Experiences Of Intimate Partner Violence (IPV) Among Women Living With HIV/AIDS: A Study Of Women Attending A Care And Treatment Clinic At Singida Regional Hospital, Central Tanzania

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ABSTRACT

Background: Intimate Partner Violence (IPV) is a serious public health problem globally. Tanzania has a high prevalence of all types of IPV, including physical, sexual and emotional violence. Although there is increasing focus on the issue of IPV, HIV status, when related to IPV, is not sufficiently discussed. HIV status is an important predictor of IPV against women, and women tend to suffer more serious psychological, physical and pathological outcomes as a result of IPV. The objective of this study was to explore the experiences and understanding of IPV among women living with HIV/AIDS attending a Care and Treatment Clinic (CTC) at Singida Regional Hospital in central Tanzania.

Design: This was a qualitative study involving in-depth interviews (IDIs) and content analysis, which was used to analyse the findings.

Results: Women who participated in this study expressed their views on their experiences of such as physical, sexual and emotional violence, instigated by their male partners. Jealousy, pregnancy, extra marital relationships and alcohol were found to be the triggers of IPV.

Conclusion: Women living with HIV experienced all three types of violence: physical, sexual and emotional. The causes of IPV were use of alcohol, disclosure of HIV status, pregnancy, jealousy, extra marital relationships and children.

Keywords: Tanzania, IPV, HIV, AIDS, women living with HIV/AIDS

1. INTRODUCTION

Intimate partner violence (IPV) is defined as behaviour within an intimate relationship that causes physical, sexual and psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviour (Das et al., 2013). It is a serious public health problem globally, as well as in Tanzania (Osinde et al., 2011, Shi et al., 2013). According to the WHO multi-country study on violence, Tanzania has a high prevalence of all types of IPV by a husband or male partner, with 41–56% of women affected (Garcia-Moreno et al., 2005; Deribe et al., 2012). According to the findings of the Tanzania Demographic Health Survey (2010), 39% of married women aged 15–49 experienced physical violence, 17% experienced sexual violence, and 36% experienced emotional violence by their current or most recent husband/partner (Tanzania Commission for AIDS (TACAIDS, 2013). Furthermore, the report showed that half of married women in Tanzania reported having experienced some form of physical, sexual, or emotional violence from their husband/partner (Msuya, Adinan, & Mosha, 2014).

A recent study conducted in sub-Saharan Africa showed an association between IPV and diagnosis of human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) (UNAIDS, 2014; Jewkes,
Sikweyiya, Morrell, & Dunkle, 2011). A landmark study in South Africa suggested that 12% of new cases of HIV infection among young women may be attributed directly to IPV. Similarly, a study of women aged 15–49 in Uganda showed that lifetime IPV increased the odds of being HIV positive by 55% (Kouyoumdjian et al., 2013). Furthermore, in the Asia-Pacific region, women living with HIV/AIDS (LWHA) are more likely than men to be targets of verbal abuse and physical violence as a result of their HIV status (UNAIDS, 2013).

High rates of IPV among women LWHA have been exacerbated by the sexual behaviour of their male partners, such as extramarital relationships, alcohol use, forced unprotected sex and corrupted relationships (Silverman, Decker, & Page, 2008). IPV among women LWHA is associated with several risk factors, such as HIV-positive status, low education or socioeconomic status, pregnancy, and being in a cohabiting relationship (Kouyoumdjian et al., 2013; Shi et al., 2013). A study conducted in the United States showed that the majority of outpatient visits by HIV-positive women experiencing IPV are for non-injury-related complaints, with most affected women not directly disclosing their IPV status, highlighting the need for comprehensive measures to identify IPV (Morse et al., 2012). IPV information is not clinically documented in most parts of the world, including Tanzania, due to the fear and shame associated with this type of violence (Morse, Lafleur, & Fogarty, 2012); (Abeya, Afework, & Yalew, 2011).

Although focus has increased on the issue of IPV, its incidence in relation to HIV status has not been sufficiently addressed. HIV-infected women are almost three times as likely as uninfected women to experience IPV (Kahabuka et al., 2012). IPV may hinder affected women from accessing medical therapy, and decrease their compliance with treatment and adherence to medication (Schafer et al., 2012); (Aryal, Regmi, & Mudwari, 2012). In addition, the effects of IPV on these women are more serious in terms of psychological, physical and pathological outcomes (Iliyasu, Abubakar, Babashani, & Galadanci, 2011). In summary, previous quantitative studies (Shi et al., 2013; Decker et al., 2009; UNAIDS 2013; Morse et al., 2012) have established that women infected with HIV are at considerable risk of violence, discrimination, ostracism and abandonment (UNESCO, 2013). As Tanzania has a high prevalence of IPV, there is a need to establish effective IPV intervention programmes to promote equality in relationships. IPV cases have been underreported in a Tanzanian context; this study will explore the current situation and provide information to enable the government, other stakeholders such as non-government organization (NGO) activists, and programme managers to address IPV and establish an appropriate system for reporting it among women LWHA. The aim of this study was to acquire an in-depth understanding of the IPV experiences of women LWHA who attended the CTC in the Singida region in Tanzania.

1.1 SOCIO-ECOLOGICAL MODEL OF IPV FACTORS IN WOMEN LIVING WITH HIV/AIDS

This study employed the socio-ecological theory developed by Heise which provides a comprehensive and clear understanding of the factors that render HIV-positive women vulnerable to IPV in central Tanzania (Heise, 1998). The individual or intrapersonal level, with regard to men, refers to intergenerational exposure
to abuse, lack of education, financial dependence and undertaking extra work outside of families, as well as excessive alcohol and drug use. For women, it refers to lack of education, unemployment and HIV status (Laisser, Nyström, Lugina, & Emmelin, 2011). The relationship level refers to men’s controlling behaviours, making decisions for the family, power, lack of financial support, being socially and psychologically depressed, refusal to use condoms, refusal to take a HIV test, denial of pregnancy and care of children, jealousy, and the blaming of women by male relatives for the deaths of male partners (Antai & Antai, 2008). The community level describes the way in which communities accept the social and economic dependence of women upon their partners by demonstrating the association between socio-economic status of men and women. Men exert power over women, who are expected to be obedient and to go out in public only with male permission (Laisser et al. 2011; Hatcher et al., 2013). The societal level explains how society accepts the norms and culture of violence against women. Tanzanian society is rigid in relation to the gender roles of men and women, whereby masculinity is linked to dominance, men are empowered, women’s ideas are not respected, and women are not allowed to question men in relation to money or material items (Nyamhanga & Frumence, 2014). A study by Krishan et al. showed that women in Ifakara, Tanzania accepted IPV and conformity as a reflection of social norms (Krishnan et al., 2012). In addition, a study conducted in Iringa, Tanzania showed that power and social norms resulted in women remaining in abusive relationships (Nyamhanga & Frumence, 2014).

1.2 DESCRIPTION OF THE STUDY SETTING
The study was conducted at the Care and Treatment Centre (CTC) and Prevention of Mother to Child Transmission (PMTCT) section of the HIV/AIDS clinic under the Reproductive and Child Health (RCH) unit of Singida Regional Hospital. The Singida region was selected as it represents the region with the highest prevalence of IPV in Tanzania; according to the Tanzania HIV/AIDS and Malaria Indicator Survey (2012), HIV prevalence in the Singida region is 3.3% (Tanzania HIV/AIDS and Malaria Indicator Survey 2011–12). Little data exists on the prevalence of IPV in the Singida region. However, according to Kivulini Organization survey conducted in 2009, 85% of women living in the Mwanza, Mara and Singida regions have experienced psychological violence, 56% have experienced physical violence, and 48% have experienced sexual violence (Organisation, 2011). Although a significant decline in overall HIV prevalence has been observed in Tanzania in the period 2008–2012, Singida is one of the eight regions in Tanzania that has witnessed an increase in the prevalence of HIV/AIDS. HIV prevalence among young women is higher than among young men, at 6.6% versus 2.8% (Tanzania Commission for AIDS (TACAIDS) et al., 2013).

1.3 STUDY DESIGN
Data were collected in this qualitative study through in-depth interviews, a flexible, investigative strategy which enabled the researcher to gain a detailed understanding of IPV experiences of women living with HIV/AIDS. The inclusion criteria/eligibility for participation included being a HIV positive woman who
attended the CTC/PMTCT clinic, and who was living with a male partner for six months or more. Individuals were excluded if they were HIV negative; HIV positive men were also not included. All individuals approached agreed to participate in the study. Due to the nature of IPV, the researcher employed a snowballing method to more easily identify eligible participants, who might otherwise be hard to locate. The limitation of using snowball techniques is that study participants may not be representative of the general population, and as the method works by chain referral, individuals are more likely to identify those with similar issues of interest.

Table 1: Characteristics of study participants

<table>
<thead>
<tr>
<th>Category</th>
<th>HIV+ women</th>
<th>Number (N = 35)</th>
<th>Male partners’ characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>20–39</td>
<td>16</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>40–59</td>
<td>18</td>
<td>32</td>
</tr>
<tr>
<td></td>
<td>60–79</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Marital status</td>
<td>Married</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Widowed</td>
<td>16</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Separated</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Cohabiting</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Deceased</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>Level of education</td>
<td>No education</td>
<td>3</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>Primary school</td>
<td>3</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Secondary school</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Source of income</td>
<td>Small business</td>
<td>20</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Farmers</td>
<td>15</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Truck driver</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Business owner</td>
<td>0</td>
<td>15</td>
</tr>
</tbody>
</table>

1.4 SOCIO-DEMOGRAPHIC CHARACTERISTICS OF STUDY PARTICIPANTS

The participants in this study were women from the Nyaturu and Nyiramba tribes who were LWHA and attending the CTC in the Singida region aged from 20–79. The majority of women were married, while others were the widows of men who had died from HIV/AIDS. Most had completed formal primary education, while a few had secondary school education. The majority of participants ran small businesses.

1.5 SELECTION OF STUDY PARTICIPANTS

The snowballing method was initiated by interviewing one woman, who was subsequently requested to identify other HIV positive women who were experiencing IPV from their male partners. The majority of HIV positive women know each other through the use of CTC services, and attend support groups which meet once a month to provide psychosocial support. As the CTC has a large number of patients and a lack of privacy, interviews were conducted in a hotel to ensure that privacy and confidentiality were maintained at all times. Women felt comfortable and had the opportunity to talk to the researcher and express their feelings.
1.6 DATA COLLECTION

In-depth interviews were used to provide detailed information about the views and experiences of women LWHA, as well as a high level view of IPV. The interviews were conducted by the first author (AK) between February and March 2014. A total of 35 interviews were conducted. Interviews were conducted in the Swahili language and transcripts were later translated into English. Each interview lasted between 45 and 60 minutes. Prior to the interview, the interviewer introduced herself to each participant, explained the purpose and importance of the study, and assured participants that all information they provided would be handled carefully and that confidentiality would be maintained throughout the study period and in the publication of results. Permission for note taking and tape recording was requested and granted by the participants.

1.7 DATA MANAGEMENT

The audio-recorded interviews were transcribed by the first author and translated from Swahili into English. A sample of the translated interviews was back-translated into Swahili to ensure that the translation had been performed correctly and accurately reflected the intended meaning. The transcripts and field notes were analysed manually by reading and re-reading to ensure familiarisation with the data. Qualitative content analysis was used to analyse the data, according to Graneheim and Lundman (Cho & Lee, 2014). Content analysis was used in a wide range of analytical approaches to analyse the data, a description of study procedures was documented so that readers of the manuscripts could understand the experiences of IPV for women LWHA. The interview texts were re-read repeatedly in order to identify relevant patterns related to the participants’ experiences and understanding of IPV. Unit codes were then assigned and sorted to form categories. Similarities and differences were considered in order to identify relationships between the codes, and the meanings were interpreted. A combination of data from field notes, participant observations, and the literature were used to clarify the concepts that arose during the content analysis.

1.8 DATA ANALYSIS

Similarities and differences between the ideas and themes that emerged from the data were first identified, and data were organized for ease of viewing to allow the research team to evaluate each topic, extract concepts and themes, and identify salient themes, recurring ideas or language, and patterns. Coding and categorizing of ideas and concepts was used to identify phrases which were used frequently, as well as ideas that emerged from how the interviewees had expressed themselves and from the stories recounted, which were then organized into codes and categories. Furthermore, the reliability of data was ensured by striving for consistency throughout the interviews, transcription, and analysis of the findings.

1.9 TRUSTWORTHINESS OF THE DATA

In this study, trustworthiness was assured by the researcher responsible for the field activity of data collection; she conducted all the in-depth interviews. Triangulation of methods was employed by using in-depth interviews and field notes, pre-defined protocols and two-way translation to ensure the validity of the
findings. By involving the research team in peer-debriefing sessions to reflect upon and discuss procedures and interpretations of the data, conformability and consistency were ensured. The reliability of data was assured by the following: credibility, through use of an empirical study design; transferability, whereby the findings are applicable in other contexts; dependability, meaning that the findings are consistent and can be replicated in other contexts; conformability, in that the findings of the study were shaped by the respondents and not by researcher bias, motivation or interest. Emotions and sympathies on IPV were controlled during data collection, so as to avoid bias.

1.10 ETHICAL CONSIDERATIONS
Ethical approval was obtained from the Muhimbili University of Health and Allied Sciences (MUHAS). Permission to conduct the study in the region was given by the Singida Regional authorities, including the Regional Administrative Secretary, Regional Medical Officer and Singida Regional Hospital managers. All interviewees completed a written informed consent form and sign it to participate in the study. The study conformed with WHO guidelines on the safe and ethical interviewing of women who experienced violence by following the guiding principles, such as not harming the women, knowing the subject, assessing the risks, preparing referral information, not making promises that could not be fulfilled, carefully selecting and preparing interpreters and co-workers, ensuring anonymity and confidentiality, providing informed consent, listening to and respecting each woman's assessment of her situation and risks to her safety, not re-traumatising women, being prepared for emergency intervention, and putting the information collected to good use, such as policy development in Tanzania (World Health Organization, Medicine, & Commission, 2003). The health care workers (HCW) involved in this study were trained in HIV/AIDS, and screening was performed correctly.

2. RESULTS
This section is structured and guided by the theory of the socio-ecological model previously described. The experiences and causes of IPV were described on four levels: individual or intrapersonal, relationship, community, and society, among women LWHA in the Singida region. A total of 35 interviews were conducted and the criteria used for the sample size was purposive sampling. The themes and categories arising from the interviews were as follows: (1) experiences of IPV among women LWHA, with subthemes of physical beatings to the extent of being hospitalized, forced sex by male partners, and experience of insulting words resulting in psychological trauma; (2) perceived causes of IPV among women LWHA with subthemes of alcohol use by male partners, negative reactions following disclosure of HIV status, effects of Nyaturu and Nyiramba culture on male partners, denial of pregnancy by male partners (as it was associated with HIV testing), jealousy associated with improvement of health status following anti-retroviral (ARV)
therapy, extra marital relationships resulting in the abandonment of families, and children as a reason to remain in an abusive relationship.

2.1 EXPERIENCES OF IPV

2.1.1 PHYSICAL BEATINGS TO THE EXTENT OF BEING HOSPITALIZED

In this study, the majority of women LWHA reported having experienced physical violence from their male partners. The violence ranged from mild to severe, up to the level of admission to hospital. They were beaten with hands, belts, sticks, sharp objects, and sometimes they were threatened that they would be killed. Some male partners locked doors on their female partners so that they could not be rescued, or they were beaten to such an extent that they could hardly do anything, including sitting. Some were beaten three times a day and they were told to kill themselves as their male partners did not want to see them. Furthermore, IPV was reported to take place in secret, in these relationships.

He used hands, trouser belt, he beat me especially on the back, and I could not wake up in the morning. I stayed the whole day inside and I did not tell people if I was beaten. I was keeping quiet though others were aware. He kicked me below the bladder and I felt like something was burning. I was admitted to the regional hospital, I was diagnosed and given some injections as well as drugs and I was told to go back home after I had taken all the drugs (Woman, aged 40).

2.1.2 FORCED ANAL SEX BY MALE PARTNERS

The findings also showed that women were forced to have sex, and that some of the male partners forced women to have anal sex without their consent. Women claimed that their male partners enjoyed having anal sex while the female partners felt embarrassed. Once they had anal sex, some women were prohibited from telling anyone by their partners, who threatened to kill them with a knife if they did not comply.

I’ve experienced this type of life for a long time now; he sometimes comes and harasses me so that we can have anal sex. I said, ‘ooh my God, why do you want to have anal sex?’ He replied, ‘are you stupid, don’t you know that anal sex is so good?’. I really felt so bad because I had never practiced anal sex. I used to hear from other people about it. When I refused, he forcibly grabbed me and sodomized me, aah! I continued with that practice, he told me that if I tell anyone or send him for charges, he will kill me. When I refuse, he beats me and closes the door and orders me to keep quiet. ‘I will kill you,’ he shouted, ‘should I take a knife?’ It’s true, he had the knife and I had no option (Woman, aged 40).

2.1.3 EXPERIENCE OF INSULTING WORDS RESULTING IN PSYCHOLOGICAL TRAUMA

In this study, women LWHA experienced emotional violence from their male partners. Men were not supportive of their female partners; they abused them using insulting words and did not respect their opinions. Male partners did not give women permission to go out at all, even if they had something important to do. If they were found elsewhere, they were insulted and beaten. They were insulted in front of their children and they were not respected in front of their parents. When relatives came to assist during illness, the women experienced psychological trauma (including psychological pain) from their male partners, which led to them to being more psychologically traumatized as they perceived that there was no hope or change of peace for
themselves. In addition, they were discriminated against and insulted by their partners and called names such as useless and unwanted, a prostitute, dying person, rubbish and idiots.

I reached a point when I just wished to take poison so that I can die but when I stayed inside I just cried and saw that I can’t do it even not to drop myself into the sea. I even stopped to go to pray, I lost my faith. I saw that I am useless in this world. He becomes so angry and he insulted me several time with words like I am a stupid, useless, rubbish, dead person, prostitute, idiot, he wishes to poison me so that I will die because I am just a dead and valueless person in this world (Woman, aged 34).

2.1.4 PERCEIVED CAUSES OF IPV AMONG WOMEN LWHA

In this study, women were asked about their views on the causes of IPV, and their responses were categorized into a number of sub-themes as presented below:

2.1.4.1 Use of alcohol by male partner

One of the causes of IPV among women LWHA was reported to be the use of alcohol by the male partner. Alcohol was mentioned as a cause of violence, in that partners drink and come home to start quarrelling, using abusive words, beating their partners severely, and demanding and forcing sex when their female partners did not feel like it, because they were tired from work or their HIV symptoms. The men also demanded food, for which they had not provided money to buy. Furthermore, alcohol led them to have extra-marital relationships, which exposed their partners to the risk of acquiring new HIV infections.

When he’s drunk he’s very quarrelsome, there’s a lot of talking and abusive language but I avoid it all by not answering him back. There are times maybe I don’t feel like it. I’m feeling sick, or maybe I just don’t feel well, or I’m tired from domestic work, then he asks for sex, then I tell him today I don’t feel like it but if he’s drunk, he then holds me forcefully and has sex without my permission (Woman, aged 34).

2.1.4.2 Negative responses following disclosure of HIV status

Disclosure of HIV test results to male partners was reported to be a major cause of IPV against women LWHA. Following disclosure of their HIV status, women received negative reactions such as unauthorised disclosure of results to their friends and community, abandonment, refusal of sex, failure to provide basic needs such as school fees for their children, insulting words, stigma and discrimination, poor communication and rudeness. Some women lied about their HIV status, others changed their behaviour and ran away from home, or created unnecessary trips as excuses to stay away from their homes for a long period of time. The women were blamed for bringing HIV and death into the family, due to the fact that it took a long time for HIV-positive women to disclose their HIV results to their partners out of fear of a negative response. Those who had disclosed their HIV results to their male partners were beaten, or partners changed their behaviour to become increasingly harsh and rude.

After I told him, I don’t know if he truly accepted it because sometimes when he remembers, he starts saying that ‘you are the one who killed me’ and I was telling him ‘let’s go and check together’. ‘He tells me ‘oo!! I am not ready today’. So there is a time he becomes furious he says ‘you are the one who killed me’ and so many other things and he beats me frequently (Woman, aged 33).
2.1.5 EFFECTS OF NYATURU AND NYIRAMBA CULTURE ON MALE PARTNERS

As in any other patriarchal society in the Singida region, men are accorded more respect than women, partly because men are the ‘breadwinners’ in the family unit. The culture in this society accepts that men are breadwinners, but raises no objections when men fail to fulfil this role. However, Nyaturu and Nyiramba men from the lower classes (mainly peasants) in Singida who do not earn income by working still expect to be respected as the head of the household. Daily life experience shows that it is mainly women who earn the income needed to sustain their families through cultivation, small scale business, selling local brew, tailoring and vending of clothes. Men, however, remain idle at home, or go to clubs to drink alcohol, and perceive women as the source of labour for the family. Upon returning home to find there is no food, male partners get angry, blaming the women for insufficient earnings. When female partners reply that it is the responsibility of men to earn money for the family, the men get angry and frustrated and become violent. Male partners thus may engage in negative behaviour, such as drinking alcohol and participating in extramarital relationships which may lead to IPV among WLHA.

When my husband comes home and finds no money and food prepared for him he gets angry and frustrated. I am the only person who earns money for our family including daily bread, paying house rent and school fees. Due to my condition, sometimes ARVs make me weak and tired. He thinks I am irresponsible for not being able to find money to prepare food for him and the family. Consequently, he gets angry and frustrated over me, he kicks out the available food (ugali and vegetable) which I have prepared for him and from there he starts violence (Woman, aged 47).

2.1.6 MALE PARTNERS’ DENIAL OF PREGNANCY DUE TO ASSOCIATIONS WITH HIV TESTING

Pregnancy was also mentioned as one of the main causes of IPV against women LWHA. It was reported that, soon after discovering that they were pregnant and informing their male partners, men became furious and protested against being responsible for the pregnancy. This anger typically resulted from reluctance to comply with the policy requirement that all pregnant women and male partners should attend a PMTCT clinic for HIV testing.

He abandoned me after I got pregnant, when I wasn’t pregnant he use to respect me, because we were to get married later on. Then after I became pregnant, he started to beat me, he changed his behaviour and became like a leopard. He was inflicting harm on me because he didn’t want to attend PMTCT clinic where HCW will ask him for HIV test, there was no communication, no understanding between us as we used to be (Woman, aged 39).

2.1.7 JEALOUSY ASSOCIATED WITH IMPROVED HEALTH STATUS

Jealousy was also mentioned in this study as a cause of IPV against women LWHA. Women who adhered to ARV regimes experienced health improvements and an associated improvement in appearance. Consequently, their partners did not wish them to associate with other men, as they had a perception that the women would have an affair.

Because of the same reason of jealousy, he accused me that the child is not his because he suspected I had an affair with other men, particularly now I am good and attractive since I have started ARV (Woman, aged 33).
2.1.8 EXTRA-MARITAL RELATIONSHIPS RESULTED IN ABANDONMENT OF FAMILIES
Women LWHA interviewed in this study said that the majority of male partners engaged in extra-marital relationships. Most women reported experiencing tiredness as a result of ARV therapy, and so refused sex and other social activities. Male partners considered them to be no longer attractive, and sought new girlfriends that were beautiful and more attractive than their female partners. The men cared for their new girlfriends more than their own families, including their children. When their female partners asked why they were late getting home, they become violent. This was well described by one participant, who said that

Sometimes he sleeps away from home and when I ask him about it, we get into a fight. (Woman, aged 34).

Another participant added

There he had another woman who came after I was chased away, he brought that woman and had one child with her (Woman aged 29).

2.1.9 CHILDREN AS A REASON TO REMAIN IN ABUSIVE RELATIONSHIPS
In this study, women LWHA suffered violence as a result of defending children from being abused by their fathers. Women claimed that their children cared for and comforted them; therefore, they were prepared to die for the sake of their children. When men saw that women were protecting their children, they directed the violence toward their female partners. Despite being abused as a female partner and protective mother, these women did not want to leave abusive relationships as they believed that the men would not be able to take care of their children properly. One participant described this:

He never took the children by force because I told him whatever you will do to me like stabbing with a knife I’m ready to die but I won’t leave my children.’ I told him, ‘I will die with my children’ (Woman aged 39).

3. DISCUSSION
According to the socio-ecological model developed by Heise (Heise, 1998), the experience of IPV among women LWHA fits well at all four levels. At the individual level, women lacked education, were financially dependent, and they undertook extra work outside their family. In our study, alcohol use, extra-marital relationships, pregnancy, and jealousy were associated with violent behaviour by men, leading to physical, sexual and emotional violence against women.

Our findings corroborate with an IPV study conducted on HIV infection among married Indian women (Kouyoumdjian et al., 2013). In our study, male partners were less educated, financially dependent, and performed extra work outside their families, such as working as truck drivers and business owners. These factors have been associated with physical violence, as reported by another study conducted in rural Kenya on social context and drivers of IPV (Hatcher et al., 2013). Alcohol among male partners was reported to be associated with all three types of IPV in this study (Heise, 1998). Such findings are similar to a study conducted in rural Uganda, where women whose partners used alcohol were five times more likely to
experience IPV than women with non-drinking partners (Koenig et al., 2003). Male partners were more likely to engage in high risk behaviours such as extra-marital relationships and antisocial activities, which led them to IPV against their female partners (Ntagira et al., 2008; Msuya et al., 2006). However, HIV-positive women were also associated with factors which contributed to violence, such as low socioeconomic status, unemployment and HIV-positive status (Msuya et al., 2006).

Women were not allowed to question their male partners; this was a cause of IPV. This observation provides evidence that, when a man’s sense of masculinity is threatened, he might react through violence (Osinde et al., 2011; Heise, 1998; Krishan et al., 2012). In this study, at the relationship or interpersonal level, the majority of HIV-positive women had a poor relationship with their male partners following disclosure of their HIV status; before the disclosure of their HIV results, they had a good relationship. Soon after the disclosure of HIV results, they experienced all three types of IPV, physical, sexual and emotional. When they refused sex, their male partners beat them and forced sex on them, and some were forced to have anal sex against their wishes. Male partners controlled the family’s economic resources, made decisions for the family, and exhibited controlling behaviours. Men used their power, and women LWHA were subordinates, which in turn contributed to IPV. A similar finding has been reported by Karamagi et al. in their study of IPV against women in eastern Uganda (Karamagi, Tumwine, Tylleskar, & Heggenhougen, 2006).

In this study, disclosure of HIV results by women LWHA was associated with negative outcomes, such as stigma and discrimination, abandonment, refusal of sex, refusal to provide for basic needs (such as food or school fees for children), and lack of social support. These findings are similar to those of a study conducted by Batte et al. in Uganda (Batte et al., 2015) and are in agreement with a study by Yona et al. in Mwanza, Tanzania (Yonah, Fredrick, & Leyna, 2014).

According to Jewkes et al., women with good relationships and good communication with their partners discuss condom use in their relationship. However, women with bad relationships and poor communication are less likely to discuss condom use as (R. K. Jewkes, Levin, & Penn-Kekana, 2003). In our study, factors triggering IPV were extra-marital relationships, refusal to use condoms, refusal to take a HIV test, denial of pregnancy, children, and jealousy. HIV-positive women experienced severe violence which made them want to end their relationships with their abusive male partners. This has also been reported in other studies (Msuya et al., 2006).

The community level describes the way in which communities accept the social and economic dependence of women upon their partners, by demonstrating the association between the socioeconomic status of men and women with controlling behaviours. Women are expected to be obedient and are not allowed to go out without partner’s permission, and men have authority over women—even when they do not provide economic or social support (Laisser et al., 2011); (Nyamhanga & Frumence, 2014). In this study, women were
extremely poor, had low socioeconomic status, were unemployed, and some were isolated from their families by the controlling behaviour of male partners. These findings are supported by a study conducted in Iringa, Tanzania which found that, due to the pattern of socialization among women, they did not have access to social or economic support such as higher education and employment. As a result, they ended up with low socioeconomic status which made them unable to leave their abusive relationships (Nyamhanga & Frumence, 2014).

Our study is also in agreement with the outcomes of a study conducted in Nepal where wives were blamed for the HIV-positive status and deaths of their husbands (Aryal et al., 2012). In our study, HIV-positive women were prepared to tolerate violence if they had young children, and also out of fear of community and church leaders. This is supported by other studies by Laisser et al. in Tanzania (Laisser et al., 2011) and in Ntaganira et al. in Rwanda (Ntaganira et al., 2008).

At the societal level, society accepts the norms and culture of violence against women and is relatively rigid in relation to the gender roles of women and men. Men are more empowered than women, based on notions of masculinity that link to dominance (Heise, 1998) (Nyamhanga & Frumence, 2014). In this study, men were empowered by society even if they were not earning money, and women’s ideas were not respected. Women were not supposed to ask men for anything, otherwise IPV may result. Similarly, the Nyaturu and Nyiramba cultures played a significant role in promoting IPV against women LWHA. The culture and norms of Nyaturu and Nyiramba society do not empower women. The issue of IPV is more related to family and community rather than to policy issues, and as a result, women suffer and cannot be helped by any means. This culture jeopardizes the rights of the majority of women in society; their voices cannot be heard because they are not respected. Financial dependence, family ties and consideration for their children place additional pressure on women to remain in violent relationships (Aryal et al., 2012). This situation is likely to affect the level of reporting, assertiveness and readiness following a violation of human rights.

4. CONCLUSION

The study explored the experiences of IPV among women LWHA attending a CTC at the Singida Regional Hospital, Central Tanzania. The study findings provide clear and important evidence of the three types of IPV, namely physical, sexual and emotional violence, experienced by women LWHA in central Tanzania.

5. STRENGTHS AND LIMITATIONS OF THE STUDY

Among the strengths of the study was the methodological part, where the researchers involved themselves in the field work and where participants were willing to discuss their experiences of IPV. We also noted the limitation of the study whereby only HIV positive women were interviewed; inclusion of HIV negative
women would permit the sharing of experiences of IPV among the two groups. Furthermore, the researcher did not interview male partners to hear their experiences of IPV from female partners.

It must also be noted that the study was qualitative, so findings cannot be generalized.

The results of this study have important implications for public health and health policy in Tanzania. The process of addressing IPV has just started in Tanzania, but its full implementation still has a long way to go. A need for health intervention exists, to address IPV among women LWHA in Tanzania.

6. RECOMMENDATIONS

We recommend community advocacy awareness of IPV among husbands/partners, and the development of robust policies to deal with male perpetrators against women LWHA in Tanzania. National HIV/AIDS programs should also integrate the implementation of IPV policies. Therefore, a quantitative study is needed to investigate a larger group of participants and examine other variables that might be associated with IPV. Since the sample size was small, interviews were conducted only at a CTC and PMTCT regional hospital rather than throughout the entire region.

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AUTHORS’ CONTRIBUTIONS

AK was involved in the design of the study, data collection, transcription, analysis and drafting of the manuscript. AS was involved in the design of the study, data collection, analysis and drafting of the manuscript. DK was involved in the design of the study, data collection, transcription, analysis and drafting of the manuscript. GF participated in the designing of the study, transcription, analysis and drafting of the manuscript. TN was involved in the study design, transcription, analysis and drafting of the manuscript. All authors have read and approved the final manuscript.

CONFLICTS OF INTEREST AND FUNDING

The authors declare that they have no competing interests.
7. REFERENCES


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