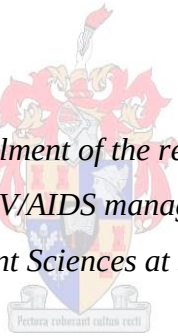
THE ROLE OF GENDER BASED VIOLENCE IN HIV TRANSMISION AMONG WOMEN IN LUSAKA - ZAMBIA

by

Bridget Ennet Chatora



Assignment submitted in fulfilment of the requirements for the degree of Master *of philosophy (HIV/AIDS management) in the Faculty of Economic and Management Sciences at Stellenbosch University*

Supervisor: Dr Thozamile Qubuda

Co-Supervisor: Dr Hikabasa Halwindi

March 2013

Declaration

By submitting this assignment electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the owner of the copyright thereof (unless to the extent explicitly otherwise stated) and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

Date: March 2013

Abstract

Introduction: Gender based violence has been associated with risky sexual behaviours such as low condom use multiple and concurrent sexual partnering with low levels of HIV self-risk perception.

Study Design: The study was a survey conducted at the Young Women Christian Association in Lusaka. Data was collected from 50 study participants aged between 18 and 49 who were self-reporting Gender Based Violence by a regular intimate partner or husband through interviewer administered questionnaires by simple random sampling.

Individual knowledge was collected on HIV/AIDS, Gender based violence, sexual practices, attitudes towards condoms use and HIV/AIDS and personal experience with gender based violence as well as Marriages and Cohabiting relations.

Findings: The study found high levels of awareness and knowledge on Gender Based violence (98%) and HIV transmission (76- 98%) respectively. The study found that 90% of females interviewed thought Gender based violence in Zambia was a serious problem with 92 % saying men who beat their wives were breaking the law. Frequency of GBV experienced by an intimate partner in the last 12 months found10% indicated having beaten 1 time , 16% beaten 2 times, 6% being beaten 3 times and 68% being beaten more than 4 times in the past. The study further found that only 40% of participants had knowledge of the **Anti-Gender Based Violence Act No. 1 of 2011.**

Conclusions: The study concluded that there were high knowledge levels of HIV and high awareness of gender based violence among the females in the study. Gender Based Violence increases vulnerability of women to risk HIV infection by reducing ability to negotiate safe sex. Condom utilisations among women who experienced intimate partner violence were low while multiple sexual partnerships were prevalent. Self-risk perception to HIV infection of women in intimate partner relationships increased when association to GBV was made.

Opsomming

Impleading: Geslagsgebaseerde geweld is wat verband hou met riskante seksuele gedrag soos lae kondoom gebruik veelvuldige en gelyktydige seksuele vennootskap met lae vlakke van MIV-self-risiko persepsie**.**

Studie-ontwerp:
Die studie was 'n opname by die Jong Vroue Christelike Vereniging in Lusaka. Data is ingesamel van 50 studie-deelnemers tussen die ouderdomme van 18 en 49 wat self-rapportering geslagsgebaseerde geweld deur 'n gereelde intieme vennoot of man deur onderhoudvoerder vraelyste deur eenvoudige ewekansige steekproefneming. Individuele kennis versamel oor MIV / VIGS, geslagsgebaseerde geweld, seksuele praktyke, houdings teenoor kondome gebruik en MIV / VIGS en persoonlike ervaring met gender-gebaseerde geweld sowel as Huwelike en WOON verhoudings**.**

Bevindinge:
Die studie het gevind dat hoë vlakke van bewustheid en kennis oor geslagsgebaseerde geweld (98%) en MIV-oordrag (76 - 98%) onderskeidelik. Die studie het bevind dat 90% van die vroue ondervra gedink Geslag gebaseerde geweld in Zambië was 'n ernstige probleem met die 92% sê mans wat hul vroue slaan die wet breek. Frekwensie van GBV ervaar deur 'n intieme vennoot in die laaste 12 maande found10% aangedui geklits 1 keer, 16% geklop 2 keer, 6% geslaan 3 keer en 68% meer as 4 keer geslaan in die verlede. Die studie het verder bevind dat slegs 40% van die deelnemers het kennis van die Anti-geslagsgebaseerde geweld Wet No 1 van 2011.

Gevolgtrekkings:
Die studie het tot die gevolgtrekking gekom dat daar hoë vlak van kennis van MIV en hoë bewustheid van geslagsgebaseerde geweld onder die vroue in die studie. Kondoom aanwendings onder vroue wat intieme maat geweld ervaar laag was terwyl verskeie seksuele vennootskappe teenwoordig was. Self-risiko persepsie tot MIV-infeksie van vroue in intieme verhoudings met vennote verhoog wanneer assosiasie te GBV gemaak.

Acknowledgments

Cecilia Chitambala, Senior Management information systems technical officer Lusaka Zambia

The Executive Director, all the staff and counselors, at Young Women Christian Association of Zambia Lusaka office.

Ms. Royter Choongo YWCA, Lusaka

Dr Qubuda Supervisor, (Stellenbosch University), Cape Town South Africa

Dr Halwindi Med local supervisor, University of Zambia -Med school, Lusaka Zambia

Dr Andrew Kumwenda, senior advisor CT/PMTCT, ZPCTII Lusaka Zambia

Mr. Mushota Kabaso, Senior Advisor Strategic information, ZPCTII Lusaka Zambia

MS. Josephine Musamba, Gender Specialist, BA Social Sciences, ZPCTII Lusaka Zambia

All the women from the YWCA Lusaka Zambia who were willing to take part in the study.

Acronyms

AIDS	Acquired Immune deficiency Syndrome
CT	Counselling and testing
GBV	Gender Based Violence.
HIV	Human Immunodeficiency Virus
KAP	Knowledge Attitude and Practice Survey
NGO	Non-Governmental Organizations
PEP	Post Exposure Prophylaxis
PMTCT	Prevention of Mother to Child Transmission
YWCA	Young Women's Christian Association
ZCCP	Zambia Centre for Communications Programs
ZPCTII	Zambia prevention care and treatment partnership project.

TABLE OF CONTENTS

CHAPTER 1 - ORIENTATION TO THE STUDY

1.1 Introduction

The first documented case of AIDS (Acquired Immune Deficiency Syndrome) in Zambia was reported in 1984. At the time very little was known about the disease and the stigma attached to it made it very difficult to obtain clear information about the mode of transmission and prevention strategies. Over the years knowledge about the disease and how the virus that causes AIDS – (the human Immune Deficiency Virus) can be transmitted and prevented have also evolved. The virus itself has also evolved with time presenting different epidemiological patterns based on sexual practices in different regions of the world.

Sub-Sahara African region suffers the worst HIV /AIDS diseases burden in the world. The region accounted for 67% of HIV infection in the world in 2008 (UNAIDS, 2009) with women accounting for more than 60 % of the infection compared to men. The feminization of this pandemic warrants a closer look at some of the factors that cause increased risk of HIV infection among women.

According to the USAID program evaluation report on "A Safer Zambia (ASAZA) Program" (2010: page 1) "Gender Based Violence (GBV) is not an isolated problem or a side component of Zambian life. Rather, it is a widespread, tragic, and daily issue that touches and impacts almost everyone's life in some way". This suggests that intimate partner violence is common yet under-reported in many countries including Zambia. The report further goes to define gender based violence to "include spousal abuse/wife battery; sexual violence against women and children; property grabbing; psychological abuse; family and child neglect; sexual cleansing, early marriage; and harmful traditional practices".

The Young Women Christian Association, YWCA, is a non-governmental faith based organization that was established in 1957 in Zambia. YWCA has 27 Branches in 8 provinces with 8 Regional offices in Chipata, Kabwe, Kasama, Kitwe, Livingstone, Lusaka, Mongu and Solwezi.

The organization is dedicated to the empowerment of women and children and supports individuals in their efforts to make positive changes in their lives. In the capital city of Zambia Lusaka the organization provides drop in and child crisis centres were temporary shelter for vulnerable or battered women and children in physical or sexual abusive relationships under the women and humans rights program. Victims of GBV are provided with non-judgmental counselling services legal advice, education on Gender Based Violence and referrals with continued support networks for continued care and monitoring. YWCA works to coordinate direct services of key partners dealing with sexual gender based violence in Zambia. The YWCA works with the Zambia police victim support unit, the child justice support forum and the Women in law in southern Africa in providing a coordinated response to gender based violence in Zambia.

According to the Zambia police services (cited in The Anti- gender based Act N0.1 of 2011) the country recorded the following defilement, assault, incest and rape cases against women.

Type of GBV as reported by Zambia police	**2008**	**2009**	**2010**	**2011**
Defilement	1237	1676	2439	1359
Indecent assault	141	188	173	114
Incest	32	30	259	28
Rape	229	244	259	211

Source Zambia police (cited by The Anti- gender based Act N0.1 of 2011)

With the Enactment of the gender policy and Anti gender based violence Act of 2011 the YWCA has reported an increase in the number of GBV cases country wide with 3, 882 cases between January and June 2012 (Times of Zambia 2012). The YWCA Lusaka reported that in June 2011 the association received 12 cases of GBV compared to 16 cases being reported in July.

1.2 Rational of the study

The feminization of the HIV pandemic in sub-Sahara Africa indicates that certain practices tend to place women in a vulnerable position for HIV transmission. Violent abuse of women by their intimate partners reduces women's ability to negotiate safe sex (American foundation for AIDS research, 2005), increases unsafe sex practices in the relationship and increases vulnerability to HIV infection. The study will investigate the role of gender based violence against women in HIV transmission. Intimate partner violent abuse of women has been associated with increased risk of HIV infection (Heisel, L, Ells and M. Gottemoeller, 1999) due to the vulnerability that women experience in abusive relationships and fear associated with violence that prevents women from seeking voluntary counselling and testing services for HIV.

The study was conducted at the Young Women Christian association in Lusaka and aimed to target heterosexually active females self-reporting Gender based violence by an intimate partner.

1.3 Research question

The research study question for this study was "What role does gender based violence play in the risk of HIV transmission among heterosexual sexually active females between 18 to 49 years who self-report intimate partner violence at the Young Women Christian Association in Lusaka –Zambia?"

1.4 Study objectives

The study objectives were threefold:

1. To establish the relationship between Genders based violence against women and risky sexual practices in such relationships.
2. To determine the level of self-risk perception of HIV infection in women in gender based violent relations.

3. To make recommendations to policy makers based on the findings on streamlining gender based violence in HIV/AIDS programs.

This dissertation is divided into 5 chapters:

1. **Chapter 1:** Introduces background information into the topic, the purpose, rationale and significance of the study
2. **Chapter 2:** Reviews available literature pertaining to the topic and highlights the knowledge gap and the relevance of this study.
3. **Chapter 3:** Describes the study design in which this study adopted a qualitative paradigm and also presents the procedures for data collection, the ethical issues and data analysis.
4. **Chapter 4:** Discusses the qualitative study findings and the sample description.
5. **Chapter 5:** Analyses, summarizes and presents conclusions and recommendations and implications for possible research, policy and practice reviews.

1.5 Summary

This chapter gave a background on the research and defined the research question. It further outlines the rational research and objectives of conducting the research.

CHAPTER 2- LITERATURE REVIEWS

2.1 Introduction

This section of the report reviews literature on Gender Based Violence, condom use HIV marriage cohabiting relationships and looked at social cultural personal factors that contributes to HIV transmission among heterosexually active females experiencing Gender based violence from an intimate sexual partner.

2.2 Gender based violence and HIV

The United Nations first defined violence against women as gender based in 1993 by acknowledging the context of women's and girls' subordinate status to men and boys in society (UN General assembly, 1993). Gupta defines gender as "the widely shared expectations and norms within a society about appropriate male and female behaviour, characteristics and roles. It is a social and cultural construct that differentiates women from men and defines the ways in which men and women interact with each other" (Gupta, 2000) and Gender based violence/Intimate partner violence as "Any act of intimate physical violence and sexual violence by an intimate partner". And WHO further outlines Sexual violence: Any sexual act , attempt to obtain sexual acts, unwanted sexual comments or advances or otherwise directed against a person's sexuality using coercion by any person regardless of their relationship to victim (WHO, 2002). UNAIDS (2007) defines risk of HIV infection as the probability or likelihood that a person maybe become infected with HIV. The risk is created, increased, and perpetuated by certain behaviours.

While many argue that both men and women experience violence patterns, risks factors and consequences are more with women compared with men (Heisel L, Ells and Gottemoeller M, 1999), states that cultural beliefs, norms and social institutions legitimize and therefore perpetuate violence against women. A multisite study conducted by WHO in 2006 showed that violence against women not only beings early in a girl's life but was prevalent up to as

much as 70%. Forced or coerced sex especially in young women may cause abrasions within their mucosal lining which may facilitate entry of not only HIV but also sexually transmitted infections. A South African study done among female adolescents showed that the majority reported their sexual debuit not only as having been forced but also repeated and unconsented (Global Business Coalition, 2007). A woman's physiological make up compared to that of a man also makes her more likely to acquire HIV during sexual intercourse compared to a man. Another study done in kwa-Zulu Natal depicted graphically how violence by an intimate partner can prevent women from protecting themselves from HIV (Varga, 1997). In this study a female suffered head injuries by her long-time boyfriend (not the first time) which landed her in hospital.

The Zambian heath demographic survey (2007) indicated that "14% of Zambian adults age 15-49 are HIV positive. Among women, the HIV rate is 16% compared to 12% among men". These figures show a clear feminisation of the HIV/AIDS epidemic in Zambia similar to in other sub-Saharan African countries. A number of studies have shown that there is a strong relationship between genders based violence and HIV. A study done in Tanzania showed that HIV positive women who experienced GBV were more compared to those that where HIV negative and of the same age group (UNAIDS, 2007). The relationship between gender based violence and HIV needs to be investigated because gender based violence may increase the risk of HIV infection of women as it renders women in such situations vulnerable to further sexual abuse as well (WHO, 2000).

2.3 Condom use, gender based violence and HIV

Condoms are available in two forms as the male and female condoms with the dual purpose of preventing unplanned pregnancy as a contraceptive method and also as an effective method of preventing HIV and sexually transmitted infections. With no doubt the most commonly used condom is the male. Condoms have been known to be effective at preventing HIV infection by between 70 to 90 % when used consistently as evidenced by a number of research studies (Crosby RA, DiClemente RF, Holtgrave DR, Wingood GM, 2002). Unprotected sexual intercourse with a partner whose HIV status is unknown is a risk

factor for HIV infection. Not only does the use of condoms protect from the HIV virus but it also prevents infection with other sexually transmitted infections that may cause mucosal lining ulceration of the sexual organs thereby also increase the risk of HIV transmission, (CDC, 2008).

The experience of violence affects the risk of HIV and other sexually transmitted infection (STIs) directly when it interferes with the women's ability to negotiate condom use (WHO, 2000).This is confirmed by a study done in south Africa which found that 44% of women with a history of sexual violence were more likely to fear asking their partner to use a condom (Kalichman and Simbayi cited in Haddock S, Hardee K, Gay, J Pawlak J M and Stellini C, 2008) and that women find it difficult to suggest condom when threatened by violence . Fear of violence not only hinders women's ability to propose condom use but may also keep them from voluntary HIV/AIDS counselling. A study done in South Africa demonstrated that women who suffered violent abuse by intimate partner had greater risk of HIV infection (Jewkes R .K, Dunkle ,K, Nduna M and Shai N, 2010).In addition gender based violence against women may increase their inability to negotiate safe sex practices due to fear of economic deprivation and abandonment (ZHDS, 2007).The report further says that in Zambia only "11% of women said they thought a woman could ask her husband to use a condom in circumstances of unfaithfulness or multiple partnering .These low figures strongly suggest that consistent condom use is usually under the control and willingness of the male partner. Individual perception that condoms reduce sexual pleasure may also force women to abandon the idea to suggest condom use to their partner. Most women are taught to believe that a man needs to be sexually happy and therefore women would rather risk having unprotected sex in order to keep their partner sexually satisfied. This is evidenced by a study carried out in Nigeria where truck drivers expressed that condoms hinder their sexual satisfaction and therefore hindered their sexual interest (Sunmola AM, 2005). It is such perceptions that reduce women negotiating power in condom use.

Another barrier to condom use may be related to the cost of buying condoms. Even though in Zambia condoms are usually made available by various Non-governmental organisations

such a society for family health and others free condoms may not always be available at the time they are needed. Coupled with factors such as economic deprivation some women may be forced to forego buying a condom to protect themselves because of the cost and also due to pressure from the intimate partner to have sex without a condom. Unprotected sex in exchange for food drink of money will usually be more profitable for a woman that is been suffering economic and financial derivation from an intimate partner. The pressure to meet her economic needs as well as look after her children only exacerbates the situation.

Another common reason for lack of condom use among married women and people in long standing relationships is that condoms are usually associated with immorality and casual relationships. (Stewart, 2000) This coupled with religious beliefs may also predispose women in cohabiting relationships to low utilization of condoms. Indeed some women would feel that their morality was questioned should a husband or intimate partner suggest condom use. (Fernandez Esquer ME Atkinson J and Diamond P, 2005) when first citing many author please write the all there after you can use et al .At times women also find it difficult to talk about condoms with their regular partner in spite of having the knowledge about HIV as this is viewed a man's prerogative to make the decision . According to a study done by Sarkar (2008) which looked at factors affecting condom use, the study found that both women and men avoided discussing condoms or HIV for fear of being perceived as promiscuous by their partner, the study also as evidence that domestic violence acts as a barrier to condom use during sexual intercourse as "many women at high risk of HIV infection face resistance and violence as a response to their request to use a condom". The study further outlines other factors that influenced women not to use condoms due to the need to feel close to their sexual partner by having unprotected sexual intercourse.

2.4 Marriage relationships and cohabiting

Relationship type's influence condom use and gender based violence and ultimately HIV transmission. According to Dube M and Sachingongu N, 2008, in the Zambia Centre for

Communications Programs report 2008, "Concurrent Sexual partnerships have been defined as Sexual partnerships that happen at the same time or overlap in time; thus where two or more sexual partnerships continue over the same period of time or where one sexual partnership begins before the other comes to an end. These partnerships are also referred to as multiple concurrent partnerships or MCP".

Dube et al, (2008) further defines multiple concurrent sexual partnerships as having more sexual partners over a period of time- the multiple partners may be concurrent but may also be sequential and monogamous. Heterosexual (male to female and female to male) transmission of HIV among cohabiting couples has been shown to be the main driver of HIV transmission in sub-Saharan Africa and evidence to shows that discordant HIV status among these couples is common .Studies done in Rwanda Zambia and other sub-Saharan African countries shows that 45 % of couples are discordant with one partner being HIV negative while the other is HIV positive (UNAIDS, 2008). However Seroconversion of the negative partner usually occurs when couples do not want to use condoms for reasons of wanting children, fear to suggest condoms as a sign of trust and low uptake of HIV couple counselling and testing services among cohabiting couples. A study done in Kenya showed that 97% of cohabiting or married couples did not use a condom in their last sexual encounter (Kenya Demographic Health Survey, 2003) Another risk factor that has been associated with increased HIV infection is in cohabiting relationships is multiple sexual partnerships involving unprotected sex (Harperin, D and H.Eppstain , 2004.).

UNAIDS (2007) indicates that "Vulnerability results from a range of factors outside the control of the individual that reduce the ability of individuals and communities to avoid HIV risk", (UNAIDS, 2007a).

Multiple and sometimes concurrent sexual partnering is very common in most sub-Saharan African countries and even though this has been associated more with men some studies have shown that women may be forced to engaged in these activates for various reasons including economic needs especially when there is deliberate economic deprivation - therefore creating vulnerability - by their regular intimate partner. Having said that studies

have shown that very few females in cohabiting relations report having 5 or more sexual partners in a year compared to males (Caral, M cited in The Lancet, 2004) The practice of having more than one sexual partner at a time either as serial monogamous relations or concurrent multiple partnerships coupled with inconsistency of condom use has been indicated as a risk factor for HIV transmission. In Africa men and women often have at least one or two concurrent partnerships that can overlap for a period of time. Studies show that very few women reported more than 5 or more sexual partners in a year (Carael M, 1995 cited in lancet, 2004). Culturally women in marriage or cohabiting relations are culturally disadvantaged to negotiate safe sex even when they are aware that their partner is unfaithful or has other multiple partners. The Zambia health demographic survey (2007) reported that only "25% of Zambian women believed that women could refuse to have sex with her husband even if he had been demonstrably unfaithful and was infected with HIV" and only a mere "11% said they thought a woman could ask her husband to use a condom in these circumstances". It is culturally acceptable for men to have more than one sexual partner and women are expected to respect this especially if the man is able to provide for his family. In some traditions men are expected to have polygamous relationships- a wife and one or several mistresses as this is perceived as a mark of a successful man. Polygamy has been associated with increased risk of HIV infection as evidenced by a study done in Kenya for the health demographics survey which found that cohabiting monogamous marriages had HIV infection rates of 7 % compared to polygamous relationships which had as high as 11% HIV infection rates (KDHS, 2003).

In most of sub-Saharan Africa, where HIV is most prevalent, marital rape is not recognized as a crime and an interesting example of this is seen in Kenya , where in spite of high rates of ever reported GBV(43%) by married women (KDHS, 2003) parliamentarians went as far as removing a clause criminalising marital rape before the passage of the Sexual offensive Act 2006 (Population Action international, 2009).

2.5 Knowledge attitudes opinions on gender based violence

UNAIDS outlines vulnerability factors to include: (1) lack of knowledge and skills required to protecting one's self and others; this may include lack condoms and skills to negotiate safe sex by using condoms, lack of correct knowledge on the transmission of HIV infection and lack of knowledge on legislation on GBV. (2) Factors pertaining to the quality and coverage of services. These include inaccessibility of health facility services and police service due to distance, cost or other factors. Where heath facilities and legislative facilities are accessible do service providers have the required skills to integrate GBV services and post exposure prophylaxis treatment and is GBV integrated into HIV /AIDS services within health facilities and local police victim support unit (3) Societal factors such as human rights violations especially where there is no guiding legal framework and lack of advocacy for women's rights.in some cases even when the laws are there the process of seeking justice may be too long as a result lives are lost as a result of GBV (Times of Zambia, 2012) Negative impacting social and cultural norms and practices such as wife cleansing and wife inheritance , beliefs and laws that stigmatize and disembowel certain populations such as widows, limiting their ability to access or use HIV prevention, treatment, care, and support services and commodities.

Local organisations that respond to gender based violence need to understand not only the law that protects women against GBV but also be able to facilitate for services in response to care for GBV victims to reduce HIV transmission.

These factors, alone or in combination, may create or exacerbate individual and collective vulnerability to HIV" (UNAIDS, 2007a).Gender based violence and HIV/AIDS are inextricably linked. The South African human rights watch (2004) reports that "Many women and girls do not report rape or sexual coercion by intimate partner; because they believe that a husband or boyfriend has a right to demand sex, and that they have low expectations of their right to control the terms of their sexual interaction"

Fear of violence not only hinders women's ability to propose condom use but may also keep them from voluntary HIV/AIDs counselling. A study done in South Africa demonstrated that women who suffered violent abuse by intimate partner had greater risk of HIV infection (Jewkes R .K, Dunkle, K, Nduna M and Shai N, 2010). This is also shown by findings in the Zambia health national surveys and agrees that gender based violence against women may increase their inability to negotiate safe practices sex due to fear of economic deprivation and abandonment (ZHDS, 2007). A tradition and cultural practice of remaining silent on marital and sexual violence in intimate relations among women is an accepted norm in most Zambian marriages. This is usually coupled with a culture of acceptance of multiple partnering among men which further increases the risk of HIV infection for women. According to the Zambia Demographic and Health Survey (ZDHS, 2007) "one in five (20%) of Zambian women have experienced sexual violence in their lifetime and 64% is perpetrated by a current/former husband/partner or boyfriend". Gender based violence /intimate partner violence usually depicts the power struggles within an intimate relationship. GBV usually goes unreported especially in marriages and cohabiting relationships in Zambia. The legal framework upon which GBV can be reported has only recently been enacted in Zambia. The Anti-Gender Based Violence Act No1 of 2011 was enacted in 2011 after numerous calls by advocates against GBV including non-governmental organisation. The act not only defines GBV but also provides legislation for both offenders and victims of GBV. It also provides for legal steps that should be taken by law enforcers and NGO when addressing GBV of a sexual nature.

2.6 Knowledge opinions and attitude on HIV/AIDS

Heterosexual transmission of the HIV virus is the major mode of transmission of the infection among sexually active adults in sub-Saharan African countries (Mbuleiteye, 2000). Physiologically, women are at greater risk of HIV infection compared to men however, there are cultural and traditional practices that also predispose women more to the virus compared to their male counterparts. Factors that have been associated with increased vulnerability of women to HIV infection include poverty or poor economic status, lack of

education, harmful cultural and traditional practices of wife cleansing, polygamy, wife inheritance, coerced sex, child (early) marriage and intimate partner violence.

Education levels of a woman will usually affect understanding and knowledge on how HIV transmission occurs and how one can prevent the spread of HIV especially in heterosexual cohabiting couples. Lack of education may also prevent individuals from accepting that HIV exists and may also foster misconceptions that a cure for HIV does exist. Lack of understand may prevent adoption of simple life saving measures such as condom use or seeking HIV voluntary counselling and testing. Education and lack of knowledge on HIV may also contribute to low Self efficacy as the woman may be unable to discuss safe sex practices with an intimate partner. Prevention of mother to child transmissions can also be affected by a mother's lack of knowledge on how HIV transmission occurs during pregnancy and this may in turn prevent her from accessing the help she needs. Increased casual sexual relationships may also result from low self-efficacy and not realising one's own risk to HIV infection as a result of casual sexual relationships and even gender based violence. Misconceptions and myths on HIV and condom use may also increase a woman's vulnerability to HIV. Education level of many women also determines their social economic capabilities and there when this is low women in cohabiting relationships are usually forced to be dependent on their partners. Women usually are found to be economically less empowered than man due to the fact that most informal sector employments opportunities may not pay as much hence perpetuate a woman economic and financial dependency on a man.

2.7 Summary

The chapter reviewed literature from other studies conducted on the association of gender based violence to increased HIV risk in violent relationships. Knowledge attitudes practices regarding Gender based violence HIV, condom use in cohabiting relationships were examined.

CHAPTER 3 - RESEARCH METHODOLOGY:

3.1 Introduction

This chapter describes the research methods used in conducting the study. It describes with the research study design and the limitations of the study. Followed by the ethical considerations undertaken during the study and sampling procedure as well the data collection and analysis process.

3.2 Study design

The study was a non-experimental quantitative Knowledge, Attitude Behaviour and Practice (KABP) survey. The survey was conducted using interviewer administered questionnaires. Study participants were woman aged 18 to 49 who were victims of gender based violence in heterosexual relations and the age group most affected by HIV/AIDS. Closed ended questions were used in the questionnaire and questions on related topics included social demographic characteristic of the participants; individual knowledge on HIV/AIDS; personal attitudes towards HIV/AIDS and gender based violence and beliefs about HIV/AIDS, sexual practices and gender based violence

3.2.1 Data collection tool

The data collection tool used was designed as a questionnaire (Appendix 1) with questions adapted from UNAIDS general population survey and World health Organization, 2002, report on Violence and health while some questions were also adopted from the USAID/Zambia Gender-Based Violence programming evaluation report for 2010 on USAID - A Safer Zambia (ASAZA) Program: other questions were also adopted from Kumwenda 2004 Mphil report while some were developed by the researcher.

3.2.2 Validity and reliability

To ensure that the desired responses were obtained during data collection the developed questionnaire was initially piloted on 5 individuals in the local community and corrections made. The results of the pilot questionnaire were not included in the final analysis.
In addition a gender expert was also used to help in the development and review the final questionnaire.

3.3 Ethical considerations

Participants willing to take part in the study were referred to the researcher by the YWCA counselling staff. Each participant was fully informed about the survey and that participation in the study was completely voluntary. The importance of the study together with how important their honest answers were to the study results was emphasised. Since the study also included sensitive, personal and intimate questions on participant's intimate relationships and personal habits, participants were assured that every piece of information they volunteered to give would be treated with strict confidentially and were therefore encouraged to respond to all questions they could answer truthfully. Participants were also informed that it would not be possible to publicly identify an individual who chose to take part in the study or to even associate them with their responses after their study. The interviewer administered questionnaire only proceeded after obtaining consent from each participant.

Ethical clearance and approval was obtained from the Stellenbosch university ethic committee South Africa Cape Town. Further clearance was obtained in Zambia from Ethics research science CONVERGE IRB (ERES) Lusaka. In addition a letter of permission to carry out the study was obtained from the Young Women Christian Association YWCA of Lusaka.

3.4 Sampling procedure

The study used simple random sampling. With an average of 80 clients reporting gender based violence at the YWCA centre over a period of 3 months, the study targeted an initial sample size of 45 study participants that would give a good statistical representation of data: At a confidence level of 95%, with a population of 80 and where p= 0.5, a confidence interval p+=0.59819, p-= 0.40181 at a standard error of 0.0501. Assuming an average response rate of 97% among urban women (ZDHS 2007, page 12), to cater for a refusal rate of 3% due to non-participation or drop out after selection ,3% of the initial sample size was added to give a final samples size of 47 (46.35). However during the process of administering questionnaires there were a few more females willing to be interviewed for the study giving a final total of 50 participants were interviewed in total.

3.5 Data collection

Data was collected over a period of 4 months after having obtained ethical clearance first from the Stellenbosch University ethics committee in South Africa and from ERES Converge, a private ethics committee in Zambia. A letter of permission to carry out study was also obtained from the YWCA Lusaka. Data was collected on social demographic characteristic of the participants; individual knowledge on HIV/AIDS; personal attitudes towards HIV/AIDS and gender based violence and beliefs about HIV/AIDS, sexual practices and personal experience with gender based violence. The data collection was done using interviewer administered questioners with interviews lasting 15 to 25 minutes per participant. The interviews were done on a one to one basis in private counselling rooms at the YWCA in Lusaka. The questions to measure Knowledge on HIV were adopted from UNAIDS general population survey. To measure gender based violence, vulnerability to HIV and risk perception, questions were obtained from World health Organization, 2002. World report on Violence and health, USAID/Zambia Gender-Based Violence programming evaluation, 2010: USAID - A Safer Zambia (ASAZA) Program: and Zambia health and demographic survey report, 2007.

3.5.1 Operational definitions:

For the purposes of the study the following Operational definitions were used:

Gender: "the widely shared expectations and norms within a society about appropriate male and female behaviour, characteristics and roles. It is a social and cultural construct that differentiates women from men and defines the ways in which men and women interact with each other" (Gupta, 2000).

Gender based violence/Intimate partner violence: Any act of intimate physical violence and sexual violence by an intimate partner.

Sexual violence: Any sexual act, attempt to obtain sexual acts, unwanted sexual comments or advances or otherwise directed against a person's sexuality using coercion by any person regardless of their relationship to victim (WHO, 2002).

3.6 Statistical analysis

The total number of questionnaires administered was 50 and the data collected was entered direct in the Statistical Packages for Social Sciences SPSS for data analysis. Descriptive statistics and frequency tables were used for the variables used in the study. Multiple linear recreations were used to predict vulnerability to HIV infection as the dependant variable from other variables such as education and income levels.

3.7 Limitations

The study limitations study had some noteworthy limitations as follows:

1. Response Bias: some questions on sexuality and personal experience with gender based violence may not have been answered truthfully by some respondents due to cultural and personal perceptions on these issues. Some Respondent's may have held back to give a true picture on their sexuality and experiences with GBV. The study did not also explore further on multiple and concurrent sexual partnerships among the participants and their partner.

The study did not explore in depth societal and individual factors such as life time experience with GBV and how these influencing gender based violence.
Future studies focusing on these aspects are suggested by the researcher.

2. Population study: the study limited participants to those that were reporting GBV to the YWCA Lusaka and did not look at the female population of Lusaka in general. This limited the sample size and also affected duration for data collection. Hence the study findings could not be generalised to the general population. This also posed a response bias on some questions such as the knowledge on where to obtain support for GBV.

CHAPTER 4 - RESEARCH FINDINGS

4.1 Introduction

The research findings are outlined in this chapter including social economic and demographics characterises of participants, marriages and cohabiting relations, personal experience knowledge and attitudes on gender based violence as well as knowledge practices attitudes on condoms and HIV/AIDS.

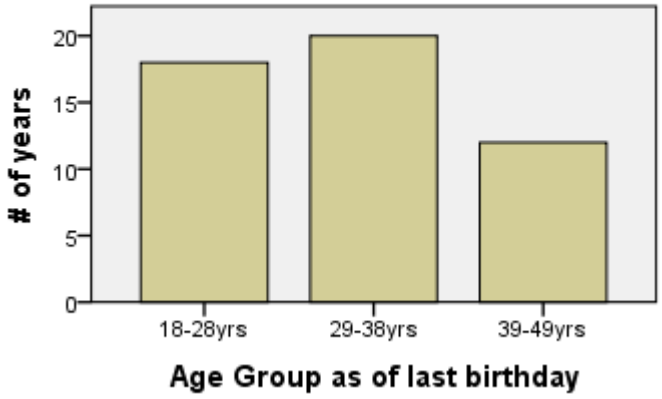
4.2 Sample size and distribution

The total number of questionnaires administered was 50 and all participants interviewed were sexually active females aged between 18 to 49 years old. Participants age range groups were as follows , between 18 and 28 years old were 18(36%), between 29 and 38 years were 20(40%) and lastly between 39 – 49 years 12(24%). The minimum age of participant interviewed was 18 years while the maximum was 48 years with a mean age of 32.58 years and median age of 34 years.

Table 1 : Sample size by age range

Age group	Frequency	Percent	Valid Percent	Cumulative Percent
18-28yrs	18	36.0	36.0	36.0
29-38yrs	20	40.0	40.0	76.0
39-49yrs	12	24.0	24.0	100.0
Total	50	100.0	100.0	

FIGURE 1: AGE GROUP DISTRIBUTION



4.3. Educational level

The study found that out of 50 participants interviewed 2 (4%) had no education at all while 13 (26%) had up to primary level education, and 23 (46%) had secondary level education. Only 12 participants (24 %) interviewed had higher than secondary school education.

Table 2: Participants educational level and school attendance

Education level Attained	Frequency	Percent	Valid Percent	Cumulative Percent
Primary	13	26.0	26.0	26.0
Secondary	23	46.0	46.0	72.0
Higher	12	24.0	24.0	96.0
No Education at all	2	4.0	4.0	100.0
Total	50	100.0	100.0	

4. 4 Economic dependency and employment

Of the 50 participants, 22 (44%) were working to earn a living and 28(56 %) were not working. When asked on sources of income in the last 12 months, 1 (2%) participant indicated being unemployed with no clear source of income. 10 (20%) indicated being self-employed whereas 20, (40 %) indicated they were employed. 12 (24%) participants indicated being dependent on partner/husband for their source of income. The remaining 7 (14%) were dependent on other sources of income.

Table 3: Participants employment and source of income in last 12 months

Source of income	Frequency	Percent	Valid Percent	Cumulative Percent
Unemployed	1	2.0	2.0	2.0
Self employed	10	20.0	20.0	22.0
Employed	20	40.0	40.0	62.0
Dependent on partner	12	24.0	24.0	86.0
Dependent on other	7	14.0	14.0	100.0
Total	50	100.0	100.0	

4.5 Marriage relationships and cohabiting

Of the 50 female participants interviewed26 (52 %) were currently married while 4 (8%) were living with a man as if married. The remaining 20 (40%) indicated they were not in a union. Of those not in a union 6 (12%) were currently divorced while 13 participants were currently on separation from their partners/husbands. The remaining 1 (2%) of those not in a union was widowed. When those who indicated that they were not currently in a union

were asked if they were previously married 14 (70%) of the 20 said they were formally married while the remaining 6 (30%) indicated they formally lived with a man as if married.

Table 4: Participants currently married or living with a man

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes currently married	26	52.0	52.0	52.0
Yes currently living with a man	4	8.0	8.0	60.0
Not in union	20	40.0	40.0	100.0
Total	50	100.0	100.0	

Participants were also asked if they were currently living together with their intimate partner/husband. Of the 50 participants, 19 (38 %) indicated they were currently living together with their partners/husbands while 30 (60%) indicated their partners/husbands were living else were. The remaining 1 (2%) were widowed and could not respond to that question.

Participants were asked if they had an intimate boyfriend in the last 12 months. Of the 50 females interviewed 20 (40%) indicated having had an intimate boyfriend in the last 12 months and the remaining 30 (60%) said they did not have an intimate boyfriend.

Participants were also asked if their husband/intimate partner had other intimate partners in the last 12 months. Out of the 50 females interviewed 41(82%) indicated knowing that their current intimate partner or husband had other intimate partners, while 3 (6%) indicated their intimate partner or husband had no other intimate partner, while the rest of the participants 6 (12%) did not know if their intimate partner or husband had other intimate partners**.** Participants were asked on the number of children they had. Of the 50 females interviewed 49(98 %) indicated they had children and only 1 participant Indicated that they did not have any children. The number of children per participant interviewed ranged from

0 to 7. The mean number of children per female interviewed was 3 (2.78) with minimum number of children per female at 1 and the maximum at 7 children.

4.6 Knowledge opinions and attitudes on gender based violence

Participants were asked on whether they had heard of Gender based Violence before. Of the 50 participants 49 (98%) participants interviewed indicated having heard of Gender based violence with only 1 (2%) indicating not having heard of GBV. Regarding gender based violence participants were asked if they thought that GBV between a man and a woman was a private affair. 19 out of 50 (38%) indicated that GBV was a private affair between a man and a woman while the rest of the participants interviewed, 31 (62%) indicated that violence between a man and a woman was not a private affair.

Table 5: Participants perception if GBV is a private affair between man and woman

IS GBV A PRIVATE AFFAIR	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	19	38.0	38.0	38.0
No	31	62.0	62.0	100.0
Total	50	100.0	100.0	

Participants were asked if they thought Gender based violence in Zambia was a serious problem. 45 (90%) of participants indicated that GBV was a serious problem in Zambia while 5(10%) thought it was not a serious problem.

Table 6 : Is GBV a serious problem in ZAMBIA

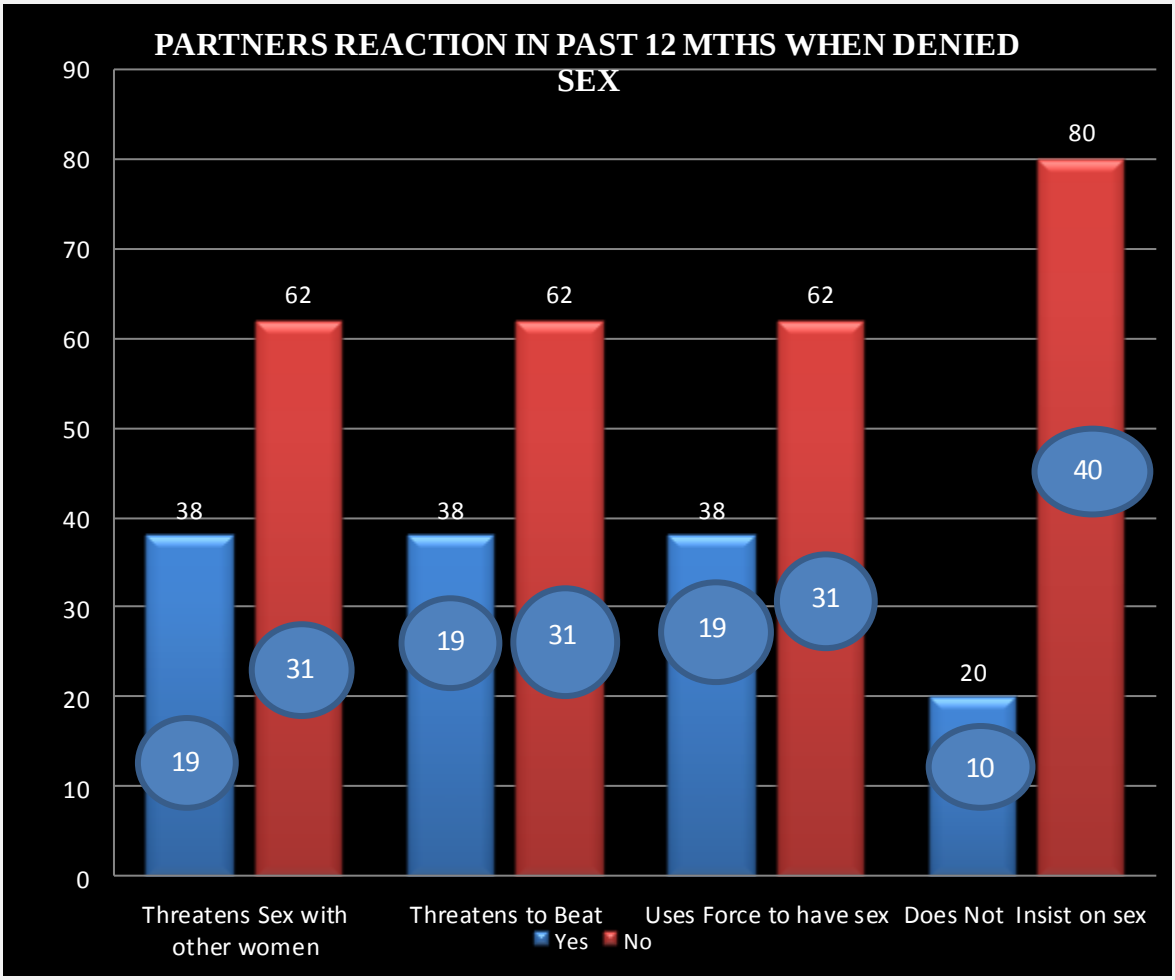
Is GBV a serious problem in Zambia	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	45	90.0	90.0	90.0
No	5	10.0	10.0	100.0
Total	50	100.0	100.0	

When asked if they thought that a man who beats his wife or girlfriend was breaking the law, 46 (92 %) thought a man who hits his wife was breaking the law, while 4 (8%) thought he was not breaking the law.

Participants were also asked on their personal experience with Gender based violence. Of the 50 participants 44 (88%) females indicated that their intimate partners or husbands had deliberately deprived them of economic or financial resources in the last 12 months while only 6 said they were not deliberately deprived.

When asked about how the partner reacts when denied sex 19 (38 %) indicated their partner would threaten to go and have sex with other women while 31 (62%) said he would not. When asked if their partner would beat them for denying them sex, 19 (38%) indicated their partner threaten to beat them while 31(62) indicated he would not beat them .When asked if their partner would use force to have sex when denied, 19 (38%) indicated their partner uses force to have sex while the rest 31(62) indicated he would not use forces. 40 (80%) indicating their partner would insist on sex when denied. However only 9 (18 %) indicated their partner would not insist to have sex when denied.

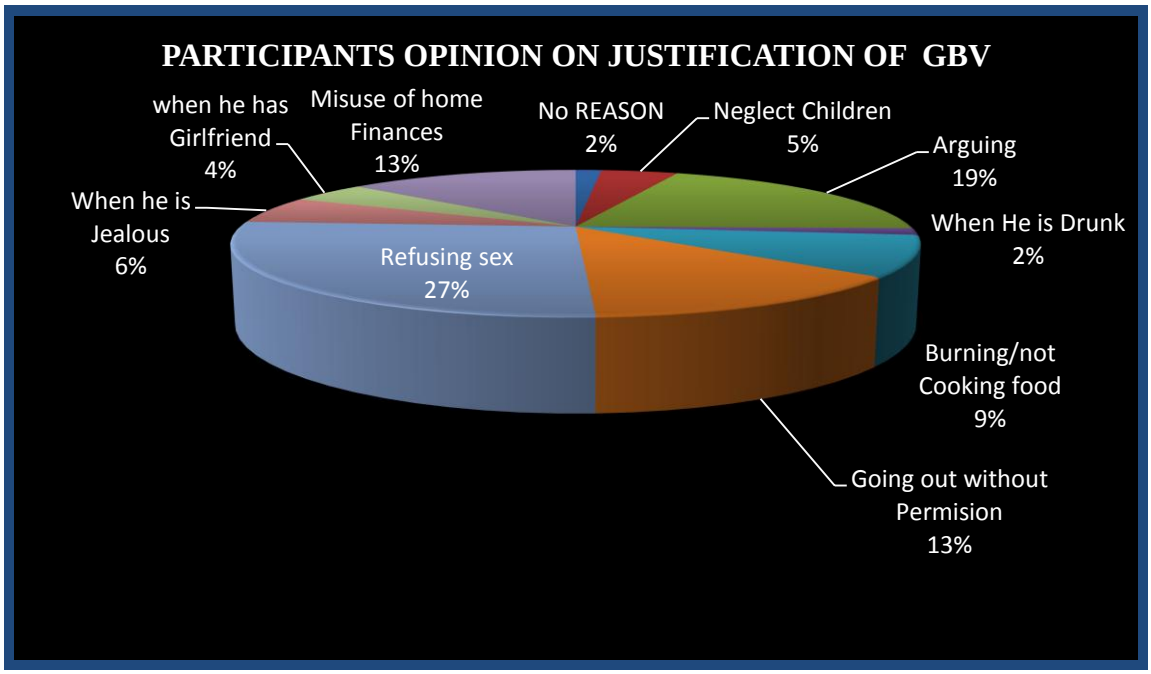
FIGURE 2:



Participants were asked on their opinion regarding justification of Gender based violence by a man. When asked if they thought a man who beats his wife for no reason at all was justified only 1 (2%) of the participants felt he was justified while the rest 49 (98%) said he was not justified. When asked if they thought a man who beats his wife for neglecting the children was justified, 3 (6%) agreed that he was justified while, while the rest 47(94%) disagreed. When asked if they thought a man who beats his wife when he is drunken 1 (2 %) agreed while the rest 49 (98%) disagreed. When asked if they thought a man who beats his wife for arguing with him is justified 13 (26 %) agreed that he is justified while the remaining 37 (74%). When asked if they thought a man who beats his wife for burning/not cooking food in the home, 6 (12 %) felt a man was justified while 44 (88%) felt he was not

justified. When asked if they thought a man who beats his wife for refusing to have sex, 18 (36%) felt a man was justified while 32 (62%) said he was not justified. When asked if they thought a man who beats his wife for going out without permission, 9 (18%) agreed that a man is justified while 41(82%) did not agree. When asked if they thought a man who beats his wife when he is jealous, 4 (8 %) felt he is justified while 46 (92%) felt he is not justified. When asked if they thought a man who beats his wife when he has a girlfriend, 3(6%) of the participants interviewed felt he was justified while 47(94%) felt he was not justified. Lastly when asked if they thought a man who beats his wife for misusing home finances, 9(18%) of participants felt he was justified while 41 (82%) said he was not.

FIGURE 3:



4.7 Experience with gender based violence

Participants were also asked on their personal experience with Gender based violence. Regarding verbal abuse 49 (98%) of the females interviewed indicated that their partner had said things that made them feel insulted, less human or humiliated in the past 12 months while only 1 (2%) indicated not having experience verbal abuse from their partner.

Participants were asked on their personal experience with physical violence by their intimate partner in the last 12 months. All 50 (100%) participants interviewed indicated having been physically beaten by their intimate partner in the past 12 month.

Participants were also asked on how often they had experienced GBV by their intimate partner/husbands in the last 12 months. Of these 5 (10%) indicated having beaten 1 time in the past year, 8 (16%) indicated having been beaten 2 times, 3 (6%) having been beaten 3 times while 34 (68%) indicated having been beaten more than 4 times in the past year.

Table 6: Participants experience with partner GBV in the last 12 months.

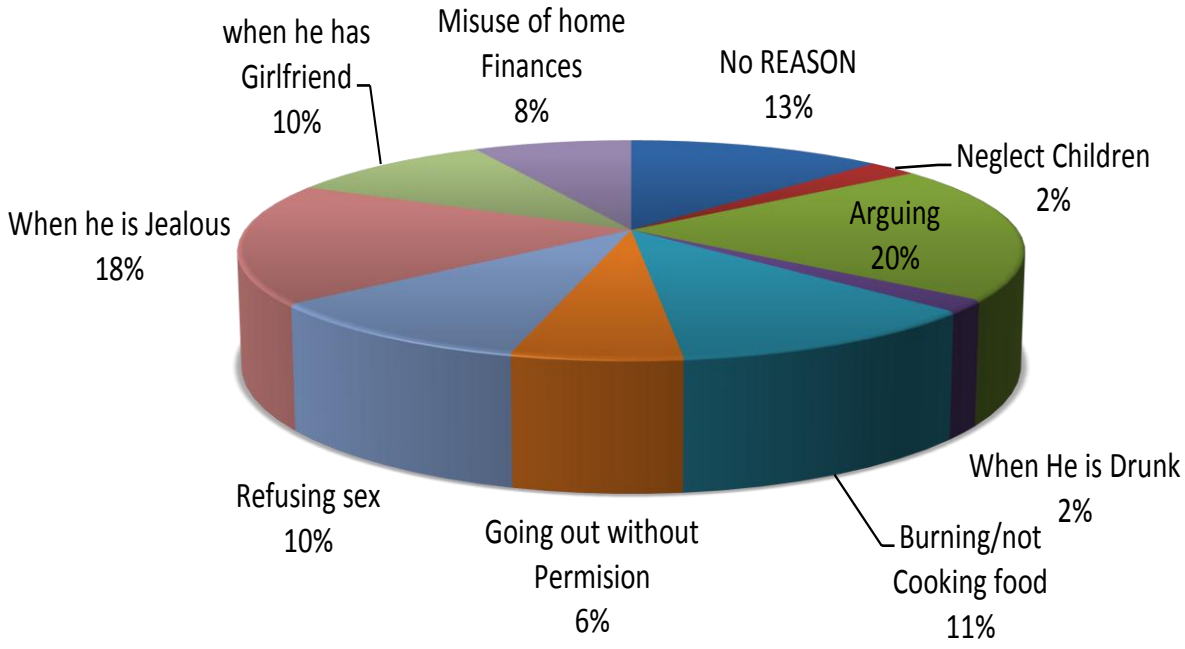
Number of beatings in 12 months	Frequency	Percent	Valid Percent	Cumulative Percent
1 time	5	10.0	10.0	10.0
2 times	8	16.0	16.0	26.0
3 times	3	6.0	6.0	32.0
more than 4 times	34	68.0	68.0	100.0
Total	50	100.0	100.0	

Participants were asked to give reason why their intimate partner/husband had beaten them in the last 12 months.

The majority of females interviewed 34 (68%) indicated the major reason for having been beaten by their partner/husband in the last 12 months was for arguing with him. The second most common reasons indicated by 30(60%) of participants was when their partner or husband is jealous. Followed by being beaten for no reason at all which was cited by 21(42%) of the participants. Being beaten for burning food or not cooking food was cited

by 19 (38%) of the participants. Being beaten for refusing to have sex and when the partner has a girlfriend was indicated equally by 17 (34%) of participants. This was followed by 10 (20%) of participants citing reason as going out without permission. Neglecting children was cited by 4 (8%) and lastly being beaten when their partner or husband is drunk was cited by 3 (6%) of participants.

Figure 3: Reasons for gender based violence in last 12 months



Participants were also asked if they have ever felt forced to have sex with their intimate partner or husband for fear of violence. Of the 50 females interviewed 35 (70 %) said they felt that they had felt forced to have sex with their partner in the past for fear of violence. The remaining 15(30%) said they have never felt forced to have sex for fear of violence.

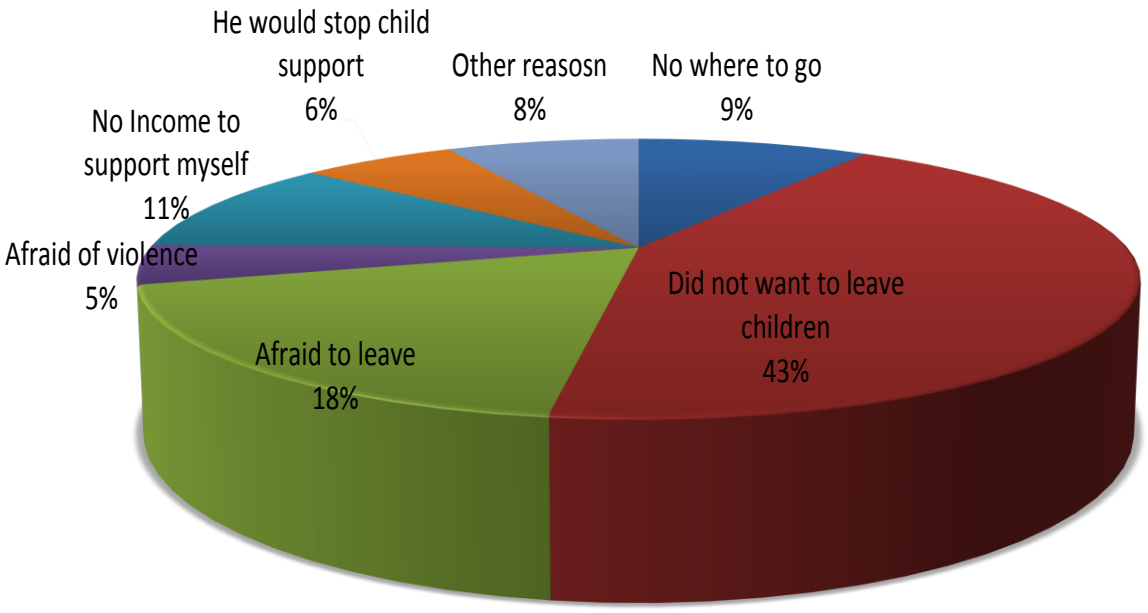
Participants were also to indicate if they ever felt loved after experiencing gender based violence by an intimate partner. Of the 50, 38 (76 %) indicated they did not feel loved after

experiencing partner violence while 12 (24%) indicated they felt loved after GBV by an intimate partner.

Participants were asked if they ever felt like leaving their partner because of the violence abuse. The majority of participants 39 (78%) indicated they felt like leaving their partner because of the violence while 11 (22%) said they did not feel like leaving.

Participants were also asked to give reasons why they have stayed with their intimate partner or husbands in spite of the abuse.6 participants (12%) of the 50 said they stayed because they had nowhere to go. Another 27 (54%) said they not leave their partner because they did not want to leave their children. Out of 50 participants 3 (6 %) indicated they were afraid to leave because of the violence, then 7 (14%) participants cited that they had no income to support themselves, another 4 (8%) indicated they were afraid to leave because their partner would stop child support. 5 (10%) indicated they had other reasons for staying with their partner or husband in spite of the violence.

Figure 4: **Participants reasons for staying in spite ofGBV**



4.8 Understanding source of support for survivors of GBV.

Participants were also asked questions to access knowledge and understanding of their source of support on gender based violence. When asked what kind of help they would get from a health facility when faced with gender based violence, out of the 50 females interviewed 18(36%) correctly indicated they would get Post exposure prophylaxis treatment (PEP) from a health facility when assaulted in GBV. The other 30(60%) females had no knowledge of PEP from a health facility after experiencing Gender Based Violence. However 2 (4%) associated a loan facilities with health centres after experiencing GBV. Participants were further asked where they would go to seek help when faced with GBV 41 (82%) said they would get help from Local police Victim support unit while 23 (46%) indicated they would seek help from the Young Women Christian Association (YWCA). None of the 50 females interviewed associated seeking help from any other local NGO.

The findings of the study agree with the 2007 Human rights watch report which reported that a number of HIV positive females on antiretroviral treatment did not know where to go for support of GBV even at health centres where they were accessing their treatment in Zambia. The report further bemoans lack of integration of GBV in to VCT and PMTCT services provided at health intuitions. It further also indicated that in spite of the willingness by health care workers to provide GBV services they lacked the skills to do so. Zambia has recently enacted the anti-gender based violence act no 1 of 2011 as a fight towards GBV. With this law in place and the many multispectral partners working on HIVAIDS what seems to be the challenge is the pace at which sensitisation and education main streaming is taking.

Participants were further asked if they knew the law that protected women against gender based violence Of the 50 females interviewed only 20 (40%) had knowledge of the Anti-Gender Based Violence Act No. 1 of 2011. The remaining 60% had no knowledge at all on this act. Participants were also asked if they knew the time frame within which to report Gender based violence 46 (96%) responded correctly that GBV should be reported within

72 hours while 1 (2%) participant indicated reporting within one week and the remaining 3(6%) participants did not know.

Table 7 : Participants knowledge on anti GBV act

	Frequency	Percent	Valid Percent	Cumulative Percent
Anti GBV ACT No1 2011	20	40.0	40.0	40.0
The fifth National development plan	1	2.0	2.0	42.0
Do not know	29	58.0	58.0	100.0
Total	50	100.0	100.0	

TABLE8: PARTICIPANTS KNOLWAGE ON TIME FRAME FOR REPORTING GBV

	Frequency	Percent	Valid Percent	Cumulative Percent
72 hours	46	92.0	92.0	92.0
one week	1	2.0	2.0	94.0
Do not know	3	6.0	6.0	100.0
Total	50	100.0	100.0	

4.9 Knowledge opinions and attitudes on HIV /AIDS

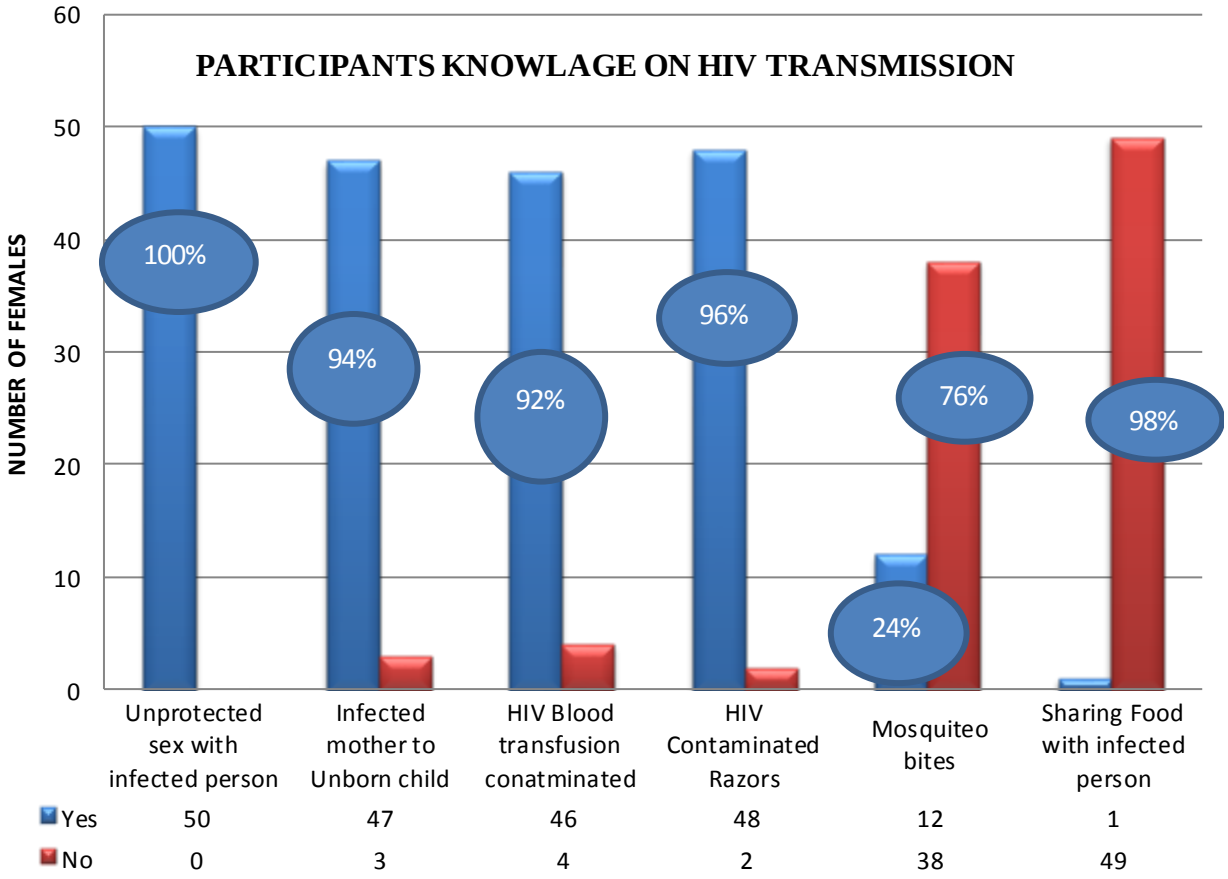
Participants were asked questions to assess their knowledge, opinions, attitudes and practices regarding HIV and AIDS as well as their knowledge and attitudes and practices condoms, condom use and their sexual practices. When asked if they had heard of HIV/AIDS, of the 50 participants, 49 (98%) indicated they had heard of HIV/AIDS and believed that it exists. Only 1 (2) indicated they had not heard of HIV/AIDS and did not believe it existed.

Participants were asked on the differently modes of HIV transmission and all the 50 (100%) participants correctly indicated that HIV can be transmitted through unprotected sex with and infected individual. On HIV transmission that occurs between mother to child, 47 (94%) participants correctly identified that an HIV positive mother could pass the virus to her unborn child and during breast feeding while 3 (6%) participants did not. When asked if HIV transmission can occur following a blood transfusion with HIV contaminated blood 46(92 %) of the females interviewed correctly mention that HIV can be transmitted with contaminated blood transfusion while 4 (8%) of the participants were incorrect.

Participants were asked if HIV transmission can occur by using an HIV contaminated razors of the 50 participants 46 (92%) correctly indicated that yes a person can get infected by HIV by using an HIV contaminated razors , while the remaining 4 (8%) participants interview incorrectly said no. Participants were further asked if they thought HIV transmission could occur through a mosquito bite only 38 (76%) correctly indicated that HIV transmission through a mosquito was not possible while the remaining 12 (24%) incorrectly indicated that HIV can be transmitted through a mosquito bite .When asked if HIV transmission can occur by sharing food or drink with and HIV positive person ,49 (98%) participants indicated correctly that sharing food or drink with an HIV positive person does not transmitted the HIV virus while only 1 (2%) incorrectly indicated that a person can get HIV infection by sharing food/drink with an infected person.

Participants were further asked if they thought there was a cure for HIV/AIDS Of all the participants only 6 (12%) incorrectly said they believed that there is a cure for HIV/AIDS. Without disclosing their HIV test results participants were asked if they have ever taken an HIV test results in the past and Of the of the 50 participants interviewed 47 (94 %) females indicated having had an HIV test in the past while only 3 (6%) indicated not having had an HIV test in the past.

Figure 5:



Participants were also asked questions related to their personal sexual practices. Participants were asked if they have ever had sexual intercourse in the past. For the purpose of the study sexual intercourse was defined as vaginal, anal or oral sex. All 50 (100%) participants interviewed confirmed that they had had sexual intercourse in the past. The mean age of sexual debut was 17 (17.12) while the minimum age of sexual debut was at 14 years and the maximum was at 21 years of age.

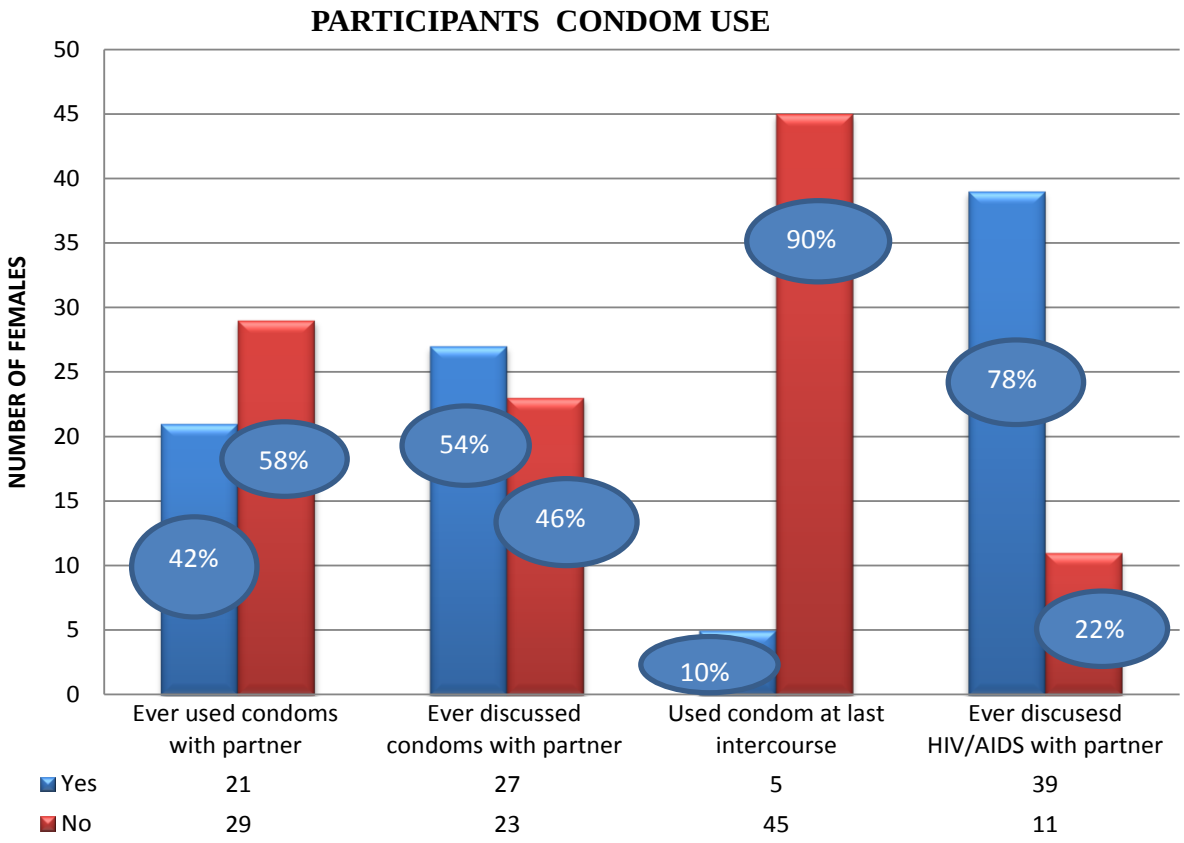
Participants were asked if they had ever felt forced to have sex with a man other than their regular intimate partner in exchange for food or drink. 20 (40%) of the females interviewed indicated they have felt forced in the past to have sex with another man in exchange for food or drink while the remaining 30 (60%) said this has never happened . Participants where further asked if in the past 12 months, their intimate partner or husband had deliberately deprived them of economic or financial resources and 43(86%) of all participants indicated their partner had deliberately deprived them of economy/financial resources in the past 12 months while the remaining 7 (14%) said they had not.

Condom use

To determine safe sexual practices and condom use Participants were asked questions on condoms and condom use in their personal sexual relations. Participants were asked if they had used a condom on their last sexual encounter. Of the 50 participants interviewed only 5 (10%) indicated having used a condom in their last sexual encounter while 45 (90%) indicated they did not use a condom in their last sexual encounter. Of those that used a condom participants were asked why they had used a condom and 2 (40%) cited wanting to prevent pregnancy as reason for using condoms, while 2 (40%) indicated that they used a condom because they did not trust their partner. The remaining 1 (20%) said they used a condom because their partner insisted on this.

Participants that had indicated not having used a condom in their last sexual encounter were further asked why they did not use a condom. Of the 45 (90%) that did not use a condom on their last sexual encounter 8(17.78 %) said that they trusted their partner , while 15 (33.3 %) said they were afraid to suggest condom use to partner , 12 (26.67%) said they preferred skin to skin during sexual contact while9 (20%) said that they did not want their partner to think that they are HIV positive and the remaining 1 (2.23%) said they did not want their partner to think that they have other partners by requesting to use a condom.

Figure 6: Condom use



Participants were asked further if they had ever wanted to use condoms but felt afraid to suggest condom use to partner and 37 (74%) out of the 50 participants indicated that yes they have wanted to use a condom but were afraid while the rest 13 (26%) said no. Of those that indicated having wanted to use a condom but felt afraid to suggest so to their partner or husband the majority of them cited fear to cause argument or a fight with their partner or husband. A few remaining indicated they feared being divorced.

Sexual behaviour

Participants were asked questions on the number of sexual partners they have had in the past 12 months. Of the 50 females interviewed 29(58%) indicated having had only 1 sexual partner in the last one year. While 13 (26%) indicated having had 2 sexual partners in the last 12 months ,while 5 (10%) indicated having had 3 sexual partners in the last 12 month and 2 (4%) indicated having had 4 sexual partners in the last 12 months .

Table 9 : Participants number of sexual partners in last 12 months

	Frequency	Percent	Valid Percent	Cumulative Percent
1	29	58.0	58.0	58.0
2	14	28.0	28.0	86.0
3	5	10.0	10.0	96.0
4	2	4.0	4.0	100.0
Total	50	100.0	100.0	

Participants were asked to clarify if they had had sexual intercourse with any another man other than their regular intimate partner or husband in the last 12 months to which 24 (48%) said they had not had sexual inter course with any man other than their intimate partner however 26 (52%) said they had had sex with another intimate partner other than their regular partner.

Participants were also asked if their regular intimate partner or husband had other intimate partners apart from themselves. The study found that 41 (81%) of the females said that their partner had other sexual intimate partners. Only 3 (6%) said their regular intimate partner had no other intimate partner apart from them. The remaining 6 (12%) however said that they did not know if their regular intimate partners had other intimate partners apart from themselves.

Table 10 : Participants husband/partner have other intimate partners

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	41	82.0	82.0	82.0
No	3	6.0	6.0	88.0
Do not know	6	12.0	12.0	100.0
Total	50	100.0	100.0	

Participants were asked questions on condom use with their regular sexual partner or husband, 29 (58%) the females indicated they have never used condoms with their regular intimate partner while 21 (42%) said they had used condoms before with their regular intimate partner.

Participants were asked further if they ever discussed condom use with their regular intimate partner and 27 (54%) of the 50 participants indicated never having discussed condom use with the intimate regular partner while 23 (46%) said they had.

Participants were also asked questions regarding having discussed HIV/AIDS with their regular intimate partner or husband in the last 12 month and 11 (22%) indicated they have never discussed HIV/AIDS with their regular partner while 39 (78%) of the participants said they have discussed HIV/AIDS with their partner before. Participants were also asked if they thought that a man should be faith full to their partner. Only 1 (2%) of the 50 participants interviewed did not believe that a man should be faithful while the rest 49 (98%) females interviewed believed that a man should be faithful to his wife.

4.10 HIV risk perception vulnerability

Participants were asked who they thought was at risk of HIV infection. Commercial sex workers and People with more than 1 intimate partner were perceived equally as being at risk by 49 (98%) of females interviewed, while both sexually active men and married

women were equally perceived to being at risk by 46 (96%) of the participants. Women were scored by 40 (80 %) as being at high risk for HIV infection.

Self-perception on HIV risk

Table 11: Participants self-perception on chance of being infected with HIV.

	Frequency	Percent	Valid Percent	Cumulative Percent
No chance	9	18.0	18.0	18.0
Small chance	12	24.0	24.0	42.0
Good chance	25	50.0	50.0	92.0
don't know	4	8.0	8.0	100.0
Total	50	100.0	100.0	

Participants were also asked questions on their self-risk perception on HIV. Of the 50 women interviewed 9 (18%) thought there was no chance of them being HIV positive, while 12 (24%) said there was only a small chance that they would be HIV positive. However 25 (50%) participants indicated there is a good chance that they could be infected with HIV while 4 (8%) participants said that they didn't know if they could be infected.

Participants were further asked if they thought that they were at risk of HIV infection of which 41(82%) said yes, while 9(18%) said no. Participants were asked questions to assess if they thought that their experience of intimate partner violence increased their risk to HIV infection 42 (84%) indicated yes while 8 (16%) indicated No. Participants were asked if they were doing something to prevent HIV infection and only 24 (48 %) indicated yes while the remaining 26 (52%) said they were not doing anything to prevent HIV infection.

4.11 Summary

This chapter presented the findings of the research study on the participant's demographic characteristics, marriages and cohabiting relationships and also presented findings on level of knowledge and awareness of GBV and HIV/AIDS among participants. The chapter also presented finding on condom use and participants personal experience with GBV.

CHAPTER 5 - DISCUSION OF FINDINGS

5.1 Introduction

This chapter of discusses the finding so of the study and relates these to other studies**.**

5.2 Discussion of findings

The females interviewed for this study were found to be between the age of 18 and 48 years old with the majority 40% being in the age group between 29 and 38 years old. Majority of participants interviewed 96% had some form of education. These findings agree with findings from the Millennium progress report that shows that Zambia is on course in achieving MDG3 target 3.A. (United Nations, 2011) Millennium development Goal number 3 to promote gender equity by eliminating disparities in primary and secondary school education by 2015 shows that the ratio of girls to boys in primary school education is at 0.96 and it is hoped that come 2015 this target will have been achieved. The study found that majority 46% of the females had gone up to secondary level education while a few 24%, had higher than secondary education. This finding on the education level of women agrees with the Zambia health demographic survey which shows that even though there is a high level of primary school education there are a low proportion of females who complete secondary school education. A study done by Crackers in 2008 was able to show that women with low level education of primary and less had 2-5 fold increased risk of intimate partner violence compared to higher education women. Even though this study cannot conclusively relate level of education to increased risk of Gender based violence the study is able to show that among the women in this study education level was above primary school was at 70%. These findings relate more to a study done by Flake, 2005 that showed that women who had higher level of education were actually more at risk to experience intimate partner violence.

While the majority of females 60 % were not economically dependent on their intimate partners or husbands a good number were dependent on their partner 24%.

The study showed that the majority of participants 98 % had children and that the females interviewed were either married or living with a man as if married while some had been in previous relationships. This agreed with the findings that showed only 38% of participants were actually living together with their intimate partner while the majority of participants were not living together with their intimate partner. However this could also have been due to the fact that participants selected for this study were those that had taken the step of self-reporting GBV by an intimate partner at the YWCA.

The study found that 98% of females were able to associate intimate partner violence as Gender based violence. This high level of knowledge of Gender based violence could also have been attributed to the fact that these females had sort help at YWCA and were actually sensitizes to Gender based violence. It would be interesting to investigate further within the general community on levels of awareness on GBV Interestingly with such high levels of awareness of Gender Based Violence only 38% of the females interviewed felt that violence between a man and his wife was a private matter. This resonates well with cultural beliefs that women are taught not to disclose physical abuse by their husbands and expected to keep matters of Gender based violence quiet. (Africa News, 2011) and agrees with the South African human rights watch (2004) reports that "Many women and girls do not report rape or sexual coercion by intimate partner; because they believe that a husband or boyfriend has a right to demand sex". Having said that the results also showed that the majority of females 62% felt Gender based violence between a man and a woman was not a private affair with the majority of females interviewed 92% saying that men who beat their wife or partners were actually breaking the law. The high levels of awareness of GBV would explain the step taken by these females in reporting their own experience with Gender based violence while on the other hand one would argue that these females were sensitizes to Gender Based Violence by their mere reporting of it and would therefore make them against GBV. The study also showed that the majority of females interviewed 90 % felt that gender based violence was a serious problem in Zambia.

Participant's personal experiences with Gender based violence showed majority of the females interviewed 88% indicating their partners or husbands having deliberately deprived them of economic or financial resources. Even though the majority of females 60% said they were not economically dependent on their partners the reality of the situation is that very few had higher than secondary school education implying that their economic power would be equally affected. Millennium development goal number 3 target to promote gender equity by increasing the share of women in wage employment compared to men shows that this target as at 2011 is sadly only at 0.34 (United nations, 2011) .The report states that the majority of females are actually in informal sector . (ZDHS, 2007) In comparison to a man, a women's earning power is usually low and therefore even though the woman maybe in formal employment her individual earnings may not be enough to give the much needed financial and resources independence. This agrees well with the study's findings that in spite of 60% of the females not being economically dependents on their partner or Husband a surprising 88% of them felt that they were deliberately economically or financially deprived by their partner or husband. Culturally partner economic and resources deprivation may also be an issue of power in the home where even though the woman is in formal employment her earnings may not be hers but her husbands.

A woman may at times be unable to perform her marital sexual duties expected by husband due to a number of reasons some of which include her biological bodily changes or indeed emotional changes. It was interesting to note that 62 % of females interviewed said their partners would use force to have sex with them and 80 %, indicating that their partner would insist on having sex in spite of their refusal to have sex. The results show how vulnerable females are to spousal sexual abuse. These results agree with Heisel et al (1999), that violence contributes towards a woman's vulnerability to HIV infection mainly by physical abuse by intimate partner and by sexual coercion by intimate partner.
This also takes away a woman's ability to negotiate safer sex practices.

While the majority of females interviewed said there was no justification for a man to beat his wife or girlfriend a few females seemed to agree that sometimes a man is justified for beating his wife when certain expectations are not met interesting the majority of females

interviewed 36% agreed more with the opinion that a man is justified for beating his wife for refusing to have sex. Again the results seem to suggest that women are dis-empowered regarding when to have sex and the man is the one who holds this strength. Studies have shown that acceptance of violence of GBV (by either females or males) tend to show an increased association to intimate partner (Johnson K B, Das MB ,2009) however this study only found that 36% of women who had experienced GBV felt that intimate partner GBV for no reason was justified.

The study also showed very high prevalence of intimate partner or husband verbal abuse, 98% of the females interviewed .Verbal abuse usually has the effects of humiliating the victim and making them feel less human. When experienced from an intimate partner this could have the negative effects of reduced self-worth perception or can trigger feelings of being unappreciated therefore fostering seeking of attention from elsewhere.

All the participants interviewed had experience physical abuse by their intimate partners in the last 12 months and the frequency of their beatings ranged from 1 to more 4 times in the last 12 months. The majority 68% of females indicated having experienced beatings by their intimate partner more than 4 times in the last 12 months. Even though some participants indicated fewer incidences of GBV in the last year more could have actually occurred however due to the cultural norms that females are taught to keep their experiences with GBV as a personal affair between a man and a woman , some case of GBV go unreported while the frequency may be underreported as the victim may have feelings of shame for having been beaten or indeed may feel that they themselves provoked the situation of violence and therefore justify the GBV on behalf of the perpetrator.

The study found that the majority of females were beaten by their partner for the reason that they argued with their intimate partner or husband or when their partner felt jealous 68%. Refusing to have sex and when the partner has another girlfriend was another reason cited for experiencing GBV. Both these two reasons however are closely linked with the first 2 reasons. From this study it is clear that arguments ensue when sex is denied or when a man feels jealous. This clearly shows how complex the reason for GBV may be and how

intertwined. Only 6% of the females interviewed indicated the reason for having experience GBV by their partner was due to alcohol abuse by their partner. Although a number of studies have been able to show that alcohol abuse has a strong relationship to GBV for example (Test, cited in WHO, 2010) this was not so in this study which could not.

The study also showed that 70% of participants felt forced to have sex with their partner in the past for fear of violence this figures agree with a study done by Claimant et al and (Claimant and Gimbals cited in Haddock et al 2008) who showed that 44% of women feared violence to suggest condom use to their partner . This agrees with the fact that sexual cohesion exists in different forms including being forced to have sex for fear of violence or being beaten.

The study showed that most females interviewed were not aware of the health services for post exposure prophylaxis that a woman can get for a health facility when faced with GBV involving sexual abuse. Only 36 % of the females correctly indicated that they would be able to get PEP services from health facilities. This low level of awareness among the females interviewed raises concern about the integration of GBV support services with HIV/AIDS education in institutions of support for GBV for vulnerable women to empower women with the knowledge they need when faced with these situations. The study showed that the females interviewed had a good understanding for source of support when faced with Gender based violence. The study also showed that the females interviewed were all well informed about where they would seek help when faced with Gender based violence. The majority 88% of them said they would go to the local police victim support unit. The fact that the majority associated the local police victim support unit with a place for help indicates the need for these places to have integrated services on GBV and HIV/AIDS for victims of GBV. Other females interviewed were able to associate the Young Women Christian Association with support for GBV yet none could associate GBV support with other Non-governmental organization. This could be because the study was conducted at the YWCA and therefore it was easier for participants to associate the YWCA with support for GBV. Having said that it also important to mention that organizations that support women in responding to GBV need to strengthen awareness of their services with the

general education campaigns and media awareness programs. This also applies to awareness of the legal statuses that protect women against violence. The Anti-Gender Based Violence Act No. 1 of 2011. Is one such very important tool that needs to be made aware of its existence and implications for offenders and victims? Knowing that there is a law that protects women would help women in Zambia to understand the gravity of GBV and also sends a clear message that GBV does break the law. Only 40% of participants had knowledge of this very important Act. This further enforces the need for to integrate GBV support services with HIV/AIDS health services.

The majority of women interviewed however were able to correctly state that GBV should be reported within 72 hours. However this finding contradicts the earlier findings on the knowledge levels on Post Exposure Prophylaxis. Post exposure prophylaxis of HIV is usually administered within 72 hours of the incident and reporting GBV within this time frame ensure that the victim is assessed for PEP and intervention is administered timely for PEP to be effective. From this study it clearly shows that there is need to integrating HIV/AIDS services with GBV support services with the low level of knowledge on health facility support on PEP and GBV.

According to the progress report on the millennium development goals (United nations 2011) Zambia targeted to reduce national prevalence rate of HIV to below 15% by the year 2015. This target has already been achieved and now the focus remains to reduce the number of new infections and as more and more people are able to live longer with the introduction of antiretroviral treatments. Having said that it is important to note that one of the key instruments in reducing new infections of HIV is by continued education on HIV/AIDS. The study showed a very high level of knowledge on existence of HIV and AIDS among the females interviewed 98% and also agrees with the ZDHS survey 2007.

All the 50 females from the study were able to identify correctly the major mode of HIV transmission as unprotected sexual intercourse with an HIV infected partner. The results are consistent with the Zambian health demographic survey findings 2007. However with other modes of HIV infection transmission such as mosquito bites only 76% indicated it

was not possible to transmit HIV infection through this mode. There is need therefore to continue HIV/AIDS transmission education to dispel some of these misconceptions on HIV transmission. Another misconception that was noted from the study was that regarding the availability of a cure for HIV/AIDS. 12 % of the females interviewed believed there was a cure for HIV. Antiretroviral treatment for HIV though being available for management of HIV infections should not be misconceived as being a cure for HIV/AIDS.

As part of the millennium development goes on reducing HIV transmission among women the current Zambian guideline on the Prevention of Mother to Child guidelines on HIV indicate that every pregnant woman should be offered an HIV test to prevent HIV transmission among new born babies. The study found that 94 % of the females that were interviewed have had an HIV test in the past. This also agrees with the Zambia health demographic studies 2007 that shows that the majority of women have had and HIV test before and also confirms that this child bearing age group of 18 year to 49 in Zambia has access to HIV testing through prevention of mother to child transmission services as part of the United nations General Assembly Special session 2001 commitment to reduce HIV transmission in women by 50 as part of the millennium goals.

The study showed that of the females interviewed the average age for sexual debut was at the age of 17; however sexual debut as early as the age of 14 was also noted. Generally in Zambia females experience their sexual intercourse much earlier than their male counterparts of the same age group. This not only exposes the girls to the possibility of more partners in their life time but the fact that they start having sex at such an early age take away their ability to negotiate safe sex and therefore increases their vulnerability to HIV. The maximum age of sexual debut was noted at 21 years of age where one would expect a girl to be more empowered on their ability to negotiate safer sex.

A good number of females 40% from the study indicated having felt forced in the past to have sex in exchange for food or drink with another man other than their regular intimate partner or husband. Again this expresses the vulnerability of women to HIV were they may feel pressurised to give in to sexual advances in exchange for financial or economic gain.

The study showed vulnerability due to economic deprivation by a regular intimate partner (86% from this study) cause women to be vulnerable to sexual cohesion and therefore the risk of HIV infection.

Interestingly the study found that there were high levels of lack of condom use among the females interviewed in the study in spite of high knowledge level on HIV transmission. 90% of females interviewed did not use a condom during their last sexual encounter in the past 12 months this agrees with study done in Kenya that showed that 97% of cohabiting or married couples did not use a condom in their last sexual encounter (Kenya Demographic Health Survey, 2003). Some females interviewed said they preferred skin to skin contact during sexual intercourse , other said they did not want their partner to think they were infected by suggesting to use condoms while other said they trusted their partners. This was interesting to note that during the same study some participants indicated that they were aware that their partner had other intimate partners yet when it came to not using condoms they justified it by saying they trusted their partner. The majority of the females from this study indicated the reason for not using condoms last time they had sex was that they were afraid to suggest condoms to their partner 33% this agrees with a study in south Africa which found that 44% of women with a history of sexual violence were more likely to fear asking their partner to use a condom (Claimant and Gimbals cited in Haddock et al 2008). Study participants were probed further if they had ever wanted to use condoms but feared to suggest this to partner at any one time in the past and 74% said they had. This agrees with the ZDHS 2007 finding which showed that only 25% of females in Zambia can actually refuse to have sex with her husband even when he was evidently unfaithful.

The responses from the participants show how complex sexuality becomes even when one is aware of the risks for HIV transmission. The study shows how the females in these abusive relationships are able to justify their lack of condom use.

The study showed that 58 % of females had indicted having only one sexual partner in the last 12 months. However when probed further and asked if they had had any other sexual partner other than their regular partner , the number of those who had had sex with only 1

partner in the last 12 months reduced to 48% . This indicates that 52% of these females in the study had more than one sexual partner in the last 12 months. Even though this may seem contradictory, the findings of the study agree with preliminary study results found by Family health international on assessing Gender and Multiple Concurrent Sexual Partnerships in Zambia in 2010. The study showed that there was need to distinguish concurrent partnerships with serial monogamous relations. Multiple partnerships may be difficult to quantify as was shown in this study.

The overall number of females with more than one sexual partner could therefore also have been be higher than that recorded as most questions of sexual nature may not be answered completely truthfully for fear of being perceived as being promiscuous.

The study also tried to establish existence of multiple partnerships among study participant's partners and found that 41 (81%) of the females said that their partner had other intimate sexual partners apart from themselves. Even though this is second hand reported information it plays a role not only as a perception or an opinion of the study participants but also in understanding the complexity of GBV and HIV transmission. According to WHO, 2004 studies done by Jewekes et al 2006, Johnson and Dad 2009, and others have shown a strong association between women's perceived infidelity and multiple sexual partnerships by their partners and intimate partner violence or sexual violence with a 1.5 to 17.1 fold estimate of greater risk (WHO, 2004). This study was therefore able to establish that 52% multiple concurrent sexual partnerships among the interviewed women existed by and that 81 % females from the study though that their regular intimate partners or husbands had other partners.

The study found that 58% of the females have never used condoms with their regular partners while 54% said they have never discussed condom with their regular sexual partner or husband. This agrees with the findings of the 1996 health demographics survey that showed that despite very high knowledge on HIV/AIDS transmission very few sexually active females and males had ever actually used condoms to prevent HIV/AIDS, pregnancy or sexually transmitted infections (ZHDS 1996). National prevalence of condom

use in 2008 was reported to be at 45.6% (UN 2011). In an effort towards the reduction of new infections to HIV the government of the republic of Zambia has undertaken to ensure that condoms are free and can be accessed easily from health facilities and NGO. Cultural norms and beliefs that prevent condom use in marriage or cohabiting couples include the view that condoms should only be used with a prostitute or that there is no place for condoms in marriage as marriage is for having children. Even though women may be willing to use condoms most are unable to suggest this to partners for various reason this results in low condom use cohabiting couples or husband and wife relationship even though multiple partnering maybe prevalent .

This study showed that more females had indicated having discussed HIV/AIDS with their partner or husband compared to those that had discussed condom use and that almost all the females interviewed believed or thought that males need to be faithful to their partners. Generally it is usually acceptable in the Zambian culture for a man to have more than one sexual partner compared to a woman.

Interestingly the study found that 78% of the females had discussed HIV/AIDs with their partner in the past, this agrees with the fact that there are high level of HIV knowledge reported by the ZHDS 2007 and 1996.

The study was able to show that commercial sex workers and people multiple sexual partners, be it male or female, were perceived to be at higher risk for HIV infection by majority of females interviewed. Surprisingly in spite of the perception expressed on high risk groups to HIV infection, some participants could not associate their own self risk perception with sexually active females with 18% of the females interviewed indication that there was no chance of them being HIV positive.

Combining the results of those who thought they have a small chance (24 %) of being HIV positive with those that said they had a good chance (50 %) gives a total of 74% of the 50 females who think they are actually HIV positive. This figure is close to the total number of Participants who thought they were at risk of HIV infection 41(82%).

When the females were probed further to associate their experience of intimate partner violence GBV to increased risk of HIV infection, 84 % of them agreed that GBV placed them more at risk to HIV infection. The study thus found high levels of self- risk perception to HIV infection among the females interviewed.

Participants were also asked if they were doing anything to protect themselves against HIV infection and 52 % of the females in this study said they were not doing anything to prevent HIV infection. This shows that in spite of high levels of self-risk perception to HIV infection almost half of the females interviewed were not doing anything to protect themselves.

5.3 Summary

The chapter discussed the study findings and relates these to findings from other studies as well as national health demographic surveys conducted on GBV and HIV.

CHAPTER 6 – CONCLUSION

6.1 Introduction

The chapter concludes the research findings and provides recommendations based on the findings.

6.2 Recommendations

Results from the study suggest that there is need to do multivariate studies to investigate further the relationship that exist between gender based violence and HIV /AIDS among women of child bearing age in Lusaka to order to understand and consolidate a comprehensive response to HIV and Gender based Violence among this population.

There is also need to integrate Gender based violence services with HIV/AIDS related services in order to have an integrated approach when dealing with women in such relationship. Integration of services should include basic HIV transmission and prevention education including condom use. Education on gender violence should also be integrated in to this basic education with focus on the laws that exist to protect women.

Pronouncements of Laws and regulations on Gender based violence also needs to be followed up with stiffer punishment to deter would be offenders. Perpetrators found breaking these laws must be brought to book irrespective of their status in society. This will give women more confidence to report cases of Gender based violence.

Advocacy and legislation on Gender based violence should be strengthen with education and awareness on the existence of the laws and organisations that are involved with gender based violence and HIV/AIDS prevention care and support programs.

Organisations such as the Young Women Christian association of Zambia that work towards addressing gender based violence and HIV/AIDS need further strengthened support and not only from the government but also internationally for expanded services.

6.3 Conclusion

The study concluded that there were high knowledge levels of HIV/AIDS transmission and high levels of awareness of gender based violence among the females interviewed for this study. Gender Based Violence increases vulnerability of women to risk of HIV infection by reducing the woman's ability to negotiate safe sex in such relationships. It was found that condom utilisation was low among women experience intimate partner violence interviewed in this study.

Concurrent and multiple sexual partnerships were prevalent among women experiencing gender based violence by an intimate partner. There were high levels of self-risk perception to HIV infection among the women interviewed. Self-risk perception to HIV infection among women in intimate partner violent relations increased when associated to personal experience with gender based violence. Support for gender based violence was associated with the local police victims support and the young women's Christian association in Lusaka. The awareness of the Anti-Gender Based violence Act no1 of 2011 of Zambia was low among women experiencing gender based violence in Lusaka. More awareness campaigns should focus at uprooting gender based violence which have a direct link to HIV infection.

REFERENCES

Abraham, N. (2004) .Sexual violence against intimate partners in Cape Town: prevalence and risk factors reported by men. *Bulletin of the World Health Organization 82(5):330-333*

American Foundation for AIDS research. (2005). Women, Sexual violence and HIV, Available from: <http://www.amfor.org>. [21 January 2011].

Bummer, D. (2002). Labour, migration and HIV/AIDS in Southern Africa. International organisation for migration.

Available from: <http://www.sarpn.org/documents/d0000587/Labour_migration_HIV-AIDS.pdf. > [20 May2011],

Carael, M. (1995). Sexual behaviour in Cleland JG, Ferry B, eds. sexual behaviour in AIDS in the developing word. London: Taylor and Francis.

CDC, (2008). 'Male latex condoms and sexually transmitted diseases', Fact sheet for public health personnel. Available from<http://www.cdc.gov/condomeffectiveness/docs/Condoms_and_STDS.pdf>. [3 January 2013]

Central bureau of Statistics, Kenya. (2003). Ministry of health Kenya and ORC macro2005, Demographic Health Survey, (2003). Calverton Maryland. Available from http://www.measuredhs.com/pubs/pdf/FR151/FR151.pdf [5 January 2013].

Crosby, R.A., DiClemente, R.F., Holtgrave, D.R., Wingood, G.M. (2002). Design measurement and analytic consideration for testing hypotheses relative to condom effectiveness against non-viral STIs. *Sex transmission infections .2002:228-31*

Dube, M. and Sachingongu, N. (2008). "Multiple and concurrent sexual partnerships in Zambia –a target Audience research report" Zambia Centre for Communications Programs.

Fernandez-Esquire M.E., Atkinson, J. and Diamond, P. (2004). Condom use self-efficacy among US and foreign born Latinos in Texas a. *J ses res 2004:41:390-9*

Flake, D.F. (2005). Individual, family, and community risk markers for domestic violence in Peru. *Violence against women, 11(3): 353-373.*

Gielen, A.C. (1997). Women's disclosure of HIV status: Experience of Mistrust and violence in an urban setting. *Women's health*, 25(3)19-31.

Global Business Coalition, (June 2007). Overview of the Feminization of HIV/AIDS in sub Saharan Africa. .

Gupta, G .R. (2000). Gender, Sexuality and HIV/AIDS: The What, the Why, and the How. Plenary Address: XIIIth International AIDS Conference.

Haddock, S., Hardee, K., Gay, J. Pawlak, J. M., and Stellini, C. (2008). Comprehensive HIV prevention; condoms and contraceptives count. Population Action international Availablefrom:<http://populationaction.org/wpcontent/uploads/2012/01/Comp_HIV_Brief.pdf [5 jan2013]

Harperin, D. and Eppstain, H. (2004). Concurrent sexual partnerships help to explain Africa's high HIV prevalence: Implications for prevention."*lancet.364 (9428):4-6*

Heisel, L., Ells and Gottemoeller, M. (1999). "Ending violence against Women." Population reports, series L.No11. [20th January 2011]

Holmese, K.K., Levin, R., Weaver, M. (2004). Effectiveness of condoms in preventing sexually transmitted infections. *World health organization report 2004; 36:534-6*

Human Rights Watch, (2004) Vol.16, No 3(A)

Human Rights Watch, (2007) Vol.19, No 18 (A) UNAIDS 2009, consultation on sexual concurrent partnerships

Availablefrom<http://www.epidem.org/Publications/Concurrency%20meeting%20recommendations_Final.pdfIbid at 156> [2 jan2013] Forced Sex and Physical violence in Brazil Peru and Thailand .WHO Multi-Country report. XI International AIDS Conference. Barcelona, Spain 2002.

Jewkes, R .K, Dunkle, K., Nduna, M. and Shai, N. (2010). "Intimate Partner Violence, Relationship Power Inequity, and Incidence of HIV Infection in Young Women in South Africa: A Cohort Study". *The Lancet 376, no. 9734, 41-48.*

Available from :< http://www.thelancet.com/journals/lancet/article/PIIS014067361060548X/abstract [5 Jan2013]

Johnson, K. B., Das, M.B. (2009) Spousal violence in Bangladesh as reported by men: Prevalence and risk factors. *Journal of interpersonal violence, 24 (6):977-995*

Available from: <http//sagepub.com/content/24/6/977> [5 Jan2013]

Kumwenda, A. (2009). The Role of Alcohol use in HIV Transmission among Grootfontein Residents in Namibia.

Limpakamjanarat, K. Maestro, T.D. Saisorns, J. (1999). HIV-1 and other sexually transmitted infections in a cohort of female sex workers in Chiang Rai. Thailand sexTransm infect.1999; 75 30-5.

Mbuleiteye, S.M. (2000). Alcohol and HIV: A case study among sexually active Adults in Rural southwest Uganda. *International Journal of Epidemiology, 29(5):911-915.*

Multiple concurrent partnerships, (2010). Availablefrom<http://www.unaidsrstesa.org/sites/default/files/multipleconcurrentpartners/MCP_Zambia-_Preliminary_Results_2010.pdf>[7 Jan 2013]

Population Action international, (2009). Factsheet "The silent partner HIV in marriage" Available from<http://www.populationaction.org/silentpartner/FactSheet Rd1.pdf > [6 Jan 2013]

Sarkar, N.N. (2008). Barriers to Condom Use" *The European Journal of Contraception and Reproductive health care June 2008; 13(2):114-122*

Stewart, H. MacCauley, A. and Baker, S. (2001). Reducing HIV infection among youth: What can schools do: key baseline findings from Mexico South Africa and Thailand? Washington DC: horizons project.

Sunmola, A.M. (2005). Sexual practices, barriers to condom use and its consistent use among long distance truck drivers in Nigeria. AIDS CARE 2005; 17; 2008-21

The Anti-Gender Based Violence Act No1 of 2011, Zambia

Times of Zambia 1 August 2012. "Reported GBV Cases Cheer YWCA",

Available from < http://www.times.co.zm/?p=7016> [4 January 2013]

Times of Zambia 2012, "PF pledges to fight GBV", 2 August 2012,

Available from < http://www.times.co.zm/?p=7152 > [4 January 2013]

The Lancet Vol 364 3 July 2004

Availeblefrom<http://www.wisdomofwhores.com/wpcontent/uploads/2010/12/Halperin-2004-concurrent.pdf > [5 Jan2013}

UNAIDSEpidemic update, 2009.

Availablefrom<http://www.unaids.org/en/Dataanalysis/Epidemiology/2009AIDSEpidemic Update/> [2 January 2013]

UNAIDS (2008). Women and HIV/AIDS: Confronting the Crisis. UNAIDS, UNFPA

United Nations. (2011). Millennium development goals progress report 2011. Ministry of Finance and National Planning. Zambia

Phiri, M. (2011). "Gender based violence surges in Zambia" 23 November 2011 Africa News.

Available from <.http://www.africanews.com/site/list_message/363484> [5 January 2013]

UNAIDS, (2004). Women and HIV/AIDS: Confronting the Crisis. UNAIDS, UNFPA and UNIFEM.

UNAIDS, (2011). General population survey. Available from <http://www.measuredhs.com/hivdata/ind_tbl.cfm.> [8 Jan 2013]

UNAIDS (2008). Report on the global AIDS Epidemic Geneva

The Global Coalition on Women and AIDS (2007). Stop Violence against Women Fight AIDS, Issue 2, 2007.

United Nations general assembly 85th plenary meeting, (1993). Declaration on the elimination of Violence against women.

Available from. <http://www.un.org/documents/ga/res/48/a48r104.htm.> [23 may 2011]

USAID/Synergy, (2004). Women's experiences with HIV sero-discloser in Africa: implications for VCT and PMTCT meeting Report. Washington, DC: USAID.

USAID/Zambia Gender-Based Violence Programming Evaluation, (2010). USAID - A Safer Zambia (ASAZA) Program: CDC - Child Sexual Abuse (CSA) & ZANELIC Programs.

World health Organization, (2002). World report on Violence and health .Geneva: World health organisation.

World health Organisation /London School of hygiene and tropical medicine, (2010). Preventing intimate partner and sexual violence against women: taking action and generating evidence. Geneva, Wold health Organisation.

World health Organization, (2002). World report on Violence and health .Geneva: World health organisation.

Available from <http://www.unfpa.org/hiv/women/docs/women_aids.pdf> [22 May 2011]

Varga, C.A. (1997). Sexual decision –making and negotiation in the Mist of AIDS: youth in kwazaulu Natal South Africa. *Health Transition review, supplement 3 to Vol 7, 199, 45-67*

Zambia health and demographic survey report, (2007).

Available from <http://www.measuredhs.com/pubs/pdf/FR211/FR211%5Brevised-05-12-2009%5D.pdf> [22 May2011]

Zambia Ministry of Health, Central Statistical Office and Macro International (1997). *Zambia Demographic and Health Survey, 1996*, Calverton, MD: Macro International.

APPENDIX 1: QUESTIONNAIR USED TO COLLECT DATA

Interviewer Administered Questionnaire for Sexually active Females aged 18-49 years in Lusaka, Zambia.

My name is Bridget Chatora. I am a Biomedical Scientist by profession, working for the Zambia prevention care and Treatment partnership project at the same time; I am pursing Master of Philosophy (HIV/AIDS Management) with the University of Stellenbosch in South Africa. As part of my school work, I am interviewing women that have reported gender based violence to the YWCA in Lusaka to enable me gather information about women's knowledge attitudes, sexual behaviour and practices related to HIV/AIDS in relation to gender based violence. This research project is designed to look at the link between gender based violence against women and the risk of HIV transmission in our town of Lusaka.
The results of this study will help to understand the vulnerability and risks towards HIV/AIDS that women who experience gender based violence are exposed to.

If you agree to participate in the study, I will ask you some personal questions which some people may find difficult or uncomfortable to answer. Your honest answers are very important so that the needs of women like you are known with regards to dealing with gender based violence and HIV/AIDS in Lusaka. Anything you say will be completely confidential. Your name will not be written on this form, and your name will never be used in connection with any of the information you give me.

You do not have to answer any Question you don't want to answer (I will skip that question and continue with the following questions), and you can end this interview any time you want. I would greatly appreciate your help in responding to this interview. The interview will take about 40 minutes. Would you be willing to participate?
Again, your name will not be connected to this questionnaire.

……
……
Signature of interviewer certifying that informed consent has been given verbally

Respondent agrees to be interviewed ….1
Respondent does not agree to be interviewed…2

Questionnaire identification number: ……

Date of interview:…….

Location:…….....

Language of interview: …….....

Home language of **Respondent**……

Start time:…….

End time:……...

Was translator used? Yes=1, No=2

Section 1: Background information (Tick the appropriate response)			
First I would like to ask some questions about you.			
Q 001	sex of the respondent	Male ☐ Female ☐	Skip to
Q 002	In what Month and year where you born?	Month …… …… Don't know …… ……☐ Year …… …… Don't know …… ……☐	
Q 003	How old were you on your last birthday?	Age in completed years ……	
Q 004	Have you ever attended school?	Yes ☐ No ☐ No response ☐	
Q 005	What is the highest level of school you have attended: primary, secondary, Higher?	Primary ☐ Secondary ☐ Higher ☐	
Q 006	Are you working to earn a living?	Yes ☐ No ☐	

		No response ☐	
Q 007	What has been your source of income in the past 12 months?	Unemployed ☐ Self-employed ☐ Employed ☐ Dependant on partner ☐ Dependant on other ☐	
Section: 2 marriage , family and Cohabiting partnership			
Now I would like to ask you some general questions about marriage and live-in partnerships			
Q 008	Are you currently married or living with a man as if married?	Yes, currently Married ☐ Yes ,currently living with a man ☐ No, Not in Union ☐ No response ☐	skip 011 skip 011
Q 009	Have you ever been married or lived with a man as if married	Yes, formally Married ☐ Yes , lived with a man ☐ No, ☐ No response ☐	
Q 010	What is your current marital status now	Divorced ☐ Widowed ☐	

		Separated ☐	
Q 011	Is your husband /partner living with you now or he is staying elsewhere?	Yes, living together ☐ No , living elsewhere ☐ No response ☐	
Q 012	Have you had an intimate boyfriend in the last 12 months?	Yes ☐ No ☐ No response ☐	
Q 013	Does your husband /partner /boyfriend have other intimate partners?	Yes ☐ No ☐ Don't know ☐ No response ☐	
Q 014	How many children do you have?	Non ☐ (Number)…… ……..	
Section 3 Gender based violence abuse.			
READ OUT: The next questions are about gender based violence against women and your experience with intimate partner violence in the past year. I am going to ask some specific questions about sex and your personal experience and beliefs with gender based violence in the last 12 months. I know it may be difficult to remember exactly, but I would like you to answer the questions to the best of your knowledge, as this information is very important for the survey. Again, this information is all completely private and anonymous and cannot be linked to you or any partner in any way			
Q 015	Have you ever heard of gender based violence?	Yes ☐ No ☐ No response	

		☐	
Q 016	Do you think that violence between a man and women is a private affair?	Yes ☐ No ☐ No response ☐	
Q 017	Do you think that domestic violence is a serious problem in Zambia?	Yes ☐ No ☐ No response ☐	
Q 018	Do you think that when a man hits his wife he is breaking the law even if she is his wife?	Yes ☐ No ☐ No response ☐	
Q 019	Does /did your partner deliberately deprive you of economic or financial resources?	Yes ☐ No ☐ No response ☐	
Q 020	In the past 12 months, has your partner reacted in any of the following ways when you refuse to have sex with him?	He threatens to go and have sex with other women, ☐ He threatens to beat you ☐ He uses force to have sex ☐ He does not insist ☐ No response ☐	
Q 021	In your opinion Do you think a man who beats his wife or girlfriend for the	Yes NO No.Res	

	following reasons is justified?	1. No reason at all ☐ ☐ ☐ 2. Neglecting children /home ☐ ☐ ☐ 3. When he is drunk ☐ ☐ ☐ 4. Argues with him ☐ ☐ ☐ 5. Burning not cooking food ☐ ☐ ☐ 6. Refusing to have Sex ☐ ☐ ☐ 7. Goes out without permission ☐ ☐ ☐ 8. When he is jealous ☐ ☐ ☐ 9. When he has a girlfriend ☐ ☐ ☐ 10. Misuse of home finances ☐ ☐ ☐	
Q 022	In the past 12 months, has your partner said things to you that made you feel insulted, less human (degrading things) or humiliated?	Yes ☐ No ☐ No response ☐	
Q 023	Have you ever been beaten by your intimate partner in the past year?	Yes ☐ No ☐ No response ☐	
Q 024	IF YES : How often?	1 time ☐ 2 times ☐ 3 times	

		☐ More than 4 times ☐	
Q 025	What was the reason for your partner /husband beating /hitting you?	Yes NO No.Res 1. No reason at all ☐ ☐ ☐ 2. Neglecting children /home ☐ ☐ ☐ 3. Burning /not cooking Food ☐ ☐ ☐ 4. For arguing with him ☐ ☐ ☐ 5. When he is drunk ☐ ☐ ☐ 6. For refusing Sex ☐ ☐ ☐ 7. Going out without permission ☐ ☐ ☐ 8. When he has a Girlfriend ☐ ☐ ☐ 9. When he is jealous ☐ ☐ ☐ 10. Misuse of home Finances ☐ ☐ ☐	
Q 026	Have you ever felt forced to have sex with your intimate partner for fear of violence?	Yes ☐ No ☐ No response ☐	
Q 027	Have you ever felt loved after experiencing intimate partner	Yes ☐	

	violence?	No ☐ No response ☐	
Q 028	Have you ever felt that you needed to leave your partner because of violence abuse?	Yes ☐ No ☐ No response ☐	
Q 029	What made you stay with your partner in spite of the abuse?	1.Nowhere to go ☐ 2.Did not want to leave my children ☐ 3.Was afraid to do so ☐ 4.Was afraid of the violence ☐ 5.No income to support myself ☐ 6.He would stop child support ☐ 7.Other ☐	
Q 030	Have you ever reported gender based violence against your partner in the past year?	Yes ☐ No ☐ No response ☐	
Q 031	Do you know the type of help you can get from a health facility when you are raped?	Post Exposure Prophylaxis & Emergency planning pills ☐ Loan facility ☐ Don't know ☐	
Understanding the sources of support for survivors of GBV?			

Q 032	Where would you go to seek help if faced with a situation of gender based violence?	The victim support at local police ☐ YWCA ☐ Other NGO (name) ☐ Do not know where to go ☐ No response ☐	
Q 033	Do you know the law that protects women from GBV?	The Anti-Gender Based Violence Act No. 1 of 2011 ☐ The Fifth National Development Plan ☐ Don't know ☐	
Q 034	Do you know the time frame within which to report GBV?	Within 72 hours ☐ Within 1 week ☐ Don't Know ☐	
Section 5 HIV/AIDS sexual behaviour			
READ OUT: I am going to ask some specific questions about HIV/AIDS, sex and your sexual partners in the last 12 months. I know it may be difficult to remember exactly, but I would like you to answer the questions to the best of your knowledge, as this information is very important for the survey. Again, this information is all completely private and anonymous and cannot be linked to you or any partner in any way.			
Q 035	Have you ever heard of HIV or AIDS?	Yes ☐ No ☐ No response ☐	
Q 036	Do you think HIV/AIDS exists?	Yes ☐ No	

		☐ No response ☐	
Q 037	Can a person get infected with HIV in the following situations?	Yes NO No.Resp 1. unprotected sex with an HIV infected person ☐ ☐ ☐ 2. An infected mother To unborn child ☐ ☐ ☐ 3. By blood transfusion contaminated with HIV ☐ ☐ ☐ 4. By Using HIV contaminated Razors ☐ ☐ ☐ 5. by mosquito bite ☐ ☐ ☐ 6.Sharing food/drink with an HIV infected person ☐ ☐ ☐	
Q 038	Do you think HIV AIDS can be cured?	Yes ☐ No ☐ No response ☐	
Q 039	Please do not tell me your results but have you ever had an HIV test before?	Yes ☐ No ☐ No response ☐	
Q 040	Have you ever had sexual intercourse before? For the purposes of this survey sexual intercourse is defined as vaginal, anal or oral sex.	Yes ☐ No ☐ No response ☐	
Q 041	At what age did you first have sexual intercourse?	Yes	

		☐ No ☐ No response ☐	
Q 042	Have you ever felt forced to have sex in exchange for food or drink with any man other than your partner?	Yes ☐ No ☐ No response ☐	
Q 043	In the past 12 months, has your partner deliberately deprived you of economic or financial resources?	Yes ☐ No ☐ No response ☐	
Q 044	Last time you had sexual intercourse did you use a condom?	Yes ☐ No ☐ No response ☐	
Q 045	IF YES What is your reason for using a condom?	Wanted to prevent HIV ☐ Wanted to prevent pregnancy ☐ Partner in ☐ Did not trust partner / he has other partners ☐ Don't know ☐	
Q 046	IF NO What is your reason for NOT using a condom?	I trust my partner ☐ Afraid to suggest condom use to partner ☐ I prefer skin to skin ☐ Partner may think I am HIV positive ☐	

		Partner may think I I have other partners positive ☐ Condoms were not available ☐	
Q 047	Have you ever wanted to use condoms but felt afraid to suggest this with your partner?	Yes ☐ No ☐ No response ☐	
Q 048	IF YES : What was the reason for your fear?	…… …… …… …… …… ……	
Q 049	How many sexual partners have you had in the last 12 months?	…… …… …… ……	
Q 050	Apart from your intimate partner have you ever had sex with any other man in the last 12 months?	Yes ☐ No ☐ No response ☐	
Q 051	Have you ever used condom with your intimate partner?	Yes ☐ No ☐ No response ☐	
Q 052	Have you ever discussed condom use with your intimate partner?	Yes ☐ No ☐ No response	

		☐	
Q 053	Have you ever discussed HIV/AIDS with your regular partner?	Yes ☐ No ☐ No response ☐	
Q 054	Do you think a man should be faithful to his partner?	Yes ☐ No ☐ No response ☐	
Section 5: HIV risk perception and vulnerability			
Q 055	Who according to you do you think is at risk of HIV infection?	Yes NO No.Res 1.Commercial sex workers ☐ ☐ ☐ 2.People with more than 1 intimate partner ☐ ☐ ☐ 3 Married women ☐ ☐ ☐ 4.Sexually active Men ☐ ☐ ☐ 5.Women ☐ ☐ ☐ Other ☐ ☐ ☐	
Q 056	What according to you are the chances that you could be infected with HIV?	No chance ☐ Small chance ☐ Good chance ☐ Don't know ☐ No response ☐	

Q 057	Do you think that you are at risk of HIV infection?	Yes ☐ No ☐ No response ☐	
Q 058	Do you think that your experience of intimate partner violence increases your risk to HIV infection?	Yes ☐ No ☐ No response ☐	
Q 059	Is there anything you are doing to prevent HIV infection?	Yes ☐ No ☐ No response ☐	
Q 060	How does your partner react when you ask him to use a condom when having sex? •	He gets offended and thinks you are suspecting him of being unfaithful ☐ He complies ☐ He insists on having sex without a condom☐	

This is the end of the interview. Thank you very much for taking time to answer these questions.