In 2009 the UNFPA reported that one in three Rwandan women will be beaten or raped in their lifetime. Additionally, Rwanda's Ministry of Gender and Development (2009) has reported that in the last five years 25% of women have experienced sexual GBV, 12% have experienced physical violence and 13% have experienced psychological violence with the main perpetrator of these acts being a husband or former partner. However, these more recent acts do not account for the estimated 250,000 women in Rwanda who suffered rape, torture and other acts of GBV during the genocide of 1994 (Human Rights Watch, 1996). During the 1994 Rwandan genocide, Rwandan soldiers and Hutu gangs systematically slaughtered 800 000 Tutsis and moderate Hutus in 100 days (Human Rights Watch, 2004). Women and young girls were systematically targeted by the Hutus and Rwandan soldiers as a result of their gender in an attempt to eradicate the Tutsis (Cohen, 2005). These women continue to suffer psychological trauma such as posttraumatic stress disorder and depression, and physiological health problems such as HIV and AIDS, fistulas, scars and chronic pain (UNFPA, 2009; Cohen 2005, African Rights, 2004). Further contributing to the interaction of GBV and HIV in this context is the affect of poverty. Post-

genocide Rwanda remains among the poorest counties in the world with 60.3% of Rwandan's living on less than a dollar a day (WHO, 2000). Additionally, 90% of Rwandan's are dependant on agriculture for their livelihood, a fact which exacerbates the negative impact of gender inequities that result in land insecurity and interacts with the cycle of GBV and HIV (Howe, 2007; Musahara, 2001).

Gender Based Violence as a Cause of HIV

The association between GBV and the victim's exposure to HIV infection are well documented. Certain groups of individuals such as female sex workers (FSW) or internationally displaced persons (IDP) have been identified as being at especially high risk of HIV infection from acts of sexual violence (Kim et al., 2009, Shannon, 2009; Shahmanesh, 2009). Kim et al., (2009) also highlights the dangers of sexual violence and subsequent HIV infection when both became the purposeful weapons of war. The majority of studies on the relationship between GBV and HIV point to sexual GBV as a common cause of HIV infection in women (Campbell, 2002; Maman, 2002; Silverman, 2008). Campbell (2002) and Dude (2007) cite power differentials in sexual relationships that result in a man's refusal to wear a condom and a belief in his right to force sexual acts as the primary link between experiences of GBV and increased risk of HIV infection. Andersonn (2008) further contributes to our understanding of GBV's role in HIV infection by reporting that perpetrators of GBV are also at risk of HIV. Grieg (2008) expands on this argument by explaining that the patriarchal nature of many societies encourages men to have multiple partners, thus increasing both their likelihood of

HIV infection and the subsequent infection of their partners. In sum, for these authors, GBV, particularly sexual violence, is a causal factor of HIV infection for both victims and perpetrators.

GBV as the Outcome of HIV Disclosure

HIV is a highly stigmatized disease cross-nationally and culturally. Communities where there is structurally supported misinformation concerning both transmission and the therapeutic benefits of ARV-treatment options are particularly affected by HIV stigma (Greig, 2008). As Greig (2008) argues, men's fear of stigmatization translates into women being more likely to get tested for HIV than men. In addition, Greig (2008) notes that women typically have increased access to health services for reproductive health concerns and thus are more likely to be tested for HIV than are men. As a result, women often have to bear the hardship of being the first partner to disclose their HIV status. Women in this position are at risk of being the victims of GBV by their partners (Gaillard *et al.*, 2002; Wingood and DiClemente, 1997). Women may also experience GBV from other members of their family and their community as a result of such stigma (Fonk, 2005).

Moving Beyond the Period of Disclosure

Though the aforementioned relationship between GBV and HIV is well documented, the absent component is what happens when GBV and HIV coexist chronically in a woman's life. As previously mentioned, women may experience

violence that is unrelated to her initial disclosure of being HIV-positive. In a study by Gielen et al. (2000), only 4% of women report GBV following a disclosure event whereas 45% reported being the victim of emotional, physical or sexual abuse at some point after being diagnosed as HIV-positive, thus further supporting that GBV is not necessarily directly related to disclosure. What remains unknown is whether or not a woman's experience of GBV is changed as a result of being HIV-positive. For instance, does the experience of GBV change for a woman once she is living openly with HIV? What are the implications for HIV and GBV prevention programs if GBV is conceptualized as a chronic problem for HIV-positive women and not just one associated with the period of disclosure?

METHODS

This study, conducted in partnership with the Women's Equity in Access to Care & Treatment (WE-ACTx) clinic located in Rwanda, sought to address how women's experiences of GBV were impacted by their HIV-positive status (Cohen, 2005).

WE-ACTx, a Non-Governmental Organisation (NGO) was developed in 2004 to bring medical services to HIV-infected women in Rwanda who were victims of genocidal violence (Cohen, 2005). WE-ACTx services now include medical services for HIV-positive families, voluntary HIV counselling and testing (VCT), prevention of mother-to-child transmission (PMTCT) and most recently, group and individual therapy sessions for individuals living with HIV (Cohen, 2005).

Our study used qualitative inquiry to gain an in-depth understanding of the experiences and perceptions of GBV among women who are living openly with HIV (as defined in this study as women whose sexual partner was aware of their HIV-positive status) (Creswell, 1994). Participants consisted of two groups: HIV positive women who were being counselled through WE-ACTx services, and counsellors who directed groups of HIV positive women who were living openly. Counsellors themselves were included in the sample as it was felt they provided intimate and important knowledge of the interaction of GBV and HIV among the women clients with whom they worked.

In total, eleven focus groups were conducted between May and June of 2009, eight with WE-ACTx patients and three with WE-ACTx counsellors. Sixty women participated: 52 were HIV-positive who attended the WE-ACTx clinic and 8 were WE-ACTx counsellors. All eleven focus groups were conducted in English and Kinyarwanda, the main regional language, by the study investigator in conjunction with a trained interpreter. Focus groups lasted approximately an hour and a half, and were located in meeting sites typically used by WE-ACTx staff for group counselling.

Focus group protocols were developed in consultation with WE-ACTx counsellors to ensure the appropriateness of the study and its applicability to the needs of their community. To best capture the affects of GBV on this community of HIV-positive Rwandan women, participants where encouraged to self-define what GBV meant to them. This was done to ensure participants were able to address any form of GBV they felt they were experiencing as opposed to meeting

a more narrow definition of physical abuse for example. It is for this reason the inclusive term GBV was used. Separate question guides were developed for participants who were patients and participants who were counsellors. Though all questions were centred on the participant's perceptions of GBV among HIV-positive members of their communities, questions aimed at participants who were counsellors were framed to differentiate between what they felt were the perceptions of GBV among their patients and among the community at large. Participants who were patients were asked to speak to their perceptions of GBV amongst HIV-positive community members in general. Distinguishing the questions between participant groups was an effort to ensure that results were more representative of the larger community as opposed to just WE-ACTx patients. Both focus group guides contained questions on perceptions and experiences of GBV among HIV-positive individuals and the ability to access services for HIV and GBV in the community. Probes and follow-up questions were also used to elicit elaboration and clarification during the actual groups.

Participants were recruited using purposive sampling from WE-ACTx patients and counsellors involved in group therapy sessions, with the goal of achieving representativeness of the setting (Maxwell, 2005). Participants in the patient group were selected based on referrals by clinic counsellors who led counselling groups of women who live openly with HIV. An honorarium was provided to participants for their travel expenses to and from their home in addition to the provision of refreshments. Sample size was determined by theoretical saturation where new categories of concepts no longer emerged.

This data was collected as part of a larger project for which all participants provided written informed consent (Ingabire, 2010). Consent was reconfirmed orally at the beginning of each focus group. All study procedures received approval from both the Kigali Institute of Health and Simon Fraser University's Research Ethics Committee.

Data Analysis

Focus groups were digitally recorded and recordings transcribed. Transcripts were analyzed using a continuous coding technique so that focus group questions could be revised if needed (Ulin, Robinson & Tolley, 2005). Both organizational and substantive categories of codes were established by reviewing, labelling and drawing connections between the data (Maxwell, 2005). Data was then organized based on the four substantive categories that captured the range of participant perceptions of the community identified experiences of GBV among women who were living openly with HIV.

RESULTS

Participants spoke to the chronic existence of GBV in their lives beyond the period of initial disclosure and how their experience of GBV has taken on new forms as a result of their HIV-positive status. Participants spoke to the interaction of the co-existence of GBV and HIV in their lives through four primary themes; 1. Poverty and land insecurity 2. Abandonment by partners 3. Access to HIV/AIDS prevention and services 4. Perceived lack of agency in sexual relationships.

Poverty and Land Insecurity

For the purpose of this presentation, poverty has been presented as a discrete finding. Nevertheless, participants continually emphasized the role of poverty in influencing other forms of GBV. The dependency created by poverty, particularly the vulnerability of being unable to obtain land and financial security influenced all other themes in our findings.

Women's dependency on men for subsistence for themselves and their children are fuelling GBV. HIV is further exacerbating the vulnerability of women to GBV and the loss of the land they depend on for the survival of themselves and their children. Several women in our study articulated that living openly as HIV-positive made them increasingly vulnerable to losing the land and property they shared with their partner, and were dependant on for their basic survival. Furthermore, participants spoke of poverty and land insecurity as a complicating factor that held them in situations of GBV and/or made them more vulnerable to acts of GBV, as two participants state;

Poverty holds women in abusive situations. Women might divorce if they could survive without the man. (*Counsellor*)

Poverty complicates issues because women are totally dependent on their husbands. (*Counsellor*)

For many participants poverty acted as a compounding factor that further exacerbated their vulnerability as an HIV-positive individual. HIV-positive women

were often dependant on care providers (typically partners) to supply the basic necessities of food, shelter and health care. This was especially relevant for participants in declining health states due to HIV who were no longer able to work or provide for themselves or their families. Lacking the resources to secure basic necessities such as food, shelter and medication, HIV-positive participants were often at the mercy of partners and family members. The dependency implicit in the provider-recipient relationship created an even greater imbalance of power that left HIV-positive participants increasingly vulnerable to GBV.

Interestingly, those female participants who had HIV-positive partners reported the man's inability to provide for the family due to their declining health state as a form of GBV experienced by the women. In addition, a lack of legal rights to land, property and children was reported by participants (particularly women, many of whose marriages were not legal) as being a form of GBV. Participants explained that such GBV denies them securities that would allow them to improve their livelihood, thus increasing their vulnerability to both poverty and the ill effects of interactions between HIV and GBV. Furthermore, if a woman refuses to surrender her property, she is often subject to further violence, as one woman states;

Husbands demand for women to sell their property (house and land) so they can use the money to find another woman who is not HIV-positive. If the woman refuses to sell the property he beats her and he sells it.

(Female patient)

Here, the selling of the property, not the later physical abuse, was identified by the participant as the most significant form of GBV experienced.

Abandonment by Partners

Abandonment of partners and children was another key theme that appeared in our research. Female participants reported GBV when their partners abandoned them and their children leaving them without money for food, rent and school fees. Many women stated they felt this abandonment was directly related to their HIV-positive status. Increasing complications were revealed as partners may return home periodically demanding sex in exchange for food and money, for which participants are now desperate due to long periods without financial support. As stated by women participant, being HIV-positive further complicated issues of abandonment as women were often physically unable to work and thus unable to secure stable income on their own;

If we are positive (HIV-positive women), men (husbands) go away for many weeks and leave us alone with the children. Then there is no money to pay rent or buy food and we may lose the land. When the men return they demand sex. (*Female patient*)

In explanation for their abandonment, women felt their partners held them solely responsible for bringing HIV into the home and infecting their children. One woman cited that;

Our men know that HIV transmits from mother to child, so if the child is HIV-positive the men blame us and disown the child as our responsibility.

(Female patient)

Counsellors were able to further expand upon the issue of abandonment as a form of GBV for HIV-positive women as they brought forth the issue of polygamy that is accepted in certain parts of Rwandan culture. Many counsellors thought that men used their partner's HIV-positive status as an excuse to pursue other relationships and take other healthy wives;

There is a problem with polygamy. The husband has another wife so it is easy to leave when there is a problem such as HIV. Polygamy is also a problem as the younger [new] wives are intimidated and beaten to prevent them from revealing themselves to the first wife. *(Counsellor)*

Counsellors further added that in an effort to prove their vitality after being diagnosed, HIV-positive men may abandon their family to seek a younger healthy wife who could provide the man with multiple children to prove the man's health. Using a partner's HIV status as the reason for taking on additional partners is an example of how participants' experience of GBV has been shaped by HIV. In addition, polygamy promotes the spread of HIV; especially in discordant couples where the HIV-positive individual has not disclosed their status.

When speaking of the theme of abandonment, it was common for all participants to view the problem as most relevant to discordant couples as blame

was placed on the HIV-positive individual for “bringing HIV into the home”. Counsellors were especially concerned with cases of men blaming their female partner for infecting them with HIV, despite the fact that in many cases the woman remained negative.

Access to HIV/AIDS prevention and services

Many participants also identified being denied the ability to secure their own health and the health of their children as a form of GBV that has resulted from being HIV-positive. Most HIV-positive participants were dependant on medication such as ARVs for their health. An inability to access health services or medications due to partners’ threats or physical abuse was a major concern for participants and a highly cited form of GBV. Also, for participants who experienced GBV before being diagnosed with HIV, being HIV-positive allowed for this new form of GBV to be inflicted upon them. In the case of women who had previously lived without GBV, being HIV-positive introduced GBV (in the form of their partner denying them access to HIV services) into their lives.

Of primary concern was the participant’s ability to take the life sustaining treatment of ARV drugs which WE-ACTx patients are all given free access to. Many participants felt they experienced GBV when they were unable to take their medication because either their partners took their ARVs for their own consumption or their partner beat them if they were found to be taking treatment for HIV, even if their partner already knew them to be positive. Concern over this form of GBV was reported by several participants, two of whom stated;

When the woman is HIV-positive and the man is HIV-negative there is conflict because the man does not want the woman to take ARVs.

(Female patient)

When I started treatment at the clinic, my husband starting beating me.

(Female patient)

These particular experiences of GBV were not a result of the women revealing their HIV status but instead a result of trying to access treatment.

The underlying reasoning for partners denying participants use of ARV medication seemed to related to fear and stigma associated with exposing themselves as HIV-positive. Participants believed that men stole their partners ARVs simply because they did not want to go to the clinic themselves to acquire their own medication as this would signify to the community that they are HIV-positive. Similarly, men did not want their partners using ARVs as this would acknowledge to both themselves and the community that HIV was present in their family. As one woman stated;

My husband refuses to go to the clinic because he does not admit he has HIV so he steals my medication. Because of this the medication is not enough for me. *(Female patient)*

In addition to being disenabled from obtaining ARVs, female participants identified experiencing GBV by being unable to access the counselling services

that the clinic offers. Many participants felt strongly that group and individual counselling services were responsible for preserving their psychological wellbeing and allowing them to “face their illness”. However, group counselling, as a matter of practicality, was typically conducted in community settings with women coming to the group from the surrounding areas. Men felt that if women were seen coming to group then the community would know that they had HIV in their family. As several women recounted, group members felt threatened by the potential for physical and psychological abuse from their partners when coming to group counselling;

Sometimes we are beaten if our partners find out we came to group because coming here shows the community that our family has HIV.

(Female patient)

My partner does not want me to come to the group because he does not want other people to know I am HIV-positive. *(Female patient)*

If our partners finds out we went to group, they will beats us when we come home, because coming here means we have HIV. *(Female patient)*

These comments were echoed by almost all of the women with partners in the groups and clearly point to the aforementioned fear and stigma that community men are perceived as associating with HIV. Interestingly, many women choose the risk of physical abuse as a lesser violence than not coming to group at all. Despite the risk involved, women continued to attend.

Perceived Lack of Agency in Sexual Relationships

The lack of agency felt by participants in negotiating sexual relationships resulted in various forms of GBV that exacerbated negative health outcomes of HIV. Female participants identified several ways in which their HIV status interacted with their experience of GBV.

Marital Rape and Transactional Sex

Participants cited experiencing GBV when they refused to have sex with their partners. Women stated that they often did not want to engage in sexual acts because of their weakened state due to HIV. Participants spoke of their partners physically forcing them to have sex or coercing them to have sex by threatening to discontinue financial support. As such, marital rape as a form of GBV is cited as a primary concern for HIV-positive women who do not wish to engage in sexual acts because of their ill health. Both participants who were patients and counsellors expressed concerns of how HIV increases their vulnerability to sexual GBV;

Women try to refuse sex because they are exhausted from ARVs or illness but are forced to have sex, especially when men are drunk.

(Female patient)

The husband is the only provider so women have no power to say no as the husband may not fulfill provider role (not buy food or pay rent) if the woman does not have sex or refuses sex without a condom. *(Counsellor)*

It is a culturally based problem as women are informed that they cannot say no to sex with their husband (women on ARVs are very weak but think they cannot say no to sex). (*Counsellor*)

Further complicating the situation is that HIV leaves women increasingly vulnerable to poverty and thus at the mercy of their male partner. As such, sex within a partnership may become transactional as illustrated by one participant;

My husband refuses to provide money for food and school fees if I do not have sex with him. (*Female patient*)

In other words, women trade sex for food and money to secure shelter, school fees and medical treatment that their partners would otherwise deny them and that they are unable to obtain on their own due to health complications from HIV.

Inability to Practice Safe Sex

When a woman did have sex with her partner, the inability to have safe sex due to a partner's refusal to wear a condom was brought forth as a form of GBV. Participants explained that their partners refuse to purchase condoms, or to allow their them to do so, as this is seen as admitting to the community that they have HIV;

Our husbands refuse to use condoms. Men do not buy condoms because they do not want anyone seeing them buying them because people will

think they are positive. If women do bring them home the husband refuses them anyways. (*Female patient*)

Here, the female participant's reliance on her partner to provide for her in the face of poverty and HIV translated into an inability to refuse unsafe sex. Thus the ways in which HIV exacerbates, or makes women more vulnerable to, the ill effects of poverty is an underlying contributing factor to the sexual GBV experienced in this case.

Family Planning

The issue of condom usage for couples affected by HIV is additionally problematic for family planning concerns. Despite being HIV-positive, men often wish to have more children as a means of denying their own failing health status. Women are often unable to negotiate their family planning wishes in these situations, even if they are HIV-positive and thus do not wish to bear additional children.

Men do not respect women's wishes for family planning. Sometimes, women do not want to have more children because they have no money and bad health (HIV-positive status), but the men demand more children and force the woman to have sex. (*Female patient*)

My husband wants another child because he says he will die in a couple years (of AIDS) and he wants to leave me with three children. I do not want to have unprotected sex with him because I do not want to contract more HIV. (*Female patient*)

Clearly, the interplay of both HIV and poverty severely compound these participants' experience of, and vulnerability to, sexual GBV. Though, victimization by sexual GBV is commonly linked to physical threat or coercion, what is important here is the manner in which being HIV-positive transforms participant's experiences of sexual GBV. Being HIV-positive resulted in participants being both increasingly vulnerable to physical harm and coercion and acted as a principal reason for their resistance to sexual acts in the first place.

DISCUSSION

The results of this study demonstrate the potential transformation of the experience of GBV for individuals who are openly HIV-positive. Many research studies have looked at how GBV results in HIV or how disclosing one's HIV-positive status may put an individual at increased risk of becoming a victim of GBV. While acknowledging the existence of these relationships and their appearance in our data, when asked about their experiences of GBV our participants primarily spoke of GBV that was not directly related to HIV-infection or a disclosure act. Instead, participants provided examples of how GBV impacts

the health and wellbeing of HIV-positive individuals and their families over the long term, and how being HIV positive exacerbates the effects of GBV. The risk of such novel experiences of GBV for both women and men is a concern requiring great attention when working with HIV-positive individuals.

New Forms of GBV

The interaction of GBV and HIV is clearly very complex. Becoming HIV positive creates opportunities for new forms of GBV, such as denying an individual the ability to maintain or improve their health status. Documented forms of GBV, such as the refusal of safe sex practices and/or the threat of partner abandonment take on distinct new meanings for HIV-positive individuals.

Health Care Practices

Especially concerning was the participants experience of GBV as being disabled from acquiring medical or psychological treatment for HIV. If an individual is prevented from accessing ARV medication, or their medication is taken from them, they will likely suffer drastic health consequences. The frequency and consistency of participant's recount of this type of GBV clearly demonstrated that it was of primary concern to them. ARV medication assists HIV-positive individuals in regaining the level of health necessary to remain participants in their families and communities. Thus not only is this form of GBV robbing individuals of their personal health but it is also negatively impacting the community at large. Also important for all female participants was the emphasis

they placed on the benefits of counselling sessions. Participants often spoke of experiencing physical and verbal GBV from their partners as a result of attending counselling sessions. However, participants were consistent in positioning the most detrimental form of GBV experienced in these circumstances as being disenabled from attending counselling.

The importance of counselling sessions to these participants, many of whom were willing to endure physical violence to attend, supports the growing body of literature addressing the need for GBV counselling to be integrated into HIV-programming (Cohen, 2005; Lang, 2007; Andersson, 2008; Jansen, 2007; Fonk, 2005). Jansen (2007) in particular calls for an integrated and holistic approach to addressing GBV and HIV. Van der Straten (1995) and Peacock (2009) extend the support for GBV counselling for HIV affected individuals by stipulating that the involvement of men in couples counselling must become a crucial component of joint strategies on HIV and GBV. Men not only need to learn strategies to reduce incidents of GBV but additionally need to be involved as part of individual and (when appropriate) couples counselling to engage in open communication about how to manage their HIV status and the role of GBV in their families (Lang, 2007). The involvement of men in counselling on HIV and GBV was supported by participants who felt that many men did not understand that ramifications of disallowing their partner from obtaining their ARV medication, or of taking this medication for their own consumption.

Implicit in participants' explaining their partners' refusal to allow them from obtaining medication or counselling for HIV was the heavy stigmatization of HIV in their communities. Both female and male participants felt that the reason men did not support their partners' clinic visits or and/or refused to attend the clinic themselves for HIV treatment was that they did not want to acknowledge to the community that their family was affected by HIV. Not only do men themselves need to be involved in the counselling process as a means of reducing the stigma that contributes to their acts of GBV, but there clearly remains much work to do in the community and society at large to reduce the stigmatization of HIV that supports such acts.

Safe Sex Practices

The experience of GBV was also transformed for HIV affected couples, when it came to family planning. Several studies have documented the association between GBV and a woman's inability to negotiate safe sex practices (Kalichman, 1998; Lang, 2007, Hamburger, 2004; Wingwood, 1998; Dunkle, 2004, Campbell, 2002). A study by Lang (2007) found a strong association between having an abusive partner and the couple's condom use. Campbell (2002) and Dunkle (2004) supported Lang's concerns positioning condom use negotiation in physically abusive relationships as particularly problematic in countries where societal structures disallow women from having input into family planning decisions. Lang (2007) even found that women who are experiencing

GBV are more likely to be pregnant, pointing to an inability to negotiate safe sex practices.

Participants in the current study echoed the findings of the above mentioned research and many had experienced GBV resulting from their partner's refusal to practice safe sex. However, participants felt strongly that once they or their partner was HIV-positive their experience of GBV in this context of safe sex practices took on an entirely new form. In cases where the man was HIV-positive, several female participants felt that the reason they were experiencing this sexual GBV, specifically the refusal to practice safe sex, was to fulfill the man's desire to reproduce to prove his vitality in the face of his HIV-positive status. In these cases, the motive behind such acts of GBV is directly linked to the man's HIV-positive status and accompanying beliefs about masculinity. Concerns of GBV in the form of marital rape also took on a new meaning for women who were HIV-positive and as a result of their poor health due to HIV, did not wish to engage in sexual acts.

Not only do such acts of GBV place HIV-positive women at risk of seroconversion or reinfection but there is the additional risk of unwanted pregnancy and potential mother-to-child transmission of HIV (Lang 2007). For women in this study, acts of sexual GBV that could threaten their own lives or those of their children as a result of HIV infection were distinct from sexual GBV that does not threaten HIV infection. The interplay of HIV with sexual GBV in

these cases is important to acknowledge as a means of accurately capturing the participants experience and potential implications for treatment.

These finding reiterate the necessity of integrating men into counselling so that they may fully understand the health risks of their GBV acts for both themselves and their partners. As Peacock (2009) stipulates, there is a growing body of evidence that clearly demonstrates that “initiatives targeting men can change the social practices of both sexes, particularly in the context of HIV/AIDS” (p.119). Kalichman et al., (2009) echoes this assertion by noting that joint interventions on HIV and GBV that target men can have the synergistic effect of reducing HIV and GBV incidences among both men and women. Along with the stigma and fear of HIV that Greig (2008) associations with men refusing HIV-testing, our results contribute to the need for more research and programming that includes men as a means of reducing the negative interactions of GBV and HIV.

Abandonment

The transformative effect of HIV on GBV was additionally apparent for women who feared their partners may abandon them. Fundamental to participants’ assertions that abandonment in the context of HIV was a form of GBV was the fact that participants relied heavily on their partners to care for them and provide resources should their condition prevent them from earning their own income. In addition, participants felt that being HIV-positive put them at increased risk of being abandoned, as their partners felt justified in seeking a

new partner who was HIV-negative. Thus in such cases, HIV took on the dual role as both an excuse for, and a complicating factor of, abandonment.

In many countries the prevalence of illegal marriages and the lack of legal rights for women make women vulnerable to the loss of land and economic resources (Cohen, 2005; Jewkes, 2000). Fawole (2008) terms this type of violence as 'economic violence' and stipulates its intimate link with poverty. Izumi (2007) supports Fawole's assertion that women are vulnerable to GBV in the form of being forced from their property and additionally notes the complicating role of HIV in these instances. In the present study, HIV status interacted with the pre-existing conditions of poverty and a lack of legal empowerment by providing the impetus for the woman's partner to abandon her. Thus HIV status not only causes discrimination but it also interacts with pre-existing societal concerns to exacerbate them into forms of GBV.

The Need for GBV Integration with HIV Programming

As previously mentioned this study supports the pre-identified need for holistic and multi-level interventions that fully incorporates GBV counselling and screening into all levels of HIV programming (Cohen, 2005; Lang, 2007; Andersson, 2008; Jansen, 2007; Fonk, 2005). Bayee (2002) stipulates that the effectiveness of interventions for HIV-positive women is in part dependent on their acknowledgement of GBV in this population. In addition, the incorporation of GBV services into HIV programming will serve to empower women and reduce their potential for further health complications, a sentiment that is supported by

this study (Cohen, 2005; Bayee, 2002). Martin & Curtis (2004) also supports Bayee's (2002) recommendations by suggesting that the integration of GBV programming into HIV programming will help interventions "achieve their full potential and simultaneously address a broader public health and human-rights issue" (p. 1411).

The findings of this study take the need for an integrated approach to GBV and HIV one step further by stipulating the need for an approach that fully acknowledges the potential for GBV among HIV-positive individuals long after the period of initial HIV disclosure and the various ways that GBV transforms specific to an individual's experience of being HIV-positive. HIV and GBV need to be viewed as mutually exacerbating the ill-effects of the other. A programming approach that remains cognisant of this, and actively attempts to mitigate it, could be effective in reducing further negative health outcomes of HIV-positive individuals.

LIMITATIONS

The sensitive nature of the subject matter of this study may have limited our findings. Both GBV and HIV status are stigmatized in this setting. The stigma may have led some participants to down play the role of GBV in their lives. Further complicating the sensitivity of these issues is the fact that focus groups were formed from pre-existing counselling groups and were held in community settings where members were likely to know each other and their respective families. Such intimate familiarity with other participants may have either

encouraged or discouraged more personal contributions from participants. The sensitivity of the subject matter was also a limiting factor as at times participants became too upset to continue and left the interview or group.

One of the primary limitations of this research is the use of translation in focus groups. The process of translation has inherent difficulties as conversation is halted to provide for translation and several times community members would speak over the translator, at which point data was likely not fully communicated. Also problematic was that in a few instances, due to absolute necessity, a male translator was used for a women's focus group. Though permission was always requested for this from the women themselves, it is possible that having a male present may have skewed the participant's responses.

Additionally, as the sample used is unique as it was composed of individuals who are already participating in counselling sessions, and therefore many of the problems experienced by the population at large might not be represented here.

INFORMING FUTURE PUBLIC HEALTH PRACTICE

The results of this study have important implications for public health practice. Currently, much of public health practice in relation to GBV and HIV centers on how to best mitigate the cycle of GBV incidents, (particularly sexual GBV), resulting in HIV infection of victims. However, there remains a limited understanding of how GBV impacts HIV-positive individuals past the period of initial status disclosure. Regardless of how an individual contracted HIV,

incidents of GBV are likely to continue post infection and in many cases may increase due to novel means of inflicting GBV on HIV-positive individuals that were brought forth in our research. Additional research is needed investigating the nature of the relationship between HIV and GBV especially for individuals living with HIV, as was clearly demonstrated in our findings, GBV and HIV do not have a linear one-dimensional relationship, but instead interact with each other in ways that transform the experience of women living with both HIV and GBV. It is also important to extend the research population used for these studies beyond those individuals already in counselling and to incorporate studies on counselling with men.

As was clearly demonstrated in our findings, GBV plays a major and often devastating role in the lives of women openly living with HIV. Therefore, public health practitioners need to remain cognisant of this fact when exploring treatment options for individuals living with HIV. Especially important is that GBV screening and counselling that looks beyond the initial disclosure period be fully incorporated in to HIV treatment programs. Also crucial is that GBV programming remain cognisant of the variety of unique forms that GBV can take for HIV-positive women, and ensure that both GBV programming and screening captures the diversity of GBV forms in this population. While working at the ground level to improve programming efforts for GBV, efforts from the public health community should also be focused on improving the legal property rights of women so that women have rights in situation of abandonment.

CONCLUSION

As demonstrated in our findings the interaction of GBV and HIV is complex and burdened with the implications of poverty. The previously documented relationship of GBV being both a cause and a consequence of HIV is extended in our study as we found that HIV results in a transformation of GBV in novel ways that risk the health and wellbeing of individuals and families. There is a need for further investigations to expand upon this transformation of GBV experienced by HIV-positive women to best inform joint HIV and GBV programming efforts. It must be kept in mind however, that the ways in which this transformation took place were often supported by widespread gender inequities and stigmatizing views of HIV.

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